EFFECTS OF NONDIRECTIVE AND PARADOXICAL THERAPIST COMMUNICATION
ON CORE THERAPEUTIC CONDITIONS AND PERCEIVED CLIENT INFLUENCE

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Paradoxical techniques in therapy have recently become popular in the treatment of a variety of problems and across theoretical orientations. This increase in the use of paradox has taken place in the absence of much experimental research. While proponents have expressed much enthusiasm for its clinical utilization, most reports as to its success have been anecdotal in nature. In addition, critics have suggested that paradoxical techniques contain low levels of core therapeutic conditions and therefore do not make the best use of the therapeutic relationship.

The purpose of this study was first to determine whether or not paradoxical communication could be designed to contain therapeutic levels of the core therapeutic conditions, and, second, to determine how paradoxical counselor communication compared to nondirective communication on the social influence dimensions of attractiveness, expertness, and trustworthiness.

For the first phase, four judges rated audiotapes on the level of the core therapeutic conditions on one of four counseling conditions (paradox high or low on core conditions, and nondirective high or low on core conditions). For the
second phase, 133 undergraduate college students were asked to listen to the four counseling conditions on audiotapes and to rate the counselor on the social influence dimensions.

Results indicated that paradoxical injunctions may be designed to reflect high levels of the core conditions of empathy and warmth, although nondirective counselor communication was rated as significantly higher on the empathy dimension. The genuineness dimension failed to statistically differentiate the four conditions. On the social influence dimensions those counselor communications with high levels of empathy and warmth were rated as more attractive, trustworthy, and expert than counselor communications with low levels of the core conditions. In addition, the expert dimension was also differentiated on the basis of technique. Paradoxical counselor communication was rated as significantly more expert than nondirective communication. Criticisms of paradoxical interventions and implications for therapy were addressed.
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During the past two decades two theories of counseling emerged by which new and existing counseling orientations have been empirically compared for gauging their potential utility for therapy. The first and oldest theory was that developed by Rogers (1957) and his colleagues (Truax, 1961; Truax & Carkhuff, 1967; Truax & Mitchell, 1971). Rogers (1957) believes that the core therapeutic conditions of empathy, warmth, and genuineness must be present at a high level in counselor communication for client change to occur. A decade of research followed this conclusion, indicating that Rogers' postulated conditions were related to therapeutic outcome (Truax & Mitchell, 1971). Research comparing different therapies on these core therapeutic conditions has become commonplace.

A second and also prominent theory of counseling was developed by Strong (1968). He believes that counseling is a social influence process in which the way the counselor is perceived facilitates the client's involvement in therapy, and thus, the client's ultimate potential for change. Strong (1968) believes that the characteristics of attractiveness, expertness, and trustworthiness are the three central criteria which a client perceives in determining
his/her degree of involvement in therapy. While research continues on these dimensions, it appears that they are influential in determining counselor involvement in therapy (Corrigan, Dell, Lewis, & Schmidt, 1980).

In the past several years the core therapeutic conditions of the client-centered approach (Rogers, 1957) and the dimensions of the social influence theory (Strong, 1968) were compared with a number of therapies and methods. Among these were psychodynamic, behavioristic, and client-centered counseling (Fischer, Paveza, Kickertz, Hubbard, & Grayston, 1975); client-centered, behavioristic, and rational emotive counseling (LaCrosse, 1977); directive counseling (Atkinson & Maruyama, 1978; Heilburn, 1974); nondirective counseling (Halpern, 1977; Hayden, 1975; Scheid, 1976); and leading and continuing responses (Ehrlich, D'Augelli, & Danish, 1979), to name a few. In spite of the apparent abundance of research, Corrigan et al. (1980) recommended further studies in order to better understand how the interviewer's theoretical orientation affects a client's perception of the counselor. This distinction is especially needed on newer, little researched therapeutic interventions.

One such therapeutic technique that has gained popularity but is backed by little research is a special class of behavioristic, directive interventions referred to as paradox. Like traditional behaviorists, proponents of paradoxical techniques (Andolfi, 1967; Haley, 1976; Watzlawick, Beavin,
& Jackson, 1967) believe that directive therapist intervention is essential for behavior change to occur. Unlike traditional behaviorists who actively encourage a client to engage in new behaviors which appear to counter his/her current problematic behavior, these paradoxical proponents encourage the client to maintain or even intensify current problem behaviors in order to ultimately change them. Therein lies the paradox: the client comes to therapy to diminish or change problem behaviors and is, instead, encouraged to maintain these behaviors. The popularity of this technique has largely developed without the support of experimental research. Comparative research between paradoxical techniques and other well-researched therapeutic interventions is especially lacking.

**Paradox in Therapy**

Within the past several years the use of paradoxical interventions as an alternative class of counselor directives increased greatly (Andolfi, 1967; Farrelly, 1974; Haley, 1976; Jackson & Bodin, 1968; Selvini-Palazzoli, 1975; Soper & L'Abate, 1977). This class of counselor directives encourages and prescribes a client's current symptomatic behavior rather than promoting alternative behaviors. These directives exert influence in a direction opposite that of desired client change instead of directly attempting to change the symptomatic behavior (Dell, 1981; Soper & L'Abate, 1977; Weeks & L'Abate, 1978). The intervention contradicts
the typical nature of counselor instruction in a behaviorally-oriented counseling relationship in which the counselor enlists client participation to make substantive changes away from the symptomatic behavior (Lopez, 1980).

In their seminal work on human communication, Watzlawick, Beavin, and Jackson (1967) define a paradox as "a contradiction that follows a correct deduction from consistent premises" (p. 188). It stands as a form of verbal communication that appears to directly contradict the metacommunication between counselor and client. The therapist utilizes the amplification of a deviation (symptom) in order to ultimately reduce or eliminate unwanted behaviors (Watzlawick, 1981). This method of behavior change rests on the premise that a client's present problems have been maintained because of the solutions attempted. The attempted solution, then, becomes the problem.

A number of paradoxical methods have been developed. Fisher, Anderson, and Jones (1981) reported three types of paradoxical interventions: (1) redefining symptoms; (2) escalating symptoms; and (3) redirecting symptoms. Redefinition is "an attempt to alter the apparent meaning or interpretation the family (or individual) places on the symptomatic behavior" (p. 28). Redefinition is also referred to as reframing and is recommended for clients with some capacity for reflection and insight. This method of paradox makes no attempt to change or alter the symptomatic behavior.
but redefines or reframes this behavior in a more favorable light. When the "negative" behavior is redefined as a more positive, helpful behavior, its repeated occurrence is often made unnecessary (Fisher et al., 1981). Watzlawick, Weakland, and Fisch (1974) identified over ten types of relabeling useful for therapeutic practice.

A second type of paradox identified by Fisher et al. (1981) is that of escalation or crisis induction. Two types of escalation have been identified. The first is similar to the learning theory principle of massed practice. By directing the client to increase in number or intensity the problem behavior, the symptoms are inadvertently put under voluntary control, thereby taking the response out of unconscious, involuntary control. Frankl's (1967) early work on stuttering is a good example of this technique. By having the stutterer increase stuttering behavior during times of stress, the problem behavior becomes conscious and under the control of the client. Over time, problem behavior yields to this voluntary control and dissipates as a symptom.

A second type of escalation is particularly useful with highly resistant or oppositional behavior (Fisher et al., 1981). Such escalation aims at increasing in intensity or frequency certain aspects of a therapeutic situation by provoking a crisis in order to ultimately reduce rigidity and force a decision or action from a client to encourage change. In the use of escalation, the therapist directs the
client to engage in behavior that will intensify to a crucial point. For example, a family was having continual difficulty with its adolescent girl's behavior while covertly encouraging the problematic behavior. Efforts to redefine, support, or redirect the family in therapy had failed. The family was encouraged to look for foster placement for the girl and was given a list of possible foster homes. A week later the family returned, reporting hours of family discussion, reduced family tension, and a decision to keep the family intact. The girl's behavior improved markedly (Fisher et al., 1981).

The final paradoxical technique reviewed by Fisher et al. (1981) is that of redirection, similar to symptom escalation. In redirection the symptom frequency is not altered, but the circumstances under which the symptom occurs are prescribed. Watzlawick et al. (1967) reported that patients with debilitating psychogenic pain were asked to shift the pain in time to a specified time each day. They were warned that the pain might be greater and that they might, in fact, feel worse during this specified time. The patients soon realized, however, that they had some control over the pain and that it need not be debilitating.

L'Abate and Weeks (1978) further described the use of paradox on a number of dimensions, though the kinds of paradox were essentially the same as those described by Fisher et al. (1981). L'Abate and Weeks (1978) suggested
that paradox can be used for individuals or in systems (transactions or relationships). They also suggested that paradox may be prescriptive, in which case the symptom is encouraged, or descriptive, in which case fantasy may be used to simulate a potentially dangerous symptom behavior; and time-bound, in which case the occurrence of some event is to happen at a specified time, or time-random, in which case an event may be suggested to happen at any time. The authors concluded that the kinds and uses of paradox are ultimately limited only by the imagination of the therapist, but skill and caution should be employed.

The understanding of why paradox seems to work is itself a matter of controversy. Frankl (1967) argued that paradoxical behavior removes debilitating anxiety which clients experience when their symptoms appear involuntarily. By directing clients to voluntarily engage in problem behaviors, therapists enable clients to sense a feeling of control over their symptoms, thus alleviating anticipatory anxiety and future symptom occurrence. Adler (1959) reported that patients using paradox improved due to an increase in self-esteem following a successful power move against the therapist who had suggest that the patients keep the symptoms.

Watzlawick et al. (1974) stated that patient change occurs because the cognitive meaning of the symptom changes when it is relabeled or reframed. Because the meaning of the symptom changes, its consequences change as well. Watzlawick
et al. (1967) suggested that therapeutic paradoxical communication is structured in such a way that it (1) reinforces the behavior the client expects to change, (2) implies that this reinforcement is the vehicle of change, and (3) thereby creates paradox because the client is told to change by remaining unchanged. In this situation the client is "changed if he does and changed if he doesn't" (p. 241).

Selvini-Palozzoli (1975) reported that the therapist’s positive connotation of all behavior forces the client to accept the positive side of a symptom he/she has ambivalently asked to have removed. By employing the technique of paradoxical intervention, the therapist offers a solution to the problem which unexpectedly contradicts the premises on which the symptom is based (Selvini-Palazzoli, 1981). Some therapists believe it is this very element of surprise that makes paradox an effective therapeutic tool. The symptom has survived everything the environment has offered to counter it, and whatever else the therapist offers must be something new and surprising (Dell, 1981).

Like conventional directives, a paradoxical directive is supported by a rationale which implies that the prescribed activity is necessary for change. The rationale links the directive to the overall therapeutic objective. What is unique about this approach is that the rationale and directive are mutually incompatible. As a result, the individual is caught in an untenable situation which essentially demands that in order to stop doing something, one must continue to do it.
While interest in paradoxical communication has increased in the past few years, paradoxes have been used in counseling for a long time. Early in this century, Stekel (1920) found that after directing impotent clients to refrain from sexual intercourse during contact with their partners, the clients immediately reported an increase in the frequency of intercourse with decreased anxiety. Somewhat later, Dunlap (1928) began a technique he called negative practice for problems such as nail biting, enuresis, and stammering. He directed the patient to practice the symptom under prescribed conditions with the expectation of extinguishing the habit.

Rosen (1953) described a method in which he had clients re-enact their psychoses. Whenever a patient began to evidence psychotic symptoms, Rosen demanded that the patient proceed to enact the symptoms. In his technique of prosocial definition, Adler (1959) prescribed predicted symptoms for the client using a paradoxical technique known as reframing. Victor Frankl (1967) was probably the first clinician to identify the paradoxical method. He used his approach, paradoxical intention, in the treatment of phobias and impulse-control behavior (Frankl, 1967, 1975).

Gerz (1962) used paradox to help clients overcome such problems as phobias. Hare-Mustin (1975) reported success using paradox with patients presenting problems of temper tantrums. Gentry (1973) cited a case in which he used
paradox to alleviate migraine headaches. Victor and King (1967) reported successful treatment of a compulsive gambler with the technique of paradox, while Morelli (1978) presented the successful application of paradoxical intention with an alcohol and drug abusing client. Haley (1967), Andolfi (1967), and Selvini-Palazzoli (1975) all reported the effective use of paradox in marital and family therapy.

Unfortunately, all of the above-mentioned reports are anecdotal in nature. While these reports are encouraging, few studies exist which are either experimental or compare paradoxical instruction with other forms of verbal direction. Three experimental studies exist, however, that seem to support the use of paradox in therapy. Solyom, Garza-Perez, Ledwidge, and Solyom (1972), using a group of psychiatric patients, evaluated the effects of paradox in the treatment of obsessive thoughts. At the outset of treatment, subjects were required to complete the IPAT Anxiety Scale, the Wolpe-Lang Fear Survey Schedule, and a Social Adjustment Questionnaire for Obsessives. Subjects also replied to a questionnaire which measures four broad categories of obsessive symptoms: (1) obsessive thoughts, (2) rituals, (3) compulsions other than rituals, and (4) horrific temptations. Patients were next instructed in the paradoxical intention technique on target symptoms but not on control symptoms. Each was told that instead of pushing the intruding obsessive thought out of his/her mind, he/she was to deliberately think obsessive
thoughts. The rationale given was that by trying to avoid obsessive thoughts, one invariably fails, and, in order to reverse this process, one must deliberately think obsessively. The ten patients were seen individually once a week for six weeks. Results demonstrated a 50% improvement rate with the experimental group on the target symptoms, but virtually no improvement on the control symptoms. The authors concluded that the treatment may have induced an attitudinal change once the subjects recognized that they had an element of control over these thoughts.

A second study by Ascher and Efran (1978) used paradoxical instruction (resisting the urge to sleep) with a small group of insomniacs for whom relaxation training and systematic desensitization had failed to work. All subjects reported significant decreases in sleep-onset latencies, remaining satisfied on a one year follow-up.

In the third study Lopez and Wambach (in press) worked with subjects on a procrastination study comparing the effects of paradoxical and self-control directives on subject change over a four week period. Subjects recruited for the study were assigned to one of two interview conditions (experimental) or to a no-interview condition (control). Subjects in the self-control group were told that in order to overcome their procrastination, they would have to engage in activities to change their study habits (self-monitoring, goal-setting, self-reinforcement). In the paradoxical
directive group subjects were told that in order to fully understand their problem behavior they would have to practice their procrastination daily. Lopez and Wambach (in press) found that both interview groups (self-control and paradoxical) improved over time more than their non-interviewed (control) counterparts. However, they found that paradoxical and self-directives facilitate change in different ways. Specifically, subjects exposed to paradoxical instruction reported a sharper rate of change in their procrastination without viewing their problem behavior as significantly more controllable.

Only one study exists which attempts to compare paradoxical injunctions with any other form of verbal direction. Fulchiero (1975) compared the outcomes of two short-term counseling interventions with subjects from her caseload. In one condition (paradoxical group) subjects were encouraged to maintain their symptomatic behavior, while in the other (non-paradoxical group) subjects were discouraged from behaving symptomatically. Based on MMPI scores and problem checklists before and after treatment, Fulchiero found no significant differences. She acknowledged that her paradoxical methods were applied indiscriminately and may have been best used for problems resistant to change.

The research presented seems to indicate that paradoxical directives have been applied to a variety of clinical problems. Paradoxical directives appear to work in that immediately
observable changes in clients' problem behaviors occur especially in problems facilitating voluntary control over specific, habituated, or reportedly involuntary behaviors. In addition, paradoxical directives are especially successful when employed in clients who are negativistic, resistant, or who have failed to respond to more traditional forms of counseling (Fisher et al., 1981; Lopez, 1980). Further, the use of paradox as a treatment intervention appears to cut across theoretical orientations and diagnostic boundaries (Fay, 1976).

Understanding how paradoxical instructions facilitate behavior change is still being debated. There is even some question as to whether an underlying understanding or theoretical basis for the use of paradox is necessary (Dell, 1981; Selvini-Palazzoli, 1981; Watzlawick, 1981). Regardless of the theoretical, philosophical, or empirical limitations of paradox, it appears to be an intervention that is here to stay. That research is needed, all agree. But clinicians seem to be content for the moment to use this treatment approach in the absence of such study.

Nondirective Therapy

The work of Carl Rogers and his associates (Carkhuff & Berenson, 1967; Rogers, 1951, 1957, 1965, 1975; Rogers & Truax, 1966; Truax & Carkhuff, 1967; Truax & Mitchell, 1971) has been a foundational building block in the development of counseling and psychotherapy. The impact Rogers has had, both
theoretically and clinically, can hardly be overstated. Rogers' work remains a standard against which other therapies are compared. Rogers believes that individuals have within themselves the ability for personality change. The basic theory behind the client-centered approach is that when a therapist's attitudes reflect certain core therapeutic conditions (empathic understanding, genuineness, and unconditional positive regard), growth on the part of the client will inevitably occur (Rogers, 1957).

These three conditions, Rogers believes, are necessary and sufficient for client personality change to occur. Rogers says that genuineness, or personal congruence, exists when the therapist's inner experiences and outer expression of those experiences match. The therapist is accurately himself in relationship with the client, being both congruent and integrated, openly expressing feelings and attitudes present in the relationship. Unconditional positive regard (warmth) includes the warm acceptance of each aspect of a client's experiences. This regard involves communicating deep and genuine caring for a client, uncontaminated by an evaluation of the client's feelings, thoughts, or behaviors. Accurate empathy occurs when the therapist is able to sense the world of a client as if it were the therapist's own. Accurate empathy is communicated in such a way as to relate to the client an understanding of what the client is feeling and the experiences underlying these feelings (Rogers, 1957).
These three core therapeutic conditions are believed to be a catalyst for greater client self-acceptance which inevitably leads to psychological growth. A violation of any of these three ingredients is believed to be sufficient to keep the client from experiencing either self-acceptance or psychological growth (Rogers, 1957). The use of reflection is the primary vehicle through which the therapist conveys the core therapeutic conditions. The use of reflection not only promotes client self-disclosure, but also helps the client to engage in self-exploration which ultimately leads to greater self-acceptance (Truax & Carkhuff, 1967).

Over a decade of research followed Rogers' (1957) statement concerning the hypothesized relationship between the core therapeutic conditions and therapeutic outcome. An abundance of research evidence now exists to suggest that counselors who communicate a high degree of accurate empathy, nonpossessive warmth, and genuineness are effective.

An early study by Truax (1961) in the now classic Wisconsin Schizophrenia Project found that therapists whose patients improved rated consistently higher on accurate empathy scales than those with deteriorated patients. In the same study significant correlations between patient outcome and therapist nonpossessive warmth and genuineness were also found. Bergin and Solomon (1963) discovered that high levels of accurate empathy in graduate student-therapist's audiotaped therapy were significantly related to outcome as judged by
their supervisors. Truax, Carkhuff, and Kodman (1965) administered pre- and post-test MMPI scales to patients receiving group therapy. When patients were divided into those groups receiving high levels of accurate empathy and those groups receiving low levels, those receiving high levels showed improvement on all MMPI subscales equal to or greater than those in the groups receiving low levels of accurate empathy.

Truax and Wargo (1966), working with institutionalized juvenile delinquents, found a significant association between the levels of empathy, warmth, and genuineness offered by a group counselor and the degree of behavioral and personality change occurring in the juvenile delinquents. Dickensen and Truax (1966) investigated the effects of group counseling on grade point average with college underachievers using a control group for comparison. At the end of the semester those students receiving high levels of core therapeutic conditions had a significantly higher grade point increase than the control group.

Halpern (1977) found that a client's self-disclosure rate was strongly related to his/her perception of the counselor's self-disclosure, warmth, and empathy. Hayden (1975) studied the verbal behavior of 20 experienced therapists and their therapeutic effectiveness. He found that the more effective the therapist, as rated by his/her professional peers, the higher the levels of empathy, positive regard, and genuineness
communicated by the therapist. Murphy and Rowe (1977) investigated the effects of the level of counselor facilitation on client suggestibility. Using clients in one of three conditions (clients of counselors rated as high on empathy, clients of counselors rated as low on empathy, and a control group), the authors found that the clients of counselors rated high in empathy demonstrated more suggestibility than clients of counselors rated low in empathy. The findings were generalized to suggest that therapists using any therapeutic orientation with clients could increase client involvement by utilizing a high level of empathy.

Heilburn (1974) investigated explanations for early defection of female counseling clients from therapy. She found that females classified as more likely to defect reported greater satisfaction with counselors employing nondirective interviewing. Claiborn, Ward, and Strong (1981) investigated the effects of clients receiving interpretations, either congruent (empathic) or discrepant (non-empathic) from their own prior beliefs about their problems. The authors found that clients receiving congruent interpretation (those whose therapists demonstrated empathic understanding) showed a greater expectation to change, a tendency toward greater change, and satisfaction with change, than those whose therapists demonstrated discrepant conditions.

Carkhuff (1969) reported that therapist warmth and accurate empathy are related to client self-exploration.
Carkhuff (1972), Truax and Carkhuff (1967), and Truax, Carkhuff, and Douds (1964) demonstrated that core therapeutic conditions are related to psychological adjustment.

The amount of research generated by the client-centered approach is truly awesome. An excellent summary of this research was reported by Truax and Mitchell (1971). The evidence for the relationship between Rogers' core therapeutic conditions and therapeutic outcome is substantial. While it has not been demonstrated that there is a causal relationship between these conditions and therapeutic outcome, or that they are either necessary or sufficient, the research has sufficiently influenced the counseling world to utilize these conditions in the training of most counseling programs.

Client Perceptions of the Therapist

A second area receiving a great deal of attention recently in counseling and psychotherapy has come from those who conceptualize the therapeutic relationship as an interpersonal influence process. Strong (1968) wrote what has become a landmark paper speculating that the nature of the counseling relationship is one of social influence. Relying on support from earlier research in social psychology (Hovland, Janis, & Kelly, 1953), he presented a two-stage model to describe the way the counselor attempts to change a client's behaviors or opinions. Strong postulated that the extent to which the counselor is perceived as expert, attractive, and trustworthy is directly related to the client's involvement.
in counseling. In the second stage the counselor uses this influence to precipitate opinion and/or behavior change in the client (Corrigan, Dell, Lewis, & Schmidt, 1980). Following publication of Strong's seminal paper, a decade of research attempted to test his hypotheses over the three proposed dimensions. While research continues, and the results in some areas are mixed, there have been sufficient results to suggest that Strong's two-stage model may be a viable way of considering the counseling process.

The research has focused on counselor attributes as perceived by the client, with the emphasis on the specifically perceived counselor characteristics of expertness, attractiveness, and trustworthiness. Strong (1968) stated that earlier studies demonstrated that the client's perception of the counselor as the source of the three characteristics is influenced by (1) objective evidence or evidential cues, (2) behavioral evidence or cues, and (3) reputational cues. For the present study only behavioral evidence of the characteristics of expertness, attractiveness, and trustworthiness are explored, holding both evidential and reputational cues constant.

Hovland et al. (1953) believe that expertness is the extent to which a communicator is perceived to be a source of valid assertion. Two studies stand out as particularly relevant to the current one. Atkinson, Maruyama, and Matsui (1978) found that students rated a directive counselor as more
credible than a nondirective counselor and as someone they would be willing to see for help. In this study the non-directive counselor presented a passive and somewhat repetitious counseling interview, while the directive interviewer was more active in attempting to influence clients. A second study by Scheid (1976) compared counselors in an inexpert condition (defined as displaying Rogers' Level 1 core therapeutic conditions) with counselors in an expert condition (defined as displaying Level 3 or above core therapeutic conditions). Scheid found that the display of high level (expert) core therapeutic conditions by the counselor affected the client's perception of counselor warmth, competence, comfort, and appeal, as well as counseling climate and client satisfaction. This finding suggests that counselors displaying high level core therapeutic conditions are perceived as more expert than those counselors displaying low level core conditions.

Strong (1968) believes that a client's perception of the counselor's attractiveness is based upon "perceived similarity to, compatibility with, and liking for" the counselor (p. 216). He believes these qualities are enhanced by the counselor's self-disclosure and use of core therapeutic conditions.

The area receiving the greatest amount of attention is the counselor's self-disclosure during an interview. One of the most consistent findings has been that disclosure begets disclosure (Corrigan et al., 1980; Cozby, 1973). However,
there seems to be a ceiling in that a moderate number of disclosures results in more favorable evaluations than either a single disclosure or a large number of disclosures (Mann & Murphy, 1975). Also, Hoffman-Graff (1977) found that when a counselor's disclosures are similar to a client's, more favorable ratings on the dependent measure are produced than when dissimilar disclosures are used.

Corrigan et al. (1980) wrote that the research suggests that greater perceived similarity and a moderate number of disclosures increase the therapist's attraction. This is consistent with research on the core therapeutic conditions in which therapist genuineness and empathy (similarity of self-disclosure) are related to positive outcomes in counseling.

Hovland et al. (1953) define counselor trustworthiness as "the degree of confidence in the communicator's interest to communicate assertions he considers most valid" (p. 21). Using this definition, Strong (1968) postulated that the counselor's perceived trustworthiness is based on, among other things, his/her sincerity and openness in counseling. There has been relatively little research on trustworthiness, possibly because the two dimensions of expertness and attractiveness may mask the effects of the counselor's perceived trustworthiness. It may also be, as Strong (1968) suggested, that trustworthiness is inherent to the social role of the counselor. However, there are two studies which have provided results of interest to the current study. Johnson and Noonan
(1972) manipulated reciprocation or non-reciprocation of clients' self-disclosures. Based on self-administered post-test ratings, they found that clients perceived counselors as more trustworthy in the reciprocating condition. The more reciprocal counselors' self-disclosures, the more trustworthy they were perceived to be.

In a second study Kaul and Schmidt (1971) manipulated the trustworthiness of the content of counselor communications. They failed to get differential ratings based solely on the perceived trustworthiness of the content. However, an interaction effect of the counselor's content and the trustworthiness or untrustworthiness of the counselor's manner was found. Based on Strong's (1968) belief that a counselor's trustworthiness is based on the sincerity and openness of his/her communication, a counselor low in reciprocating self-disclosure is expected to be rated low in perceived counselor trustworthiness.

The research on the social influence dimensions of therapy raises a number of questions relevant to the present study. Are counselors who use paradoxical communication, which is directive, perceived as more or less expert than those who use nondirective communication with high level core therapeutic conditions? Can counselors using paradoxical directives high in core therapeutic conditions be rated as high in attractiveness as counselors using nondirective communication? How does counselor genuineness, a function of the similarity and
number of counselor self-disclosures, effect how counselors using paradoxical or nondirective communication will be rated on the attractiveness dimension? Since paradoxical communication has been labeled as somewhat deceptive and manipulative (Coleman & Nelson, 1957; Haley, 1976), will it be perceived as less trustworthy than nondirective counselor communication? Or, will communication high in core therapeutic conditions or counseling orientation (nondirective or paradoxical) determine whether counselors are viewed as trustworthy?

In summarizing future research needs of counseling as a social influence process, Corrigan et al. (1980) suggested that little work has been done to assess the perceived effects of counselor influence as a function of counselor orientation and stated that this would be a fruitful area for future studies. The present study will attempt in part to respond to this need.

Rationale for the Present Study

Unlike the nondirective client-centered approach, paradoxical techniques have not been compared to other approaches, nor have there been studies in which the client's perceptions of the therapist utilizing this popular intervention were measured. Yet significant questions exist to warrant such a study.

As early as the late 1950's, Coleman and Nelson (1957) noted the apparent discrepancies between the client-centered approach and paradoxical techniques. They cautiously noted
that the use of paradox in therapy is questionable in three areas. First, paradox is seen as a violation of the therapist's role as "ambassador of reality" (p. 30), thereby undermining therapist genuineness and empathy. Second, because the therapist is not genuine, and in fact is deceiving, there is a clear undermining of interpersonal trust. Related to this, the therapist's lack of confidence in the client's ability to change on his/her own seems to put conditions on the therapist's positive regard for the client. Finally, these researchers believe that paradoxical techniques can be seen as a vehicle for the expression of the therapist's sadistic impulses.

These early criticisms have not undergone experimental research. However, there does seem to be some anecdotal support suggesting that these criticisms may be well-founded. Farrelly (1974), whose use of provocative therapy is paradoxical in nature, left his training as a client-centered therapist, stating that Rogers' core therapeutic conditions are neither necessary nor sufficient for therapy. He reported that the therapist's responsibility is to provoke the client into new behaviors. Further, he contended that the therapist not having fun in therapy is probably not effective. In a review of Farrelly's book, Whitaker (1979) adds support to these criticisms by saying that "one of the most persistent and gruesome myths of our psychotherapy culture is that enough 'unconditional positive regard' will convert an emotional or psychosomatic cripple into a vibrant, self-assertive adult" (p. 105).
Haley (1976) gave further credence to the criticism that paradox may undermine trust by suggesting that, in using paradoxical technique, the therapist often withholds information from the client, ostensibly to define the boundaries between client and therapist and to individuate the client. This seems to be a direct contradiction to Rogers' concept of genuineness. Haley further asserted that while it is usually unwise for a therapist to tell a falsehood to a client, there are times when therapeutic maneuvers in which the therapist purposefully deceives the client for his/her own good are acceptable. This deception seems, in Rogerian terms, to undermine trust as well as respect in the therapeutic relationship. The deception further appears to demonstrate a lack of empathic understanding for the client's problem.

In a recent review of paradoxical techniques (Soper & L'Abate, 1977), the authors discussed a variety of interventions including double binds, tasks, written instructions, positive interpretation, paradoxical intention, and hypnosis. In all cases the client is kept from the true intention of the intervention and encouraged to engage in behaviors which appear antithetical to symptom removal. Farrelly (1974) carried this a step further when he asserted that sarcasm, ridicule, and exaggeration are appropriate uses of paradox to promote behavior change. Fisher, Anderson, and Jones (1981) suggested that in part, due to the nature of paradox, its use constitutes the highest risk for subsequent no-show appointments and
premature termination. They suggested that with the careful, skillful, and well-timed use of paradox, the risk of negative outcome may be diminished. In summary, paradoxical interventions appear, on the surface, to contradict the necessary and sufficient conditions for therapy as set forth by Rogers (1957) and further clarified by Truax and Carkhuff (1967), and to risk undermining potential client psychological growth in the process as well as involvement in therapy.

Three recent studies have attempted to compare these two apparently contradictory orientations. Troemel-Ploetz (1980) reported that paradox is not associated with client-centered therapy because it is not considered to be empathic. Rather, paradox is seen to systematically add to and change what the client means or to purposefully misunderstand and manipulate what he/she says. By using linguistic analysis of three empathic interventions, Troemel-Ploetz suggested that therapist-client communications operate in linguistically complicated ways and carry deeper, more indirect levels of meaning. He believes, therefore, that empathic communication has properties also found in effective paradoxical interventions. He concluded that his results indicate that therapists' communications and interventions show common linguistic properties in terms of enabling client change regardless of the theoretical orientation of the therapists. He thereby diminished the differences of these therapies with regard to their impact on therapeutic outcome.
A second study by Fischer, Paveza, Kickertz, Hubbard, and Grayston (1975) analyzed the relationship between theoretical orientation and the counselor's display of the three core therapeutic conditions. Noting the ongoing debate over which psychotherapeutic orientations make the most effective use of core therapeutic conditions, they studied counselors from psychodynamic, behavioristic, and humanistic orientations. Their results indicated no significant differences between the therapists of any of the three theoretical orientations. The authors concluded that the criticism that any one theoretical orientation possesses inadequate relationship skills may be unfounded.

Finally, in the third study, Ehrlich, D'Augelli, and Danish (1979) studied the comparative effects of six counselor verbal responses on clients' verbal behavior and their perceptions of the counselors. In a counseling analogue study each participant played the role of client in a simulated helping interaction. Counselor responses included affect, content, advice, open questions, closed questions, and influencing. Both content and affect responses were called continuing responses because they were nondirective and were believed to promote continued client exploration. The other four responses were considered to be leading responses because they represented "an attempt by the counselor to direct the client toward specific thoughts or actions" (p. 391).
Relevant to the present study is the comparison of the nondirective responses (reflection of content and affect) to advice, defined as a statement that provides or encourages a mode of behavior (action or thought) for the client. While paradoxical techniques may encourage continuation of the same behavior, these techniques are nevertheless considered as a form of advice because they provide a mode of behavior for the client to follow.

Looking at the comparison between the nondirective responses and the advice responses, the conclusions are mixed. Ehrlich et al. (1979) found that affect responses, a class of nondirective responses, were the most desirable in eliciting desirable client behaviors. They were particularly facilitative in eliciting client self-referrent pronouns, helping client exploration, and changing behavior. In addition, counselors reflecting affect were perceived by clients to be the most attractive, expert, and trustworthy of all six conditions. Content-reflecting counselors were also facilitative in eliciting self-referrent pronouns, second only to affect-reflecting counselors; however, these counselors were not perceived by clients as particularly expert, attractive, or trustworthy. In between these two nondirective verbal responses fell the more directive, advice-giving counselors. Counselors utilizing advice as a verbal response were perceived as trustworthy, expert, and attractive, ranking second only to affect-reflecting counselors. However, advice
was not effective in eliciting desirable client behavior, ranking next to last of the six conditions in eliciting self-referent pronouns. The authors noted the dilemma these results present to counselors using advice, in that the advice may not elicit desirable client behavior. On the other hand, if counselors do not give advice, clients' expectations of counselors' roles may not be met. Advice may then be good for the clients' perceptions of counselors, but, in fact, produce little or no behavior change in clients.

Taken together, these three studies present a confusing picture of the effect of nondirective and directive or paradoxical counselor communication. The Troemel-Ploetz (1980) study suggests that while superficially, nondirective and paradoxical communication may appear to be vastly different, they are similar at a deep and meaningful level. Therefore, they should be equally effective in enabling client change. Fisher et al. (1975), looking at the use of relationship in therapy, believe that both client-centered and the more directive therapies (behavioristic) possess adequate relationship skills to enable client change. Finally, Ehrlich et al. (1979) believe that nondirective, affect-reflecting counselor communications seem to elicit desirable client behaviors in a way that more directive, advice-giving communications do not, even though both are perceived similarly on the social influence dimensions of trustworthiness, attractiveness, and expertness.
Left unanswered are whether or not paradoxical counselor communication and nondirective counselor communication can be designed to be similar on Rogers' core therapeutic conditions of empathy, genuineness, and warmth. Or, are they so different that they cannot be designed to similarly reflect these conditions believed to be related to client change? Secondly, regardless of their relatedness on the core therapeutic conditions, how are they perceived with regard to counselors' expertness, trustworthiness, and attractiveness? As Corrigan et al. (1980) have posed the question, how do these two orientations compare with regard to the perceived effects of counselor influence, which is believed to be related to client involvement in therapy?

**Statement of the Problem**

The purpose of this study was, in the first phase, to compare paradoxical and nondirective communication on Rogers' (1957) core therapeutic conditions. There seemed to be sufficient anecdotal evidence to suggest that paradoxical communication may operate at a very low level with respect to the core therapeutic conditions (Farrelly, 1974; Haley, 1976; Whitaker, 1979). At the same time proponents of paradoxical techniques provided a number of anecdotal claims as to the effectiveness of this intervention. While research was largely anecdotal, Rogers and his associates (1967) empirically demonstrated a robust relationship between the core therapeutic conditions and therapeutic outcome in well-controlled
experimental research. To date, this has not been accomplished on paradoxical interventions.

Several questions came to mind regarding this newly-popular technique. First, was paradox necessarily different from nondirective communication on the core therapeutic conditions? Were they mutually-exclusive entities? Or, could paradox be designed to operate at a high level of the core therapeutic conditions while still qualifying as paradox? Was it possible, as Tromel-Ploetz (1980) suggested, that high level core therapeutic properties could be found in paradoxical interventions? With scripts designed to differentiate paradox and nondirective communication on high and low core therapeutic conditions, the present study hypothesized that

1. Counselors in scripts designed to reflect high core therapeutic conditions will be rated higher on empathy, warmth, and genuineness than counselors in scripts designed to reflect low core therapeutic conditions regardless of counselor orientation;

2. Counselors in scripts designed to reflect nondirective communication high in core therapeutic conditions will be rated significantly higher on each of the three measures of empathy, warmth, and genuineness than counselors in scripts designed to reflect paradoxical communication high in core therapeutic conditions.

A second question, equally important, was related to clients' perception of paradoxical therapists. If, as Strong (1968) suggested, counseling was an interpersonal influence process, it seemed important for clients to perceive counselors in such a way as to maximize their likelihood of involvement in the therapeutic process. Regardless of whether paradoxical
communication actually operated at a high level on the core therapeutic conditions, how was it actually perceived by clients in terms of social influence? The observation by Fisher et al. (1981) regarding premature termination and a high rate of client no-shows seemed to suggest a less than desirable client involvement in therapy with counselors using paradoxical communication.

The research on perceived counselor expertness suggested that an interaction effect might be expected with regard to the counseling conditions being measured. One study (Atkinson, Maruyama, & Matsui, 1978) found counselor directiveness to be significantly related to perceived expertness. A second study (Scheid, 1976) found that counselors displaying high level core therapeutic conditions were perceived to be more expert than those displaying low levels. Because the present study compared directive paradoxical to nondirective counselor communication and high and low level core therapeutic conditions, the following hypotheses were made.

3. Counselors with scripts reflecting high level core therapeutic conditions will be perceived as more expert than counselors with scripts reflecting low level core therapeutic conditions regardless of counselor communication.

4. Counselors with scripts reflecting paradoxical communication will be perceived as more expert than counselors with scripts reflecting nondirective communication regardless of level of core conditions.

5. Counselors with scripts reflecting paradoxical communication with high core therapeutic conditions will be perceived as more expert than counselors with scripts reflecting nondirective communication with high core therapeutic conditions.
6. Counselors with scripts reflecting non-directive communication with high levels of core therapeutic conditions will be perceived as more expert than counselors with scripts reflecting paradoxical communication with low levels of core therapeutic conditions.

7. Counselors with scripts reflecting paradoxical communication with low levels of core therapeutic conditions will be perceived as more expert than counselors with scripts reflecting nondirective communication with low levels of core therapeutic conditions.

Previous research on the dimension of perceived counselor attractiveness determined that it was counselor similarity and number of self-disclosures on which clients based their perception of counselor attractiveness (Corrigan et al., 1980; Hoffman-Graff, 1977; Mann & Murphy, 1975). Self-disclosure and similarity of disclosure seemed to relate to the core therapeutic conditions of empathy and genuineness. Based on this previous research, the following hypotheses were made.

8. Counselors with scripts reflecting a high level of core therapeutic conditions will be perceived as more attractive than counselors with scripts reflecting a low level of core therapeutic conditions regardless of counselor orientation.

9. Counselors with scripts reflecting non-directive counselor communication with high level core therapeutic conditions will be perceived as more attractive than counselors with scripts reflecting paradoxical communication also with high level core therapeutic conditions.

10. Counselors with scripts reflecting non-directive communication will not be perceived as more attractive than counselors with scripts reflecting paradoxical communication regardless of level of core therapeutic conditions.

The dimension of trustworthiness has been identified with sincerity and openness in counseling. Research suggested that
reciprocity of subjects' self-disclosures and content of counselor communication were related to perceived counselor trustworthiness (Johnson & Noonan, 1972; Kaul & Schmidt, 1971). This again seemed to be related to the core therapeutic conditions of genuineness and empathy. The following were therefore hypothesized with regard to trustworthiness.

11. Counselors with scripts reflecting high level core therapeutic conditions will be perceived as more trustworthy than counselors with scripts reflecting low level core therapeutic conditions regardless of counselor approach.

12. Counselors with scripts reflecting non-directive counselor communication high in core therapeutic conditions will be perceived as more trustworthy than counselors with scripts reflecting paradoxical counselor communication low in core therapeutic conditions.

13. Counselors with scripts reflecting non-directive communication will not be perceived as more trustworthy than counselors with scripts reflecting paradoxical communication regardless of level of core therapeutic conditions.

Method

Subjects

The four judges rating the audiotaped role plays were selected from advanced doctoral level students familiar with the core therapeutic conditions and the rating instruments. Subjects for the final phase of the study were 40 males and 93 females recruited from undergraduate psychology classes at North Texas State University in Denton, Texas. Subjects were recruited by asking for persons willing to listen and rate audiotapes of counseling sessions. They were each
awarded points toward their final grade for participation. They were further assured anonymity and were assured of the voluntary nature of the study. Volunteers were asked to sign a release form (Appendix A) which indicated their willingness to participate in the study.

**Instruments**

Four instruments were used for this study. A *Scale for the Measurement of Nonpossessive Warmth* is a five-point scale that ranges from a high level (5) where the therapist warmly accepts the patient's experience as part of that person without imposing conditions, to a low level (1) where the therapist expresses dislike or disapproval or is selective or evaluative in expressing warmth. This scale has been validated in extensive process and outcome research in counseling (Carkhuff & Berenson, 1967). Numerous reliability studies have been done on this instrument with reliability coefficients ranging from .48 to .95 with a mean reliability coefficient of .70 (Truax & Carkhuff, 1967; Appendix B).

A *Scale for the Measurement of Therapist Genuineness or Self-Congruence* defines therapist genuineness on five levels. At a very low level the therapist denies feelings or presents him/herself as defensive in the interaction. At this level there exists a considerable discrepancy between what he/she says and what he/she experiences. At a high level of genuineness the therapist is freely him/herself rather than presenting a professional facade or being defensive. This
scale has also been extensively validated in outcome research in counseling (Truax & Carkhuff, 1967). Reliability studies have found the range of reliability coefficients of .25 to .95 with a mean of .62 (Truax & Carkhuff, 1967; Appendix C).

A Scale for the Measurement of Accurate Empathy is a scale originally designed with nine scale points (Truax & Carkhuff, 1967); however, in a reformulation of this scale by Carkhuff (1969), the scale was reduced to five scale points to better conform to the previously mentioned scales. Recent research (Engram & Vandergoot, 1978) has determined that the newer Carkhuff scale and the earlier Truax and Carkhuff scale have high over-all agreement and therefore can be used interchangeably for research. This scale measures the therapist's sensitivity to current client feelings and his/her ability to accurately communicate this understanding. At a low level (1) the therapist seems completely unaware of even the most conspicuous client feelings; at a high level (5) the therapist is able to respond unerringly to the content, affect, and level of intensity of the client's immediate experience. Again Truax and Carkhuff have validated the instrument in numerous studies. Studies yielding reliability coefficients have had a range of from .43 to .95 with the mean reliability coefficient of .69 (Truax & Carkhuff, 1967; Appendix D).

The Counselor Rating Form is made up of 72 adjectives on 36 bipolar scales. This instrument was developed by Barak and Lacrosse (1975) in studying Strong's prediction of the
existence of three dimensions of perceived counselor behavior: expertness, attractiveness, and trustworthiness (Strong, 1968). There are twelve adjective pairs for each of the three dimensions rated on a seven-point Likert-like scale. It is a self-administered instrument with a range of scores for each dimension of 12 to 84. Validity studies have found the instrument capable of differentiating among and within counselors exhibiting varied interview behaviors (Kerr & Dell, 1976; LaCrosse & Barak, 1976). Reliability studies using the split-half correlation method have found reliabilities of .87 for expertness, .85 for attractiveness, and .90 for trustworthiness. These studies have also found a considerable degree of overlap and inter-correlatedness (LaCrosse & Barak, 1976; Appendix E).

Procedures

Four role play scripts were designed to reflect one of four counseling conditions (Appendices F, G, H, I). Two conditions were designed using nondirective counselor communication, one high and one low on the dimensions of empathy, warmth, and genuineness. The other two conditions used paradoxical counselor communication, again one script being high in the dimensions of empathy, warmth, and genuineness, the other being low in these dimensions. These scripts were designed by advanced doctoral level students and mental health professionals familiar with both nondirective and paradoxical communication. Transcripts presented in Truax and Carkhuff
(1967) exemplifying high (5) and low (1) levels of the core therapeutic conditions were adapted for the procrastination problem. In two of the scripts, one with high and one with low levels of the core conditions, a paradoxical injunction was embedded in the text. These two tapes were critiqued by a faculty member knowledgeable in paradox and modified where necessary. All the scripts were then critiqued by a faculty expert on the core conditions and modified. This resulted in four scripts: nondirective and paradoxical scripts each with high levels of the core conditions, and nondirective and paradoxical scripts each with low levels of the core conditions. Similar scripts have been used successfully in other counseling experiments and analogues as a way of controlling counselor communication (Hoffman-Graff, 1977; Lopez & Wambach, in press). The therapist and the client in the role play audiotapes were advanced doctoral level students familiar with all of the four counseling conditions.

In the nondirective scripts counselor behavior was characterized by reflecting or paraphrasing the content spoken by the subject (Appendices H, I). In the scripts high in interpersonal process, counselor behavior was characterized as being high in empathy, warmth, and genuineness (Appendices F, H). In the scripts low in interpersonal process, counselor behavior was characterized as being low in empathy, warmth, and genuineness (Appendices G, I).

The paradoxical scripts encouraged change of the problem behavior (procrastination) and at the same time prescribed
the performance of that behavior as part of the change process. As with the Lopez and Wambach (in press) interview, the scripts contained (1) a behavioral prescription encouraging the client to procrastinate under time-limited conditions, and (2) a rationale linking the prescriptive to the overall change process, giving the prescription credibility (Appendices F, G). One paradoxical script contained high levels of the core therapeutic conditions while the other script contained low levels.

For the first phase of the study, the four judges were trained to use the Carkhuff scale on Accurate Empathy (Carkhuff, 1969), and the Truax and Carkhuff scales on Genuineness and Warmth (Truax & Carkhuff, 1967). Each judge received at least four hours of training rating training tapes. After playing a training tape, judges rated one of the core conditions on the dependent measure. They discussed their ratings until some consensus was reached regarding the scale point definition of the condition presented. This was done until raters consistently reached or exceeded the criterion of .80 for interrater reliability (Tinsley & Weiss, 1975; Winer, 1971). Continual checks were made on reliability during the actual rating. Training tapes were interspersed among research tapes to insure that raters had not drifted from scale point definitions (Gormally & Hill, 1974). When the criterion for training was obtained on training tapes based on examples from Truax and Carkhuff (1967), each rater
independently rated the four experimental audiotaped role plays. The order of the tapes was presented randomly to the raters as a group, and the raters had no prior knowledge about the tape they were about to rate (Appendices J, K).

In the second phase of the study, students were randomly assigned to listen to one of the four audiotapes. The audiotapes were group-administered to no more than 15 subjects. Prior to listening to the interviews, each subject listened to an audiotaped explanation of the experiment which stated that the subject was to imagine being the client in the audiotape and fill out a short questionnaire on the counselor after hearing the tape (Appendix L). After listening to the tape, the students independently rated the counselor on the audiotape on the adjectives from the Counselor Rating Form scales (Appendix E) on the dimensions of trustworthiness, attractiveness, and expertness. The entire experiment lasted approximately thirty minutes.

At the close of the session, the subjects were debriefed about the nature of the experiment. They were asked about their feelings and thoughts regarding the procedure in order for the interviewer to identify any adverse reactions from the experiment. Subjects were also reminded that all information which they disclosed was confidential.

**Design and Statistics**

For the first phase of the study, the four judges rated all four counseling conditions using the rating scales for the
core therapeutic conditions (Appendices B, C, D). A $t$-test was used to compare combined means of scripts designed high with those designed low on the core conditions. A one-by-four analysis of variance (ANOVA) was then utilized to compare judges' ratings on all four counseling conditions (non-directive and paradoxical scripts with high or low levels of core therapeutic conditions).

For the second phase of the study, 133 subjects were randomly assigned to each of the four counseling scripts. In a two-by-two factorial design, one two-factor dimension was counseling condition (paradoxical and nondirective), and the other two-factor dimension was level of core therapeutic condition (high and low). The dependent measure used was the Counselor Rating Form (LaCrosse & Barak, 1976; Appendix E), using the three dimensions of trustworthiness, expertness, and attractiveness. Analysis of these three dependent measures was computed using a multivariate analysis of variance (MANOVA) within a two-by-two factorial design as recommended by Corrigan et al. (1980).

Results

Overall interrater reliability for the raters judging the tapes on the core therapeutic conditions was .94, meeting the criteria for training. For the three separate dimensions the interrater reliability was .97 for empathy, .98 for warmth, and .82 for genuineness (Winer, 1971). Interrater agreement was also calculated as recommended by Tinsley and
Weiss (1975). For interrater agreement a Lawlis and Lu (1972) chi-square analysis was computed. The chi-square indicated that the raters were exercising power and observed agreement significantly greater than could be expected on the basis of chance, $X^2 = 38.98, p < .01$. A measure of agreement (Tinsley & Weiss, 1975) was calculated to determine whether observed agreement was high, moderate, or low. The $T$-value was $T = .94$, indicating that in addition to observed agreements being greater than chance, there was a high degree of interrater agreement among the judges. Taken together, this indicates that among the judges rating core conditions, both interrater reliability and interrater agreement were well within the established criteria.

A $t$-test was executed on the means of the scripts which were combined either high or low on empathy, warmth, and genuineness, regardless of counseling technique (Table 1). A significant difference was found between scripts designed to reflect either high or low levels of the core conditions regardless of counseling technique. For the empathy dimension, tapes designed to be high in empathy ($M = 4.50$) were found to be rated significantly higher than tapes designed to be low in empathy ($M = 1.63$), $t = 7.67, p < .001$. Similarly, tapes designed to reflect high levels of warmth ($M = 4.38$) were rated significantly higher than tapes designed to reflect low levels ($M = 1.50$), $t = 8.88, p < .001$. Finally, tapes which were designed to reflect high
levels of genuineness ($M = 3.75$) were rated significantly higher than tapes designed to reflect low levels of genuineness ($M = 2.50$), regardless of technique, $t = 2.76$, $p < .05$.

Means and standard deviations on the core conditions comparing the four possible counseling conditions (paradox and nondirective designed with either high or low levels of empathy, warmth, and genuineness) are presented in Table 2. A one-way analysis of variance (ANOVA) using empathy as the dependent variable indicated a significant difference between treatment conditions, $F(3,12) = 30.47$, $p < .01$. In comparing mean differences of the treatment conditions, a Duncan multiple range test (Winer, 1971) indicated that the nondirective condition high in empathy ($M = 5.0$) was significantly greater than the paradoxical condition also high in empathy ($M = 4.0$), and, as predicted, both were significantly higher than either nondirective ($M = 2.0$) or paradoxical ($M = 1.25$) conditions designed to be low in empathy.

A one-way analysis of variance (ANOVA) using the dependent variable of warmth also indicated a significant difference between counseling conditions $F(3,12) = 28.78$, $p < .01$. A Duncan procedure indicated that both paradoxical ($M = 4.0$) and nondirective ($M = 4.75$) scripts designed high in warmth were significantly greater than paradoxical ($M = 1.5$) or nondirective ($M = 1.5$) designed low in warmth. On the dependent variable of genuineness, however, no significant difference was found between conditions.
It was hypothesized that all three core conditions would significantly differentiate scripts designed to be high from those designed to be low on these conditions. However, only two, empathy and warmth, were judged to be significant. Therefore, further reference to the core conditions refers only to these two conditions.

A major prediction was that the counseling conditions would be different on the dimensions of trustworthiness, attractiveness, and expertness. To test this prediction, a multivariate analysis of variance (MANOVA) was conducted on the three dependent variables using Hotelling's technique (Winer, 1971) of MANOVA (Table 3). Multivariate F ratios were significant for both main effects: counseling technique, F(3, 127) = 8.30, p < .01, and core conditions in counseling, F(3, 127) = 5.26, p < .01. For the interaction of technique by core condition, a nonsignificant F ratio was found.

A univariate analysis of variance (ANOVA) was then performed on each dependent variable (Table 4). For the dependent variable expertness, a significant difference was found for the core conditions which include empathy and warmth, F(1, 129) = 11.79, p < .01, as well as for counseling technique, F(1, 129) = 8.22, p < .01. For trustworthiness a significant effect was found for the core conditions of empathy and warmth, F(1, 129) = 14.07, p < .01, but not for counseling technique, F(1, 129) = .48, p > .05. For attractiveness a significant effect was also found for the
core conditions of empathy and warmth, $F(1, 129) = 15.51$, $p < .01$, but again not for counseling technique, $F(1, 129) = .001$, $p > .05$. Means and standard deviations are seen on Table 5. Intercorrelations of the dependent measures are presented on Tables 6 and 7.

Counselor communication using high levels of empathy and warmth was perceived as more attractive, trustworthy, and expert than counselor communication low on those conditions. There was no significant difference with regard to counselor technique for attractiveness and trustworthiness. For the expertness dimension, however, there was a significant difference on the counselor technique, with paradoxical communication perceived as more expert than nondirective counselor communication.

**Discussion**

The major finding of this study is that paradoxical counselor communication and nondirective counselor communication are not perceived differentially by judges on the basis of technique alone, with the exception of the dimension of perceived expertness and empathy. With regard to social influence processes, this suggests that counselors using paradoxical communication are perhaps equally effective involving clients in therapy as counselors using nondirective communication, and more likely to involve clients when the dimension of perceived expertness is a critical variable. However, when the dimension of empathy is particularly crucial, nondirective communication with high levels of this dimension is the therapy of choice.
Rogers' (1957) contention that high levels of empathy, warmth, and genuineness are necessary and sufficient conditions for positive counseling outcome is supported in an abundance of research (Truax & Mitchell, 1971). General findings regarding these conditions support the contention that counselors using high levels of these core therapeutic conditions are more likely to achieve desirable counseling outcome that counselors using only low levels (Truax & Carkhuff, 1967). Scripts for the present study are designed to reflect either high or low levels of the core conditions based on examples presented by Truax and Carkhuff (1967). Therefore, the prediction is that counselor communication using high levels of core conditions are differentiated from counselor communication using low levels by experienced raters.

As predicted in hypothesis 1, counselor communication designed to reflect high levels of core conditions is rated significantly higher in empathy, warmth, and genuineness than counselor communication designed to reflect low levels of core conditions, regardless of counseling technique. These results are not surprising in that the scripts are purposely designed to differentiate high from low levels of core conditions. This finding confirms that the scripts reflect what they were intended to reflect. They are constructed in ways which conform to the operational definitions of the core conditions. As such they are used confidently in carrying out the remainder of the study.
Hypothesis 2, which predicts that nondirective counselor communication high in core conditions will be rated as more empathic, warm, and genuine than paradoxical communication also high in the core conditions, is partially supported. Both scripts are judged to contain high levels of empathy as designed; however, nondirective communication is rated significantly higher than paradoxical communication. This is not surprising since empathy is identified as the cornerstone of nondirective therapy (Rogers, 1975). It would be surprising, in fact, to find this hypothesis unsupported. An interesting finding is that paradoxical communication is also able to be designed with high levels of empathy. According to Truax and Carkhuff (1967), a level 3 response on the core conditions is the minimum effective therapeutic level required to promote client change in counseling. In the current study both nondirective ($M = 5.0$) and paradoxical ($M = 4.0$) communication, which are designed to be high in the core conditions, exceed this minimum therapeutic level on empathy. This suggests, as Fischer et al. (1975) state, that high levels of empathy can be found in good therapy of many different orientations. However, when empathy is a particularly critical variable for positive counseling outcome, nondirective counseling may be somewhat more effective than paradoxical techniques.

On the condition of warmth, both paradox and nondirective scripts with high levels of the core conditions are rated significantly higher than either paradox or nondirective
scripts with low levels of the core conditions. However, unlike the condition of empathy, no significant differences exist between nondirective and paradoxical scripts both with high levels of the core conditions. While both contain high levels of warmth, the nondirective script is not judged to have a higher level of warmth than the paradoxical script. Perhaps the condition of empathy is more uniquely a part of nondirective communication, whereas warmth is not as unique to any single modality. However, because both are judged to contain high levels of warmth, this again substantiates claims that high levels of the core conditions are found in effective therapeutic communication of varying orientations (Fischer et al., 1975).

A surprising result is found in relation to the third core condition of genuineness. Unlike the conditions of empathy and warmth, counselor communication designed to be high in genuineness is not rated significantly different from counselor communication designed to be low in genuineness. This is an unexpected finding in that the tapes are designed to differentiate between high and low levels of this condition based on scripts presented by Truax and Carkhuff (1967).

Several possible explanations may account for this discrepancy. First, there is more variability on the genuineness dimension than on either empathy or warmth. Because of the small number of judges (four), there is too
much variability for a significant $F$. With either a larger number of raters or less variability, a significant difference might be found. It is recommended that future studies use a larger number of judges to avoid this problem.

Two possibilities may account for the greater variability on the genuineness dimension. First is the possible variability of the genuineness measure itself, making it difficult to clearly distinguish high from low levels of genuineness. Possible support for this explanation is found in the research on the core conditions. In their review of 31 published studies, Truax and Mitchell (1972) found that for 17 of these studies, reliability ratings for genuineness were the lowest of the three dimensions reported. In only four of these studies, the reliability ratings for genuineness were judged to be the highest. This suggests that the dimension of genuineness may be the most difficult to reliably rate. In the present study the reliability rating of .82 is substantially less than those of empathy (.97) and warmth (.98), but nevertheless higher than most of those reported by Truax and Mitchell (1972). This suggests that in the present study, judges have less difficulty judging this dimension than in previous studies, and that the lack of significant differences between high and low levels of genuineness is not likely due to inadequate rating discrimination by the judges.

A second possibility, and one more likely, is related to the judges' perceptions of the symptom prescription aspect of
paradox as violating their own values for genuineness in a counseling relationship. The judges, all upper level doctoral students, are able to recognize both nondirective and paradoxical communication on the audiotapes. Perhaps the judges' values for honesty in a therapeutic relationship, equated here with genuineness, conflicts with the use of symptom prescription. Perhaps their sophistication in counseling "shoulds" (e.g., not deceiving the client) affects their ratings of tapes designed to be high in genuineness and paradox. That is to say, when judges experienced in counseling are presented with audiotapes designed to reflect high levels of genuineness and paradoxical communication, the discrepancy poses a contradiction to their belief that the two must somehow be mutually exclusive. This contradiction appears to be central to the judges' difficulties in distinguishing high from low levels of genuineness in the current study. Raters naive in counseling theory might not address the apparent discrepancy and might be better able to dichotomize high from low levels. Or perhaps it is not possible to design paradoxical communication that can be perceived as high in genuineness. Perhaps, as Coleman and Nelson (1957) believe, paradoxical techniques are inherently deceiving and ingenuine, and they are able only to be perceived as such. Future research might compare ratings between judges sophisticated in counseling and naive judges with no preconceived ideas regarding counseling "shoulds."
In Strong's (1968) seminal paper he argues that the process of involving clients in therapy in order to facilitate change is based in part on the client's perceptions of the therapist as expert, trustworthy, and attractive. He believes that counselors perceived high in these areas could use this as a strong base to influence clients in therapy. A decade of research summarized by Corrigan et al. (1980) seems to support Strong's primary contention that these social influence dimensions are in fact related to client involvement in therapy and subsequent counselor influence.

With regard to the social influence dimension, hypotheses 3 through 7 are related to the expert dimension. Hypothesis 3 postulates that counselor communication high in empathy and warmth will be perceived as more expert than counselor communication with low levels of these dimensions regardless of technique. This hypothesis is supported and suggests that counselor communication with high levels of empathy and warmth is perceived as more expert than counselor communication containing low levels of these core conditions, without regard to technique used. This addresses the apparent strength the core conditions have on enhancing counselor communication and indicates the usefulness of these conditions for client perceptions of therapists' expertness.

Based on existing research (Atkinson et al., 1978), hypothesis 4 predicts that paradoxical communication will be
rated as significantly more expert than nondirective communication regardless of level of core conditions present. This hypothesis is also supported, indicating that counselors who want to be perceived as expert are well-advised to consider using more directive, paradoxical techniques in counseling. Research which supports perceived counselor expertness as important for positive counseling outcome includes working with members of certain ethnic groups (Atkinson et al., 1978), counseling certain children's groups (Hartley, 1969), attempting to change client opinion (Strong & Schmidt, 1970), and, finally, attempting to teach specific skills or change habits (Heppner & Dixon, 1978). In these instances in which the client's perception of the counselor as expert is critical in involving clients and/or facilitating client change, the use of paradoxical techniques instead of nondirective techniques appears to be preferable.

Hypotheses 5, 6, and 7 are not supported, as no interactions are evident. The findings on hypotheses 3-7 suggest that high levels of empathy and warmth are important in differentiating counselors' expertness, and that counselors using high levels of empathy and warmth are more likely to be perceived as expert by clients than counselors using low levels of these core conditions. In addition, when technique alone is considered, counselors using paradoxical communication are more likely to be perceived as expert than counselors using nondirective communication, regardless of level of core conditions of empathy and warmth utilized.
Technique alone does not differentiate pseudoclients' perceptions of the attractiveness dimension. Rather, the level of empathy and warmth present differentiates pseudoclients' perceptions of attractiveness in counselor communication. This supports hypothesis 8 which postulates a significant difference between conditions based on the level (high or low) of core therapeutic conditions present. However, hypothesis 9, which postulates a difference in perceived attractiveness based on technique with equally high levels of core conditions, is not supported, as no interactions are apparent. Hypothesis 10, postulating no differences between pseudoclients' perceptions of attractiveness with regard to technique alone, is upheld.

Together these results support Strong's (1968) suggestion that attractiveness is enhanced by counselor display of the core conditions, regardless of technique used. This again appears to support findings in a study by Fischer et al. (1975) that relationship abilities exist across theoretical orientation and are not the domain of any one approach. Nondirective communication high in empathy and warmth is not rated as significantly higher in attractiveness than paradoxical communication high in these core conditions. Again, the use of core therapeutic conditions may be more important than the technique used. Using these conditions may, in addition, be a critical consideration when the client's perception of counselor attractiveness is important for counseling progress.
Finally, on the social influence dimension of trustworthiness, hypothesis 11 predicts that counselor communication with high levels of core conditions will be perceived as significantly more trustworthy than counselor communication with low levels of these core conditions. This hypothesis is supported, replicating Strong's (1968) earlier research findings on the relationship between trustworthiness and the core therapeutic conditions. It also once again points to the importance of using high levels of the core conditions for client involvement regardless of orientation or technique utilized.

One of Strong's (1968) criteria for counselor trustworthiness is perceived honesty. The paradoxical technique of symptom prescription is criticized as deceiving the client (Coleman & Nelson, 1957) by assigning tasks which seem contradictory to desired symptom relief. The use of paradox appears to be somewhat less than forthright on the part of the therapist. However, pseudoclients' perceptions of therapists using the two counseling techniques are not significantly different. Hypothesis 12, predicting a significant difference (interaction effect) between nondirective communication with high levels of empathy and warmth, and paradoxical communication with low levels of these conditions, is not supported. Hypothesis 13, predicting no difference on pseudoclients' perceptions of trustworthiness between nondirective and paradoxical communication, is
upheld. These findings suggest that when considering the dimension of trustworthiness, one may not consider technique alone as sufficient to enhance perception of counselor trustworthiness. The use of high levels of empathy and warmth appears to be more critical than the technique used. It also counters the criticism of Coleman and Nelson (1957) that the use of symptom prescription is perceived as inherently less trustworthy than other, more conventional approaches. With regard to trustworthiness, it appears that the level of empathy and warmth is a more critical element than technique.

Limitations of the current study are primarily those related to analogue studies in general, those of external validity. The first limitation relates to the uncertain similarity between the pseudoclient subjects who rate the audiotapes and the client to whom the subjects listen in the audiotaped simulation. In this study the subjects are not screened or pre-selected on the basis of sex or presence of the audiotaped client's problem. Ratings may not, therefore, reflect perceptions of actual clients of the same sex and with a similar presenting problem as the audiotaped client. In addition, the audiotaped counselor is a trained associate of the experimenter rather than a recognized professional. Typically, in a university setting, clients have the option of professional counselors or graduate interns for counseling. The expertise of the actual counselor may vary somewhat from that of the one used in this study.
Perhaps the central limitation, and one which has not yet been thoroughly researched, is the question raised by Corrigan et al. (1980) on whether findings obtained in settings that differ from ordinary counseling can be generalized to actual counseling. This is itself an empirical question beyond the scope of this study. However, research involving real clients in real counseling situations would enhance the generalizability of the findings. This may run the risk, however, of compromising internal validity and should be taken into consideration. Situations that approximate the counseling setting while preserving the internal validity of the study, such as the quasi-counseling model proposed by Lopez and Wambach (in press), seem to be a good compromise. This suggested procedure combines analogue and the naturalistic counseling situation, a procedure future studies would be well-advised to consider (Munley, 1974).

A curious lack of finding and an area for future research is related to the core condition of genuineness. There is not a significant difference in the rating of scripts designed to reflect high and low levels of genuineness. As a result, comparisons between nondirective and paradoxical communication are limited to the core conditions of empathy and warmth. It is suggested that perhaps the prior training of the judges influences their perceptions of paradox as being less than honest. Future research might focus on pre-screening judges more carefully to monitor pre-existing
biases. Another possibility would be to train judges naive in counseling to use the rating scales, thereby reducing the problems of judge bias. Presenting the tapes to the judges individually in a random order would further prevent rater bias due to either fatigue or adaptation effects which is not controlled when the tapes are presented randomly to the group.

Procedurally, instead of using a one-way analysis of variance (ANOVA) to compare the core conditions, raters might be used to randomly read and pre-sort the scripts into one of the four conditions, based on perceived level of core conditions and technique. A two-by-two repeated measure design could then be used to analyze differences between the four groups on the level of core conditions present. With a smaller error term, the likelihood of finding significance which actually exists may be greater. It is possible that if a significant difference exists on the genuineness dimension, it might be detected using the repeated measures design. Future research might use this method as a more powerful means for analyzing the data. Also, using more than four judges per cell could increase the confidence with which the results are interpreted. This procedure is especially indicated because of the homogeneity of variance on the empathy measure (Table 2). By increasing the number of judges rating the core therapeutic conditions, a more accurate variance could be computed. The results could then be interpreted with a greater degree of certainty.
Finally, future research might compare paradoxical communication to other directive orientations on the dimension of expertness. It is difficult to determine whether paradox is perceived as more expert because of the paradoxical nature of the directive or simply because it is, like many other therapies, directive and task-prescribing. Perhaps simply giving a client specific tasks to accomplish for symptom relief is adequate for the client to perceive the counselor as more expert than a nondirective counselor. Perhaps, however, the fact that symptom prescription seems to run counter to the desired goal of symptom relief, a kind of reverse psychology, gives the client the idea that the counselor knows something not readily apparent to the naive observer and is therefore more expert than the average counselor. Future research comparing conventional directive tasks with paradoxical tasks might yield the answer.

In summary, the current study suggests that, based on social influence theory, both paradoxical and nondirective counselor communication may be perceived as equally effective in influencing clients in therapy. In addition, counselors using paradoxical communication appear to have the advantage of being perceived as more expert, thus enhancing their counseling base. Further, this study replicates in part previous findings by Fischer et al. (1975) that counselor use of high core therapeutic conditions enhances perceived attractiveness, expertness, and trustworthiness by potential
clients. While the use of the high level core conditions is present in both therapeutic techniques, nondirective communication is perceived as significantly more empathic. While paradoxical communication is judged as less empathic than nondirective communication, it may be designed to be sufficiently empathic for positive outcome in therapy, according to levels established in earlier research (Truax & Carkhuff, 1967). Warmth is not differentiated by technique; however, the study concludes that paradoxical communication may be designed to contain high levels of warmth. None of the four conditions is perceived as significantly different on the genuineness dimension.

The current study suggests that whether counselors use paradoxical or nondirective techniques, they are perceived to be more effective as counselors by utilizing high levels of the core therapeutic conditions of empathy and warmth. Further, and more importantly, this study substantiates claims (Fischer et al., 1975; Troemel-Ploetz, 1980) that high level relationship skills are not the domain of any one theoretical orientation. Finally, this study challenges criticisms that paradoxical communication is contraindicated for use in therapy based on properties unique to it that might interrupt or undermine the therapeutic process (Coleman & Nelson, 1957; Fisher et al., 1981). This study also contradicts observations that paradox does not need to have high levels of core conditions in order to be effective in encouraging client involvement (Whitaker, 1979).
Appendix A

Informed Consent Agreement

NAME OF SUBJECT: _____________________________________________

1. These research forms are being used to further our knowledge in the area of counselor influence. There should be no harm whatsoever in completing these forms.

2. I hereby give consent to Myron Beard to use the forms I am filling out for research purposes only. I understand that this information is confidential and that my name will be removed from these instruments after they are organized together.

3. I have heard a clear explanation and understand the nature and purpose of the procedure, as well as the discomforts involved and the possibility of complications which might arise. I have seen a clear explanation and understand the benefits to be expected. I understand that the procedure to be performed is investigational and that I may withdraw my consent for status. With my understanding of this, having received this information and satisfactory answers to the questions I have asked, I voluntarily consent to the procedure designated in Paragraph 2 above.

DATE

SIGNED: _____________________________________________

SUBJECT

SIGNED: _____________________________________________

WITNESS
Appendix B

A Tentative Scale for the Measurement of Nonpossessive Warmth

Level 1:

The therapist is actively offering advice or giving clear negative regard. He may be telling the patient what would be "best for him," or in other ways actively approving or disapproving of his behavior. The therapist's actions make himself the locus of evaluation; he sees himself as responsible for the patient.

Level 2:

The therapist responds mechanically to the client, indicating little positive regard and hence little nonpossessive warmth. He may ignore the patient or his feelings or display a lack of concern or interest. The therapist ignores client at times when a nonpossessively warm response would be expected; he shows a complete passivity that communicates almost unconditional lack of regard.

Level 3:

The therapist indicates a positive caring for the patient or client, but it is a semipossessive caring in the sense that he communicates to the client that his behavior matters to him. That is, the therapist communicates such things as "It is not all right if you act immorally," "I want you to get along at work," or "It's important to me that you get along with the ward staff." The therapist sees himself as responsible for the client.

Level 4:

The therapist clearly communicates a very deep interest and concern for the welfare of the patient, showing a nonevaluative and unconditional warmth in almost all areas of his functioning. Although there remains some conditionality in the more personal and private areas, the patient is given freedom to be himself and to be liked as himself. There is little evaluation of thoughts and behaviors. In deeply personal areas, however, the therapist may be conditional and communicate the idea that the client may act in any way he
wishes--except that it is important to the therapist that he be more mature or not regress in therapy or accept and like the therapist. In all other areas, however, nonpossessive warmth is communicated. The therapist sees himself as responsible to the client.

Level 5:

The therapist communicates warmth without restriction. There is a deep respect for the patient's worth as a person and his rights as a free individual. At this level the patient is free to be himself even if this means that he is regressing, being defensive, or even disliking or rejecting the therapist himself. At this stage the therapist cares deeply for the patient as a person, but it does not matter to him how the patient chooses to behave. He genuinely cares for and deeply prizes the patient for his human potentials, apart from evaluations of his behavior or his thoughts. He is willing to share equally the patient's joys and aspirations or depressions and failures. The only channeling by the therapist may be the demand that the patient communicate personally relevant material.
Appendix C

A Tentative Scale for the Measurement of Therapist Genuineness or Self-Congruence

Level 1:

The therapist is clearly defensive in the interaction, and there is explicit evidence of a very considerable discrepancy between what he says and what he experiences. There may be striking contradictions in the therapist's statements, the content of his verbalization may contradict the voice qualities or nonverbal cues (i.e., the upset therapist stating in a strained voice that he is "not bothered at all" by the patient's anger).

Level 2:

The therapist responds appropriately but in a professional rather than a personal manner, giving the impression that his responses are said because they sound good from a distance but do not express what he really feels or means. There is a somewhat contrived or rehearsed quality or air of professionalism present.

Level 3:

The therapist is implicitly either defensive or professional, although there is no explicit evidence.

Level 4:

There is neither implicit nor explicit evidence of defensiveness or the presence of a facade. The therapist shows no self-incongruence.

Level 5:

The therapist is freely and deeply himself in the relationship. He is open to experiences and feelings of all types—both pleasant and hurtful—without traces of defensiveness or retreat into professionalism. Although there may be contradictory feelings, these are accepted or recognized. The therapist is clearly being himself in all of his responses, whether they are personally meaningful or trite. At level 5
the therapist need not express personal feelings, but whether he is giving advice, reflecting, interpreting, or sharing experiences, it is clear that he is being very much himself, so that his verbalizations match his inner experience.
Appendix D

Carkhuff's Empathic Understanding in Interpersonal Processes Measurement Scale

Level 1:

The verbal and behavioral expressions of the helper either do not attend to or detract significantly from the verbal and behavioral expressions of the helpee(s) in that they communicate significantly less of the helpee's feelings and experiences than the helpee has communicated himself.

Level 2:

While the helper responds to the expressed feelings of the helpee(s), he does so in such a way that he subtracts noticable affect from the communications of the helpee.

Level 3:

The expressions of the helper in response to the expressions of the helpee(s) are essentially interchangeable with those of the helpee in that they express essentially the same affect and meaning.

Level 4:

The responses of the helper add noticeably to the expressions of the helpee(s) in such a way as to express feelings a level deeper than the helpee was able to express himself.

Level 5:

The helper's responses add significantly to the feeling and meaning of the expressions of the helpee(s) in such a way as to accurately express feelings levels below what the helpee himself was able to express or, in the event of ongoing, deep self-exploration on the helpee's part, to be fully with him in his deepest moments.
Appendix E

Counselor Rating Form

Listed below are several scales which contain word pairs at either end of the scale and seven spaces between the pairs. Please rate the counselor you just saw on each of the scales.

If you feel that the counselor very closely resembles the word at one end of the scale, place a check mark as follows:


OR


If you think that one end of the scale quite closely describes the counselor then make your check mark as follows:


OR


If you feel that one end of the scale only slightly describes the counselor, then check the scale as follows:


OR


If both sides of the scale seem equally associated with your impression of the counselor or if the statement is irrelevant, then place a check mark in the middle space:


Your first impression is the best answer.

PLEASE NOTE: PLACE CHECK MARKS IN THE MIDDLE OF THE SPACES.
<table>
<thead>
<tr>
<th>Agreeable</th>
<th>Unagreeable</th>
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<td>Alert</td>
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<tr>
<td>Unappreciative</td>
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<td>Close</td>
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<td>Incompatible</td>
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<td>Dishonest</td>
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<td>Negative</td>
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<td>straightforward</td>
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<td>trustworthy</td>
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<tr>
<td>genuine</td>
<td>phony</td>
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<tr>
<td>warm</td>
<td>cold</td>
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</table>
Appendix F

Paradoxical/High Core Conditions Interview

Therapist: Well, how have you been doing on your procrastination problem this week?

Client: (pause, quietly muttering) Ah, OK I guess.

T: (tentative but concerned) Do you look kind of down today or is that my imagination?

C: (pause, then discouraged) Yeah. I've had this procrastination problem so long I, ah, don't know what to do about it. I, ah, guess I'm feeling like I'll never improve.

T: (warm, concerned) It sounds like you're really feeling lousy about this problem and its really got you discouraged. Kind of like you're feeling helpless about it.

C: (sad, discouraged) Yeah, it gets old after awhile and I just wish it would go away and leave me alone.

T: (warm, empathic) Its a helpless kind of feeling and its hard to understand why the problem keeps coming back.

C: (pause, resigned) I guess I just feel stuck.

T: (soft, understanding) You're feeling you just don't know which way to turn, not knowing what to do.

C: (slowly, frustrated) Yeah, that's about it, and I don't understand why it keeps coming up.

T: (understanding) It sounds like you're confused about it and it has really thrown you for a loop. I'm wondering if its possible that you're not fully aware of your
procrastination or do not understand it entirely.

C: (pause) What do you mean?

T: (tentatively) Maybe why you feel so helpless is because you haven't had the awareness of what is going on and why you procrastinate. Maybe the key to controlling it is understanding it better. What do you think?

C: (softly, tentative) You mean that maybe if I understand it better it might help me and I could get more control over it, is that it?

T: (affirming, but tentative) Yes, that's right. I have an idea to help you make more systematic observations, but I'm reluctant to share it with you because I don't want to force you to do something you might not want to.

C: (pause) I'm really feeling at the end of my rope, and I would appreciate anything you could offer.

T: (understanding) You're feeling like you've run out of options and it would be OK to give you a suggestion.

C: Yeah, I'm open.

T: (affirming but not too pushy) OK, great. What I would like you to do is to select one thirty-minute period each evening. Select the time when you are alone at a quiet study desk, arrange your books but keep your books and notes closed, just set up as if you were to study. Do you understand so far?

C: You want me to get all my things ready just like I normally study at a quiet place for thirty minutes, but leave my notes and books closed.
T: (factually) Yes, that's right. And your task in that situation is to try to sit and concentrate on procrastinating. Resist studying as long as you can, and be aware of the thoughts and feelings that may emerge. Observe what happens as you try to concentrate on procrastination. Do you follow me?

C: (tentatively) I think so. You want me to concentrate on procrastinating instead of trying to study. Is that right?

T: (affirming) Yes, exactly. If the urge to open any books or notes arises, concentrate on frustrating it and observing the effects. Push yourself to the limit and spend as much of this time as you can procrastinating and observing. (pause) OK? At the end of the period, make a mental note of your observations. Repeat the procedure each night during the week for the thirty-minute period. How do you feel about this?

C: I think I understand the task, but I guess I'm a little confused. In order to understand procrastination better, you basically want me to observe how I feel while procrastinating?

T: That's right. It may seem a little confusing and perplexing at first. But this will help us get a better handle on this problem.

C: OK. I'll start tonight.
Appendix G

Paradoxical/Low Core Conditions Interview

Therapist: Well, how have you been doing on your procrastination problem this week?

Client: (pause, quietly muttering) Ah, OK I guess.

T: (matter-of-factly) OK, huh. Well, let’s hear about it.

C: (pause, then discouraged) Well, I’ve had this procrastination problem so long, I...ah...don’t know what to do about it. I...ah...guess I’m feeling like I’ll never improve.

T: (unconcerned and professional) I’ll bet you are feeling lousy. You’ve had this problem a long time now. Remember, it will probably take awhile to clear it up.

C: (sad, discouraged) Yeah. But, it...ah...gets old after awhile and I just wish it would go away and leave me alone.

T: (professional) Well, things don’t always happen just the way we want them to, do they? Sometimes we just need to stomach some of the unpleasantness in life. But in time, things usually turn out for the best.

C: Yeah, I guess. I’m just...ah...confused and don’t really understand why it...ah...keeps coming up.

T: (professional) Well, we work with a lot of these procrastination problems. Usually it’s just a matter of the student getting a better understanding of the problem.

C: (discouraged) But I feel I’ve tried everything and it just keeps coming back.
T: (professional and critical) Usually the key to controlling it is understanding it better. I have an idea that might help, but I don't want to tell you because I don't think that you will do it.

C: (weakly) I'll...ah...do anything to get relief from this problem.

T: (professional; matter-of-factly) Well, OK then. Since understanding this problem is important, I have a task I want you to follow during the next week. I want you to make systematic observations on your procrastination. How does that sound?

C: (perplexed) I...ah...don't understand what you're...ah...asking.

T: (professional; emotionless) Well, here it is. I want you to select thirty minutes each evening. Select the time alone at a quiet study desk. Arrange your books, but keep your books and notes closed. Just set up as if you were to study. Do you understand, so far?

C: You want me to get all my things ready just like I normally study at a quiet place for thirty minutes, but leave my notes and books closed.

T: (matter-of-factly; autocratic) Yes, that's right. And your task in that situation is to try to sit and concentrate on procrastinating. Resist studying as long as you can, and be aware of the thoughts and feelings that may emerge. Observe what happens as you try to concentrate on procrastination. Do you follow me?
C: (tentatively) I think so. You want me to concentrate on procrastinating instead of trying to study. Is that right?

T: (gruffly) Yes. Well, do you think you can do that? If the urge to open any books or notes arises, concentrate on frustrating it and observing the effects. Push yourself to the limit and spend as much of this time as you can procrastinating and observing. (pause) OK? At the end of the period, make a mental note of your observations. Repeat the procedure each night during the week for the thirty-minute period. How do you feel about this?

C: (cautious, reluctant) I think I understand the task, but I guess I'm a little confused. In order to understand procrastination better, you basically want me to observe how I feel while procrastinating?

T: (abrupt) Well, even if it sounds confusing, I want you to do it. Believe me, we've tried this on a number of cases and it really seems to help.

C: (reluctantly) OK. I'll do whatever you say.
Appendix H

Nondirective/High Core Conditions Interview

Therapist: Well, how have you been doing on your procrastination problem this week?

Client: (pause, quietly muttering) Ah, OK I guess.

T: (tentative but concerned) Do you look kind of down today or is that my imagination?

C: (pause, then discouraged) Yeah. I've had this procrastination problem so long I, ah, don't know what to do about it. I, ah, guess I'm feeling like I'll never improve.

T: (warm, concerned) It sounds like you're really feeling lousy about this problem and it has really gotten you discouraged. Kind of like you're feeling helpless about it.

C: (sad, discouraged) Yeah, it gets old after awhile and I just wish it would go away and leave me alone.

T: (warm, empathic) It's a helpless kind of feeling and it's hard to understand why the problem keeps coming back.

C: (pause, resigned) I guess I just feel stuck.

T: (soft, understanding) You're feeling you just don't know which way to turn, not knowing what to do.

C: (slowly, frustrated) Yeah, that's about it, and I don't understand why it keeps coming up.

T: (understanding) Sometimes when we don't understand what happens to us, it's confusing and really frustrating,
and we just don't know what to do.

C: (pause, sad) The longer this goes on, the more scared I get...afraid of failing, afraid of what my parents or friends might think, just plain afraid.

T: It's scary to think of what could happen and what others may think of you. Scary to think of having those close to you reject or be angry with you.

C: (deep sigh, then dejected) And then I begin feeling guilty, like I'm letting everyone down, everyone that cares for me.

T: Mhm. Feeling like a lot of people are pulling for you but you're disappointing them. Sounds like a pretty lonely-type feeling. I guess you must be feeling a pretty heavy load on you right now.

C: Yeah, I do. Even though my mom and dad tell me they understand and not to worry about it, I do want to do well for them and for me.

T: Mhm. Pleasing yourself and others close to you is important to you, even when you know they will care for you regardless of what happens.

C: Yeah. (pause) But you know, at times I tell myself that I can do it. Even though it's a battle sometimes I really believe I can get over this. After all, it's not life or death (short snicker).

T: (brighter) So even in your darkest moments you sense an inner ability to overcome your procrastination and
realize that while it's serious it's not the end of the world.

C: (lighter, but tentative) Yeah. So that while I'm down in the dumps today, maybe someday I will be able to get a handle on this problem. I mean, not everyone has a procrastination problem.

T: (affirming) I suppose that one thing you are saying is that even though you have this studying difficulty, other people seem to deal with it and this gives you the feeling that maybe you can too.

C: (a little better) That's it. It's just a matter of getting a better understanding of what is behind it all.
Appendix I

Nondirective/Low Core Conditions Interview

Therapist: Well, how have you been doing on your procrastination problem this week?

Client: (pause, quietly muttering) Ah, OK I guess.

T: (matter-of-factly) OK, huh. Well, let's hear about it.

C: (pause, then discouraged) Well, I've had this procrastination problem so long, I...ah...don't know what to do about it. I...ah...guess I'm feeling like I'll never improve.

T: (unconcerned and professional) I'll bet you are feeling lousy. You've had this problem a long time now. Remember, it will probably take awhile to clear it up.

C: (sad, discouraged) Yeah. But, it...ah...gets old after awhile and I just wish it would go away and leave me alone.

T: (professional) Well, things don't always happen just the way we want them to, do they? Sometimes we just need to stomach some of the unpleasantness in life. But in time, things usually turn out for the best.

C: Yeah, I guess. I'm just...ah...confused and don't really understand why it...ah...keeps coming up.

T: (parental and professional) Well, understanding might be nice, but who's to say that by simply understanding your problem it would go away?

C: (pause; sad) It's just that...ah...the longer it goes
on, the more scared I get. Afraid of failing...afraid of what my parents or friends might think...just plain afraid.

T: (professional) Afraid, huh? Yeah, I suspect anyone in your position would be afraid. Remember, though, you're the only one that can straighten it out.

C: (impatiently) I know, I know. I just don't want to let everyone down that cares for me.

T: (cold) You've got to learn how to respond to this thing. You can either like it or learn how to handle it in a way that doesn't make you more unhappy. You've got to take more control over your life.

C: (dejected) Yeah, I guess you're right.

T: (professional) It looks to me like you can either learn to take charge of this studying thing or learn to live with it. Isn't that about the size of it?

C: (sad and frustrate) Yeah. Sure. Either get control of my procrastination or learn to live with it. I just wish I knew how. Somehow I get the idea that I'll have this problem the rest of my life.

T: (professional) It seems that way now. Like it's going on and on and on and on. But I have confidence that you can lick this problem. You just need to keep trying harder and I know you'll make it.

C: (resigned) I just...ah...wish I...ah...believed that.

T: (parental) Someday, I'm sure things will get better
for you. Like I say, just keep trying harder and you'll make it.

C: (dejected) Yeah. I guess. (pause) There are times that I...ah...think I...ah...can get over it and gain more...ah...self-control.

T: (professional; parental) See. At times you are able to see through this thing. After all, it's not the end of the world (slight laugh).

C: (tentative, dejected) Yeah. I know I'm down in the dumps today. Maybe someday I'll get a handle on this procrastination problem. I...ah...mean, not everyone has it.

T: (professional; unemotional) Right. Not all people have studying problems and you don't have to either. I'm sure in time this will pass. It's just a phase for you now.

C: (dejected; discouraged) Well, I...ah...hope so. Maybe someday I will understand this problem and lick it.
Appendix J

Instructions to Judges

You are about to listen to a short enactment of a counseling session in which the female client is seeking help from the male therapist for a problem she is having. The female client has been coming into the counseling center for three weeks. This recording is an excerpt from her third counseling session with the counselor. Following the recording, you will be asked to rate the session on the core therapeutic conditions. You may take notes during the tape if you wish. This is tape number ___. The tape will now begin.

-------------------

TAPE

-------------------

Now please rate the counselor on all three core therapeutic conditions on the form you have before you.
Appendix K

Core Conditions Rating Form

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td></td>
</tr>
<tr>
<td>Warmth</td>
<td></td>
</tr>
<tr>
<td>Genuineness</td>
<td></td>
</tr>
</tbody>
</table>
Appendix L

Audiotaped Instructions

You are about to listen to a short enactment of a counseling session in which the female client is seeking help from the male therapist for a problem she is having. The female client has been coming into the counseling center for three weeks. Her problem upon coming was that she always seemed to be having difficulty studying and never seemed to feel like really getting down to reading her assignments. This is referred to as procrastination on the tape. This recording is an excerpt from her third counseling session with the counselor. Now, imagine that you are the client. Try to imagine how you would feel about the counselor in this session. Relax and get comfortable. Many people find it helpful to close their eyes while listening to the tape. If this would be helpful to you, feel free to do so. Following the recording, you will be asked to rate the session.

------------------

TAPE

------------------

Now please rate the counselor on the Counselor Rating Form you have before you. Do not put your name on the form, as all responses are kept anonymous. When you have finished rating the counselor, hand the form to the experimenter and you may leave. You may now begin rating. Thank you.
Table 1

Means, Standard Deviations, and t-Values of Core Conditions on Scripts Designed High or Low on These Conditions

<table>
<thead>
<tr>
<th>Core Condition</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>t</th>
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<tr>
<td>Empathy</td>
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<td></td>
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<td></td>
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<tr>
<td>High Script</td>
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<td>4.50</td>
<td>0.926</td>
<td>7.67**</td>
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<tr>
<td>Low Script</td>
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<tr>
<td>Warmth</td>
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<td></td>
<td></td>
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<tr>
<td>High Script</td>
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<td>0.518</td>
<td>8.88**</td>
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<tr>
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<td>0.756</td>
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</tr>
<tr>
<td>Genuineness</td>
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<td></td>
</tr>
<tr>
<td>High Script</td>
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<td>3.75</td>
<td>1.035</td>
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<tr>
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*p < .05

**p < .01
Table 2

Means and Standard Deviations of Core Conditions by Counseling Technique

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<tr>
<th></th>
<th>Empathy&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Warmth&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Genuineness</th>
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<tbody>
<tr>
<td></td>
<td>Mean</td>
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<td>Nondirective</td>
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<tr>
<td>Low EW</td>
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<td>0.00</td>
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<sup>a</sup><sub>p < .01 (Paradox/High EW > Paradox/Low or Nondirective/Low EW; Nondirective/High > Paradox/High EW)

<sup>b</sup><sub>p < .01 (Paradox/High EW and Nondirective/High EW > Paradox/Low EW or Nondirective/Low EW)
Table 3

Multivariate Source Table for Attractiveness, Expertness, and Trustworthiness Dependent Measure

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<tr>
<th>Source</th>
<th>Hotellings Value</th>
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<th>F</th>
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<td>Technique</td>
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<sup>a</sup>EW represents core conditions of empathy and warmth

*<i>p < .01</i>
Table 4

Analysis of Variance of Social Influence Dimensions

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<tr>
<th>Dependent Measures</th>
<th>Source(^a)</th>
<th>Sum of Squares</th>
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<td>.001</td>
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<td>EW x Technique</td>
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<td>Trustworthiness</td>
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<td></td>
<td>Technique</td>
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\(^a\)EW represents core conditions of empathy and warmth

\(^*\)p < .01
Table 5

Means and Standard Deviations of Social Influence Dimensions on Core Conditions, Technique, and Core Condition by Technique

<table>
<thead>
<tr>
<th>Social Influence Dimensions</th>
<th>Core Conditions</th>
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<th>Technique by Core Condition</th>
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<td>High vs. Low</td>
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<td>Attractiveness</td>
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<td>Trustworthiness</td>
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<td></td>
<td>48.41</td>
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<tr>
<td>*p &lt; .01</td>
<td>(comparing these means by a Hotellings technique)</td>
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Table 6

Intercorrelations Among the Core Therapeutic Conditions

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<th></th>
<th>Empathy</th>
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<th>Genuineness</th>
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<tr>
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<td>.8562</td>
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<td>Genuineness</td>
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Table 7

Intercorrelations Among the Social Influence Dimensions

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