THE VALIDATION OF A SELF-REPORT MEASURE OF CLIENT READINESS FOR THERAPY

by

Clifford M. Berish

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CLIFFORD M. BERISH

A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

DOCTOR OF PHILOSOPHY

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ABSTRACT

The construct of client readiness for therapy was researched through a sequence of validational studies with a self-report measure, the Client Readiness for Therapy Inventory (CRTI). The history of this construct, including previous measurement efforts and its current place in the field of psychotherapy research were reviewed. The CRTI was tested on a client sample, item and factor analyzed, and compared with results previously obtained from an analogue sample (Berish, 1984). Nine principal components were extracted, rotated to varimax solutions, and interpreted from both samples. The factors from the clinical sample were labelled: (1) Expected Internal Change, (2) Therapy Mindedness, (3) Current Emotional Distress, (4) Faith in Therapy, (5) Introspected Will to Change, (6) Personal Responsibility, (7) Risk Taking, (8) Disclosure Tolerance, and (9) Interpersonal Trust. Coefficients of congruence (Gorsuch, 1986) calculated for all possible factor pairings across the two samples revealed three highly invariant and twelve moderately invariant comparisons. Truncated, unitized scale scores were created from the nine clinical factors, and Pearson correlation coefficients of clients' scores on these dimensions were studied in relation to (a) intake therapists' ratings of the clients' readiness for

therapy, (b) content analytic measures of three CRTI factors derived from therapists' intake reports, (c) clients' scores on the Stages of Change Questionnaire (McConnaughy, Prochaska, & Velicer, 1983), (d) Therapist rated treatment outcome, and (e) the duration of therapy. Overall, intake therapists' ratings and client scores on the Stages of Change scales were significantly related to clients' CRTI scale scores, and provided incremental validation for the interpretations of the CRTI factors. Outcome criteria examined were related to client scores on only two CRTI scales, but were related to intake therapist ratings. The content analytic measures yielded convergent validational support for two of the three factors examined. A second analogue study was conducted, which generated new pro- and con-trait items for some of the CRTI scales. Implications for conceptualizing dimensions of client readiness for therapy, as well as the client processes involved at different stages of change were discussed. Future studies with the CRTI were suggested to increase its clinical utility, and further validate the scales.

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CLIENT READINESS FOR THERAPY: IMPORTANT UNTAPPED VARIANCE OR SELF-PROTECTIVE CLINICAL LORE?

"Client readiness for therapy" has periodically emerged, under one label or another, as a concern in psychotherapy theory and research. The construct has appeared as "therapy readiness" (e.g., Grant & Grant, 1950), "counseling readiness" (e.g., Heilbrun Jr., 1962), "motivation" (e.g., Keithly, Samples, & Strupp, 1980), "responsibility" (e.g., Schroeder, 1960), "hope" (e.g., Gottschalk, 1974), "faith" (e.g., Bergman, 1958), "placebo effects" (e.g., Patterson, 1985), "nonspecific factors" (e.g., Gomes-Schwartz, 1978), "expectations" (e.g., Goldstein & Shipman, 1961), "emotional arousal" (e.g., Frank, 1974), "need to change" (e.g., Cartwright & Lerner, 1963), and "desire for change" (e.g., Sifneos, 1968). Widely believed to be a significant ingredient in therapy (e.g., Frank, 1979; Gomes-Schwartz, Hadley, & Strupp, 1978; Korchin & Sands, 1983; Lambert, Shapiro, & Bergin, 1986; Stiles, Shapiro, & Elliott, 1986), the client's readiness for therapy is pointed to as an explanation for treatment failures (e.g., Miller, 1985), and as an untapped source of variance in the overall therapy research puzzle (e.g., Smith, Glass, & Miller, 1980). Nonetheless, this construct

has only recently begun to be systematically conceptualized, measured, and researched (Berish, 1984, 1987; Dean, Beutler, Helmstetter, & Meredith, 1989; McConnaughy, Prochaska, & Velicer, 1983; Prochaska & DiClemente, 1982, 1983; Rosenbaum & Horowitz, 1983). Consequently, the relationships between the various dimensions of the construct, and their roles in therapy, have yet to be clarified.

Current Trends in Psychotherapy Research

For the past few decades psychotherapy researchers have not valued investigations of this unclear construct (Meltzoff & Kornreich, 1970; Kazdin, 1979; Frank, 1979). Kazdin (1979) has suggested that:

> The relative lack of a clear theoretical base may accord so-called nonspecific factors a lower research priority ... [because] ... research often places a premium on making predictions about variables that not only produce change but also support a theoretical position about psychopathology or psychotherapeutic change (p.847).

Frank (1979) addressed this issue similiarly, although in a more confrontational style:

> Features which are shared by all therapists have been relatively neglected, since little glory derives from showing that the particular method one has mastered with so much effort may be indistinguishable from other methods in its effects (p.74).

In the past decade, however, there have been noticeable changes in the field of psychotherapy research, establishing new research priorities (e.g., Garfield & Bergin, 1986;

Parloff, London, & Wolfe, 1986; Stiles, et al., 1986; Strupp, 1986; Vandenbos, 1986), under which "Nonspecific effects are given unprecedented credence" (Borgen, 1984, p.584).

Changing Questions

Numerous reviews of the literature had forecasted (e.g., Fiske, 1977; Frank, 1979; Goldfried, 1980; Gomes-Schwartz, Hadley, & Strupp, 1978; Gottman & Markman, 1978; Phillips & Bierman, 1981; Smith et al., 1980; Wilkins, 1979) and have recently documented (e.g., Garfield & Bergin, 1986; Parloff et al., 1986; Stiles et al., 1986; Strupp, 1986; Vandenbos, 1986) the evolution of the basic questions guiding therapy research. First, is psychotherapy effective? Second, are the more than 250 therapies (Herink, 1980) differentially effective? Third, what are the significant ingredients of effective therapy?

For thirty years the field has tried to empirically answer Eysenck's (1952) historic challenge regarding the efficacy of psychotherapy (American Psychiatric Association, 1982; Garfield, 1981; Gottman & Markman, 1978; Smith et al., 1980; Strupp, 1986), and to document the system of therapy which produced the most beneficial outcomes (e.g., Goldfried, 1980; Luborsky, Singer, & Luborsky, 1975; Sloane, Staples, Cristal, Yorkston, & Whipple, 1975; Smith & Glass, 1977). This research was accelerated in the 1970's by

government policy reviews concerning third party payments, the consumer movement, and insurance companies, who all wanted evidence that psychotherapy works before agreeing to the more than one billion dollars which would be involved in reimbursing the industry (e.g., London & Klerman, 1982; Marshall, 1980; Parloff, 1982; Phillips & Bierman, 1981).

In 1977, Smith and Glass introduced their method of meta-analysis to combine and evaluate large numbers of independent studies in an apparently unbiased fashion. Based on 475 controlled studies, and tens of thousands of persons, they derived estimates of 1,766 measured effects for all types of therapy, client, and outcome, and concluded:

> The results show unequivocally that psychotherapy is effective . . . an applicant for therapy who is no better off than average (i.e., is at the 50th percentile) in psychological well-being, compared to all those who have not received psychotherapy, rises to the 80th percentile as a result of psychotherapy. At the end of treatment, he is better off than 80 percent of those who need therapy but remain untreated (Smith et al., 1980, p. 124).

Although effect size estimates, as well as methods suggested for estimating the effect sizes, have varied (e.g., Fiske, 1983; Rosenthal, 1983; Wortman, 1982), Smith et al. (1980) and Glass and Kleigl (1983) pointed out that all estimates are nonetheless large, when compared with other social science interventions. A consensus was reached that psychotherapy is significantly more effective than no treatment (Vandenbos, 1986).

Proponents of different therapies were challenged to show that their approach was effective, and superior to other approaches. Appropriately, the term "Grand Prix" was used to refer to the large-scale, comparative therapy studies of the time. When no overall differences in therapy outcome were found between leading therapy approaches (Luborsky et al., 1975; Sloane et al, 1975, Smith & Glass, 1977), Luborsky et al. (1975) concluded "Everyone has won and all must have prizes"(p.995).

The introduction of meta-analysis (Smith & Glass, 1977), provided a new context for debate. Equal outcomes of different therapies were found in Smith et al.'s (1980) meta-analysis, once confounds such as the reactivity of the outcome measures were partialled out. This was supported in reanalyses of subsets of their data (Andrews & Harvey, 1981; Landeman & Dawes, 1982; Prioleau, Murdock, & Brody, 1983) and in meta-analyses of an essentially different sample of studies (Shapiro & Shapiro, 1982).

As Parloff (1982) observed, policy makers were not satisfied with these conclusions because it was not possible to identify differentially effective therapies. No empirical information was available to avoid the potential "fiscal hemorrhage" (p. 721) if national health insurance were extended to cover psychotherapies. Many clinicians also were not pleased with the findings, because they failed to support the unique advantages of the particular theory

each espoused (Korchin & Sands, 1983; Parloff, 1982). Consequently, more clinicians became discontent searching for answers within the limited confines of their particular school of therapy; hence the growing climate of eclecticism (e.g., Beutler & Clarkin, 1990; Borgen, 1984; Garfield, 1980; Garfield & Kurtz, 1977; Goldfried, 1980, 1982; Highlen & Hill, 1984; Ivey, 1980; Korchin & Sands, 1983; Marmor & Woods, 1980; Norcross, 1986; Prochaska, 1984; Wachtel, 1977).

The field now seeks answers to the apparent paradox articulated by Stiles et al. (1986): Why do we find a lack of differential effectiveness between therapies utilizing diverse techniques? The change in research priorities was proclaimed by Vandenbos (1986) in his introduction to the American Psychologist's special issue on psychotherapy research. Vandenbos stated:

> single-focus 'outcome' (or efficacy) research should be a 'thing of the past'...and...the field appears ready to focus on more theoretically relevant and clinically useful research directly addressing the process of change during psychotherapy (p.111).

In the current Zeitgeist, a new question has become pressing: "are the positive effects reported attributable to the specific interventions of psychotherapy or to the nonspecific and placebo influences routinely associated with all therapies?" (Parloff et al., 1986, p.323). Two schools of thought have emerged with opposing answers to this query. One (e.g., Hosford, Burnett, & Mills, 1984; Kiesler, 1966;

Paul, 1967; Telch, 1981) asserts that the former interpretation is correct, while the other (e.g., Frank, 1973, 1974, 1979, 1981; Goldfried, 1980, 1982; Korchin & Sands, 1983) argues for the acceptance of the latter as the significant ingredients in psychotherapy.

Contributing impetus to the search for significant therapy variables, Smith et al.(1980) reported that in the 475 studies they meta-analyzed:

> Less than ten percent of the variation in effect size was determined by client diagnosis, intelligence, age, mode of presentation, therapy modality, therapist experience, internal validity of the experiment, type, time, and reactivity of the measurement (p.105).

Clearly, we are still unable to specify the important variance in psychotherapy. Some believe that the psychotherapeutic process with its "spontaneous interactions, subjective experience, and knowledge based on intuition..." (Parloff et al., 1986, p.343) may never lend itself to scientific scrutiny. Nonetheless, efforts to identify and measure potentially significant ingredients in therapy are necessary for practical as well as scholarly concerns. Two approaches will be briefly reviewed, focussing on their contrasting perspectives on 'client readiness for therapy' variables.

The Prescription Approach

Stiles et al. (1986) traced the Prescription Approach to Kiesler's (1966) critique that "... psychotherapy

research was hampered by 'uniformity myths' -- implicit assumptions that therapies, clients, and methods were all interchangeable" (p. 168). A solution was soon offered by Paul (1967), whose formulation -- later dubbed the "litany" by Parloff (1979, p.305) -- provides the framework for therapy research in this approach. Paul (1967) proclaimed:

> The question towards which all outcome research should ultimately be directed is the following: 'What' treatment, by 'whom' , is most effective for 'this' individual with 'that' specific problem, and under 'which' set of circumstances (p.111).

A multidimensional grid model was created, which held clinical appeal because it offered potential "prescriptions" (Goldstein & Stein, 1976) tailored to specific disorders (Stiles et al., 1986). Borgen (1984) described the logic of this approach in the context of the trend toward eclecticism, by fitting it to an analysis of variance metaphor:

> Recent studies show no main effects for therapists from different theoretical orientations. Then if we are to improve service delivery, we need to attend to the disordinal interactions and optimally match treatments with problems, that is, provide differential or prescriptive treatment (p.584).

It has been observed (e.g., Borgen, 1984; Parloff, 1982; Stiles et al., 1986) that advocates of the Prescription Approach are the most vocal critics of the accuracy and sensitivity of the equal outcome findings, such as the meta-analyses (e.g., Eysenck, 1978; Rachman & Wilson, 1980; Wilson, 1982; Wilson & Rachman, 1983). Two criticisms

offered are: (1) that differences in techniques' effectiveness may have been obscured by the lack of standardization of treatment deliveries; and (2) traditional outcome measures fail to reflect particular changes that differentiate treatments (e.g., Agras, Kazdin, & Wilson, 1979; Rachman & Wilson, 1980).

The first criticism has led to greater specification of, and adherence to standardized procedures for treatment delivery -- "manualization" (Borgen, 1984; Parloff et al., 1986; Stiles et al., 1986) among both cognitive-behavioral (e.g., Beck, Rush, Shaw, & Emery, 1979; Linehan, 1984) and dynamic therapies (e.g., Klerman, Weissman, Rounsaville & Chevron, 1984; Luborsky, 1984; Strupp & Binder, 1982). It has also led to the development of research strategies to identify active elements within complex treatment procedures -- "dismantling methodology" (Kazdin, 1980). Stiles et al. (1986) suggested that the second criticism underlies the expanding field of behavioral assessment (e.g., Barlow, 1984; Haynes, 1978). It also suggests a way of understanding how different therapies can be considered equivalent. Given the extent of individual differences and the wide range of outcome measures employed, therapies may well be equally successful at satisfying clients, because clients want different things out of therapy. Thus for example, an annual client satisfaction survey conducted at a university counseling centre which employs therapists of

differing, even contradictory philosophies and techniques, typically finds equal proportions of satisfied clients for the different therapists (Burke, personal communication, 1980). Stiles (1983) summarized this issue as follows:

> Current psychotherapeutic treatments are diverse, but no more diverse than successful patterns of living. Different psychotherapies may open up different ranges of options for their clients and produce systematically different kinds of healthy personality change.(p.183).

This reasoning is consistent with the prescription approach, as it suggests adding a dimension of individual patterns of living to the prescription matrix. These changes reflect the reductionist philosophy of rigorous specification and operationalization for scientific (in the logical positivist sense) advancement.

In efforts to demonstrate that therapeutic effects can be attributed to specific, identifiable treatments rather than to 'placebos' (dismantling methodology), client readiness for therapy variables have recently drawn increasing attention (e.g., Kazdin, 1980; Parloff et al., 1986; Prioleau et al., 1983; Wilson & Rachman, 1983). It is believed that truly prescriptive therapy will have arrived only when variance due to specific treatments will surpass that due to individual and therapist variables (Borgen, 1984; Hosford, Burnett, & Mills, 1984; Telch, 1981). The medical conception of placebo is invoked here (e.g., Kirsch, 1978, 1986; Ross & Olson, 1981; Wilkins, 1979), and so-called 'nonspecific' variables include many traditionally

conceptualized client, therapist , and relationship factors, in addition to other nonspecific treatment effects. These are relegated to a category of noise variables, to be controlled or eliminated (e.g., Borgen, 1984; Hosford et al., 1984; Prioleau et al., 1983; Telch, 1981; Wilson & Rachman, 1983). Ardent proponents of this perspective, such as Telch (1981), have argued that when more potent treatment techniques are developed, 'nonspecific' factors will become insignificant due to the strength of the treatment effects.

With the increasing acceptance of cognitive data (e.g., Wilson, 1982), some research has been conducted to identify client attitudinal and personality variables relevant to differential treatment assignment (e.g., Beutler, 1979; Beutler & Clarkin, 1990; Blashfield & Morey, 1979; Bruch, Heisler, and Conroy, 1981; Bruch, Juster, and Heisler, 1982; Buckalew, Ross, and Starr, 1981; Diloreto, 1971; Garfield, 1978; Gilbreath, 1967, 1968; Kanfer, 1972; Rallo, 1986; Shapiro, 1975; Stein & Stone, 1978). Most studies, however, have looked at readily available client characteristics such as demographic data, existing personality measures, and diagnostic information. Only a limited quantity of research has attempted to conceptualize or develop measures for client readiness factors, because they are considered relatively unimportant. Karoly (1980) is perhaps one exception, who has tried to conceptualize certain client readiness variables from a cognitive information processing

framework. He acknowledged afterward: "the pieces have yet to be tied together in a neat package" (p. 245). Most attention has been directed to the "what treatment" for "that specific problem" cells of the prescription matrix.

Although the prescription approach's multidimensional grid model seems to offer promise for discovering the significant ingredients in therapy, more and more researchers have noted the unrealistic framework of this approach, in view of the tens of thousands of cells (type of client * therapist * treatment * problem * setting, etc.) that would be required (e.g., Bergin & Lambert, 1979; Borgen, 1984; Horowitz, 1982; Stiles et al., 1986). Even with the capabilities of meta-analyses to combine 475 studies into the grid simultaneously, there is insufficient data available to analyze the complex interactions involved (Shapiro, 1985; Smith et al., 1980), let alone adding additional dimensions, such as individual patterns of living, as they become important. Thus while the concept of prescriptions tailored to clients seems theoretically sound and a worthy ideal, it doesn't appear attainable within the foreseeable future, given the presently vast number of variables that would need to be taken into account.

The Common Factors Approach

In contrast to the prescription viewpoint, the Common Factors Approach accepts the conclusion of equivalent

outcomes for different therapies (e.g., Stiles et al., 1986). Repeated findings from converging sources form the basis of the argument that it must be the features common to all therapies which account for their effectiveness (e.g., Frank, 1969, 1971, 1973, 1974, 1979, 1982; Goldfried, 1980, 1982; Korchin & Sands, 1983; Marmor & Woods, 1980; Strupp, 1973, 1976; Strupp & Hadley, 1979; Wachtel, 1977). It has been asserted that the significant ingredients of all approaches to psychological healing have much in common, whether practised by faith healers, shamans, witch doctors, or professional psychotherapists (e.g., Frank, 1973; Korchin & Sands, 1983; Tseng & McDermott, 1975), or found in naturally occurring support networks (e.g., Janis, 1983), or paraprofessional and self-help situations (e.g., Hattie, Sharpley, and Rogers, 1984; Strupp & Hadley, 1979).

In contrast to the atomistic, reductionist prescription approach, some common factors proponents stress the need for a new paradigm (cf. Kuhn, 1970) which can cross the traditional boundaries between therapy schools, at a new level of abstraction from what is directly observable (e.g., Goldfried, 1980; Prochaska, 1979, 1984). Goldfried has articulated this prospective shift for common factors therapy researchers as follows:

> It might be helpful to conceptualize the therapeutic enterprise as involving various levels of abstraction ... At the highest level of abstraction we have the 'theoretical framework' to explain how and why change takes place, as well as an accompanying 'philosophical stance' on the nature of human functioning. In the search for

> commonalities, it is unlikely that we can ever hope to reach common ground at either the theoretical or the philosophical level. Indeed numerous differences can be found at this level within the psychoanalytic, behavioral, and humanistic orientations. At the lowest level of abstraction, we have the therapeutic 'techniques' or clinical 'procedures' that are actually employed during the intervention process. Although commonalities across approaches may be found in the realm of specific techniques (e.g., role-playing, relaxation training), it is unlikely that such comparisons would reveal much more than trivial points of similarity. I would suggest, however, that the possibility of finding meaningful consensus exists at a level of abstraction somewhere between theory and technique which, for want of a better term, we might call 'clinical strategies'. Were these strategies to have a clear empirical foundation, it might be more appropriate to call them 'principles' of change. In essence, such strategies function as clinical heuristics that implicitly guide our efforts during the course of therapy. (p.994).

The common factors approach focuses on variables which are considered nonspecific in the prescription approach. Common factors proponents have argued that the 'placebo' concept from pharmacology is inappropriate as a control variable for psychotherapy research, because effective psychotherapy ingredients include what are considered placebo variables to chemotherapists (e.g., Bootzin & Lick, 1979; Kirsch, 1986; Klein, Zitrin, Woerner, & Ross, 1983; Lambert, Shapiro, & Bergin, 1986; Patterson, 1985; Strupp & Hadley, 1979; Wilkins, 1984). In the common factors approach, therefore, client readiness for therapy is believed to be an important determinant of therapy process and outcome.

Korchin and Sands (1983) have compiled a comprehensive list of principles common to psychotherapies. Rather than focussing on one aspect, they outlined an integrated picture, including therapist, relationship, client, and other variables. They divided such factors initially into two, not mutually exclusive, classes: the "therapeutic climate" and "specific therapeutic processes". Under the former are included cultural beliefs of the time and place, the patient's faith, expectations, and motivation for change, and the qualities of the therapist -- including status, the explanatory value of the theoretical framework, personal qualities, and the nature of the therapeutic relationship. With regard to specific therapeutic processes, they include suggestion and persuasion, emotional arousal, learning and relearning, self-exploration and understanding, feedback and reality testing, practise and rehearsal, and mastery and success experiences. The "climate" provides the conditions for some combination of the "processes". Finally, Korchin and Sands assert that these factors exist in all therapies, whether or not proponents are aware of, or wish to acknowledge them.

Prochaska & DiClemente (1982, 1983) have also constructed a most comprehensive model, called "transtheoretical therapy", based on an integration of eighteen systems of therapy (Prochaska, 1979), the identification of ten processes of change (Prochaska &

DiClemente, 1983; Prochaska, Velicer, DiClemente & Fava, 1988), and an exploration of client "stages of change" (DiClemente & Prochaska, 1982). Change is conceptualized in cognitive decision-making terms (c.f., Woolams, 1980), and analyses of a self-report measure they developed (McConnaughy, Prochaska, & Velicer, 1983) identified four different stages of change. The successive stages were labelled Precontemplation, Contemplation, Action, and Maintenance, and have been cross-validated in a large clinical sample (McConnaughy, DiClemente, Prochaska, & Velicer, 1989). Different clinical strategies are suggested at each stage of client change for optimal results. These recent efforts are beginning to provide the historically lacking theoretical base for client readiness for therapy variables, as well as needed measures and empirical data related to the process of client change.

The common factors approach, in contrast to the prescription ideal, seems more attainable. If indeed a new level of conceptualization can be found at which the existence of common significant ingredients can be demonstrated, the number of potential variables one would need to include in a multidimensional grid might become manageable. Essentially, this difference between the prescription and common factors approaches can be thought of, extending Borgen's (1984) ANOVA metaphor: Common factors proponents suggest the use of factor analyses to

reduce the number of variables, before running ANOVAs on the grid. In this sense, these two approaches seem to be ultimately quite compatible. The question then becomes one of determining the significant common core factors. Three different loci have been empirically studied in this search.

The idea of a common core of therapist factors was first suggested by Rosenzweig (1936; cited in Korchin & Sands, 1983), and has been supported, expanded, and revised since that time (e.g., Fiedler, 1950; Frank, 1973; Goldfried, 1980; Korchin & Sands, 1983; Prochaska, 1984; Rogers, 1957; Schofield, 1964; Strupp, 1976). There has not, however, been a consensus on the number or nature of common therapist strategies. Goldfried (1980) for example, proposed two possible "clinical strategies" (p. 994) common to all therapy approaches. One was providing the client with new, corrective experiences, and the other was giving the client direct feedback. Stiles et al. (1986) observed that most proposals include caring for, and communicating a new perspective to the client. They also suggested that the general therapist factor solutions underly the recent upsurge of eclecticism (e.g., Beutler, 1983; Garfield, 1980; Goldfried, 1982; Held, 1984).

The therapeutic relationship has also been proposed as the key common factor in therapy (e.g., Bordin, 1979; Luborsky, 1976, 1984; Marziali, 1984b). The rationale is that "competent therapists of all persuasions are able to

establish a positive emotional bond and a sense of mutual collaboration with receptive clients ... [which] ... carries most of the therapeutic weight" (Stiles et al., 1986, p.173). Researchers have attempted to identify the elements that constitute such a therapeutic alliance. Several measures have been developed (e.g., Hartley & Strupp, 1983; Luborsky, 1984; Marziali, Marmar, & Krupnick, 1981; Moras & Strupp, 1982). Studies have tended to find, as Stiles et al. (1986) observed: "the client's contribution to and perception of the therapeutic alliance, rather than the therapist's, best predicts successful outcome" (p. 173) (Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983; Horowitz et al., 1984; Marziali, 1984a).

The client's readiness to change in therapy is a third possible locus for the active ingredients in all successful therapies. Frank (1979) asserted that: "the major determinants of therapeutic success appear to lie in aspects of patients' personality and style of life...[therefore]...a first step...would be...screening out candidates expected to respond favorably to any form of help" (p.312). Frank has suggested further that the reason therapists of the more than 250 schools (Herink, 1980) may all believe their brand of therapy is successful, is because they all encounter a similiar proportion of clients who are ready to change for the better, regardless of the type of therapy involvement. This could also explain the apparent paradox presented by

Stiles et al. (1986). Examples of variables suggested in this regard are client expectations and motivation, but include the range of labels cited in the opening paragraph of this paper. The logic of this view lies in the belief that it is ultimately the client who must change for therapy to be successful, and thus the client's perceptions, attitudes, beliefs, expectations, etc. must be the locus of significant therapeutic change variables. For example, independent ratings of therapist empathy have yielded inconsistent relationships with therapy outcome. When clients were used to evaluate their therapists' levels of empathy, however, it was consistently related to outcome (Gurman, 1977). This suggests that empathy, as clinicians define it, may not be as important as any therapist behavior that the client perceives as understanding.

Critics of the common factors approach have aptly noted that even if commonalities are found at a new level of abstraction, they may be worthless if they cannot be operationalized without reinvoking the usual differences between the various therapies (e.g., Messer, 1981; Wilson, 1982). In evaluating the status of the common factors approach, Stiles et al.(1986) observed:

> The earlier hope of finding a common core in the therapist's personal qualities or behavior appears to have faded. However, there is now more hope of finding a common core in client's behavior or attitudes or in the alliance between therapist and client. All of these 'common core' solutions run the risk of receding into unmeasurable abstraction, and much current work is aimed at moving from relatively global conceptualizations to detailed and reliable measurement (p.175).

That is precisely the purpose of this research: detailed and reliable measurement of client attitudes that may constitute a significant common core of therapy. The need for such work and the validity of Stiles et al.'s caution about unmeasurable abstraction will become clearer in the following section.

Previous Attempts to Assess Client Readiness Variables

Previous research on the measurement of client readiness has appeared in isolated studies, often utilizing relatively unique methods of measurement, with inadequately demonstrated reliability and validity. Most research has been concerned with determining whether a measure was predictive of therapy outcome, rather than with determining whether the construct or "standard system of measurement" (Aftanas, 1988) was reliable or valid. This is quite consistent with other domains in the field (e.g., Meehl, 1978; Rorer & Widiger, 1983) -- "not achieving the kind of construct validation and building of nomological nets envisioned in the Cronbach and Meehl...[1955]... blueprint." (Borgen, 1984, p.595). Thus researchers are debating whether, for instance, client motivation constitutes a significant factor in the prediction of psychotherapy outcome, before an adequate measure of motivation is available. Furthermore, given the lack of construct validity, indeed, even construct explication, the

implications of a demonstrated predictive validity can be, at best, highly speculative.

Conceptualizations of client readiness variables have varied from immediate and temporary feeling states (e.g., Goldstein & Shipman, 1961), to attitudes (e.g., Fischer & Turner, 1970), and personality traits (e.g., Heilbrun, Jr. & Sullivan, 1962). Although practically no two studies are sufficiently similar to be considered replications, there are certain commonalities which allow for an integrative analysis. Aftanas (1986) defines measurement in psychology as the utilization of a standard system (any discriminative process) to map magnitudes of a property or attribute onto a number system. Measurement situations are thereby differentiated according to the type of standard system employed. In the majority of studies assessing client readiness factors, the human observer (i.e., clinical judgement) has been utilized to reflect magnitudes of "motivation" onto some formal numerical system, usually with the aid of rating scales. A few investigations have employed independent standard systems, with which the client interacts (e.g., projective tests), or which involve complex multistage formats. Finally some test-initiated self-report measures have been tried.

Human Observer as the Standard System of Measurement

Studies utilizing clinical judgement as the standard system have varied significantly with respect to the degree of operationalization of the criteria for making judgements, the nature of the empirical system (e.g., direct client contact vs. contact with report/s of the client vs. contact with videotape of client, etc.), as well as the recording latency (i.e., time between observing and rating).

"Therapy readiness" was introduced as a research variable more than four decades ago by Grant and Grant (1950), who referred to the construct as "the client's attitudinal set at the beginning of therapy" (p. 156). They demonstrated that two trained people could independently rank order recorded first interviews with clients as to the amount of therapy readiness, with an inter-rater reliability estimate of .92. Essentially this showed that whatever the construct was, these two researchers had similar understandings of it, even though they did not share an explicit definition before doing their rankings.

One of these authors (Grant & Grant, 1950) noted the dimensions which she presumed to be related to therapy readiness and used to aid her in ranking clients. These were:

> (1) How easily does the client verbalize during the hour? (2) To what degree can the client express feelings rather than unemotional verbalizations? (3) What ability does he have to express and deal with "real" problems? (4) What is the subject's aim in therapy? Is it to solve a specific problem, reorganize things in general, or

> to finish growing up? (5) What amount of work does the client assume he is going to do in proportion to the contribution of the therapist? (6) How much present anxiety exists? Is this anxiety seen by the client as related to himself, to the external situation, or to both? (p. 156).

Burnham (1952) found support for their findings, and extended them with a different human standard system. She found that six clinical psychologists demonstrated significant agreement on their assessments of therapy readiness from the protocols of various clinical test batteries. Furthermore, she found that the psychologists' evaluations of therapy readiness correlated significantly with independent psychiatrists' ratings of the clients' therapy involvement, once the clients were in the therapy situation (r = .20, p < .01), thus providing some criterion validity for her construct as well. Most importantly, Burnham had the construct broken down into what she called "minor traits" ("Productivity", "Rigidity", "Motivation for Change", "Energy Level", and "Emotional Depth") and discovered that the agreement tendency was greater for the whole construct of therapy readiness, than the average of the judges' evaluations of the minor traits. The agreement for the minor traits did not seem to surpass chance expectations. She concluded that the "Gestalt nature of the concept . . . [is] . . . pointed up" (p. 581). It is also apparent that this attempt to identify separate components of therapy readiness was possibly unsuccessful because the minor traits were inadequately conceptualized.

Conrad (1952) and Strupp, Wallach, Wogan, and Jenkins (1963) had therapists report on former clients, and found that the most significant determinant of therapeutic success as judged by these therapists in retrospect, had been the client's motivation. Conrad used open ended questionnaires for therapists to record the information, while Strupp et al. used 5-point rating scales. Neither the criteria for motivation nor therapeutic success were operationalized, and the recording latency was, in some instances, as long as two years.

Rosenthal and Frank (1958) had medical students doing intakes and based on the medical students' reports to their supervisors, the supervisors then rated the patient's motivation for treatment on a 3-point scale. They found these ratings to be the only one of eight characteristics studied that showed a significant relationship to the frequency of judged improvement at discharge. Interestingly enough, however, it was the low motivation group that had the highest rate of improvement, while the group with moderate motivation had the lowest improvement rate. Without explication of their criteria, or even definitions, for rating motivation or improvement, it is difficult to account for these findings.

Siegel and Fink (1962) introduced a slight differentiation to the standard system of measurement through judgements of a patient's motivation, as either good

or poor, by an entire interviewing clinical team. Although they provided examples of their definitions for good or poor motivation, they did not state the manner by which members of the intake team arrived at a single judgement. The team consisted of a social worker, a psychologist, a psychiatrist, and the psychiatric director of the clinic. Subjects were all outpatients. Judgements of patient motivation were in the expected direction in relation to condition at discharge (improved -- unimproved) and the proportion of sessions missed, but their findings did not attain the significance levels they set ($.05 > p < .10$). They claimed for the latter dependent variable that "significant differences would be expected if similar distributions were found in a population 20 percent larger than the one studied" (p. 172), and concluded that there is a need for a more operational definition of patient motivation.

In another effort to provide a clearer definition of motivation, Kernberg, Burstein, Coyne, Appelbaum, Horwitz, and Voth (1972) attempted to describe different components of motivation according to psychoanalytic theory (Appelbaum, 1972), and assessed patients accordingly. Considerations included: (1) whether the patient emphasized that he wanted to change, (2) was willing to pay for the prescribed treatment, (3) was honest, and (4) did not seem to derive much secondary gain from the illness. They found that

highly motivated patients did well and patients with low motivation did poorly (Horwitz, 1974).

Sifneos provided an even more explicit assessment of the construct (e.g., Sifneos, 1968). Sifneos (1968, 1971, 1975) developed seven explicit criteria for evaluating patients' motivation for psychotherapy, which were assessed by an intake team. These included: (1) An ability to recognize that the symptoms are psychological in nature, (2) A tendency to be introspective and to give an honest and truthful account of emotional difficulties, (3) Willingness to participate actively in the treatment situation, (4) Curiosity and willingness to understand oneself, (5) Willingness to change, explore, and experiment, (6) Realistic expectations of the results of psychotherapy, and (7) Willingness to make reasonable sacrifices (Sifneos, 1968, p. 272-274). They found that patients who showed good motivation at intake usually did well in psychotherapy of short duration while those who were poorly motivated did poorly. They collapsed the motivation ratings to produce four groups of patients -- poor or no motivation, questionable, fair to good, and good to excellent motivation. They did not provide any statistical analyses of their data, but rather presented percentages which showed that 88% of the improved patients had been rated in the fair to excellent motivation range, while only 40% of the unimproved patients were rated in the top two categories for motivation.

These findings should be considered in the light of the strict outcome criteria employed. Sifneos defined therapeutic successes only when both patients' and therapists' independent self-reports clearly indicated improvement. Therapeutic failures were considered as involving a lack of progress in therapy as viewed by both patient and therapist. Finally, "Patients who terminated the treatment on their own initiative were considered as failures even if their therapist thought that some progress had taken place" (p. 275). Although these criteria would produce fewer successes if anything, it adds a dimension of "drop out" prediction criteria, which may not be totally desirable (cf., Heilbrun, 1961, 1962, 1964 to be described later).

Sifneos's results are very similar to those of Malan (1976), who found that 85% of the patients who scored highest on his outcome criteria were either rated as of initially high motivation, or showed a marked increase in motivation during the first sessions. On the other hand, 40% of the patients who were rated lowest on motivation showed no improvement. Patient's motivation was rated on a 5-point scale. Inter-rater reliabilities ranged from .67 to .82 with a mean of .76.

Keithly et al., (1980) refined Sifneos's procedures and conducted probably the best controlled study of motivation with the human as the standard system of measurement.

First, they dropped one and added three items to Sifneos's criteria. This created a nine item scale, and explicated the construct further. The dimensions they added were (1) taking personal responsibility for seeking help, (2) level of felt distress, and (3) post-interview expectations (i.e., impact of the intake interview). Second, they videotaped initial interview sessions with clients. Two independent raters viewed selected segments of the interview to assess the client's motivation. They reported that guidelines for rating the attributes were established in pilot work, but did not state what these were. Inter-rater reliability for all nine criteria was reported as 0.62 to 0.84 (p. 91). The relationships of initial motivational level to several process and outcome measures were examined. Both the therapists' and the independent clinicians' ratings of global change were significantly related to initial motivation, providing strong support for the contention that client motivation is an important factor in the determination of therapy outcome. Patient's self-ratings of change showed a positive but nonsignificant relationship. Of the process measures taken, motivation was found to be positively related to the patient's participation, and negatively related to the patient's hostility and the therapist's negative attitude in the third session. This strong relationship between motivation and therapy process diminished, however, as therapy progressed. The authors

suggested that other factors appear to mitigate the influence of motivation in later stages of therapy. They point out the likelihood, however, of the therapist-patient interactive effect resulting from the initial patient motivation.

A further variant to efforts to assess motivational variables with the human as standard system has evolved as part of several ambitious efforts to measure all of the variables which were considered to be relevant to psychotherapy outcome. Luborsky et al. (1971) listed all the variables researched in relation to psychotherapy outcome, and Auerbach, Luborsky, and Johnson (1972) constructed a Prognostic Index consisting of 31 such variables, as well as other factors they believed clinicians use in evaluating patients. They performed a factor analysis which yielded five factors, one of which they labelled Aptitude for Psychotherapy. The highest loading on this factor was achieved by motivation. Assessments for each variable were performed during a semi-structured intake interview, with the aid of a 5-point rating scale. Auerbach et al. (1972) and Luborsky, Mintz, Auerbach, Christoph, Bachrach, Todd, Johnson, Cohen, and O'Brien (1980) found three of their main factors to be predictive of therapy outcome, but Aptitude for Psychotherapy was not. Rounsaville, Weissman and Prusoff (1981), however, using the same Prognostic Index but different outcome measures, found

the Index overall and the Aptitude for Therapy factor related to outcome. In all of these studies, however, motivation is combined with the variables labelled "insight, secondary gain, anxiety tolerance, patient's expectations, interviewer's prediction and attractiveness" (p. 66) to obtain Aptitude for Psychotherapy.

In a similarly large scale study by Frey III, Heckel, Salzberg and Wackwitz (1976), pretherapy measures were obtained from what they called the Child Scale. This is a list of 15 variables considered important for family therapy that are assessed by intake interviewers on 5-point scales. In this case, however, motivation was a variable in its own right, and was found to be the only variable which significantly predicted therapists' ratings of improvement. Motivation ratings from intake in this study also significantly predicted parents' ratings of success at termination.

More recently, Rosenbaum and Horowitz (1983) developed the most explicit measure of motivation using a human standard system. They initially constructed 125 rater-items, that "include all the elements previously mentioned in psychotherapy literature" (p.348). After being examined by ten experienced clinicians, this pool was reduced to 36 items. They did not state clearly on what basis items were chosen or discarded. Of the 36 remaining items, they report that 23 related to positive contributions to motivation,

while thirteen were considered indicants of decreased motivation. Rosenbaum and Horowitz explained that since they considered it "unlikely that these can simply be added together to get a summated 'net' motivation score" (p. 349), they created two separate scales. The 23 items, each one rated on a seven-point scale, constituted their Motivation for Psychotherapy Scale (MOPS). The thirteen item scale of negative items was dropped from further study because its reliability was too low.

Fifty-seven videotapes of pretherapy interviews were observed by three raters (two advanced graduate students and one recent graduate) who provided the judgements for the MOPS items. Subjects were "nonpsychotic outpatients diagnosed as suffering from stress response syndromes ... following the death of a parent or spouse" (Rosenbaum & Horowitz, p. 349). They were offered free, twelve session treatments for agreeing to volunteer for the research project. The reliability reported for the MOPS was .74 (intraclass correlation coefficient, pooled form), with individual items ranging from .40 to .90. Internal consistency was reported at .93, while the single judge reliability was .49.

They performed a principal components factor analysis on the averaged judges' ratings, extracting four factors with eigenvalues greater than one. They reported that similiarly interpretable results were found with varimax and

oblique rotations. They presented the oblique rotational solution "because we think that the four dimensions are conceptually interrelated" (p. 349).

Rosenbaum and Horowitz interpreted their factors as: (1) Active Engagement, (2) Psychological Mindedness, (3) Incentive-Mediated Willingness to Sacrifice, and (4) Positive Valuation of Therapy. They found that global ratings of motivation by the same judges correlated best with the Active Engagement factor (.88), and less for Psychological Mindedness (.31), Incentive-Mediated Sacrifice (.43), and Positive Valuation of Therapy (.25).

Rosenbaum and Horowitz concluded that motivation is a complex, multidimensional construct. Items taken from previous research examining unidimensional constructs (e.g., Keithly et al., Sifneos, etc.) were spread among the different factors they identified. Of further interest were some preliminary findings with regard to the predictive validity of their factors. They found that the " active engagement variable interacts with a number of therapist action variables to yield significant predictions of the outcome of therapy, while the psychological mindedness variable does not produce comparable results" (p. 351). Presumably, they dropped the other three factors for their predictive study as they had previously indicated difficulty with their interpretation. Rosenbaum and Horowitz concluded from this preliminary validational attempt that " If

'motivation for psychotherapy' is to prove useful in psychotherapy research, it must define some restricted, clearly delineated conceptual domain which provides some predictive power" (p. 351).

Summary

Although most investigators did not specify what they considered motivation to be or how they judged it, the majority of the research reported a relationship between motivation and outcome (one study produced contradictory results). The few studies that did specify some explicit criteria for rating aspects of motivation (e.g., Keithly et al., 1980; Sifneos, 1968) provided the most compelling results. Rosenbaum and Horowitz's (1983) factor analysis of raters' judgements of different motivation criteria strongly suggests the possibility that, in the earlier studies, investigators may have been considering separate and different aspects of the patient's behavior when they were measuring motivation. Moreover, only Keithly et al., and Rosenbaum and Horowitz utilized independent raters. Other biases become likely as well in studies where retrospective ratings were used, particularly when a therapist rates his client's initial motivation two years after terminating the client (cf. Arkes, 1981; Faust, 1986).

Nevertheless, the gradual development of more explicit criteria for human raters has led to the identification of

dimensions of the motivational process, that will ultimately need to be integrated to develop a comprehensive assessment of a client's readiness for therapy. Rosenbaum and Horowitz's study is an excellent demonstration of the need for a clarification of the dimensions of the construct.

Independent, Interactive Standard Systems--Projective Tests

While the aforementioned assessment strategies rely on the clinician to make judgements about magnitudes of targeted attributes, in this section the measurement processes all utilize some standard stimulus-test-situation with which the client interacts. The elicited behavior is scored and interpreted according to explicit, standard instructions. Thus the standard system, ideally, would be independent of the human judgement process. Since these measurement procedures force the researcher to explicate and operationalize the constructs of interest, studies using independent, interactive standard systems have focussed on relatively specific components of the client's readiness for therapy.

Brady, Reznikoff and Zeller (1960) used two projective tests from their Psychiatric Attitudes Battery (Reznikoff, Brady, and Zeller, 1959) to assess patients' expectations of improvement; one reportedly involved six of the 21 incomplete sentences comprising their Sentence Completion Attitudes Test, while the other consisted of two picture

cards -- their Picture Attitudes Test. A score of 1, 2, or 3 was assigned to each item (card or sentence) to indicate a high, moderate or low expectation of improvement. They stated that the scoring reliability has been published elsewhere, but on review, it is only reported for a separate sample of 675 altogether different items. It appears to range from .70 to .88. Patients, although initially rated on an 8-point scale, were classified as either improved or unimproved for their analyses, and expectations were collapsed into the categories of either high or low. Their chi-square analyses revealed no significant effects for either of their projective measures. It is noteworthy, however, that the heterogeneous patient sample they selected were all in-patients. Many of the patients had electroshock, insulin-coma, or psychotropic drug therapy, and all participated in a variety of avocational and social rehabilitation programs at the hospital. Because of these complicating treatments, it was not a satisfactory test of psychotherapy ingredients.

Richert (1976) used Reznikoff et al.'s (1959) Sentence Completion Attitudes test with clients who sought therapy at a Counseling Center. In contrast to Brady et al., however, he used 16 items from the test as his measure of the client's attitude toward therapy. Richert reported that the items were scored on a 3-point scale for the favorableness or positiveness of the attitude, and that inter-rater

reliability was .72. Three outcome measures were utilized, two of which Richert considered measures of cognitive change and one which he labelled the client's acceptance of himself. Richert's data suggested a "positive linear relationship between attitude toward therapy and cognitive change" (p. 441). Attitude toward therapy did not appear to be related to the measure of client acceptance of self.

Although the Richert and Brady et al. studies appear to differ essentially only in terms of their different subjects (outpatients receiving psychotherapy and inpatients receiving a variety of treatments other than therapy, respectively), it is difficult to integrate their findings for the following reasons. In the first place, Brady et al. reportedly used six items from the Sentence Completion Test while Richert, claiming to replicate their measure, used sixteen items. This raises the question as to whether the two measures may indeed be considered the same. Furthermore, Brady et al. labelled their measure expectations of improvement whereas Richert labelled it attitudes toward therapy. Finally, Richert utilized another measure (to be discussed in the next section on self-report measures) which he called Degree of Change Expected (DCE), and reported a nonsignificant relationship between the Sentence Completion Test items and his DCE measure (a label very similar to that label used by Brady et al. for the Sentence Completion items). Taken together, these studies

illustrate the problems involved in the area due to the lack of construct explication, and inconsistency in the meanings of the labels attached to variables.

Two other investigations have been reported which utilized content-analytic procedures to investigate the client readiness variables of hope (Gottschalk, 1974) and acceptance of responsibility (Schroeder, 1960). Schroeder (1960) used the Gilbert Self-Interview Test, on which the client spends about 3 minutes describing his/her "real attitudes and feelings both good and bad" and "problems, if any" relating to 10 broad topics (p. 468), to elicit client behavior on tape. She developed five categories of client statements which related to the client's acceptance of responsibility in his/her life, scored either "plus" (as the active agent), "minus" (as the recipient of an agent's activity) or "check" (when neither of the above applied). Inter-rater reliabilities ranged from .69 to .94 for scoring the statements. The reliability of the sum of all responsibility statements (the total score) was .94. The other variables examined were "difficulty", which was defined as those clients who "do not really 'get into' therapy" or take a long time (p. 469) -- scored on a 2-point scale; and "movement", based on the Hunt-Kogan Movement Scale (see Schroeder, 1960) -- scored as high or low for the analyses. Her results showed that high responsibility scores, difficult therapy, and high movement were all

positively associated with each other ("Movement" is considered a measure of change in therapy). Schroeder concluded that her measure of responsibility should be "sharpened" and that "motivation be investigated in conjunction with responsibility for predicting therapy outcomes" (p. 471).

Gottschalk (1974) had subjects produce 5-minute speech samples in response to standard instructions pretending to be a study of speaking habits "about any interesting or dramatic personal life experiences" (p. 779) to study the "hope" evidenced in the subject. Hope was defined as:

> a measure of optimism that a favourable outcome is likely to occur, not only in one's personal earthly activities but also in cosmic phenomena and even in spiritual or imaginary events (p. 779).

He developed seven content categories, four scored plus and three scored minus. All his raters were trained until they achieved an inter-rater reliability of at least .85. Gottschalk specified that he considered the dimension measured more of a psychological state than a trait, and provided numerous construct validational studies. Of relevance to the present paper is an investigation with patients at a Mental Health Crisis Intervention Centre. He found that pretreatment Hope scores significantly predicted relative degrees of improvement in psychological, interpersonal, vocational, and somatic malfunctioning, measured as changes in Psychiatric Morbidity scale scores

(Gottschalk, Mayerson, & Gottlieb, 1967). Once again, the treatment of clients in crisis may not be an adequate representation of the process of therapy. Nonetheless, Gottschalk's Hope scale is one of the few relatively validated standard systems utilized to assess client readiness variables.

Summary. The sparse research employing independent, interactive standard systems is even more inconsistent than when human observers have been utilized. This may be a function of the small number of studies, however, since the utilization of these standard systems represents an attempt at standardization of the assessment procedures, over and above clinical judgement. Major difficulties with these projective techniques, due to their theoretically unlimited response options, center around their scoring reliabilities. A further problem concerns the untested validity of the assumption of client projection. There is little research evidence to indicate that any of the formal aspects of responses to sentence completion items are systematically related to any personality-relevant behaviors, or to support the use of impressionistic or clinical analyses of the content of the responses, even for the more developed versions of these standard systems (Lanyon & Goodstein, 1971). On the other hand, the more structured approaches to content analysis have been demonstrated to be useful (Lanyon & Goodstein, 1971). Their precision, however, is related to

their specificity, and thus they are not likely to be fruitful for measuring global multidimensional constructs, such as client readiness for therapy, unless the construct can first be broken into specific, delineated dimensions. Finally, the research with these standard systems points to some additional components of the overall construct system such as responsibility and hope.

Test-Initiated Self-Report Standard Systems

These assessment procedures are differentiated from the previous categories because, in this case, a structured test with limited response options (cf. Wiggins, 1973) is employed to initiate self-reports from clients. Thus respondents are assumed to adopt a self-analysis perspective in order to reply to the test's questions (Aftanas, 1986). Standard systems in this measurement situation vary with respect to their construction -- empirical vs. theoretical. The theoretical tests vary with regard to the degree of construct validity, if any, that has been established.

Heilbrun and his colleagues (1961, 1962, 1964; Heilbrun & Sullivan, 1962) developed a "Counseling Readiness Scale" (CRS) based on the Adjective Check List (ACL; Gough, 1960), to help identify clients who would "remain in counseling long enough for some benefits to accrue" (1962, p. 112) and those who would leave prematurely. The scale was derived empirically, based on a contrasted groups strategy where the groups were either "drops" or remainers.

> A drop subject was one who: (1) failed to keep his initial screening appointment; (2) failed to meet with his assigned counselor despite a mutual agreement in the screening interview to begin personal counseling; or (3) met with his assigned counselor but terminated on his own initiative prior to the sixth interview (Heilbrun & Sullivan, 1962, p. 112).

The measurement procedure involved clients checking off those adjectives they considered self-descriptive from the ACL. Initially, it was found to differentiate significantly between terminators and remainers for males but not females (1962). In a subsequent validational study the discriminatory power for females was improved (1964). Of particular interest was the finding that counseling-ready males and females tended to ascribe the contemporary cross-sex characteristics to themselves.

There are 52 adjectives for males and 37 for females which are keyed from the 300 items on the ACL. Although their studies indicate that the drop-remainer groups can be discriminated, the overall predictive accuracy varies from 59% for males, to 72% for females, and from 57% for drops to 79% for remainers (1964).

Due to the empirical construction of the test it is difficult to know what these results mean for the constructs of interest. If they can be taken at face value, then it appears that the scales measure some aspect of self-acceptance or non-acceptance, and this may be related to the client's evaluation of their degree of conformity to the stereotyped male-female role attributes. The utility of

such a measure will be limited by the extent that such sex-role stereotypes change over time.

A further problem with the Counseling Readiness Scale involves the "outcome criterion" of staying in therapy for more than five sessions. Although it has been a common belief for some time that a client can only benefit from therapy if s/he continues to attend, and conversely, will not benefit if s/he drops out, Smith et al. (1980) found in their meta-analysis that length of stay in treatment did not significantly correlate with successful outcome. In Smith et al.'s meta-analysis, however, the clients did remain at least long enough to complete outcome measures. In any case, this measure may not be an adequate criterion of successful therapeutic outcome. Thus the validity of the CRS construction strategy is questionable.

Nonetheless, this outcome criteria was again employed by Cartwright, Lloyd, and Wicklund (1980) who combined the ACL-Counseling Readiness Scale with intake workers' assessments and also found that potential "drops" could be screened. Sixty-two percent of those predicted to drop out of therapy did so. The remaining 37 percent predicted to drop did not. In this study, however, the criterion was extended to nine hours of therapy instead of the 5th session. The addition of the human standard system did not appear to improve upon the accuracy of the Counseling Readiness Scale as used by Heilbrun.

A type of self-report standard system which has been utilized on several occasions involves two separate administrations of a self-report measure under different conditions, which the researchers combine to produce a distinct hypothetical construct. Goldstein and Shipman (1961) administered symptom-intensity self-report inventories under "present self" (PS) and "expected self" (ES) test-taking orientations to create a construct of patient expectancies of outcome. They found that the patients' perceived symptom reduction after only one session of therapy was significantly predicted by the discrepancy between the PS and ES measures. It is not known whether this expectancy effect would also hold for longer therapy durations.

Richert (1976) employed a similar measurement process to assess "degree of change expected" (p. 439). Butler-Haigh Q sorts, involving a nine-category forced-distribution sort, were performed by subjects under present-self and expected-self after therapy instructions. Richert found a significant positive relationship between the degree of change expected and patient's satisfaction at the end of therapy. Interestingly, Goldstein and Shipman had reported a curvilinear relationship between patient expectations and perceived symptom reduction, whereas Richert's data showed a linear relationship between expectancies and satisfaction. Richert suggested the possibility that prolonged contact

with the therapist in his study may have offset the impact of disappointment attendant upon failure to meet overly high initial expectations. In addition, the largest degree of change expected in his study was 1.55 on a 2-point scale, so the absence of curvilinearity might have resulted from the lack of expectations high enough to engender the disappointment that Goldstein and Shipman posit as essential for a decrease in perceived improvement.

Cartwright and Lerner (1963) employed a similar self-report system to investigate a variable they called "need to change". Ten personal constructs were obtained for each client by administering Kelly's Role Construct Repertory Test (Kelly, 1955). Clients then rated themselves on a 5-point scale under "present-self" and "ideal-self" orientations for their ten personally relevant constructs -- the discrepancy creating the "need to change" variable. Outcome was measured by having therapists rate clients' "integration", "organization (defensive versus open)" and "present life adjustment" on nine-point scales after the second interview and after the last interview. A further component to the improvement score was the therapists' ratings of outcome, again on nine-point scales. Cartwright and Lerner found that their pretherapy measure significantly predicted outcome in nondirective therapy.

Summary. Clearly the greatest advantage of the self-report measures is that the scoring reliability is high.

This is possible because there is no need for the judgement of a clinician to obtain the formal quantities of the attributes of interest. At the same time, however, the biases inherent in the subject's self-assessment, such as social desirability (e.g., Crowne & Marlowe, 1964; Edwards, 1967) are introduced into the pool of potential standard system error. Many test construction techniques have been developed which attenuate these biases (cf. Cronbach, 1970; Wiggins, 1973), but they cannot be eradicated completely.

It is interesting to note that all of the self-report measures which have been utilized have proved to be good predictors of the criterion with which they were associated. These measurement procedures appear to be the simplest to empirically validate, but the construct validity for these standard systems has been conspicuously absent. In one study investigating the construct validity of the self-ideal discrepancy (Grigg, 1959), the concept was not related to several other constructs with which it theoretically should have been associated. The empirically constructed CRS is even more questionable in terms of the meaning of the construct.

Nevertheless, the utilization of test-initiated self-report standard systems can be the least time-consuming, simplest, and most readily standardized measurement procedures available to assess client readiness variables. A test constructed such that the meaning of a response to

the test could be validly and reliably understood, would offer not only a clarification of the concepts involved in client readiness, but a practical assessment instrument (e.g., Cronbach, 1970; Wiggins, 1973).

Client Readiness Variables and Therapy Outcome--Conclusion

In view of the relatively few studies and inconsistent results, only speculative conclusions can be offered. In spite of the general belief of the importance of client readiness, the empirical data are not unequivocal. Poor measurement procedures particularly preclude the possibility of interpreting the findings with confidence. It may be that the strength of the relationship between client readiness variables and outcome varies with the variable chosen for investigation, the standard system utilized to measure the attributes of interest, as well as the outcome criteria employed. Clearly, at least some research has employed measurement procedures that have tapped some client variables related to some therapeutic outcome criteria.

The proportion of the outcome variance that is accounted for by client readiness variables is difficult to assess from prior research. Only several studies have provided enough data from which this may be calculated. In Richert's (1976) study, the degree of change expected by patients accounted for 22% of the variance in the patient satisfaction outcome measure. Gottschalk's Hope scale

measure (1974) accounted for only 7% of the significant changes reported on the psychiatric morbidity scores of their crisis clients. In the best controlled study, Keithly et al. (1980) found their measure of motivation accounted for 42% of the therapist's overall assessment of improvement and 44% of the clinician's independent assessment of improvement. It is noteworthy that both Richert and Gottschalk focussed on different, but rather specific components of client readiness, while in the Keithly et al. study, the nine explicit categories of motivation could be considered a much broader assessment of the content area encompassed by client readiness variables. In the study by Frey III et al. (1976) it is unclear what motivation variable was being assessed. In any case, it accounted for 19% of the therapists' outcome ratings and 13% of parents' ratings of improvements.

An important question at this point is whether, for instance, the substantial variance accounted for by client readiness in Keithly et al. would add significantly to the meagre 10% accounted for in Smith et al.'s (1980) overall meta-analysis of therapy effectiveness. Smith et al. had not included 'motivation' in their regression analyses, nor in their estimate of therapy variance accounted for, presumably because a valid measure had not been available to therapy researchers.

Development of the Client Readiness for Therapy Inventory

Several years ago, Berish (1984; 1987) attempted to clarify and develop a self-report measure of the construct referred to as the client's attitudinal set at the beginning of therapy (e.g., Grant & Grant, 1950). Previous research suggested that this construct, or family of constructs was not unidimensional, but rather multidimensional. The appropriate number and nature of its components, however, were unclear, and became the focus of this early research. The Client Readiness for Therapy Inventory (CRTI), a scale of 92 items and six factors, was the result of this research. This earlier work is important to review, because the present research continues the development and validation of the CRTI.

An initial item pool of approximately 100 items was generated from a review of the literature, as well as interviews conducted with eight staff clinicians at the Psychological Service Centre, University of Manitoba. Items were mostly written to be situationally relevant to the client who appears at an intake for therapy, as opposed to general attitudinal surveys or trait-like conceptualizations (c.f., Magnusson & Endler, 1977). Ten items were adapted from Fischer and Turner's (1970) research questionnaire intended to measure attitudes toward seeking help. All items were attached to seven-point Likert-type scales, anchored from strongly agree to strongly disagree.

Various nuances of "personal responsibility", "will to change", "external influences", "expectations of change", "level of present discomfort", and "psychological mindedness" were hypothesized as components of client readiness for therapy. Four clinicians (two of whom were not initially interviewed), were asked to respond to the entire set of items, first, as if they were the "most ready to change client" they could imagine, and, second, as if they were the "least ready to change client" they could imagine. When at least three of the four judges agreed on the keying direction of the variable, the item was retained. Other items were revised if the judges could indicate what ambiguities they perceived, and then retested for agreement. Finally, 91 "readiness" items constituted the CRTI. They were grouped according to several hypothesized components, and successively inserted into the test order, one from each group. On occasion, when two items were written to be essentially similiar, they were purposely spread further apart in the order. Twenty social desirability items from the Personality Research Form (PRF; Jackson, 1967) were adapted for use (attached to seven-point scales) and inserted as every fifth item on the CRTI. A neutral item was inserted at the beginning of the questionnaire.

The CRTI was administered to 450 introductory psychology students in an analogue study. Subjects were told "to answer these questions the way you <u>imagine you</u>

would if you were in the situation of seeking counseling or psychotherapy". Individual item distributions and each item's loading on social desirability were examined. Seventy-seven readiness items' distributions were judged to be good approximations to the normal curve. All items retained for the scales loaded more on their respective content valid factors than they did on social desirability. The correlation matrix of the readiness items was highly significant.

A number of factor analyses were performed and examined. A principal axis extraction, varimax rotated factor analysis resulted in an eight factor solution that was considered most appropriate (in light of Scree test and simple structure criteria). The six interpretable dimensions were labelled: (1) Current Emotional Distress, (2) Faith in Therapy, (3) External Attribution of Responsibility, (4) Self-Confidence in Client Role, (5) Guardedness, and (6) Fear of Risk Taking. These concepts were seen as theoretically meaningful, as they could serve to integrate some of the inconsistent or unclear dimensions suggested by previous writers. In addition, they seemed to be potentially important aspects of the change process in therapy.

Briggs & Cheek (1986) asserted that "the key to good scale development is ...[sound]... conceptualization early on, followed up with rigorous validation work" (p. 130).

The factors found with the CRTI, tested and supported the intuitive grasp of client readiness for therapy used to develop the measure. As Briggs & Cheek (1986) further noted, however, "factors are simply inferences that always require further validation" (p. 109).

The Validation of Self-Report Measures

Self-report measures consist of subjects' responses to test items. The actual physical responses are concrete variables, or what Cronbach and Meehl (1955) and Torgerson (1958) called "indicants". They are considered to represent hypothetical internal states of subjects. "To the extent that a variable is abstract rather than concrete, we speak of it as being a construct " (Nunnally, 1970, p. 139). Some maintain that constructs are real entities (eg. Loevinger, 1957), while others believe they are creations from scientists' imaginations (e.g., Nunnally, 1970). A "nomological net" is comprised of some combination of a number of constructs and indicants which have, ideally, lawful relationships that can be specified (Cronbach and Meehl, 1955). Large nomological nets are basically theories.

Nunnally (1970) noted that, "Validity is a matter of degree rather than an all-or-none property and validation is an unending process" (p.133). The validation of a self-report test is a gradual incremental process, which seeks to relate subjects' responses to other meaningful variables.

Numerous labels for sometimes different, but sometimes the same types of validity exist in the literature. Content, criterion, concurrent, conceptual, construct, convergent, predictive, face, discriminative, trait, substantive, and nomological validity are all encountered in the measurement context. Similiarly, a number of labels for self-report test construction strategies are used, including empirical, logical, correspondance, theoretical, factor analytic, construct, actuarial, rational, sequential, and analytic. Test construction strategies are chosen according to the purposes intended for the measure. The validities are concerned with whether the test is meeting its purpose and measuring what it's intended to. Messick (1981) observed that "Each of the classical views of test validity carries with it a tacit prescription for test development" (p. 575). Differences between test construction strategies are thus differences in emphases on the different types of validity.

Content validity (also called intrinsic validity, circular validity, relevance and representativeness) refers to the extent that items are representative of a specified domain of interest (Aftanas, 1986; Nunnally, 1970). Predictive validity (also called empirical, concurrent, statistical, and criterion validity) is the extent to which some criterion can be predicted by the standard system. Construct validity, the most recent conceptual innovation

(Cronbach & Meehl, 1955) is by far the most complicated and disputed (e.g., Aftanas, 1986; Nunnally, 1970). It has been called trait validity (Campbell, 1960), substantive validity (Loevinger, 1957), nomological validity (Cronbach & Meehl, 1955), factorial validity (Nunnally, 1970), and convergent and discriminant validity (Campbell & Fiske, 1959). Nunnally (1970) explained construct validity in terms of generalizability theory. Aftanas (1986) stated that it relates to "the appropriateness of a given standard system as a measure of the construct of interest" (p. 61) and explained general strategies for its assessment. It seems that construct validity refers to the extent that the boundaries and relationships of a given measure of a construct are empirically specified and logically consistent. In this sense, it can be seen as subsuming the other validities under it. Further clarification of exactly what is meant by construct validity requires an analysis of ontological, epistemological and other metaphysical issues at the heart of science, and current attempts are underway (e.g., Messick, 1981). Indeed there are conferences specifically on construct validity (Messick, 1981).

Nunnally (1970) suggested that the process of construct validation has three aspects: "(1) specifying the domain of observables; (2) determining to what extent all, or some, of those observables correlate with one another or are affected alike by experimental treatments; and (3) determining

whether or not one, some, or all measures of such variables act as though they measured the construct." (p.141).

Anastasi (1988) suggested that correlational analysis of a given measure with other theoretically related measures, factor analysis to identify isolated components which are related to the construct being measured, experimental manipulations using and testing the measure in predicted ways, and giving the measure to contrasted groups believed to differ in terms of the construct, are all general strategies for construct validation.

Campbell & Fiske (1959) proposed a correlational technique called convergent and discriminant analysis, which involves measuring several traits (constructs) by several different methods. The "existence" of the constructs is supported if different standard system assessments of them are correlated. A particular standard system's assessment of the construct of interest is also supported to the extent that it discriminates between different traits.

Nunnally (1970) suggested "Factor analysis is at the heart of the measurement of psychological constructs" (p. 151), and it "plays a part in all three types of validity" (p. 150). Factor analysis helps to explicate constructs particularly, in determining "the internal statistical structure of a set of variables said to measure a construct" (p. 151). It also plays a role in predictive validity by suggesting predictors, and in content validity, by

suggesting ways to revise an instrument. Comrey (1978) explained

> the best use of factor analysis takes place in a programmatic series of investigations in which the researcher is constantly refining his conception of the factor structure and the variables that represent the factors, ... and ... improving the factors (p. 649).

Tests are constructed, evaluated, and revised with regard to their particular purposes. Although these are often similiar and overlapping, there are instances when the approaches diverge. This seems to result from different ultimate concerns: applied versus theoretical. Whereas an empirical test would be revised to heighten its relation to an external measure deemed important in an applied setting, tests developed in the construct approach would not. Messick (1981) stated this is because they "could become biased as a measure of the construct and consequently distort empirical estimates of the lawful connections with other constructs in the theoretical or nomological network" (p. 576). On the other hand, in the construct approach a test would be revised to increase the homogeneity, unidimensionality or internal consistency of a group of items, so the construct was easier to interpret in terms of the theory on which it was based (Briggs & Cheek, 1986). In all instances, to validate a measure is to attach meaning to it through its empirical relationships with variables considered important.

Statement of the Research Problem

Client readiness for therapy has not been fully linked to a clear theory of client change in therapy. Prochaska and DiClemente (e.g., 1983) have provided a framework for understanding different stages of change and different processes involved during each stage. They noted, however, that "what moves individuals into seriously contemplating change is not clear..." (p. 393). It is in this context that the dimensions identified in earlier work with the CRTI (Berish, 1987) would seem to have the clearest theoretical relevance. As Comrey (1978) pointed out, "The initial investigation gives a first approximation to what the factor structure should be" (p. 649). The CRTI factors previously derived therefore define a hypothetical domain of client readiness for therapy. The current research problem was to further validate the CRTI.

As a consequence of the indeterminancy of factor analytic procedures, factor structures are particularly unstable (e.g., Briggs & Cheek, 1986; Golden, Sawicki, & Franzen, 1984; Gorsuch, 1983). Thus the CRTI factor structure needed to be tested for its invariance, to see if it was merely an artifact of the sample used. This was especially pressing because of the analogue situation, and because the items were constructed to be relevant to the client seeking therapy.

If factor congruence was found across different samples, it would be indicative of the robustness of the standard system. If the CRTI was not similiarly meaningful to actual clients (i.e., not invariant), the previous analogue findings would be of little value. The factor structure derived from the clinical sample, if appreciably different, would be the one to guide future work with the CRTI, including other analyses in this study. Thus the validity of the analogue situation, and the meaning of the CRTI derived from it, had to be tested.

A second problem involved the lack of external criteria used to validate the CRTI factors. Judges had agreed that the items seemed relevant to client readiness for therapy; they had agreed on the direction in which the items were related to the construct; and factor analyses suggested that the items were related to each other in meaningful ways. It was desirable to see if meaning could be established for the CRTI through its empirical relationships to related therapy criteria, as well as to other standard system assessments of the constructs of interest. The CRTI should correlate with other methods of measuring the same constructs. Previous studies have used human judgement, content analyses, and self-report standard systems. Employing all three standard systems to assess the construct in the same study would provide an opportunity for further construct validation in terms of their convergent validity. In addition, the

development of the Stages of Change Questionnaire (McConnaughy, Prochaska, & Velicer, 1983) would provide another client self-report measure, which is conceptually closely related to the CRTI, since both measures should provide assessments of differentially ready-to-change clients. Thus this would offer an opportunity for further construct validation of the CRTI, and might suggest which therapy readiness dimensions do move clients from one stage of change to another. This could also provide an important theoretical linkage for the dimensions identified within the overall construct of client readiness for therapy.

Since there are also applied purposes to the development of the CRTI, it would be useful to begin to examine its relation to some measure of therapy outcome. This is conceptually similiar to Gorsuch's (1983) suggestion of including criterion variables in diagonal factoring procedures as marker variables. It would allow future revisions to be guided by this beacon. In addition, it might provide a tentative answer to the question previously posed: would client readiness for therapy add any explained variance to the nomological net of empirical therapy factors?

Overview of Design

There were two broad goals to this investigation. First, as research on the significant ingredients in

therapy, the purpose was to explore the dimensions of "client readiness for therapy". Second, as functional assessment research, the purpose was to estimate the reliability, validity and clinical utility of the CRTI, and determine what revisions needed to be done. This research invoked an exploratory, sequential research strategy with several stages of analyses on three different samples. Some results from initial stages of analysis provided the data for, and determined the exact nature of subsequent analyses, while some stages were carried out simultaneously.

The overall strategy involved five stages -- two for each of the aforementioned goals, and one to prepare for future revisions. The first stage was comprised of numerous internal analyses of clients' responses to the CRTI. This item and factor analytic data provided interpretable dimensions of client readiness for therapy. The second stage then involved comparisons of the clinical data, with data obtained in the student-analogue situation. Individual item distributions, item loadings on specific factors, factor distributions and overall factor structures were compared. This provided an assessment of the robustness of the client readiness for therapy dimensions, and of the validity of the client-analogue situation.

The next two stages were designed to assess the construct and predictive validity of the client-derived CRTI. In stage three, content analyses of archival,

narrative intake reports were developed and refined. In order to measure maximally similiar dimensions of client readiness, the lexicon for these analyses was determined by the most invariant dimensions found in the factor analyses of both the analogue and the client data. In addition, archival outcome data was coded from client files, and clients' stages of change were assessed at intake with another self-report measure. Finally, clinical scales were developed based on the CRTI factors (factor score estimates), creating self-reported client readiness for therapy variables. Subsequently, stage four involved the assessment of the degree to which these CRTI scales measured what they are theoretically intended to, in relation to the concurrent measures of client readiness to change and client stages of change, and to eventual therapy outcome. Correlation matrices examining clients' scores on the CRTI scales in relation to their scores on the other standard system assessments, and therapy outcome variables were examined.

The final stage was designed to produce new items for the CRTI factors, and particularly items that could be used to balance the pro-trait and con-trait content within CRTI scales, to address potential future response set problems. It involved the generation of new items and their administration to a new student-analogue sample.

METHOD

Subjects

Clinical Sample

One hundred and forty-six clients returned completed CRTIs. Based on the most recent third of the data collected, this constituted approximately a 53% return rate. One hundred and thirty six (93.15%) were drawn from clients seeking therapy at the Psychological Service Center (PSC), University of Manitoba. This is a free, outpatient service available to the entire city of Winnipeg, and is generally not used in high proportion by students. An additional ten clients (6.85%) were obtained from the University's Counseling Center (CC), which primarily serves the student population and their families at the University of Manitoba. Eighty-six clients (58.9%) were female, and forty-eight (32.88%) were male. Twelve (8.22%) did not report gender. The average reported client's age was just over thirty-two years, with the range extending from sixteen to sixty-eight. For the one hundred and thirty-two clients reporting the number of sessions they had had when completing the CRTI, the median was one session (the intake), and the mean was 13.76 sessions.

Additional information was available on a subset of forty-three clients. Twenty (46.5% of subset) clients had previously related care. Four (9.3%) clients were involved in concurrent related care. Four (9.3%) clients presented in crisis. The duration of clients' presenting problems included three (7.0%) of up to one month, eight (18.6%) of from one to six months, and thirty-two (74.4%) of greater than six months.

For the clients on whom therapy duration data were available (n = 40), the average number of weeks in therapy was 21.28, with a range of one to ninety-nine weeks. The average number of sessions, for the cases that contained this information (n = 38) was 15.68, but the median was 8.5. For the clients on whom "Reasons for Termination" data were available (n = 36), termination because problems were reduced occurred with 38.9% of the cases, because of a referral to a more appropriate agency with 8.3%, because the client was considered unmotivated with 38.9%, and because of the end of the school year with 13.9%. Termination was mutually determined in 48.7% of cases, determined by the client in an interview 10.3%, by client not showing for other than the first interview 15.4%, by client outside of the interview with notification 12.8%, and was determined by the therapist in 10.3% of 39 cases for which these data were available.

Unavailable data were not the result of client's attrition, but rather a function of varying record keeping practices of client's therapists.

Intake Therapist Raters

Therapists who perform intakes at the PSC include experienced staff clinicians (liscenced Ph.Ds, MSWs) as well as student-therapists in practicum training from the University's graduate Clinical Psychology Program and the School of Social Work. Fifty-three intake therapist raters (41.7%) were male, while seventy-four (58.3%) were female. Nineteen did not report gender. The average experience of these therapists was 8.34 years, and ranged from one month to twenty-five years. The median experience was five years. Therapists represented a wide variety of therapeutic orientations.

For a small sample of cases (n = 27), when a second therapist was also involved in the intake, s/he was also asked to complete the intake therapist rating form (ITRF). These secondary intake therapists were comprised of 37% males, and 63% females, with average experience of 5.25 years, and a range of experience from one month to twenty-five years. It is entirely possible, indeed likely, that therapists may have been the primary intake rater for some cases, and the secondary one for other cases. The most likely scenerio would have involved a staff member or senior

student as primary intake therapist, with student as secondary intake therapist. Both therapists' ratings were recorded for these twenty-seven clients. The secondary intake therapist ratings were only used to estimate interrater agreement.

Intake therapists may or may not have become the clients' therapists if services were provided beyond the initial assessment. While data were not available on the eventual therapists, it can be safely assumed that most ongoing therapists were practicum students, and thus less experienced than the average intake therapist raters.

First Analogue Sample

The CRTI was administered to 450 regular session, introductory psychology students at the University of Manitoba. They received experimental course credit for being in class at the time the questionnaire was administered, whether they chose to complete a questionnaire or not. The sample was drawn from seven different sections of the course, spanning six instructors. There were 233 male (51.8%) and 217 female (48.2%) subjects. Thirty subjects indicated that they had been in therapy or counseling before (6.7%). Nine subjects, who had written at least one "joke" on their completed questionnaires, were included (2.0%), but coded as suspect data. The mean age of subjects was 19.75 years with a standard deviation of 2.99 years. The age

range extended from 17 to 46 years. The only restriction placed on subjects' participation was that they considered themselves fluent in English.

Second Analogue Sample

A new pool of potential CRTI items was administered to 222 regular session, introductory psychology students at the University of Manitoba. They received experimental course credit for completing the questionnaire. There were 85 male (41.1%) and 122 female (58.9%) subjects. Fifteen did not report gender. Twenty subjects indicated that they had been in therapy or counseling previously (9.60%). One hundred and thirty-six subjects (68.0%) were under twenty years of age; fifty-one (25.5%) were between twenty and twenty-five years of age; eight (4.0%) were between twenty-six and thirty; five (2.5%) were over thirty; and twenty-two did not report age. The only restriction placed on subjects' participation was that they consider themselves fluent in English.

Procedures for Data Collection

Clinical Sample

Two somewhat different procedures were used to procure the clinical CRTI data. Initially, the author approached therapists at the PSC and the CC and asked them if they

would be willing to participate. If they agreed, they were then requested to ask their clients at intake, if they would participate, and to administer the CRTI. As giving the CRTI to clients is not normal procedure at this clinic, many therapists failed to comply with this request. This procedure yielded only approximately fifty subjects, much less data accumulation than expected considering the number of potential clients coming to the PSC for intakes.

Thus a research assistant was hired to approach each intake at the PSC and ask the client and therapist, at that time, if they would be willing to participate in a research project, which would involve completing some questionnaires. This procedure increased the rate of data accumulation considerably. Clients returned their questionnaires to the researcher, in stamped and addressed envelopes provided. Thus clients' responses were not known to their therapists. Clients were, of course, told that services provided to them would in no way depend on their decision to participate or not, nor on how they filled out the questionnaires (see cover letter, Appendix A). Client file numbers were recorded along with questionnaire numbers, so that other file data could later be collected for those clients who returned their completed questionnaires.

The procedure for data collection at the University CC was essentially similar to that described as the first procedure at the PSC. Some therapists there chose to

participate, while others did not. There were no client data available from the CC other than the completed CRTIs.

All data collected were coded directly from the questionnaires into a mainframe computer data set. Archival data from PSC files were collected by photocopying intake reports and treatment summary forms, with client names deleted. The initial client contact form was decoded from PSC computer files, and recoded along with the other archival data into the mainframe data set. When the content analyses of intake reports were completed they were also coded into the mainframe data set.

First Analogue Sample

The experimenter contacted introductory psychology instructors and arranged to visit their classes at specified times. Students were informed that they would receive credit for merely being there and were asked if they would complete a questionnaire. Most students completed the CRTI, as shown in Appendix B. The only instructions were the ones written on the covering letter (see Appendix C). These were read aloud by the experimenter once all students who chose to participate had received a questionnaire. The instructions to subjects were "to answer these questions the way you imagine you would if you were in the situation of seeking counseling or psychotherapy." The only question which came up several times from participants was whether

they were to purposely present themselves as they imagined "patients" would be like, or whether to answer as themselves now, and just use their imaginations for the specific questions involving therapy-specific information (e.g., One participant explained that it was difficult to answer item #21 "I was under pressure from others to come into therapy."). Participants were told to use the latter strategy, and answer as they feel/think now.

All data were collected and coded on the questionnaires themselves. Information on subjects' age, sex, and whether they had been in therapy before was gathered on face sheets. An "irresponsible-respondent" category was also created for coding. This was mostly comprised of participants who, on the face sheet at "SEX:_____", wrote, for instance "as often as possible" or some comment like that. One subject drew pictures all over the questionnaire after answering only 20 items, while one subject was observed to be randomly answering the items without reading them. In all, nine subjects were coded as "irresponsible-respondents" and their data were similarly included in the raw data files.

Second Analogue Sample

Short descriptions of, and sample items from the six dimensions of client readiness for therapy identified in earlier research (Berish, 1984), were presented to an upper level undergraduate class in Abnormal Psychology of

approximately forty-five students. They were asked to write pro- and con-trait items for each of the dimensions, as they understood them to be. This pool of a few hundred items was pared down and combined with marker variables from each of the six factors, to create 12 pro- and 12 con-trait items for each dimension (two factors were short some con-trait items). This created a 140 item version of the CRTI, plus one direct item about readiness to benefit from therapy. All items were anchored to five-point Likert-type scales ranging from strongly agree to strongly disagree, so responses could be recorded on computer sheets (see Appendix D).

This version of the CRTI was administered to a second analogue sample in the same manner as described for the first analogue sample with one exception. Instead of administering the questionnaire to all students who were present during class time, students were invited to come to a special questionnaire administration session outside of class time. This helped eliminate the need for an "irresponsible-respondent" category of subjects. Data were recorded directly onto IBM computer answer sheets and computer read and compiled.

Clinical Research Measures

Pretherapy

(1) The CRTI is a 112 item self-report measure, with all items anchored to seven-point Likert-type scales, ranging from strongly agree to strongly disagree. The first item is a neutral item. Twenty items from the Personality Research Form (P.R.F.), which are meant to measure social desirability (Jackson, 1967), were adapted for this research. In contrast to the PRF's T/F response format, the social desirability items were anchored to 7-point rating scales, and interspersed among the "readiness" items. Thus the CRTI included seventy-one content relevant items. A copy is shown in Appendix B.

(2) The Client Contact Form (CCF) used at the PSC was completed by intake therapists after their initial meeting with the client, usually immediately following the session. It contained yes/no, multiple choice, and checklist-type items pertaining to the client's presenting problems' duration, previous related care, concurrent related care, as well as whether there had been a "crisis" in the client's life. This information was in a structured format and was usually coded in PSC computer files on clients. No reliability or validity data were available on the CCF. A copy of this form is shown in Appendix E.

(3) The Intake Therapist Rating Form (ITRF) was a simple measure designed for earlier research to obtain global therapist ratings of client attributes which were hypothesized to be related to therapy readiness. After each intake session, PSC therapists were given an ITRF. One hundred and fifty-one were returned to the researcher, usually by University mail. Therapists who completed the ITRFs provided four ratings of their assessments of certain client attributes. All items were attached to seven-point Likert-type scales (see Appendix F for copy of form letter to therapists, and Table 1 for ITRF item content). Pilot work with this measure had indicated that it produced insufficient variability for individual items to be useful. With the present sample, therefore, the four items were combined, and produced a normally distributed, internally consistent (Cronbach's alpha = .82) measure of intake therapist-rated client readiness for therapy.

When more than one therapist was involved in the intake, as when a staff member and a practicum student did the intake together, both were given ITRFs and asked to complete them independently. The correlation between independent ITRF combined ratings for the twenty-seven such instances was $r = .58$ ($p < .001$). Only the primary intake therapists' ratings were used for the other analyses.

(4) Narrative intake reports are normally written by intake therapists after the initial session/s. A content

Table 1

Intake Therapist Ratings

Variable	Item Content
T1	I would rate this clients desire to change himself/herself as:
T2	I would predict the likely outcome in therapy with this client will be:
T3	I would rate this client's readiness to become involved in a therapeutic relationship as:
T4	I would rate my personal satisfaction from working with this client as:

Note: Cronbach's Alpha for 4 items = .82

analytic method was developed for scoring such reports. It was designed to measure the amount of client readiness for therapy in factors found to be invariant across the analogue and clinical samples. Twenty-five reports were considered usable from target client files, and content analysed using the coding rules developed.

The coding scheme was the result of a protracted process involving independent coders scoring the intake reports, discussing differences and generating clearer definitions and rules. After numerous such efforts, it became clear that only a few dimensions could be retained in a coder's mind at once, and so only those factors which proved highly congruent across the samples were used. These of course, were also those dimensions that were most clearly defined. Revisions of the coding rules were halted when it was discovered that each coder's agreement with himself upon reassessment after 3 months, did not appear to produce greater agreement than that between the independent coders. Eight of the 25 reports were finally randomly selected to test for interrater agreement.

(5) The Stages of Change Questionnaire (SCQ) is a 32 item self-report measure, with all items anchored to five-point Likert-type scales, ranging from strongly disagree to agree. The questionnaire was developed by Prochaska and colleagues (e.g., McConnaughy, Prochaska, & Velicer, 1983). Four stages of client change are considered to be measured,

labelled Pre-Contemplation, Contemplation, Action, and Maintenance (see Tables 2-5 for scale items' content, and Appendix G for a copy of the SCQ used). Coefficient Alphas reported for the stage scales were .88, .88, .89, and .88 respectively (McConnaughy et al., 1983, p. 371), and were comparable, though slightly lower, upon successful cross-validation with a large clinical sample (McConnaughy et al., 1989).

Thus there were two client self-report standard systems, two standard systems involving therapist judgements of latent client attributes, and one standard system derived from therapist-produced information about the clients. Theoretically, these various measures should all share some variance associated with the client's readiness to change in therapy.

Outcome Measures

The PSC treatment summary form (TSF), a seven-variable, therapist-rated outcome measure, was normally completed by therapists following termination of their clients (see Appendix H). It provided information on the total number of sessions, the client's status at termination with respect to the presenting complaints (6-point scale), the client's present level of functioning (5-point scale), the need for further short and long term treatment (5-point scales), the nature of the termination (6 option, forced-choice), and the

Table 2

Pre-Contemplation Stage of Change Scale

Key	Item Content
A	As far as I'm concerned, I don't have any problems that need changing.
A	I'm not the problem one. It doesn't make much sense for me to be here.
A	Working on problems is pretty much of a waste of time for me because the problems don't have to do with me.
A	I guess I have faults, but there's nothing that I really need to change.
A	I may be part of the problem, but I don't really think that I am.
A	All this talk about psychology is boring. Why can't people just forget about their problems?
A	I have worries but so does the next person. Why spend time thinking about them?
A	I would rather cope with my faults than try to change them.

Note: Cronbach's Alpha for 8 items = .76

Table 3

Contemplation Stage of Change Scale

Key	Item Content
A	I think I might be ready for some self-improvement.
A	It might be worthwhile to work on my problems.
A	I've been thinking that I might want to change something about myself.
A	I'm working on my problems in order to better understand myself.
A	I have problems and I really think I should work on them.
A	I wish I had more ideas on how to solve my problems.
A	Maybe someone will be able to help me.
A	I hope someone will have some good advice for me.

Note: Cronbach's Alpha for 8 items = .79

Table 4

Action Stage of Change Scale

Key	Item Content
A	I am doing something about the problems that had been bothering me.
A	I am finally doing some work on my problems.
A	At times my problems are difficult, but I'm working on them.
A	I am really working hard to change.
A	Even though I'm not always successful in changing, I am at least working on my problems.
A	I have started working on my problems but I would like help.
A	Anyone can talk about changing; I'm actually doing something about it.
A	I am actively working on my problems.

Note: Cronbach's Alpha for 8 items = .82

Table 5

Maintenance Stage of Change Scale

Key	Item Content
A	It worries me that I might slip back on problems I have already changed, so I am ready to work on my problems.
A	I have been successful in working on my problems but I'm not sure I can keep up the effort on my own.
A	I'm not following through with what I had already changed as well as I had hoped, and I'm working to prevent a relapse of my problems.
A	I thought once I had resolved my problems I would be free of them, but sometimes I find myself struggling with them.
A	I may need a boost right now to help me maintain the changes I've already made.
A	I'm working to prevent myself from having a relapse of my problems.
A	It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.
A	After all I had done to try and change my problems, every now and again they come back to haunt me.

Note: Cronbach's Alpha for 8 items = .84

reason for termination (4 option, forced-choice). Forty-three TSFs were available in the target files.

The four Likert-type therapist-rated outcome scales were combined, as with the ITRFs, and produced an internally consistent (Cronbach's alpha = .83), normally-distributed therapist-rated measure of outcome (see Table 6). The forced-choice items were treated as dichotomous, discrete variables.

Table 6

Therapy Outcome (therapist ratings made at termination)

1. Status at Termination (Severity of Presenting Complaints after Treatment)
2. Present Level of Functioning (Relative to others of same age, sex, ethnic status, and socioeconomic status)
3. Degree of Need for Further Short-Term Treatment
4. Degree of Need for Further Long-Term Treatment

Note: Cronbach's Alpha for 4 items = .83

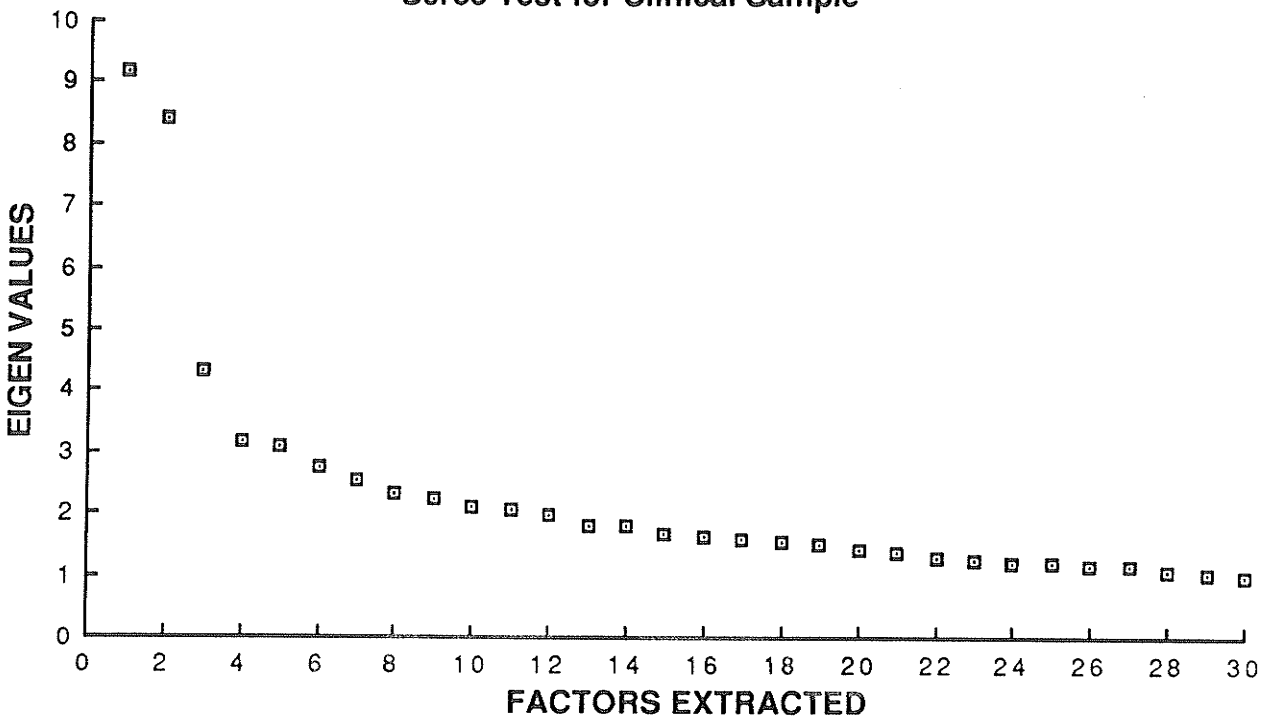
ANALYSES AND RESULTS

Stage 1: Dimensions of Readiness

The first goal of this research project was to determine the dimensions of client readiness for therapy found in the clinical data. Bartlett's Chi Square test for the significance of the correlation matrix of the CRTI items indicated that the data were suitable for meaningful factoring (Chi Square = 7163, df = 4095, $p < .001$). Half of the items (46) were reflected, so that all 91 were then scored in the positive or ready-to-change direction. Item endorsement frequency histograms were computed, and examined for large deviations from the normal curve. Eighteen items were judged to be skewed enough to warrant flagging for possible influences on item intercorrelations. Principal components were extracted from the correlation matrix of the 91 content relevant CRTI items. The SPSSX mineigen default extracted 29 factors with eigenvalues greater than one. These eigenvalues were plotted to perform Cattell's Scree Test (Cattell, 1966), as shown in Figure 1. Inspection of the figure revealed that nine or ten factors would be optimal to extract.

Principal component and principal axis extractions of varying numbers of factors were performed to see which solution seemed most interpretable, and if any differences

Figure 1
Scree Test for Clinical Sample



resulted from the different analyses. No appreciable differences were found and there seemed to be nine interpretable factors. At this point, a scree test from the analogue data was examined, to see what number of factors could be reasonably extracted from it, so that both sets of data would be later comparable. Although eight factors had previously been used from the analogue data, the scree indicated that nine could also be reasonably extracted (see Figure 2). Thus the number of factors extracted from both data sets were nine. Because both principal factor extraction methods produced similiar solutions, the principal components were retained for further study. This eliminated the possibility of obtaining negative eigenvalues, and eliminated the need to estimate commonalities (Gorsuch, 1986).

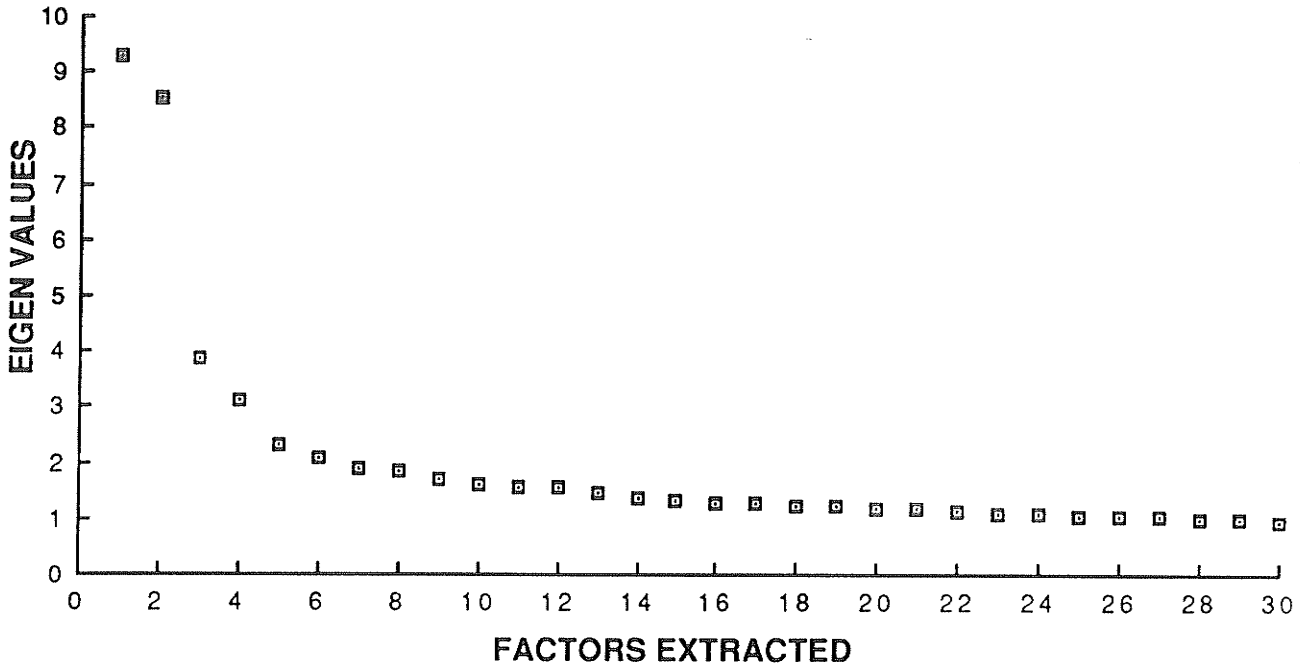
Varimax, quartimax, and oblimin rotations were examined for the nine factor solutions. No appreciable differences for the factors' interpretations were evident, so the orthogonal varimax solution was retained for further analyses, as it best satisfies the simple structure criteria (Gorsuch, 1986).

Initial Clinical Factor Interpretations

Since the principal component extraction was retained, which uses unities in the diagonal of the correlation matrix, only those items loading > 0.40 were retained for

Figure 2

Scree Test for First Analogue Sample



interpretations and further analyses. Any loadings below this value would be commonly considered of insufficient significance as they contain too much error variance (Gorsuch, 1986). With this cutoff point, in only one instance did an item appear on more than one factor (above 0.40). This is item R42, which loads on both factor 4 and 7. Twenty-six items did not load on any factors above 0.40, and so were excluded from further use. These items came from several of the originally theorized constructs, including dimensions that were identified in the factor analyses. These residual items are shown in Appendix I. Maximum weight for factor interpretations was assigned to items having the highest loadings. The following interpretations are based on the factor analyses alone. Additional results presented later help to refine, and speculate further on the factors' interpretations.

Clinical Factor 1: This factor had 11 items loading > 0.40 (see Table 7). It was labelled "Expected Internal Change" as it appeared to reflect a client's expectations to change as a result of therapy. Because the items contained a number of references to the client's internal state, and particularly ones that seemed to suggest the client was averse to facing certain inner feelings, it was hypothesized that the locus of the client's expected change was internal. This factor seemed to represent a very state-like dimension, related to the client's uncertainty about change, and the

Table 7

Clinical Factor 1: Expected Internal Change

Key	Loading	Item Content
A	.640	I expect to be somewhat changed after therapy. (R112)
A	.627	At times I am afraid to let others know what I am really feeling. (R28)
A	.591	I am ashamed of elements of my past. (R27)
A	.548	I expect to be a different person after therapy. (R91)
A	.532	I expect my therapist to help me uncover things about myself, about which I am now unaware. (R26)
A	.517	I feel that therapy is/will be one of the most important things I have done in my life. (R31)
A	.510	At times I am afraid to admit to myself what I am really feeling. (R68)
A	.505	A lot of things seem to be changing in my life now. (R61)
A	.476	I expect that therapy will be quite uncomfortable at times. (R57)
D	- .420	I often make decisions that are based more upon what I can do so I will lose the least, than on what I can do to gain the most. (R19)
A	.402	I expect therapy to involve many sessions. (R9)

Note: Cronbach's Alpha for 11 items = .80

expectation that therapy would have some effect on the direction of future change.

Clinical Factor 2: This factor had 13 items loading > 0.40 (see Table 8), and was labelled "Therapy Mindedness". All items consisted of common attitudinal blocks to getting involved in therapy, with which the client disagreed. Thus high scorers likely had some facilitative beliefs about therapy, such as therapists need not be feared, problems and feelings are best not avoided, and seeking help from a therapist is not shameful. High scorers on this factor were hypothesized to be "immunized" against common early attitudinal resistances to therapy involvement.

Clinical Factor 3: Labelled "Current Emotional Distress", this factor contained 8 items loading > 0.40 (see Table 9). It appeared to reflect state-like feelings of distress in the client, including, for example, emotional pain, confusion, and dissatisfaction. The high scorer seemed to feel a lack of control and an inability to cope. Finally, it seemed only natural to infer that the high scorer also felt very much in need of help.

Clinical Factor 4: With 7 items loading > 0.40 (see Table 10), this factor was labelled "Faith in Therapy". It seemed to reflect a set of optimistic beliefs about the value of therapy. The positive valuation, or faith, in therapy was signified by a willingness to sacrifice for therapy (money, time) as well as some stated trust in the

Table 8

Clinical Factor 2: Therapy Mindedness

Key	Loading	Item Content
D	.594	A skilled therapist could trick me into changing even if I didn't want to. (R102)
D	.569	There is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears without resorting to professional help. (R111)
D	.567	Keeping one's mind on a job is the best solution for taking care of personal worries and concerns. (R69)
D	.537	I am afraid that a therapist will know many things about me that I do not. (R72)
D	.535	I believe that emotional feelings only get in the way of solving personal problems. (R104)
D	.519	A lot of talking about one's feelings and problems just makes things worse. (R48)
D	.518	A person with a strong character can get over mental conflicts by himself/herself, and would have little need of a therapist. (R106)
D	.516	Emotional difficulties tend to work out by themselves. (R97)
D	.507	I prefer not to be observed by others while awaiting my therapy session. (R78)
D	.479	Therapy involvement is a sign of personal weakness. (R39)
D	.458	I don't really believe anyone can be of help to me - I have to do all on my own. (R43)
D	.434	I feel uneasy about seeing a therapist because of what some people would think. (R53)
D	.434	There are books I can buy which would eliminate the need for a therapist. (R44)

Note: Cronbach's Alpha for 13 items = .82

Table 9

Clinical Factor 3: Current Emotional Distress

Key	Loading	Item Content
A	.787	I feel like things are falling apart in my life. (R110)
D	.761	I feel more satisfied with my life now than ever before. (R12)
A	.693	I feel more confusion now than just about any other time in my life. (R52)
A	.587	I feel more emotional pain now than just about any other time in my life. (R84)
D	.522	I feel quite content with the way I am now. (R41)
A	.469	It's very important to me that I change something about the way my life is going right now. (R33)
A	.465	I feel that I am not in control of my life. (R74)
A	.422	I often feel like I simply can't cope with all the hassles in my life. (R6)

Note: Cronbach's Alpha for 8 items = .84

Table 10

Clinical Factor 4: Faith in Therapy

Key	Loading	Item Content
A	.622	If a fee was charged for therapy I would be willing to pay. (R49)
A	.524	A skilled therapist might be able to convince me to change my mind about some things. (R7)
A	.470	I am optimistic that the outcome of my therapy will be positive. (R77)
D	.469	I don't think my therapist could possibly be wiser than me. (R37)
A	.435	I believe my therapist will maintain strict confidentiality regarding our discussions. (R11)
A	.431	I would willingly confide intimate matters to a therapist if I thought it might help me. (R42)
A	.418	If my therapist gave me homework assignments to do between sessions, I would have the time to do them. (R101)

Note: Cronbach's Alpha for 7 items = .67

therapist's integrity. High scorers likely believed that therapists had some knowledge and/or skills which would benefit them as clients.

Clinical Factor 5: This factor had 10 items loading on it and was labelled "Introspected Will to Change" (see Table 11). It seemed to reflect willful movement toward change as well as, or perhaps based upon, self-reflection and introspection. With no items loading above 0.60, and only one item above 0.50, it was difficult to interpret what elements of this dimension were most salient. The high scorer was thought likely to have spent some time reflecting about life, problems, and changes thought necessary, thus high scores may have represented reported self-awareness. At the same time, the high scorer seemed to be saying that in coming to therapy, and approaching change, there was a clear desire to lead life in a self-directed, willful manner.

Clinical Factor 6: Comprised of five items loading > 0.40, this factor was labelled "Personal Responsibility" (see Table 12). It appeared to reflect the client's attributions of responsibility for problems, and their solutions. It was keyed such that a high scorer likely assumed personal responsibility for life predicaments, whereas the low scorer likely tended to blame outside circumstances and/or people. The lowest item suggested that the client's acceptance of personal responsibility also extended to the therapy relationship.

Table 11

Clinical Factor 5: Introspected Will to Change

Key	Loading	Item Content
A	.571	I should not postpone leading my life the way I want to. (R63)
D	.499	I have no idea at all what changes I'd need to make in myself to feel better. (R93)
A	.469	My current problems are a lasting result of my childhood experience. (R8)
D	.451	I think I probably spend less time than other people thinking about my life. (R16)
D	.439	I was under pressure from others to come into therapy. (R21)
A	.432	I have/had already tried some ways of helping myself before coming in for therapy. (R71)
D	.431	I was forced to come to therapy against my will. (R109)
D	.410	I believe that I am as effective a person as I will ever be. (R79)
A	.404	I have some ideas about what changes I would like to make in my life. (R14)
A	.400	No one can really make me change - I have to want to change. (R34)

Note: Cronbach's Alpha for 10 items = .66

Clinical Factor 7: This factor also had 5 items loading on it, and was labelled "Risk Taking" (see Table 13). It seemed to reflect a willingness, perhaps even a desire, to take risks with new and unknown experiences. The high scorer was likely more than willing to experiment with life and try new things. In contrast, the low scorer tended to prefer to remain safe rather than deal with feelings of uncertainty.

Clinical Factor 8: This factor had only 3 items loading > 0.40 and was labelled "Disclosure Tolerance" (see Table 14). As the items in this triplet were all statements about not disclosing personal problems and/or experiences, with which the client disagreed, it seemed appropriate to consider the factor as only reflecting tolerance for disclosure, rather than openess per se. The high scorer was thus assumed to maintain an open posture only insofar as to say: "I'm not saying I won't open up". Less conservatively interpreted, this factor may have reflected the client's readiness to self-disclose in therapy.

Clinical Factor 9: This factor had 4 items loading > 0.40, but the highest loading was only 0.52 (see Table 15). It was labelled "Interpersonal Trust" as it seemed to reflect the client's belief that other people would respond supportively.

Table 12

Clinical Factor 6: Personal Responsibility

Key	Loading	Item Content
D	.703	I believe that my problems are mostly due to circumstances beyond my control. (R82)
D	.661	I believe that the solution of my problems will depend mostly on other people or circumstances. (R88)
D	.632	I believe that my problems are mostly due to other people and circumstances. (R32)
A	.460	I believe that my problems are, to a fair extent, my own making. (R3)
D	.434	I think I will require a very specific type of therapist. (R13)

Note: Cronbach's Alpha for 5 items = .69 (Alpha for first four items only = .72)

Table 13

Clinical Factor 7: Risk Taking

Key	Loading	Item Content
A	.639	I sometimes like to do things in a new way just for the different experience. (R47)
D	.590	I'd rather be safe than sorry when it comes to personal risks. (R29)
A	.584	I consider myself to be someone who is willing to take risks at times. (R96)
D	.562	I am generally afraid to try new things. (R67)

Note: Cronbach's Alpha for 4 items = .70

Table 14

Clinical Factor 8: Disclosure Tolerance

Key	Loading	Item Content
D	.620	There are certain problems which should not be discussed or shared with anyone. (R94)
D	.594	There are experiences in my life that I would not discuss with anyone. (R56)
D	.544	There are certain problems which should not be discussed outside of one's immediate family. (R105)

Note: Cronbach's Alpha for 3 items = .67

Table 15

Clinical Factor 9: Interpersonal Trust

Key	Loading	Item Content
D	.523	I have alot of difficulty developing trust in others. (R83)
A	.519	I would willingly confide intimate matters to a therapist if I thought it might help someone I care about. (R76)
A	.409	I believe that the important people in my life will support the changes I want to make. (R92)
A	.404	I want to know myself as deeply as possible. (R103)

Note: Cronbach's Alpha for 4 items = .49

First Analogue Factor Interpretations

In order to maximize the ease of comparability and interpretability between the clinical and analogue factor solutions, the archival analogue data were analyzed using the same factor analytic techniques as were employed with the clinical data. The same (46) items were reflected, nine principal components were extracted, and rotated to a varimax solution. As mentioned before, the Scree Test had been examined, and considered appropriate for extracting nine factors. Other extractions and rotations were also examined previously, and produced the same factor patterns, in any case. Items loading > 0.40 were retained for interpretations.

Analogue Factor 1: This factor had 10 items loading > 0.40, and was labelled "Current Emotional Distress" (see Table 16). It appeared to reflect state-like feelings of distress in the client, much as Clinical Factor 3 did. Interpretations offered for Clinical Factor 3 would also apply here.

Analogue Factor 2: With 14 items loading > 0.40, this factor was labelled "Faith in Therapy" (see Table 17). It seemed basically equivalent to Clinical Factor 4, and interpretations were the same. It appeared to reflect the respondents belief that a therapist could and would help, and thus therapy was positively valued.

Table 16

First Analogue Sample, Factor 1: Current Emotional Distress

Key	Loading	Item Content
A	.747	I feel more emotional pain now than just about any other time in my life. (R84)
D	.734	I feel quite content with the way I am now. (R41)
A	.725	I feel more confusion now than just about any other time in my life. (R52)
A	.697	I feel like things are falling apart in my life. (R110)
A	.672	It's very important to me that I change something about the way my life is going right now. (R33)
A	.649	I feel that I am not in control of my life. (R74)
D	.641	I feel more satisfied with my life now than ever before. (R12)
A	.580	I often feel like I simply can't cope with all the hassles in my life. (R6)
A	.486	At times I am afraid to let others know what I am really feeling. (R28)
D	-.481	I have a lot of difficulty developing trust in others. (R83)

Note: Cronbach's Alpha for 10 items = .81

Table 17

First Analogue Sample, Factor 2: Faith in Therapy

Key	Loading	Item Content
A	.747	I believe that a therapist will be able to help me solve my problems. (59)
A	.608	If a fee was charged for therapy I would be willing to pay. (R49)
A	.583	I am optimistic that the outcome of my therapy will be positive. (R77)
A	.580	I expect my therapist to help me to uncover things about myself, about which I am now unaware. (R26)
A	.566	I assume that my therapist will know more than me about solving personal problems. (R2)
A	.522	I expect to be somewhat changed after therapy. (R112)
A	.529	A skilled therapist might be able to convince me to change my mind about some things. (R7)
A	.518	I feel that therapy is/will be one of the most important things I have done in my life. (R31)
A	.516	I believe that my therapist will maintain strict confidentiality regarding our discussions. (R11)
A	.502	I think therapy will be a shared responsibility between myself and my therapist. (R23)
D	.481	I don't expect to feel better when I've finished therapy. (R64)
A	.454	I expect to be a different person after therapy. (R91)
A	.418	I would willingly confide intimate matters to a therapist if I thought it might help me. (R42)
A	.408	A person with an emotional problem sometimes might not solve it alone; s/he is likely to resolve it with professional help. (R62)

Note: Cronbach's Alpha for 14 items = .83

Analogue Factor 3: This factor had 12 items loading > 0.40 (see Table 18), and was labelled "Personal Responsibility", similar to Clinical Factor 6. It seemed to reflect the respondents' attributions of responsibility for life's problems and their solutions.

Analogue Factor 4: This factor had only 4 items loading > 0.40, and only one item > 0.50 (see Table 19). It was previously labelled "Self-Confidence in Client Role" (Berish, 1984), and was still difficult to interpret.

Analogue Factor 5: With 7 items loaded on this factor (see Table 20), it was labelled "Disclosure Tolerance", similar to Clinical Factor 8. It appeared to reflect not only disagreement with statements about not disclosing problems, but also contained one item (R86) reflecting an openess about disclosure. The lower three loading items all seemed to reflect more of a stigma tolerance, which was likely related to the disclosure tolerance.

Analogue Factor 6: This factor had 5 items loading on it (see Table 21) and was labelled "Risk Taking", similar to Clinical Factor 7. It appeared to reflect respondents' willingness to take risks in facing the unknown.

Analogue Factor 7: This triplet had only low-moderate loadings (see Table 22) and was considered uninterpretable. It was not labelled.

Analogue Factor 8: This factor also had only 3 items loading > 0.40 (see Table 23), but they were higher loadings

Table 18

First Analogue Sample, Factor 3: Personal Responsibility

Key	Loading	Item Content
D	.667	I believe that the solution of my problems will depend mostly on other people or circumstances.(R88)
D	.607	I believe that my problems are mostly due to other people and circumstances (R32)
D	.574	I believe that my problems are mostly due to circumstances beyond my control. (R82)
D	.495	I believe that personal misfortune is a punishment for a sinful life. (R98)
D	.478	I usually act the way I do because other people make me act that way. (R58)
D	.465	Regardless of what I or my therapist might do, one cannot alter what is fate. (R22)
D	.443	A skilled therapist could trick me into changing even if I didn't want to. (R102)
D	.442	I think that heredity has played the most important role in determining what I am like. (R66)
D	.442	I believe that a therapist will be able to tell me the "secret formula" for the solution of my problems. (R17)
D	.431	I believe that I am now as effective a person as I will ever be. (R79)
D	.418	Keeping one's mind on a job is the best solution for taking care of personal worries and concerns. (R69)
D	.412	I believe that emotional feelings only get in the way of solving personal personal problems. (R104)

Note: Cronbach's Alpha for 12 items = .77

Table 19

First Analogue Sample, Factor 4: Self-Confidence in Client Role

Key	Loading	Item Content
A	.583	No one can really make another person change - they have to want to. (R99)
A	.474	No one can really make me change - I have to want to change. (R34)
A	.462	I believe that the important people in my life will support the changes I want to make. (R92)
A	.407	I would willingly confide intimate matters to a therapist if I thought it might help someone I care about. (R76)

Note: Cronbach's Alpha for 4 items = .63

Table 20

First Analogue Sample, Factor 5: Disclosure Tolerance

Key	Loading	Item Content
D	.565	There are certain problems which should not be discussed or shared with anyone. (R94)
D	.542	There are certain problems which should not be discussed outside of one's immediate family. (R105)
D	.537	There are experiences in my life that I would not discuss with anyone. (R56)
A	.471	I would discuss my therapy with my friends if they were interested. (R86)
D	.466	I feel uneasy about seeing a therapist because of what some people would think. (R53)
D	.436	I prefer not to be observed by others while awaiting my therapy session. (R78)
D	.406	A person with a strong character can get over mental conflicts by him/ herself, and would have little need of a therapist. (R106)

Note: Cronbach's Alpha for 7 items = .66

Table 21

First Analogue Sample, Factor 6: Risk Taking

Key	Loading	Item Content
D	.662	I am generally afraid to try new things. (R67)
A	.632	I consider myself to be someone who is willing to take risks at times. (R96)
D	.486	I'd rather be safe than sorry when it comes to personal risks. (R29)
D	.427	I often make decisions that are based more upon what I can do so I will lose the least, than on what I can do to gain the most. (R19)
A	.407	I sometimes like to do things in a new way just for the different experience. (R47)

Note: Cronbach's Alpha for 5 items = .65

Table 22

First Analogue Sample, Factor 7: Uninterpreted

Key	Loading	Item Content
A	.434	I expect therapy to involve many sessions. (R9)
D	-.425	I think I will require a very specific type of therapist. (R13)
A	.414	I want to know myself as deeply as possible. (R103)

Note: Cronbach's Alpha for 3 items = -.28

than in the previous triplet. Although still difficult to interpret, it was labelled "Awareness of Changes Needed". It seemed to reflect a degree of respondent's reported awareness of changes required to feel better, but this awareness was likely only a recent, emerging attitude.

Analogue Factor 9: This factor was only a dubious doublet (see Table 24) and was not labelled. One item was from a stigma tolerance concept and the other from a psychological mindedness concept.

Stage 2: Factorial Invariance

A most important purpose of this research was to assess the invariance of the factor pattern, to see if the interesting factors that emerged in the first analogue sample could be replicated. It was felt that a conservative test of the stability of the factors would be provided by employing exploratory factor analytic methods to derive the clinical factor solution, and then comparing the solutions with the analogue sample findings. The endorsement frequency distributions obtained for individual items were examined and found to be remarkably similar. Twenty-seven factors with eigenvalues greater than 1 were extracted from the analogue data, while a similar but not identical number, 29, were evident in the clinical sample data. The respective Scree tests were thus very similar, and both indicated that 9 factors would be an appropriate number to

Table 23

First Analogue Sample, Factor 8: Awareness of Changes Needed

Key	Loading	Item Content
D	.641	I have known exactly what needs to be done for my life to be better for quite a long time already. (R87)
D	.598	I have no idea at all what changes I'd need to make in myself to feel better. (R93)
A	.523	I have some ideas about what changes I would like to make in my life. (14)

Note: Cronbach's Alpha for 3 items = -.67

Table 24

First Analogue Sample, Factor 9: Uninterpreted

Key	Loading	Item Content
D	.453	There is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears without resorting to professional help. (R111)
D	.426	A lack of physical exercise is often at the root of emotional problems. (R73)

Note: Cronbach's Alpha for 2 items = .17

extract. The 9 clinical factors accounted for 41.7% of the total tests' variance, while the 9 analogue factors accounted for 38% of the variance. Thus the overall picture of the tests' variability was similar across both samples.

The most important evaluations of the similarity of the factors were done using coefficients of congruence (eg., Gorsuch, 1983; Harman, 1976). Every test item's loading on every factor was used in calculating the coefficients, so that data from all the items, including those loading only minimally were also taken into consideration in comparing the factors. Each of the 9 clinical factors was compared with each of the 9 analogue factors, with resulting coefficients shown in Table 25.

As can be seen, the comparisons between three pairs of factors produced high coefficients of congruence (> 0.70) and there were 12 additional moderately congruent comparisons (0.40 - 0.69) in the matrix. The first Clinical Factor, "Expected Internal Change" seemed to contain elements of Analogue Factors "Current Emotional Distress" ($\underline{c}$ = .61), "Faith in Therapy" ($\underline{c}$ = .55) and uninterpretable Analogue Factor 7 ($\underline{c}$ = .46). The second Clinical Factor labelled "Therapy Mindedness" was highly congruent with the Analogue sample factor "Personal Responsibility" ($\underline{c}$ = .74) and moderately congruent with the Analogue Factor "Disclosure Tolerance" ($\underline{c}$ = .55) and uninterpreted Analogue Factor 9 ($\underline{c}$ = .50). "Current Emotional Distress" the third

Table 25

Coefficients of Congruence Between CRTI Clinical and First Analogue Sample Factors

	Clinical Sample Factors								
First Analogue Sample	Expected Internal Change	Therapy Mindedness	Current Emotional Distress	Faith in Therapy	Introspected Will to Change	Personal Responsibility	Risk Taking	Disclosure Tolerance	Interpersonal Trust
Current Emotional Distress	**.610**	-.103	**.817**	.107	.216	-.098	-.291	-.063	-.212
Faith in Therapy	**.546**	.292	.142	**.766**	.300	-.040	.064	.203	.312
Personal Responsibility	-.231	**.742**	-.209	.126	**.481**	**.620**	.222	.333	.125
Self-Confidence in Client Role	.256	.173	-.055	.341	**.421**	.125	.292	.181	**.502**
Disclosure Tolerance	-.149	**.550**	-.221	.389	.247	.024	.328	**.592**	.017
Risk Taking	-.344	.134	-.303	-.052	.065	.012	**.625**	.120	.145
(Uninterpreted)	**.464**	-.169	.249	.139	.130	-.157	.142	.165	.101
Awareness of Changes Needed	.016	.220	-.253	.056	**.447**	.104	.277	.158	.122
(Uninterpreted)	-.120	**.496**	.065	.088	.059	.058	.015	.294	.006

Note. Coefficient Evaluation: HIGH = > .7, MED = .4 - .7, LOW = .1- .3.

Clinical Factor and first Analogue Factor extracted, produced the highest coefficient of congruence ($\underline{c}$ = .82). "Faith in Therapy", Clinical Factor 4 and Analogue Factor 2, were also highly congruent ($\underline{c}$ = .77). The fifth Clinical Factor "Introspected Will to Change" produced moderate coefficients of congruence with Analogue Factors labelled "Personal Responsibility" ($\underline{c}$ = .48), "Self Confidence in Client Role" ($\underline{c}$ = .42) and "Awareness of Changes Needed" ($\underline{c}$ = .45). Clinical Factor 6, "Personal Responsibility" proved to be moderately congruent with the similarly labelled Analogue Factor ($\underline{c}$ = .62), and did not seem to be related to any other Analogue Factors. "Risk Taking", the seventh Clinical and sixth Analogue Factors extracted respectively, proved moderately congruent across samples ($\underline{c}$ = .62), relating mostly to each other. The Clinical "Disclosure Tolerance" Factor related moderately and most to the Analogue Factor of the same name ($\underline{c}$ = .59). Finally, the ninth Clinical Factor, "Interpersonal Trust" related moderately and most to the Analogue Factor labelled "Self Confidence in Client Role" ($\underline{c}$ = .50). These coefficients of congruence shed further light on the interpretations of the Clinical Factors, as well as on potential differences between the analogue and actual clinical subjects who participated in this research.

CRTI Clinical Factor Intercorrelations from Oblique Rotation

In addition to the coefficients of congruence which may be interpreted somewhat like correlation coefficients across the samples, the correlations between the nine factors from the clinical sample were examined. The nine principal components were extracted and oblique rotations were performed with delta set at zero and at .5. Both analyses produced virtually identical factor correlation matrices. These delta values are known to allow for fairly oblique solutions (Nie, Hull, Jenkins, Steinbrenner, & Brent, 1975). Nonetheless, these rotations produced factors similiar to the orthogonal rotations, and thus showed that the factors, in their extracted state, were only minimally correlated. The matrix of factor correlations from the rotation with delta set at zero is presented (see Table 26). The highest correlation, .22, existed between factors two and three, "Therapy Mindedness" and "Current Emotional Distress". Factor one, "Expected Internal Change", correlated .20 with factor nine, "Interpersonal Trust", and .198 with factor eight, "Disclosure Tolerance".

Creation of CRTI Clinical Scales and their Intercorrelations

In order to investigate the relationships between the CRTI dimensions and the other variables in this study, client variables based on the nine clinical factors were created. The factors from the clinical sample were

Table 26

Factor Correlation Matrix From Oblique Rotation

	Expected Internal Change	Therapy Mindedness	Current Emotional Distress	Faith in Therapy	Introspected Will to Change	Personal Responsibility	Risk Taking	Disclosure Tolerance	Interpersonal Trust
Expected Internal Change	-								
Therapy Mindedness	-.072	-							
Current Emotional Distress	-.037	.220	-						
Faith in Therapy	.123	.147	.046	-					
Introspected Will to Change	-.149	.099	-.008	.026	-				
Personal Responsibility	.096	-.016	-.103	.101	-.029	-			
Risk Taking	-.029	-.060	.017	-.106	.001	-.032	-		
Disclosure Tolerance	.198	-.030	-.051	.019	-.067	.076	-.020	-	
Interpersonal Trust	.203	.129	.046	.114	-.075	.111	.002	.112	-

Note. Delta = 0.

truncated, retaining only those items loading > .40. Both weighted scale scores and unitized scale scores were computed, and both produced very similiar correlational patterns. The unitized scale scores were retained for further investigation because they were easier to handle. Thus the truncated, unitized factor score estimates constituted the "CRTI Clinical Scales" for the remaining correlational analyses. It is important to note that these scale scores were not exactly the same as true factor scores, which would be based on all items' loadings and exact weightings.

While the factor correlations from the oblique rotation provided an indication of the degree of association between the CRTI factors, the correlations between the CRTI clinical scales were also examined to see how this sample of clients' responses to these variables interrelated. The correlation matrix of clients' scores on each of the nine clinical scales is presented in Table 27. As can be seen, even though the factor analysis extracted orthogonal components, the truncated, unitized scale scores were correlated, showing relationships between clients' responses to the different dimensions. This is quite common to find when true factor scores are not actually calculated using all items, and such scales are created (Nunnally, 1967). Note also, that the pattern of intercorrelations was similar to the invariance patterning across samples, as for example, clients'

Table 27

Pearson Correlation Coefficients Between Client Scores on Truncated, Unitized CRTI Clinical Scales

	Expected Internal Change	Therapy Mindedness [a]	Current Emotional Distress [b]	Faith in Therapy [c]	Introspected Will to Change [d]	Personal Responsibility [e]	Risk Taking [f]	Disclosure Tolerance [g]	Interpersonal Trust [h]
Expected Internal Change	-								
Therapy Mindedness	-.062	-							
Current Emotional Distress	.497***	-.146	-						
Faith in Therapy	.247**	.270***	.100	-					
Introspected Will to Change	.135	.344***	-.024	.291	-				
Personal Responsibility	.006	.272***	-.131	.176*	.281***	-			
Risk Taking	-.191*	.205**	-.315***	.015	.043	.033	-		
Disclosure Tolerance	-.048	.311***	-.133	.137	.196*	.060	.213**	-	
Interpersonal Trust	-.010	.175*	-.179*	.367***	.033	.073	.203**	.196**	-

Note. [a] n = 136. [b] n = 136,139. [c] n = 137 - 139. [d] n = 134 - 139. [e] n = 138 - 142. [f] n = 138 - 145. [g] n = 134 - 140. [h] n = 136 - 142.

* $p < .05$, one-tailed. ** $p < .01$, one-tailed. *** $p < .001$, one-tailed.

responses to the items assessing "Expected Internal Change" correlated most highly with client responses to the "Current Emotional Distress" and "Faith in Therapy" items.

Social Desirability

The twenty items adapted from the Personality Research Form (Jackson, 1967) were combined to form a unitized social desirability scale as well. The correlations of each item to it's content relevant scale and to social desirability were computed. All items retained for the clinical scales correlated more with their respective content valid scales than with the social desirability scale.

Stage 3: Content Analyses

A related exploratory study was conducted to provide a different standard system to assess client readiness for therapy. The construction of a content analytic measure provided a means of evaluating the convergent validity of CRTI dimensions. In addition, this was done to explore the potential use of archival narrative intake reports, which are typically available in clinical settings but not used for research.

Twenty-five archival reports were eventually considered usable to test this unobtrusive means of measuring therapist-reported client readiness for therapy. The three highly congruent factors across the analogue and clinical

samples were the dimensions coded. Thus Current Emotional Distress, Faith in Therapy, and Personal Responsibility, as reported by intake therapists in their "typical" intake reports were scored according to rules developed for this purpose. Essentially, definitions of the factor interpretations were used to determine the presence or absence of each of the targeted dimensions.

Several intake reports were independently coded, compared, and the discrepancies were discussed. Rules were developed to minimize ambiguities, which basically involved minimizing inferences needed for coding. For example, if an intake report read: "The client was left unemployed and homeless", rules were developed in this case, such that this was not scored as Distress, unless the report specifically stated that the client was distressed about the events. This eliminated unnecessary coder inferences about what circumstances result in subjective distress, which were a source of intercoder disagreement. The unit of analysis was defined as a grammatical sentence, and scores of +1, -1, or 0 were assigned for each unit. Report lengths varied considerably, from 13 to 76 sentences. Net scores for each dimension were examined, both as raw scores and as adjusted by the total number of sentences in the intake report. In some instances, the intake report writer made an overall judgement and comment about the client's "motivation", which did not clearly fall into any of the three categories being

scored, but seemed important nonetheless. Thus a fourth lexicon category was created to tally such occurrences.

Agreement was initially calculated with respect to two different, but related coder judgements. One was whether a unit contained any information relating to the lexicon categories, and the other was in terms of agreement for assigning a unit to a particular category, if there was agreement that it should be coded. The average total agreement for 8 randomly selected cases on the denotability (existence) of the dimensions was 87%. The average agreement for differentiating the dimensions for category assignment was 95%. In addition, Cohen's (1960) Kappa was computed to assess the interjudge agreement for the 300 units scored from the eight randomly selected intake reports. It was highly significant ($\underline{k}$ = .534; $\underline{z}$ = 5.18, $\underline{p}$ < .0000003).

Results reported for the 25 cases were based on one coder's findings. The average number of units in a report was 37.08, but the average number of sentences scored as either +1 or -1 was 4.56 per report. Thus, only 8.13% of intake report sentences were judged to be related to the three targeted client readiness for therapy dimensions, including remarks about overall client "motivation". The mean net Current Emotional Distress score was +2.0, mean net Faith in Therapy score was -0.24, and mean net Personal Responsibility score was -1.0. The correlations between the

total number of units in a report with the number of units coded as relevant, and the resulting scores for each dimension were insignificant. Thus the raw count scores, unadjusted for report length were considered more appropriate to use. The correlations of the content analysis derived measures with the CRTI clinical scale scores for the same dimensions are presented in Table 28. As can be seen, there was clear evidence of convergent validity for the Current Emotional Distress (CED) factor, and some for Faith in Therapy (FIT).

Stage 4: CRTI Scale Scores' Correlations with Criterion Variables

In addition to discovering the meaning of responses to the CRTI from analyses of the questionnaire itself, it was considered important to begin to examine the CRTI scale scores' relationships with theoretically meaningful criterion variables. The variables chosen in this research included a concurrent measure, intake therapist ratings of client readiness for therapy, a predictive measure, therapist-rated outcome at termination, as well as an additional client self-report measure on the client's stages of change (McConnaughy et al., 1983, 1989).

The intake-therapist rater items were combined to produce a four-item measure of good internal consistency (alpha = 0.82), and with a distribution that closely

Table 28

Pearson Correlation Coefficients Between CRTI Scale Scores and Content Analytic Measures

Content Analytic Derived Measures	CRTI Truncated, Unitized Scale Scores: Current Emotional Distress (n = 22)	Faith in Therapy (n = 24)	Personal Responsibility (n = 24)
Current Emotional Distress	.528**	.305	.139
Faith in Therapy	.440*	.428*	-.018
Personal Responsibility	-.337	-.012	-.227

Note. * p < .05, one-tailed. ** p < .01, one-tailed.

approximated the normal curve. Similarly, the four therapist ratings made at therapy termination were combined. All of these seemed to reflect slightly different ways of judging outcome. This produced a therapist-rated outcome measure, with good internal consistency (alpha = 0.83), that closely resembled the normal curve in its distribution. The four stages of change scales were each internally consistent in this sample as well (alphas = 0.76, 0.79, 0.82, and 0.84 consecutively).

The CRTI scale scores' correlations with these variables are shown in Tables 29 - 31. Overall, client scores on the CRTI clinical scales showed significant relationships with their scores on the Stages of Change Scales, and in theoretically meaningful fashions (see Table 29). There were also significant correlations with intake therapist judgements, although not all scale scores were equally associated with therapists' judgements (see Table 30). Finally, client scores on only a few clinical scales were significantly related to eventual outcome in therapy, and duration of therapy. Unexpectedly, some scale scores were negatively correlated with outcome (see Table 31).

The relationships of intake therapists' ratings and the content analytic measures of their intake reports to the outcome variables were also computed. The combined intake-therapist ratings were significantly positively correlated with the combined therapist-rated outcome measure (see Table

Table 29

Pearson Correlation Coefficients Between Client Scores on Truncated, Unitized CRTI Scales and Stages of Change Scales

	CRTI Scales									
Stages of Change Scales	Expected Internal Change[a]	Therapy Mindedness[b]	Current Emotional Distress[c]	Faith in Therapy[d]	Introspected Will to Change[e]	Personal Responsibility[f]	Risk Taking[g]	Disclosure Tolerance[h]	Inter-personal Trust[i]	Overall Therapy Readiness[j]
Pre-contemplation	-.298	-.662***	-.116	-.569***	-.411*	-.242	-.222	-.412*	-.336*	-.664***
Contemplation	.554***	.228	.512**	.428**	.170	-.044	-.082	-.068	-.059	.265
Action	.233	.367*	.335*	.381*	.130	-.232	.240	.232	.323*	.385*
Maintenance	.440**	-.074	.389*	.172	.089	.038	-.188	-.265	-.164	.245
Total SCQ	.458**	-.059	.519**	.221	.051	-.194	-.099	-.236	-.109	.114

Note. [a] n = 28 - 29. [b] n = 29 - 31. [c] n = 29 - 30. [d] n = 28 - 30. [e] n = 28 - 30. [f] n = 29 - 31. [g] n = 29 - 31. [h] n = 27 - 29. [i] n = 29 - 31. [j] n = 25.

* $p < .05$, one-tailed. ** $p < .01$, one-tailed. *** $p < .001$, one-tailed.

Table 30

Pearson Correlation Coefficients Between Client Scores on Truncated, Unitized CRTI Scales and Intake Therapists Ratings of Client Readiness for Therapy

	CRTI Scales									
Therapist Ratings	Expected Internal Change a	Therapy Mindedness b	Current Emotional Distress c	Faith in Therapy d	Introspected Will to Change e	Personal Responsibility f	Risk Taking g	Disclosure Tolerance h	Interpersonal Trust i	Overall Therapy Readiness j
T1	.084	.168*	.143	.111	.221**	.256**	-.055	-.011	.132	.296***
T2	.040	.229**	.003	.085	.251**	.298***	-.027	-.009	.129	.233**
T3	.138	.252**	.197*	.184*	.255**	.232**	-.080	.077	.072	.341***
T4	.205*	-.044	.122	.116	.159*	.138	-.125	-.004	.191*	.200*
Overall Therapist Rated Readiness	.150	.191*	.151*	.161*	.277***	.286***	-.093	.020	.160*	.341***

Note.

T1 = I would rate this clients desire to change himself/herself as: ;

T2 = I would predict the likely outcome in therapy with this client will be: ;

T3 = I would rate this client's readiness to become involved in a therapeutic relationship as: ;

T4 = I would rate my personal satisfaction from working with this client as:

$$\text{Overall Therapist Rated Readiness} = \sum_{1}^{4} T_i.$$

[a] n = 117 - 118. [b] n = 119 - 121. [c] n = 120 - 121. [d] n = 119 - 121. [e] n = 117 - 119. [f] n = 122 - 124. [g] n = 122 - 124. [h] n = 118 - 120. [i] n = 121 - 123. [j] n = 107 - 108.

* $p < .05$, one-tailed. ** $p < .01$, one-tailed. *** $p < .001$, one-tailed.

Table 31

Pearson Correlation Coefficients Between Client Scores on Truncated, Unitized CRTI Scales and Outcome Variables

Outcome Variables	CRTI Scales									
	Expected Internal Change	Therapy Mindedness	Current Emotional Distress	Faith in Therapy	Introspected Will to Change	Personal Responsibility	Risk Taking	Disclosure Tolerance	Interpersonal Trust	Overall Therapy Readiness
O1[a]	-.228	.199	-.057	-.329*	.097	-.227	-.211	.347*	.061	-.111
O2[b]	-.217	.361*	.004	-.078	.215	.005	.035	.350*	.084	.244
O3[c]	-.211	.174	-.034	-.210	.377*	.121	.123	.324*	.088	.222
O4[d]	-.253	.331*	-.134	-.173	.295*	.316*	-.053	.377*	-.004	.243
Overall Outcome[e]	-.207	.337*	-.045	-.242	.266	.039	-.134	.393**	.127	.158
Weeks in Therapy[f]	-.355*	.231	-.127	-.093	.316*	.155	.149	.038	-.079	.083
Number of Therapy Sessions[g]	-.319*	.202	-.144	-.028	.249	.150	.082	.005	-.025	.049

Note.

O1 = Status at termination (severity of presenting complaints after treatment);

O2 = Present level of functioning (relative to others of same age, sex, ethnic status, and socioeconomic status);

O3 = Degree of need for further short-term treatment;

O4 = Degree of need for further long-term treatment.

Overall Outcome = $\sum_{1}^{4} O_i$. Overall Therapy Readiness = $\sum_{1}^{9}$ CRTI Scale Scores.

[a] n = 33 - 38. [b] n = 35 - 40. [c] n = 34 - 39. [d] n = 33 - 38. [e] n = 31 - 36. [f] n = 34 - 38. [g] n = 34 - 38.

* $p < .05$, one-tailed. ** $p < .01$, one-tailed.

32). Intake therapists' ratings did not relate significantly to client scores on any Stages of Change scales (see Table 33). Finally, primary intake therapists' ratings were examined in relation to the secondary intake therapists' ratings (see Table 34). As noted earlier, the combined ratings correlated significantly, and provided further reason to utilize the ITRF items in combination.

Stage 5: Factor Analyses of New CRTI Items, Second Analogue Sample

The purpose of this stage was mainly to generate new items reflecting both pro- and con-trait dimensions of the original six factors (Berish, 1984). In addition, writing new items for the factors provided an opportunity to further assess the scope of the constructs. Finally, this study was also used to test the items with five-point Likert-type scales, in comparison to the seven-point scales previously utilized.

Bartlett's Chi Square test for the significance of this correlation matrix was calculated, and found significant (Chi Square = 32958, df = 9730, p <.001). Principal components were extracted from the correlation matrix of the 140 items. A Scree test was plotted and examined (see Figure 3). It indicated that 7 or 8 factors would be optimal to extract, so both 7 and 8 factors were rotated to varimax solutions and examined. The resulting factor

Table 32

Pearson Correlation Coefficients Between Criterion Variables

	Outcome Criteria						
	O_1	O_2	O_3	O_4	$\sum O_i$	Weeks in Therapy	Number Sessions
Intake Therapist Ratings[a]							
T1	.201	.320*	.087	.272	.235	.211	.247
T2	.100	.085	.048	.244	.163	-.068	-.112
T3	.426**	.305*	.146	.268	.327*	.125	.111
T4	.226	.303*	.149	.325*	.316*	-.004	.019
$\sum T_j$	.287	.322*	.142	.336*	.310*	.097	.095
Content Analytic Measures[b]							
Current Emotional Distress	.003	.275	-.109	.157	-.005	.243	.365
Faith in Therapy	-.238	-.028	.045	-.266	-.189	-.204	-.368
Personal Responsibility	-.078	-.346	-.096	-.106	-.180	-.286	-.342

Note.

T1 = I would rate this clients desire to change himself/herself as: ;

T2 = I would predict the likely outcome in therapy with this client will be: ;

T3 = I would rate this client's readiness to become involved in a therapeutic relationship as: ;

T4 = I would rate my personal satisfaction from working with this client as: ;

O1 = Status at termination (severity of presenting complaints after treatment);

O2 = Present level of functioning (relative to others of same age, sex, ethnic status, and socioeconomic status);

O3 = Degree of need for further short-term treatment;

O4 = Degree of need for further long-term treatment.

[a] n = 28 - 32. [b] n = 18 - 22.

* $p < .05$, one-tailed. ** $p < .01$, one-tailed.

Table 33

Pearson Correlation Coefficients Between Intake Therapist Ratings and Client Scores on Stages of Change Scales

Stages of Change Scales	n	Intake Therapist Ratings				
		$\sum T_i$	T1	T2	T3	T4
Precontemplation	31	-.087	-.048	-.154	-.155	.085
Contemplation	30	.071	.192	-.001	.102	-.076
Action	29	-.081	- .019	-.141	.072	-.210
Maintenance	31	.084	.360*	-.103	.149	-.160
Total SCQ	29	-.056	.203	-.187	.014	-.234

Note.

T1 = I would rate this clients desire to change himself/herself as:;

T2 = I would predict the likely outcome in therapy with this client will be: ;

T3 = I would rate this client's readiness to become involved in a therapeutic relationship as: ;

T4 = I would rate my personal satisfaction from working with this client as: .

*$p < .05$, one-tailed.

Table 34

Pearson Correlation Coefficients Between Independent Intake Therapist Ratings of Client Readiness to Change

	T1	T2	T3	T4	ΣT_{1i}
$T2_1$	.453**	.269	.489**	.496**	.535**
$T2_2$	.335*	.162	.279	.319	.344*
$T2_3$	.309	.300	.374*	.379*	.420*
$T2_4$	.493**	.298	.274	.449**	.467**
ΣT_{2i}	.527**	.342*	.465**	.544**	.583***

Note. n = 27.

T1, $T2_1$ = I would rate this clients desire to change himself/herself as:

T2, $T2_2$ = I would predict the likely outcome in therapy with this client will be:

T3, $T2_3$ = I would rate this client's readiness to become involved in a therapeutic relationship as:

T4, $T2_4$ = I would rate my personal satisfaction from working with this client as:

*p < .05, one-tailed. **p < .01, one-tailed. ***p < .001, one-tailed.

patterns were virtually the same, whether 7 or 8 factors were extracted, except for an uninterpretable low doublet as the last factor in the eight factor solution. Thus the seven factor solution was retained for examination. Items which loaded > 0.40 are presented (see Tables 35- 41). The factor interpretations were similar to previous descriptions for those labelled Current Emotional Distress, Faith in Therapy, Personal Responsibility, and Risk Taking, and included the marker items from the original CRTI. It was interesting that Factors 6 and 7, labelled Guardedness and Openess respectively, thought to be polar opposites on the same dimension, resulted in two separate factors here. The fifth factor was considered uninterpretable. As can be seen from the Tables, this study generated a healthy new pool of both pro- and con-trait items for the Current Emotional Distress, Faith in Therapy and Risk Taking scales. The Personal Responsibility factor had ample new items, but only ones in the pro-trait direction. The Guardedness and Openess factors had some new items, but remained surprisingly small.

Figure 3

Scree Test for Second Analogue Sample

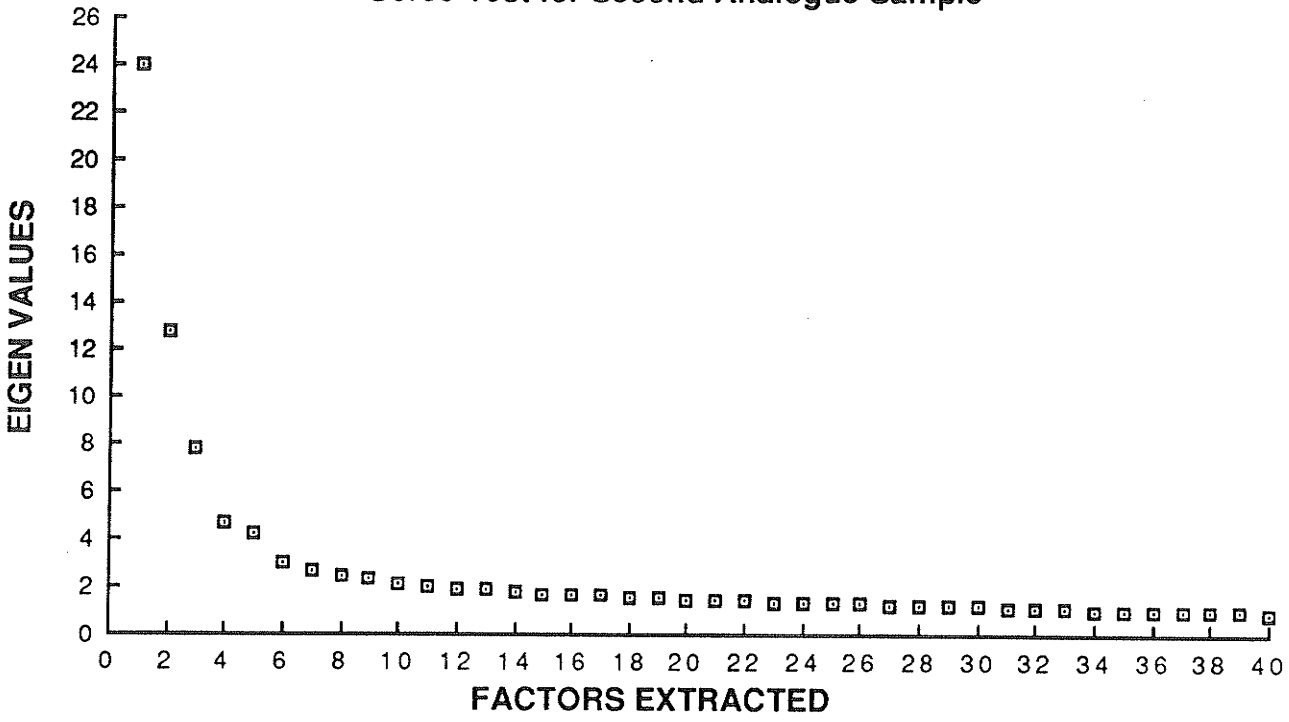


Table 35

Second Analogue Sample, Factor 1: Current Emotional Distress

Loading	Item Content
.788	I am more distressed now than at any other time in my life. (R122)
-.762	I feel more satisfied with my life now than ever before. (R20)
-.754	My life is going in the direction I always hoped it would. (R80)
.751	I really don't think very highly of myself these days. (R98)
.735	I feel like I need help with my life now. (R86)
.729	I often feel like I simply can't cope with all the hassles in my life. (R62;CRTI:R6)
-.700	I feel like everything in my life is well under control. (R68)
-.697	Things are going smoothly in my life. (R116)
-.693	I feel energetic and happy to be alive almost everyday. (R137)
-.688	I am satisfied with the life I have made for myself. (R92)
.687	I feel like things are falling apart in my life. (R2;CRTI:R110)
.668	I feel like I'm fighting with myself on every decision I have to make. (R132)
-.665	I feel quite content with the way I am now. (R8;CRTI:R41)
.664	I feel quite powerless about changing my life situation these days. (R99)
.655	I feel like I am not in control of my life. (R50;CRTI:R74)
.647	I feel more confusion now than just about any other time in my life. (R26;CRTI:R52)
-.642	Things couldn't be going better for me than they are now. (R56)
-.627	I feel like all my dreams and goals are being accomplished.(R128)
.614	I feel more emotional pain now than just about any other time in my life. (R14;CRTI:R84)
.604	It's very important to me that I change something about the way my life is going. (R38;CRTI:R33)

Table 35 cont.

Second Analogue Sample, Factor 1: Current Emotional Distress Continued

-.589	I feel less distress now, than at other times in my life. (R32)
-.589	I am not in need of help now. (R44)
.525	I really want to change. (R64)
.505	The important people in my life demand too much of me. (R111)
-.474	Nowadays, I am enjoying the simple pleasures of life. (R104)
-.450	I wish everything in my life would just stay the way it is for awhile. (R55)
-.446	I have known exactly what needs to be done for my life to be better for quite a long time already. (R4;CRTI:R87)
.436	I don't feel like I get any support for the changes I want to make in my life. (R106)
.414	I need to be encouraged to develop self-confidence but I haven't anyone to help me. (R82)
.402	Life keeps changing too fast for my liking. (R67)
.402	At times when I would like to do something new, I often don't try it. (R115)

Table 36

Second Analogue Sample, Factor 2: Faith in Therapy

Loading	Item Content
-.779	I think therapy would be a waste of time. (R120)
.761	I feel confident that if I would confide in my therapist, s/he would be able to help me. (R35)
.725	Therapy has become more accepted and I feel it is a wise approach to take. (R83)
.711	I believe that professionals who have been trained to help people like me, can and do. (R136)
.709	Coming for therapy gives me hope that I will be understood. (R90)
-.700	I don't believe a therapist can know anything about me, which I don't already know. (R84)
-.691	I expect to be unchanged after therapy. (R72)
.690	I feel ready to benefit from psychotherapy. (R141)
-.683	I am doubtful that a therapist will be helpful to me. (R60)
.669	I think a therapist will look at my problem from an objective view and will help me deal with it. (R126)
.664	I have complete confidence in therapists. (R114)
-.651	I don't think a therapist could help me, because s/he is not in my shoes. (R96)
-.631	I don't think therapists know any more about solving human problems than the average person would. (R36)
-.626	A therapist isn't any more likely to help me, than a friend would be. (R130)
-.616	I don't expect to feel better when I've finished therapy. (R12;CRTI:R64)
.611	I believe that my therapist has my best interests in mind. (R102)
.599	I am optimistic that the outcome of my therapy will be positive. (R18;CRTI:R77)
.592	I expect my therapist to help me to uncover things about myself, about which I am now unaware. (R42;CRTI:R26)
.592	I feel confident about being a client in therapy. (R76)

Table 36 cont.

Second Analogue Sample, Factor 2: Faith in Therapy Continued

.580	If a fee was charged for therapy, I would be willing to pay. (R30;CRTI:R49)
.565	I believe that a therapist will be able to help me solve my problems. (R6;CRTI:R59)
.556	I believe that my therapist will maintain strict confidentiality regarding our discussions. (R54;CRTI:R11)
.552	I will be ready to be open and talk through my problems to solve them. (R23)
-.532	All therapists want is to make money from other people's troubles. (R139)
-.521	I don't think therapy is anything more than modern witchcraft. (R24)
.458	I would willingly confide intimate matters to a therapist if I thought it would help me. (R78;CRTI:R42)
.440	I am eager to "tell my story" to my therapist. (R138)
.429	A skilled therapist might be able to convince me to change my mind about some things. (R66;CRTI:R7)
-.415	I don't feel the therapist should ask questions that are not related to my problem. (R101)
-.406	I would not be willing to be very inconvenienced in order to obtain therapy. (R48)

Table 37

Second Analogue Sample, Factor 3: Personal Responsibility

Loading	Item Content
.629	I am responsible for most of the things that happen to me in my life. (R105)
.595	It is best to take reponsibility for your own actions. (R57)
.552	No one can really make me change - I have to want to change. (R40;CRTI:R34)
.542	I believe that my problems are largely my own making. (R9)
.538	I am in control of my own life and am responsible for what happens to me. (R93)
.534	Everyone is reponsible for their own lives. (R117)
.487	No one can really make another person change - they have to want to. (R52;CRTI:R99)
.460	I believe that I alone have the power to resolve my problems. (R33)
.454	If my problems are to be solved, it will have to be through my changes. (R45)
-.446	I believe that my problems are mostly due to other people and circumstances. (R15;CRTI:R32)
.438	I want to know myself as deeply as possible. (R28;CRTI:R103)
-.436	I believe that my problems are mostly due to circumstances beyond my control. (R27;CRTI:R82)
.414	I believe my problems are all my fault. (R69)

Table 38

Second Analogue Sample, Factor 4: Risk Taking

Loading	Item Content
-.658	I don't like to take chances where my life is concerned. (R43)
.627	I consider myself someone who is willing to take risks at times. (R7;CRTI:R96)
.615	I sometimes like to do things in a new way just for the different experience. (R37;CRTI:R47)
.595	I like to experience new things in my life. (R49)
.582	I think I would like to sky dive or race cars. (R109)
-.569	It is best to avoid the unknown, if at all possible. (R91)
.538	Trying new things adds excitement to one's life. (R97)
-.526	By taking new risks I may lose the stability that I now have. (R127)
-.518	I'd rather be safe than sorry when it comes to personal risks. (R19;CRTI:R29)
-.500	I take risks only if I have carefully thought out all the possible outcomes to the risk. (R31)
.500	The way to live is to try new things and not be afraid of change. (R85)
.477	I believe I am capable of succeeding in anything I do. (R88)
.473	Even though changes reflect uncertainty, I usually welcome them as challenges. (R140)
.403	I enjoy making up my own mind about my life. (R112)

Table 39

Second Analogue Sample, Factor 5: Uninterpreted

Loading	Item Content
.521	The way to survive life is to stick to a rigid schedule. (R79)
.508	I will share my problems with anyone who is genuinely willing to listen. (R95)
.459	I usually act the way I do because other people make me act that way. (R87;CRTI:R58)
.417	I am only seeing a therapist so everyone will leave me alone. (R108)
.404	A skilled therapist could trick me into changing even if I didn't want to. (R51;CRTI:R102)

Table 40

Second Analogue Sample, Factor 6: Disclosure Reluctance

Loading	Item Content
-.568	I enjoy opening up and confiding in others. (R71)
.567	When I disclose intimate information about myself, I feel very vulnerable and uncomfortable. (R135)
.548	I am usually very careful about who I open up to. (R89)
.519	I feel uneasy about seeing a therapist because of what some people would think. (R65;CRTI:R53)
.517	Therapy would be a very strange experience for me. (R118)
.501	There are certain problems which should not be discussed or shared with anyone. (R29;CRTI:R94)
.484	There are experiences in my life that I would not discuss with anyone. (R5;CRTI:R56)
.456	There are certain problems which should not be discussed outside one's immediate family. (R17;CRTI:R105)
-.423	If I have a problem or am feeling stress, my first instinct is to talk to someone about it. (R59)
.420	If I talk about me and my problems honestly, I fear that I will be regarded as less of a person. (R113)

Table 41

Second Analogue Sample, Factor 7: Disclosure Tolerance

Loading	Item Content
.523	I feel that it is helpful to tell others about one's problems, because it takes the burden off one's shoulders. (R47)
.473	The more someone knows you, the more they can help you. (R119)
.456	I enjoy opening up and confiding in others. (R71)
.442	If I have a problem or am feeling stress, my first instinct is to talk to someone about it. (R59)
.428	If someone really knew what I think and feel, they would really like me. (R129)

DISCUSSION

This exploratory research completes several validational steps of a self-report measure of client readiness for therapy. The current sequence of studies provides empirical bases for determining the meaning of clients' responses to the CRTI. Some clarifications of readiness for therapy dimensions are suggested, while additional questions are raised. Results are discussed with an eye to evaluating the current status of the CRTI and determining what future work is required to enhance the utility of the test.

Overall, the results are encouraging yet mixed. While some dimensions of readiness emerge clearly from the CRTI, other dimensions are difficult to identify. Some factors are consistent with the original theorizing used to develop the item pool, and are robust across different samples of the analogue-clinical generalizability gradient. In other instances, the dimensions seem to recombine into different constructs when going from one population to the other. Some factors have good internal consistencies while the internal consistencies of other factors are still too low. Most factor interpretations are supported by their scales' empirical relationships to concurrent validational variables, and have implications for processes of client

change in therapy. The predictive validity for therapy outcome appears low, but the validity of the outcome criterion is questionable.

Multidimensionality of Client Readiness for Therapy

One of the first issues addressed by this research concerns the dimensionality of client readiness for therapy. Although Burnham's (1952) study suggests that therapy readiness might most appropriately be considered on a unidimensional "gestalt" level, the past decades have seen increasing differentiation of this concept. Recent research (e.g., Berish, 1987; Rosenbaum & Horowitz, 1983) has attempted to clarify the dimensionality of this construct. The present study provides support for thinking in terms of multiple dimensions of client readiness for therapy.

It is still not clear exactly how many different dimensions are optimal. Scree tests of three different samples of responses to the CRTI indicate that at least four, and probably six to nine interpretable factors, explain meaningful variance from the CRTI. The multidimensionality of client readiness is also strongly supported by the invariance of factors across samples, and the differences found between clinical scales' relationships with criterion variables. The gradual delineation and clarification of separate dimensions should provide a clearer understanding of client feelings, attitudes, and

beliefs that are important for therapy processes. Clearly, there can be no "right" number of dimensions, and the question of the optimal number of dimensions is best answered, ultimately, through studies of each dimension's validity.

Dimensions of Client Readiness for Therapy Measured by the CRTI

Initial factor interpretations were offered based on the factor analyses alone. Further elaborations of possible factor interpretations based on the additional results follow. Some results, and the speculations offered from them, should be viewed tentatively at this time. This is especially true for the intercorrelations of the clinical scale scores, because as estimates of orthogonal dimensions, their intercorrelations are most prone to be sampling artifacts (Nunnally, 1967). In addition, implications derived from correlations with the individual items, of the four-item measures of therapist-rated outcome and intake therapist-rated client readiness for therapy, should be considered highly speculative.

(1) Expected Internal Change

The first clinical factor, labelled Expected Internal Change, is surprising to discover in the clinical sample. It does not emerge in the First Analogue Sample and the

items which group together to constitute this dimension come from several different originally theorized variables. On the other hand, previous researchers (e.g., Brady et al., 1960; Cartwright & Lerner, 1963; Goldstein & Shipman, 1961; Richert, 1976) have conceptualized expectations as an important dimension of therapy readiness. From the coefficients of congruence, this clinical factor appears to contain elements of Current Emotional Distress, Faith in Therapy as well as lesser amounts of several other analogue factors. Thus it would seem to cut across analogue dimensions, rather than replicate any one or even two of them clearly. In the clinical sample, however, client scores on the Expected Internal Change scale correlate positively and significantly with their scores on the Distress and Faith scales also, and negatively with scores on the Risk Taking scale. Thus clients' Expected Internal Change seems to be related to their Emotional Distress and Faith in Therapy.

The internal consistency of the Expected Internal Change scale is adequate, and its endorsement frequency distribution is normal, meaning clients respond differently to the scale as a whole. This indicates that discriminability is adequate for this clinical scale, and it is suitable for correlational analyses. Three of the items on this factor including the two highest loading ones, however, have markedly skewed endorsement frequency

distributions, as most clients tend to agree with items R112, R28, and R57. This suggests the possibility that the items may group together as a result of their similiar skewness and same keying direction, more than as a function of relevant item content. One item on this factor, however, is keyed in the "disagree" direction, thus it isn't likely the whole factor can be explained as a simple response set phenomenon. Future studies with this factor's items will need to explore this further.

The other validational indices seem to support a particular interpretation of the Expected Internal Change factor. First, clients' scores on the clinical scale correlate positively with intake therapists' ratings of the client's readiness to change. Because client expectations have been found to be predictive of improvement after only one session (Goldstein et al., 1961), ideally, they should be related to intake therapist judgements. Interestingly, however, clients' scores on the Expected Internal Change scale correlate negatively with duration of therapy, and with eventual therapy outcome. This suggests that high scorers may appear to be good clients at intake, but they don't remain in therapy long enough for benefits to occur. Thus high scores on this dimension may be indicative of clients who are frequently seen in crisis, where centers have such a service. Such clients often appear distressed and in need of help, but also may not follow through with

the hard, painful work of changing in therapy. If this is an accurate interpretation of high client scores on this dimension, then it might also explain why it would not appear in the analogue study. Being a state-like dimension, perhaps it is only identifiable within the domain of actual clients in need of help. The analogue clients, in contrast, asked to imagine seeking therapy, might not have their feelings organized in such a fashion.

The correlational pattern with the stages of change measure is also somewhat supportive of this interpretation. Client scores on the Expectations of Internal Change clinical scale are negatively correlated with their scores on the Precontemplation stage of change scale, and positively correlated with Contemplation of change scores. Further, client scores on the Action stage scale do not show any significant relationship with their scores on this clinical scale, supporting the idea that this particular attitudinal dimension may be important for clients early in therapy but not when it comes to the work involved in changing. Client scores on the Expected Internal Change scale correlate significantly with their scores on the Maintenance of change phase scale, which is not interpretable at this time.

The clients' Expectations of Internal Change are positively related to their intake therapists' ratings of client readiness for therapy. This is mostly due to intake

therapists judging clients with high expectations of internal change to be personally satisfying to work with, and to a lesser extent, seeing these clients as ready to become involved in a therapeutic relationship. Speculating, one might imagine that such clients in crisis might have a strong pull on therapists to help them. Then these correlations would make sense to the extent that it is reasonable to assume many therapists are in the field because helping others in need is rewarding to them. At the same time though, intake therapists seem to have the insight not to predict positive outcomes for clients with high Expectations of Internal Change, nor do they even rate these clients as having high desires to change.

Clearly future work will need to be done with this factor before it can be interpreted confidently. First and foremost, it should be cross validated in another clinical sample. In addition, it would be important to write new items, particularly con-trait ones, to see if the factor interpretation is accurate, and to control for any response set influences which may be affecting the items' intercorrelations. Many researchers have talked about the expectations of change construct, and it would be informative to see if this scale would correlate with other measures of clients' expectations of change. As noted earlier, previous researchers found both linear and curvilinear relationships between client expectations and

outcome (Brady et al, 1960; Richert, 1976). Thus if this factor is well developed, future work might aim to establish some cutoffs for the dimension, which could likely explain some of the incongruous past findings.

(2) Therapy Mindedness

The second clinical factor to emerge from the factor analysis is labelled Therapy Mindedness. It contains items that had been previously considered components of Stigma Tolerance by Fischer & Turner (1970), and Psychological Mindedness as originally theorized (Berish, 1984). A number of researchers also previously measured this dimension (e.g., Grant & Grant, 1950; Keithly et al., 1980; Rosenbaum & Horowitz, 1983; Sifneos, 1968). The internal consistency of the clinical scale is good and the endorsement frequency is normally distributed. One potential problem with this factor is that all items are keyed for disagree, opening up the possibility of response set bias.

The pattern of congruence coefficients between Therapy Mindedness and the analogue factors shows that it replicates the Responsibility factor from the first analogue sample, and contains some elements from Disclosure Tolerance, Stigma Tolerance and Psychological Mindedness. This is understandable because these high and medium coefficients of congruence are all with analogue factors that could well be subsumed under the general rubric of Therapy Mindedness. In

the future, however, this factor will need to be cross validated in another sample to make sure it does not break down into these smaller, separate components. In addition, it would be important to write and test pro-trait items, to ensure that this factor's interpretation is accurate, and that a potential response set of, for example, disaquiescence, is not unduly affecting the item variability.

Client scores on the Therapy Mindedness scale correlate positively and significantly with their scores on six of the other clinical scales, but negatively and significantly with their scores on the Distress scale. Clients' Therapy Mindedness scale scores are highly and significantly negatively related to their Precontemplation stage of change scores, not related to their Contemplation stage scores, and significantly correlated with their Action phase of change scores. Thus Therapy Mindedness seems to be important in pretherapy, such that it may be required to overcome the pre-contemplation stage of (not) changing. It also seems important during the actual action phase, as Therapy Mindedness is likely incompatible with many of the typical resistances to change clients might have then. The Therapy Mindedness scale scores are also significantly related to global therapist rated outcome, mostly due to their positive relationship with the judged client's degree of functioning at termination, relative to others of the same age, sex,

ethnic status, and socio-economic status. In contrast to Rosenbaum & Horowitz's (1983) finding that this dimension was not predictive of outcome, Therapy Mindedness appears related to some aspect of eventual outcome in this study.

The importance of this factor is further suggested by intake therapist judgments of clients' readiness for therapy, with which client scores on the Therapy Mindedness scale are significantly related. Clients higher on the Therapy Mindedness clinical scale are seen by intake therapists as having higher desire to change, and being more ready to become involved in a therapeutic relationship. Furthermore, their predicted outcomes in therapy, by intake therapists, are better. In contrast, Therapy Mindedness scale scores are not related to intake therapists' judgements of their personal satisfaction from working with clients. Thus therapy minded clients seem to be accurately judged ready to change by intake therapists, but not considered personally satisfying clients to work with.

(3) Current Emotional Distress

The third clinical factor, Current Emotional Distress, is probably the clearest dimension to emerge from this research. It has been previously researched (e.g., Keithly et al., 1980) and widely discussed (e.g., Miller, 1985). The present measure possesses good internal consistency; its endorsement frequency distribution is normal, and the factor

contains both pro- and con-trait items. The coefficient of congruence across the first analogue and clinical samples is high, indeed the highest in the matrix. Furthermore, in the Second Analogue Sample, the highest loading item (newly created) is "I am more distressed now than at any other time in my life", strongly supporting the label and interpretation of this factor in the other samples. In addition, the content analytic derived measure of Current Emotional Distress is significantly related to the CRTI self-report measure of this construct. In short, it seems that this factor is in fact measuring what may confidently be considered the client's current emotional distress.

The client's level of Distress is significantly and positively related to scores on the Expected Internal Change scale, which supports the image of the client in crisis who appears for relief of experienced distress. Intake therapists judge the client's level of distress to be related to the client's readiness for therapy overall, but not as indicative of the predicted outcome in therapy. Moreover, the level of client Distress is not, in fact, related to eventual outcome, as measured in this research.

Client scores on the Distress scale are not related to their scores on the Precontemplation of change scale. They seem to become most important during the Contemplation of change, and continue to be significant factors in the Action and Maintenance stages of change. Thus Distress is seen to

be an important motivator, as is widely believed and was originally theorized by clinicians surveyed (Berish, 1984). It does not, however, appear to be related to outcome in therapy. The most likely interpretation of these findings seems to be that clients who appear for therapy with high levels of Distress, as with high Expectations of Internal Change, probably can only be assumed to be seeking relief from such distress. This may be important in moving clients into Contemplation of change, but may or may not entail change in a more substantial sense. Clients often seem to want relief from their pain but may not want to work hard, or change to obtain it. This interpretation is consistent with Miller's (1985) analysis in which he concluded: "It appears that client distress is a two-edged sword. Although it may inspire the search for a change strategy, the strategy chosen may be one of fear reduction rather than adaptive behavior change" (p. 95).

Current Emotional Distress seems to be an important, although complicated component of client readiness for therapy. With the item pool already in existence and the many new items tested in the second analogue study, it will be easy to create a well-balanced scale of distress. This component of the CRTI should provide a very useful means of gaining further understanding about the relationship between client distress and the process of change in therapy.

(4) Faith in Therapy

The fourth clinical factor is labelled Faith in Therapy, but might also be aptly named Positive Valuation of Therapy. It is variously conceptualized in previous studies (e.g., Berish, 1984; Gottschalk, 1974; Keithly et al., 1983; Rosenbaum & Horowitz, 1983; Sifneos, 1968) so is not surprising to find. It is highly congruent across the analogue-clinical samples, and is also correlated with the content analytic derived measure of the construct. The scale contains both pro- and con-trait items, and the second analogue study produced many additional good items. Surprisingly, the internal consistency of the factor from the clinical sample is less than desirable, but this should be raised when the scale is augmented with new items. There is also a surprising lack of high loading items on the factor in the clinical sample, in contrast to the loading patterns in the first and second analogue studies. Thus while it is very supportive of the factor's interpretation to see it emerge in each study, the lack of very high loading items in the clinical study suggests that, for actual clients, some further clarification of this dimension's definition may be possible. Nonetheless, its current interpretation seems clear.

Client scores on the Faith in Therapy clinical scale correlate positively and significantly with their scores on the Expected Internal Change, Therapy Mindedness,

Introspected Will to Change, Personal Responsibility, Disclosure Tolerance and Interpersonal Trust clinical scales - most of the other clinical factors. Overall they are significantly related to intake therapists' ratings of clients' readiness for therapy, and this is mostly due to therapists' judgements concerning the client's readiness to become involved in a therapeutic relationship.

Clients' scale scores on Faith in Therapy relate negatively to eventual therapy outcome, suggesting it is actually a poor prognostic sign for clients to have a lot of faith in therapy. This finding is somewhat puzzling, but may be interpreted in at least two ways. First, having a lot of faith in therapy, and thus their therapists, may reflect clients' wishes to be cured by some powerful helper, which may actually hamper therapeutic change (e.g., Appelbaum, 1972). This is supported by the findings that intake therapists' ratings of predicted outcome and the clients' desire to change are not related to clients' level of Faith, and especially by the negative correlations with therapy outcome. Alternatively, in this particular study, the majority of therapists are graduate students in training, and clients' faith may have been misplaced or mismanaged in this sample. This interpretation is supported by the pattern of correlations with the Stages of Change measures showing Faith may be important for early stages of change as well as the Action stage. Moreover, if the wish

for a powerful helper to provide a cure is the correct interpretation, then I would expect to see Faith scale scores negatively correlated with Personal Responsibility scale scores. But they are significantly positively correlated. Nor is there any evidence of such a relationship between Faith and Responsibilty from the coefficients of congruence across samples.

In spite of these explanations, the data clearly show Faith in Therapy scores are negatively related to therapy outcome, contrary to what is generally accepted. It would probably be very informative to see how clients' scores on the Faith in Therapy scale, if measured at different points during therapy, would relate to outcome. Perhaps Faith is important in getting people to come for therapy, but its predictive power, or absence thereof, might be more telling if it was measured after a significant time in therapy. The establishment of scale score cutoffs might also help clarify this finding, in that different levels of Faith in Therapy might be associated differently with outcome. For example, clients with high Faith scores may be searching for a powerful healer, to the detriment of their therapy. While clients with moderate, perhaps optimal levels of Faith, might be hampered by less competent therapists. It would be very important, therefore, to attempt to replicate these findings with a sample of experienced therapists. In any case, scale score cutoffs are needed for closer inspection of possible nonlinear relationships to outcome.

(5) Introspected Will to Change

The fifth clinical factor to emerge from the factor analyses is labelled Introspected Will to Change. It contains both pro- and con-trait items and is distributed normally, but its internal consistency is less than desirable, and there are no high loading items. It will need additional work, generating new items which load highly, before its meaning can be confidently interpreted.

Both Sifneos (1968) and Keithly et al., (1983) considered this an important dimension, and it was so hypothesized in the theorizing used to generate the first item pool (Berish, 1984).

It does not, however, appear as such in the first analogue study. The clinical factor is moderately congruent with three different analogue factors - Responsibility, Self-awareness, and Self-Confidence in Client Role, all of which seem conceptually related. Clearly, these dimensions need to be better defined. Client scores on the Introspected Will to Change clinical scale correlate significantly and positively with their scores on the Therapy Mindedness, Faith in Therapy, Personal Responsibility and Disclosure Tolerance scales.

This clinical factor does not seem particularly related to client stages of change, except insofar as clinical scale scores are negatively correlated with scores on the Precontemplation (not ready to change) stage scale.

Introspected Will to change may be necessary for clients to begin to contemplate changing. It is surprising that client scores on this scale are not related to their scores on the other stages of change scales. In contrast, client scores on this clinical scale are significantly related to all intake therapists' judgements of the client's readiness to change, suggesting it is important. Moreover, clients' Introspected Will to Change scores are positively related to eventual outcome in therapy, and the duration of therapy, further suggesting that this factor is important.

Unlike the 'wish' to be relieved of distress and hopeful expectations of change, this factor seems to perhaps measure a more considered, trait-like dimension that is an important ingredient for change to take place. If this does reflect a more stable personality characteristic, then that might explain why client scores on this scale show essentially null relationships with the various stages of change scales, once change has already been contemplated.

Additional items will need to be generated for this factor, designed to load highly on the hypothesized underlying dimension, so its interpretation can be clarified. At this time, it is possible to speculate that items reflecting self-awareness and personal determination might be worthy of future attempts to develop this factor. It will, of course, also be important to replicate this dimension again with a new sample, to ensure that it is not

some sampling artifact of this particular study. While Introspected Will to change seems to be an important dimension of client readiness for change, its definition requires further clarification.

(6) Personal Responsibility

The sixth clinical factor is labelled Personal Responsibility, and has been researched by several other investigators (e.g., Grant & Grant, 1950; Keithly et al., 1980, Schroeder, 1960). Its moderate congruence with the first analogue factor of the same label is supportive of its interpretation, particularly in view of the relatively low coefficients of congruence it produces with other analogue factors. Because of the apparent clarity of its meaning, this dimension was used in the content analyses. Those results do not provide further support for the dimension's interpretation, however, suggesting the veridicality of one or both of these standard system assessments of Personal Responsibility is questionable. Reflections on some of the difficulties encountered trying to clarify ambiguous scoring definitions with its assessment from intake reports, suggest that the content analytic method may still need further clarification. Specifically, it is not clear whether to consider this dimension as healthy, productive personal responsibility, or more like destructive self-blame, or even whether these both form a single dimension.

Intake Therapist ratings are significantly related to clients' personal responsibility scale scores, as would be expected from the clinical literature and from thinking of Personal Responsibility as a healthy, necessary ingredient for change in therapy. Intake therapists' ratings of the client's desire to change, readiness to become involved in a therapeutic relationship, and predicted outcome all significantly positively relate to clients' Responsibility scale scores.

Client scores on the clinical scale are not, however, significantly related to their scores on the Stages of Change scales, and show mixed correlations with therapist-rated outcome items. They are negatively related to therapists' reflected assessment of the severity of presenting complaints, that is, higher responsibility scores are associated with less presenting problem amelioration. Conversely, clients' responsibility scores are significantly positively related to therapists' reflected assessment of need for further long term treatment (positive outcome). This is quite puzzling since both ratings are conceptually and empirically thought to be indicants of successful therapy outcome. No other clinical scale scores show this paradoxical relationship to the outcome ratings. Clients' scale scores on Responsibility do not correlate significantly with either of the other two outcome judgements, nor with the combined outcome measure.

Clients' Personal Responsibility scale scores correlate positively and significantly with their Therapy Mindedness and Introspected Will to Change scale scores, which theoretically makes good sense; but they also correlate with Faith in Therapy scale scores, which isn't as easily understandable. They correlate negatively with their Current Emotional Distress scores, which may make sense assuming a related construct of Self-Concept.

In the Second Analogue Study, some additional, high loading pro-trait items are generated, so the factor should be well balanced for future work. The internal consistency is less than desirable, but acceptable, and should increase with the addition of the new items.

(7) Risk Taking

The seventh clinical factor is labelled Risk Taking. It contains only four items, but the keying direction is balanced and internal consistency is adequate. This factor emerges again in the second analogue study, and provides an ample number of new items to supplement the CRTI clinical scale. This factor is replicated across the first analogue and clinical samples too. Even though the coefficient of congruence is only moderate, it is clearly higher than this factor's congruence with any of the other factors in the analogue study. It may not be surprising to find this factor cross validated, because given the absence of any

therapy-related content in the scale items, the hypothetical analogue conditions should be easier for subjects to fulfill.

Client scores on the Risk Taking clinical scale correlate positively and significantly with those of the Therapy Mindedness, Disclosure Tolerance and Interpersonal Trust scales, while they are negatively related to the scale scores of Expected Internal Change and Current Emotional Distress. This is understandable theoretically, if once again, one imagines a related construct of Self-Concept. A healthy self-concept would allow a person to feel ready to take risks, self-disclose, and trust, while it would likely be related to an absence of distress and expected change.

Intake therapists' ratings of clients' readiness for therapy are not related to client levels of Risk Taking as measured by the CRTI clinical scale. Nor are any of the therapy outcome ratings predictable from client scores on this scale. Furthermore, client scores on the Risk Taking scale do not appear to be related to their scores on any of the Stages of Change scales. Thus, although this dimension may be confidently interpreted, it seems to be of no current clinical significance. It was originally theorized as a potentially important readiness for therapy dimension, and has been so conceptualized by other researchers as well (e.g., Sifneos, 1968; Keithly et al., 1980), but the present results suggest that, as it is currently measured, it does

not appear to provide additional information for understanding the process of client change in therapy. This finding may be due to the absence of therapy-related content in the current items, insofar as the importance of risk taking may only become salient as a state-like, in-therapy process variable.

Future work with this factor might involve attempts to make the item content more therapy relevant, and state- rather than trait-like. If, upon replication, however, client scores on the clinical scale still bear no relationships to important clinical criteria, it would be best to simply drop this dimension from the CRTI altogether. In this case, further investigations of this dimension might proceed with some other standard system assessments, such as are used in current process research.

(8) Disclosure Tolerance

The eighth clinical factor to emerge is labelled Disclosure Tolerance even though it was originally conceptualized to be Openess (Berish, 1984). It shows moderate congruence across the analogue and clinical samples. Thus even though the factor is comprised of only three items for the clinical analyses, it seems to possess some stability. Clients' scores on the clinical Disclosure Tolerance scale are significantly positively correlated with those from the Therapy Mindedness, Faith in Therapy,

Introspected Will to Change, Risk Taking and Interpersonal Trust scales.

One potential problem with this factor, that was not anticipated, is that all the items are keyed in the same direction. Moreover, in the second analogue study two separate factors emerge, labelled Disclosure Reluctance and Disclosure Tolerance. Each appears to measure what was conceptualized as the two polarities of this supposed single dimension. In fact, some of the items are the same on both factors, but simply loaded in opposite directions. This will need to be explored further, by using more pro- and con-trait items together, to see if the dimension can be sharpened, and perhaps to delineate two different dimensions here.

Clients' scores on the Disclosure Tolerance scale do not relate to intake therapists' ratings of the client's readiness to change. They do significantly relate to all of the therapists' outcome judgements, however, and indeed are the best predictors of successful therapy outcome. This indicates that it will be important to work on this factor to clarify its meaning, as it may be a clinically important aspect of readiness to change. As for the Stages of Change scales, clients' Disclosure Tolerance scores are negatively correlated with their Precontemplation stage scores, but are not significantly related to their scores on other stages' scales. Given this clinical scale's lack of validation

through intake therapist ratings, its minimal relationship to the Stages of Change measures, and the confusing emergence of separate factors in the new analogue study, the predictive validity of the Disclosure Tolerance scale with outcome should be viewed cautiously. Future work will need to clarify the meaning of this observed correlation.

(9) Interpersonal Trust

The ninth clinical factor is labelled Interpersonal Trust. It is moderately congruent with the original analogue factor labelled Self-Confidence in Client Role. There are no high loading items and the internal consistency is not acceptable. Thus this factor's meaning cannot be confidently interpreted at present.

Clients' scores on the Interpersonal Trust scale relate significantly to Intake Therapists' ratings of client readiness to change, but not to any of the outcome ratings. These scores also relate negatively to the Precontemplation of Change scale scores, as do all the CRTI scales, and positively to the Action stage of change scores. Among the other CRTI clinical scales, clients' Interpersonal Trust scores correlate most with their scores on the Faith in Therapy scale. They also correlate positively with other CRTI scale scores, that might all be related to a healthy self-concept, and correlate negatively with their Distress and Expected Change scale scores. Future work with this

factor will need to generate new items to sharpen the dimension's definition, before any firmer conclusions about it can be reached.

Implications

Two important implications emerge from examining the patterns of clients' CRTI scale scores against a backdrop of the factors' interpretations. The first is that self-concept, and more specifically, self-worth, may be an important dimension which would correlate with client scores on many of the CRTI clinical scales. In particular, client scores on the Distress and Expected Change scales seem related to an underlying low self-esteem, while client scores on the other CRTI scales seem to generally correlate with what would be expected from clients with more intact self-concepts. This interpretation is consistent with previous investigators' use of self-concept related measures to assess client readiness for therapy (e.g., Cartwright & Lerner, 1963). Thus it would be interesting to explore this further by administering a self-concept or self-worth measure along with the CRTI scales.

The other pattern that seems important to explore further involves potential cutoffs for each clinical scale that could be used for diagnostic purposes. It has been previously theorized (e.g., Berish, 1984; Miller, 1985; Richert, 1976) that dimensions such as those assessed by the

CRTI might not simply be linearly related to the various clinical criteria explored in this research. Different thresholds or cutoffs might need to be established for the scales before the significance of these factors can be fully understood. For instance, it seems likely that a certain amount of distress is necessary to begin to contemplate change, but too much distress might interfere with the process of change. There are probably different thresholds for the CRTI clinical scales that are required to move from one stage of change to another as well. To research this would require an extremely large sample size so that varying categories, such as high, medium, and low scores on the CRTI scales could be established, and the corresponding different groups of clients compared. This would allow for a much finer exploration of the CRTI dimensions, and would likely provide some important, needed information for the CRTI to be used as a clinical tool. It could be expected to explain some of the negative correlations with some of the validational criteria as well.

Intake Therapists Judgements of Client Readiness for Change

Although intake therapists were used to make judgements of client's readiness for therapy primarily to assess the concurrent validity of the CRTI, the findings related to these judgements are interesting in their own right.

Intake therapists were asked to make four ratings of the clients they saw during intake, and these were combined to form an internally consistent scale of therapist-rated client readiness for therapy. This measure correlates positively with therapy outcome overall, as measured by similiarly combining four archival therapist ratings of the client at termination. This suggests that intake therapists are good judges of client readiness for change in therapy. The specific intake rating item (T2) asking for a direct prediction of therapy outcome, however, does not correlate significantly with the combined outcome measure, nor with any of the four individual outcome ratings. Most of the predictability seems to come from intake therapists' ratings of the client's readiness to become involved in a therapeutic relationship (T3). Ratings of the therapist's personal satisfaction from working with the client (T4) and the client's judged desire to change (T1) also seem to contribute positively. These trends seem to support current beliefs and findings about the importance of the therapeutic relationship (e.g., Bordin, 1979; Luborsky, 1984; Marziali, 1984b; Orlinsky & Howard, 1986). Future studies should examine client scores on the CRTI scales in relation to the quality of the therapy relationship, assessed as therapy progresses.

The intake therapists' ratings are significantly related to client scores on all of the CRTI scales except

the Risk Taking and Disclosure Tolerance scales, and client scores on the CRTI as a whole correlate very significantly with Intake Therapists' overall ratings. Ratings of the client's desire to change (T1) seem most related to clients' scores on the Personal Responsibility, Introspected Will to Change, and Therapy Mindedness scales. Client scores on the same three clinical scales are also the most highly related to intake therapists' outcome predictions (T2). Interestingly, intake therapists do not seem to be as highly influenced by client levels of Current Emotional Distress or Expected Internal Change, as indicators that clients truly desire to change themselves (T1). In rating clients' readiness for a therapeutic relationship (T3), however, the client's measured level of Distress and Faith in Therapy are significantly related to the therapist judgements, in addition to the aforementioned three factors. As for therapists' expected personal satisfaction (T4), clients' scores on the Expected Internal Change and Interpersonal Trust scales are the two which correlate highest.

Intake therapist ratings do not correlate significantly with any of the client's scores on the stages of change scales. This is somewhat surprising if one hypothesizes that different amounts of the CRTI dimensions are present, perhaps necessary, at different stages of change. Perhaps it reflects the possibility that intake therapists' judgements are not so much influenced by the client's

particular stage of change at intake, as they are by the client's levels of readiness for change, that is, the client's attitudinal resources for the therapy change process.

One of the very interesting findings about intake therapists concerns their intake report content. Of 927 sentences coded from 25 different intake reports and many different intake therapists, only about 12% (114) contain information relating to the CRTI factors of Distress, Responsibility, or Faith in Therapy, or contain any overall statements about client motivation/ readiness. Apparently, even though intake therapists' judgements of clients' readiness for therapy appear to possess predictive validity, they are seldom reported in the intake reports. One can only speculate at this time as to why this might be the case. Perhaps it reflects our training emphasis on diagnosing specific types of psychopathology and this constitutes the focus of intake assessment reports. This could be explored in an additional content analytic study, with an expanded lexicon to categorize the remaining 88% of intake report content. Perhaps it reflects therapists' beliefs that the client's readiness for therapy is an unchangeable given, so not worth reporting. And perhaps it is simply 'tradition', related to the relative lack of attention accorded client readiness constructs in most theories of therapy. Regardless of the reason, the present

data suggest that intake therapists are able to make useful judgements about clients' readiness to change, and perhaps more attention should be focused on such assessments. Therapist interventions might then be geared to client readiness variables to facilitate change (e.g., Miller, 1985; Prochaska & DiClemente, 1982).

Therapy Outcome Predictions

The outcome measures used in this research are derived from the therapists' perspective, which is known to differ somewhat from clients' and society's perspectives (e.g., Strupp, 1973). Their use was determined by practical limits, such as their ready availability at the PSC, rather than ideal conditions, where one could use whatever measures desired. The sample size which includes outcome measures is also smaller than desirable, due in part to the duration of therapy. Additional outcome data on clients who are not yet terminated would likely become available in the near future. Nonetheless, combining the four ratings provides an internally consistent and normally distributed outcome variable. It possesses discriminability and is suitable for correlational analyses, and so serves as some beacon of therapy outcome. Naturally it would be necessary to utilize much more sophisticated, multi-perspective outcome assessments before any confident conclusions about outcome predictability could be made. The results pertaining to

therapy outcome should therefore be viewed very tentatively, as the validity of the outcome criteria is questionable.

With these limitations in mind, it is still interesting to note that both intake therapist ratings and client scores on two CRTI scales significantly correlate with therapy outcome. The content analytic measures do not correlate with outcome, but the two factors which show some concurrent validity between the content analyses and the CRTI scale scores, Distress and Faith, do correlate, although negatively, with outcome.

Perhaps the best indicator of outcome in this study is the therapists' rating of the status of the presenting complaints at termination, because it is the only rating which takes into account a conceptual pre- and post-assessment. The other three judgements do not take into account the client's initial level of presenting pathology, and so are confounded as measures of change in therapy.

The proportion of overall outcome variance accounted for by the combined intake therapist ratings is approximately 9.6%. The proportion of overall outcome variance accounted for by client scores on the highest CRTI scale predictor, Disclosure Tolerance, is approximately 15.4%.

What seems more important regarding outcome, is the finding that client scores on certain CRTI scales are negatively related to therapy outcome. This may be due to

the absence of cutoff points for the scale scores, the establishment of which might demonstrate that some nonlinear relationships between client scores on the CRTI scales and outcome are more harmonious with the data. Or it may reflect the possibility that some new thinking about the dimensions of readiness for change in therapy is required. This will be important to pursue in future research with the CRTI.

Overall, it is not surprising that assessments of the client's attitudinal and feeling dimensions at the beginning of therapy may not account for a very large proportion of outcome variance. Many other factors would naturally be involved in determining outcome. That the CRTI may relate to outcome at all is encouraging, but needs to be replicated, especially with outcome measured from varying perspectives, including client's self-assessments and less reactive measures (cf., Smith et al., 1980).

The findings with respect to duration of therapy should be considered in light of the heavily skewed distributions which the number of weeks and number of sessions variables displayed. With all the current emphasis on time limited therapies it would be most useful to be able to predict which clients will require what number of sessions. Only client scores on the Expectations of Internal Change scale show a significant trend with shorter time in therapy, while scores on the Introspected Will to Change scale are

associated with longer durations of therapy. These may reflect differences in clients' presentations of their considered and sustained needs to change, versus immediate wishes for relief. A much larger sample, one that would be representative of varying therapy durations, would be needed to achieve normal distributions of the duration variable, and to explore these issues more thoroughly.

Stages of Change

The stages of change, as assessed through clients' self-reports at the beginning of therapy show some of the most interesting relationships to the CRTI scales. The Precontemplation Stage, during which a client is considered not ready for change, is indeed negatively correlated with client scores on all the CRTI scales. Thus those clients high on Precontemplation at intake, are low on the therapy readiness dimensions measured by the CRTI. This provides excellent construct validation for the CRTI scales and additional explanatory power for the Precontemplation stage scale.

Client scores on the Contemplation of Change Stage scale, during which clients are considered to be thinking of change, are significantly associated with high levels of Expected Internal Change, Current Emotional Distress and Faith in Therapy. These dimensions are thus indicated as potential motivators to seriously considering changing.

That is, pain, the wish for its removal, and some positive valuation of therapy as an avenue for relief may be important precursors for clients who come to therapy to begin consideration of change. This finding is consistent with the extant literature (e.g., Garfield, 1978, 1986).

For the Action stage, when clients are already working on their problems, client scores on the Distress and Faith scales remain important, but their scores on the Therapy Mindedness and Interpersonal Trust scales also come into play. This suggests that working on one's problems is associated with the elimination of many of the common resistances to change (Therapy Mindedness) as well as being ready to trust others. An important implication, or perhaps corroboration of a "clinical" tenet, from this finding, is that therapists need to work to eliminate, or undercut clients' attitudinal resistances in order to pave the way for clients' active work to change.

Client scores on the Maintenance Stage scale show a significant relationship with their scores on the Expected Internal Change and Current Emotional Distress scales, both of which are interpreted as involving an almost wish-like desire for relief of discomfort. As previously noted, these dimensions seem important for the Contemplation stage as well. It should be remembered that all clients in this study completed the SCQ at intake. Thus scores on the Maintenance Stage scale of the SCQ, as measured in this

study, might be considered more as a client return to the Contemplation of change stage, motivated by recurrance of distress and wish for relief. An important future study could involve administrations of the SCQ and the CRTI at externally defined, different stages of therapy. Practical limits make this difficult, but it might help clarify more about the relationships between the CRTI dimensions and SCQ stages of change. Overall, the data suggest that the CRTI dimensions may be closely involved in understanding and explaining how clients move between these stages of change.

Current Status of the CRTI

The first stage required in order to measure anything is denotability, or establishing some encounterability with the attributes of interest (Aftanas, 1988). In self-report measurement of hypothetical personality characteristics, attitudes, and feelings, this means it is important to be able to clearly define the constructs of interest, and the criterion measures. With respect to client readiness for therapy, this has historically been problematic. The current research utilizes questionnaire items which initiate client (respondent) self-exploration of dimensions which are thought to be related to therapy readiness. Previous work with these items found clinical judges agreed on their content validity. The current work to further develop the CRTI, however, continues to find problems with clear

definitions of some dimensions. This program of exploratory factor analytic research with the CRTI must therefore be considered an iterative process, with continued returns to the first measurement stage of definition, or denotability.

Several dimensions appear to be clearly denotable with the CRTI at present, which is particularly encouraging. Additional work will need to sharpen the new factors emerging from the clinical sample. The results of this research suggest that future work on item endorsement frequencies, and studies designed to generate potential pro- and con-trait item pools can be done under analogue conditions. While some factors demonstrate invariance from the analogue situation, there are clearly some dimensions which do not prove invariant. Therefore it would seem more useful for future factor definition work to utilize client samples, even though these are much more difficult to obtain.

The current version of the CRTI provides items tested for their endorsement frequencies, relative correlations with social desirability and content relevant factors, and meaningful intercorrelations. A substantial number of items pass these tests. The factors are tested on analogue and clinical samples, and validated with some clinically relevant criterion variables. The utilization of different standard systems (eg., therapist raters, content analyses, and an additional self-report measure) also demonstrates

that some significant content relevant variance is associated with the self-report CRTI. Thus it seems to be a viable means of studying client readiness for therapy.

At this point, additional work will be required before the CRTI can be used diagnostically or clinically. Future studies are needed to provide further information on the instrument's reliability and validity, lest the CRTI become merely another source of confusing findings in the psychotherapy research field. For research purposes, however, the CRTI may be useful, to match pretreatment groups for example, when comparing different clinical treatments. In the future, once reliable and valid cutoffs are established for replicated factors, it would be interesting to see if and how CRTI scores interact with different therapeutic interventions. CRTI assessments at different stages of therapy, with more homogeneous client populations and therapy interventions, and with additional criterion measures, would all be worthwhile future endeavours. The steps taken in this research, however, are considered most important at this time, to validate the measurement of client readiness for therapy. Based on the research to date, the CRTI appears to be a promising tool for measuring and clarifying dimensions of clients' attitudes, feelings, and beliefs, considered relevant to their readiness for change in therapy.

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APPENDIX A: COVERING LETTER TO CLIENTS

Dear P.S.C. Client,

The attached questionnaire is part of a study to find out what thoughts, feelings, and related attitudes clients have when coming for counseling or psychotherapy. There are no "right" or "wrong" answers; it is your feelings and thoughts that are important here. What I would ask you to do is to take approximately 15 minutes of your time to answer the questions. Please answer the questions based on how you feel or think at this time.

Of course your answers to these questions will be treated confidentially. This means that scores will only be used in group form, and no one individual's scores will be examined. Your identity will remain anonymous.

Your therapist will be asked some questions about you too, because I am also interested in seeing what his/her perceptions are. Your therapist will definitely not see your questionnaire. Of course the service you receive here is in no way related to whether you choose to complete the questionnaire to help with this study, nor will your service be related to how you answer the questions.

After you turn in the questionnaire, if you would be interested in receiving a brief description of the general results (i.e., not your personal results), there will be address labels at the front desk on which you should provide your mailing address.

Thank you for your participation. I think you will find the questions interesting. You can drop off the questionnaires at the front desk the next time you come in.

Sincerely,

Cliff Berish
Graduate Student in Clinical Psychology

Age: _____

Sex: M/F (circle)

Date: _____

Approximate time in therapy:

_____ _____ _____
years months weeks

Approximate number of sessions to date:

_____

APPENDIX B: CLIENT READINESS FOR THERAPY INVENTORY (CRTI)

Answer each item by circling the number which best indicates how you feel/think. The numbers represent the same points from Strongly Agree ... Strongly Disagree throughout the questionnaire. Do no leave out any questions.

	STRONGLY AGREE		AGREE		DISAGREE		STRONGLY DISAGREE
1. I mostly do not remember my dreams.....	1	2	3	4	5	6	7
2. I assume that my therapist will know more than me about solving personal problems.....	1	2	3	4	5	6	7
3. I believe that my problems are to a fair extent my own making.....	1	2	3	4	5	6	7
4. This really seems like a bad time in my life for a change.....	1	2	3	4	5	6	7
5. I always try to be considerate of the feelings of my friends.....	1	2	3	4	5	6	7
6. I often feel like I simply can't cope with all the hassles in my life.....	1	2	3	4	5	6	7
7. A skilled therapist might be able to convince me to change my mind about some things.....	1	2	3	4	5	6	7
8. My current problems are a lasting result of my childhood experience.....	1	2	3	4	5	6	7
9. I expect therapy to involve many sessions.....	1	2	3	4	5	6	7
10. I often take some responsibility for looking out for newcomers in a group.....	1	2	3	4	5	6	7
11. I believe that my therapist will maintain strict confidentiality regarding our discussions.....	1	2	3	4	5	6	7
12. I feel more satisfied with my life now than ever before.....	1	2	3	4	5	6	7
13. I think I will require a very specific type of therapist.....	1	2	3	4	5	6	7
14. I have some ideas about what changes I would like to make in my life.....	1	2	3	4	5	6	7

	STRONGLY AGREE						STRONGLY DISAGREE
15. In the long run humanity will owe a lot more to the teacher than to the salesman.....	1	2	3	4	5	6	7
16. I think I probably spend less time than other people thinking about my life.....	1	2	3	4	5	6	7
17. I believe that a therapist will be able to tell me the "secret formula" for the solution to my problem.....	1	2	3	4	5	6	7
18. I would discuss my therapy with my family if they were interested.....	1	2	3	4	5	6	7
19. I often make decisions that are based more upon what I can do so I will lose the least, than on what I can do to gain the most	1	2	3	4	5	6	7
20. Nothing that happens to me makes much difference one way or the other.....	1	2	3	4	5	6	7
21. I was under pressure from others to come into therapy.....	1	2	3	4	5	6	7
22. Regardless of what I do or my therapist might do, one cannot alter what is fate.....	1	2	3	4	5	6	7
23. I think therapy will be a shared responsibility between myself and my therapist.....	1	2	3	4	5	6	7
24. It is more important what one does than what one feels about what one does.....	1	2	3	4	5	6	7
25. I have a number of health problems.....	1	2	3	4	5	6	7
26. I expect my therapist to help me to uncover things about myself, about which I am now unaware.....	1	2	3	4	5	6	7
27. I am ashamed of elements of my past.....	1	2	3	4	5	6	7
28. At times I am afraid to let others know what I am really feeling.....	1	2	3	4	5	6	7
29. I'd rather be safe than sorry when it comes to personal risks.....	1	2	3	4	5	6	7

	STRONGLY AGREE						STRONGLY DISAGREE
30. I often have the feeling that I am doing something evil.....	1	2	3	4	5	6	7
31. I feel that therapy is/will be one of the most important things I have done in my life.....	1	2	3	4	5	6	7
32. I believe that my problems are mostly due to other people and circumstances.....	1	2	3	4	5	6	7
33. It's very important to me that I change something about the way my life is going right now.....	1	2	3	4	5	6	7
34. No one can really make me change -- I have to want change.....	1	2	3	4	5	6	7
36. It is probably best not to know everything about oneself.....	1	2	3	4	5	6	7
37. I don't think my therapist could possibly be wiser than me.....	1	2	3	4	5	6	7
38. I can pinpoint an event which led to my decision to seek therapy.....	1	2	3	4	5	6	7
39. Therapy involvement is a sign of personal weakness..	1	2	3	4	5	6	7
40. I almost always feel sleepy and lazy.....	1	2	3	4	5	6	7
41. I feel quite content with the way I am now.....	1	2	3	4	5	6	7
42. I would willingly confide intimate matters to a therapist if I thought it might help me.....	1	2	3	4	5	6	7
43. I don't really believe anyone can be of help to me -- I have to do it all on my own.....	1	2	3	4	5	6	7
44. There are books I can buy which would eliminate the need for a therapist.....	1	2	3	4	5	6	7
45. My memory is as good as other people's.....	1	2	3	4	5	6	7
46. The problems I want to talk about in therapy are of relatively recent origin.....	1	2	3	4	5	6	7

	STRONGLY	AGREE		AGREE		DISAGREE	STRONGLY	DISAGREE
47. I sometimes like to do things in a new way just for the different experience.....	1	2	3	4	5	6	7	
48. A lot of talking about one's feelings and problems just makes things worse.....	1	2	3	4	5	6	7	
49. If a fee was charged for therapy I would be willing to pay.....	1	2	3	4	5	6	7	
50. I am not willing to give up my own privacy or pleasure in order to help other people.....	1	2	3	4	5	6	7	
51. What I choose to do can determine what my life will be like.....	1	2	3	4	5	6	7	
52. I feel more confusion now than just about any other time in my life.....	1	2	3	4	5	6	7	
53. I feel uneasy about seeing a therapist because of what some people would think.....	1	2	3	4	5	6	7	
54. I insist on knowing the details of my therapists' personal life if I am to work with him/her.....	1	2	3	4	5	6	7	
55. Most of my teachers were helpful.....	1	2	3	4	5	6	7	
56. There are experiences in my life that I would not discuss with anyone.....	1	2	3	4	5	6	7	
57. I expect that therapy will be quite uncomfortable at times.....	1	2	3	4	5	6	7	
56. I usually act the way I do because other people make me act that way.....	1	2	3	4	5	6	7	
59. I believe that a therapist will be able to help me solve my problems.....	1	2	3	4	5	6	7	
60. We ought to let the rest of the world solve their own problems and just look out after ourselves.....	1	2	3	4	5	6	7	
61. A lot of things seem to be changing in my life now..	1	2	3	4	5	6	7	

	STRONGLY AGREE						STRONGLY DISAGREE
62. A person with an emotional problem sometimes might not solve it alone; s/he is likely to resolve it with professional help.....	1	2	3	4	5	6	7
63. I should not postpone leading my life the way I want to.....	1	2	3	4	5	6	7
64. I don't expect to feel better when I've finished therapy.....	1	2	3	4	5	6	7
65. My life is full of interesting activities.....	1	2	3	4	5	6	7
66. I think that heredity has played the most important role in determining what I am like.....	1	2	3	4	5	6	7
67. I am generally afraid to try new things.....	1	2	3	4	5	6	7
68. At times I am afraid to admit to myself what I am really feeling.....	1	2	3	4	5	6	7
69. Keeping one's mind on a job is the best solution for taking care of personal worries and concerns.....	1	2	3	4	5	6	7
70. I often question whether life is worthwhile.....	1	2	3	4	5	6	7
71. I have/had already tried some ways of helping myself before coming in for therapy.....	1	2	3	4	5	6	7
72. I am afraid that a therapist will know many things about me that I do not.....	1	2	3	4	5	6	7
73. A lack of physical exercise is often at the root of emotional problems.....	1	2	3	4	5	6	7
74. I feel that I am not in control of my life.....	1	2	3	4	5	6	7
75. I am able to make correct decisions on difficult questions.....	1	2	3	4	5	6	7
76. I would willingly confide intimate matters to a therapist if I thought it might help someone I care about.....	1	2	3	4	5	6	7

	STRONGLY AGREE						STRONGLY DISAGREE
77. I am optimistic that the outcome of my therapy will be positive.....	1	2	3	4	5	6	7
78. I prefer not to be observed by others while awaiting therapy sessions.....	1	2	3	4	5	6	7
79. I believe that I am now as effective a person as I will ever be.....	1	2	3	4	5	6	7
80. I believe people tell lies any time it is to their advantage.....	1	2	3	4	5	6	7
81. I would be prepared to make big changes in my life situation (e.g., move, change jobs, etc.) if it seemed important in therapy.....	1	2	3	4	5	6	7
82. I believe that my problems are mostly due to circumstances beyond my control.....	1	2	3	4	5	6	7
83. I have a lot of difficulty developing trust in others.....	1	2	3	4	5	6	7
84. I feel more emotional pain now than just about any other time in my life.....	1	2	3	4	5	6	7
85. Rarely, if ever, has the sight of food made me ill..	1	2	3	4	5	6	7
86. I would discuss my therapy with my friends if they were interested.....	1	2	3	4	5	6	7
87. I have known exactly what needs to be done for my life to be better for quite a long time already.....	1	2	3	4	5	6	7
88. I believe that the solution of my problems will depend mostly on other people or circumstances.....	1	2	3	4	5	6	7
89. It's important to me that my therapist get to know me well, in order for me to work with him/her.....	1	2	3	4	5	6	7
90. I find it very difficult to concentrate.....	1	2	3	4	5	6	7
91. I expect to be a different person after therapy.....	1	2	3	4	5	6	7

	STRONGLY AGREE						STRONGLY DISAGREE
92. I believe that the important people in my life will support the changes I want to make.....	1	2	3	4	5	6	7
93. I have no idea at all what changes I'd need to make in myself to feel better.....	1	2	3	4	5	6	7
94. There are certain problems which should not be discussed or shared with anyone.....	1	2	3	4	5	6	7
95. I am always prepared to do what is expected of me...	1	2	3	4	5	6	7
96. I consider myself someone who is willing to take risks at times.....	1	2	3	4	5	6	7
97. Emotional difficulties tend to work out by themselves.....	1	2	3	4	5	6	7
98. I believe that personal misfortune is a punishment for a sinful life.....	1	2	3	4	5	6	7
99. No one can really make another person change -- they have to want to.....	1	2	3	4	5	6	7
100. Many things make me feel uneasy.....	1	2	3	4	5	6	7
101. If my therapist gave me homework assignments to do between sessions, I would have the time to do them..	1	2	3	4	5	6	7
102. A skilled therapist could trick me into changing even if I didn't want to.....	1	2	3	4	5	6	7
103. I want to know myself as deeply as possible.....	1	2	3	4	5	6	7
104. I believe that emotional feelings only get in the way of solving personal problems.....	1	2	3	4	5	6	7
105. There are certain problems which should not be discussed outside of one's immediate family.....	1	2	3	4	5	6	7
106. A person with a strong character can get over mental conflicts by him/herself and would have little need of a therapist.....	1	2	3	4	5	6	7

	STRONGLY AGREE		AGREE		DISAGREE		STRONGLY DISAGREE
107. I am willing to look at the possibility that some of the ways I have "always done things" has contributed to my problems.....	1	2	3	4	5	6	7
108. I feel that only a therapist near to my own age will will be effective for me.....	1	2	3	4	5	6	7
109. I was forced to come to therapy against my will.....	1	2	3	4	5	6	7
110. I feel like things are falling apart in my life.....	1	2	3	4	5	6	7
111. There is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears without resorting to professional help....	1	2	3	4	5	6	7
112. I expect to be somewhat changed after therapy.....	1	2	3	4	5	6	7

APPENDIX C: COVERING LETTER TO ANALOGUE SUBJECTS

Dear Participant:

This is a study to help to develop a questionnaire to be administered to people initially presenting themselves for counseling or psychotherapy. If you have never been in counseling or psychotherapy, what I would ask you to do is to answer these questions the way you imagine you would if you were in the situation of seeking counseling or psychotherapy. If you have had counseling or psychotherapy, what I would ask you to do is to answer these questions the way you would have just before you began therapy. Of course your answers to these questions are anonymous and confidential.

As you read each question, you might find it helpful to ask yourself (cue yourself with) "how would I feel/think if I were now seeking therapy?".

Thank you for your participation,

Sincerely,

Cliff Berish

APPENDIX D: CRTI ADMINISTERED TO SECOND ANALOGUE SAMPLE (R-CRTI)

Answer each item by darkening the number on your answer sheet, which best indicates how you feel/think. Indicate the extent to which you tend to agree or disagree with each statement. There are FIVE possible responses to each of the questionnaire items:

STRONGLY AGREE ..... A

AGREE ..... B

UNDECIDED C

DISAGREE ..... D

STRONGLY DISAGREE ..... E

1. I mostly do not remember my dreams.
2. I feel like things are falling apart in my life.
3. I believe that the solution of my problems will depend mostly on other people or circumstances.
4. I have known exactly what needs to be done for my life to be better for quite a long time already.
5. There are experiences in my life that I would not discuss with anyone.
6. I believe that a therapist will be able to help me solve my problems.
7. I consider myself someone who is willing to take risks at times.
8. I feel quite content with the way I am now.
9. I believe that my problems are largely my own making.
10. I have no idea at all what changes I'd need to make in myself to feel better.
11. I believe that mental illness should be discussed as openly as heart disease.
12. I don't expect to feel better when I've finished therapy.
13. I consider myself someone who is willing to take risks at times.
14. I feel more emotional pain now than just about any other time in my life.

STRONGLY AGREE ..... A
AGREE ..... B
UNDECIDED C
DISAGREE ..... D
STRONGLY DISAGREE ... E

15. I believe that my problems are mostly due to other people and circumstances.

16. I believe that the important people in my life will support the changes I want to make.

17. There are certain problems that should not be discussed outside one's immediate family.

18. I am optimistic that the outcome of my therapy will be positive.

19. I'd rather be safe than sorry when it comes to personal risks.

20. I feel more satisfied with my life now than ever before.

21. When I think about it, I deserve to be in the situation I am in now.

22. I'm very unsure of what my role as client should be.

23. I will be ready to be open and talk through my problems to solve them.

24. I don't think therapy is anything more than modern witchcraft.

25. A lot of things seem to be changing in my life now.

26. I feel more confusion now than just about any other time in my life.

27. I believe that my problems are mostly due to circumstances beyond my control.

28. I want to know myself as deeply as possible.

29. There are certain problems which should not be discussed or shared with anyone.

30. If a fee was charged for therapy, I would be willing to pay.

31. I take risks only if I have carefully thought out all the possible outcomes to the risk.

32. I feel less distressed now, than at other times in my life.

33. I believe that I alone have the power to resolve my problems.

STRONGLY AGREE ..... A
AGREE ..... B
UNDECIDED C
DISAGREE ..... D
STRONGLY DISAGREE ... E

34. I'm afraid I may fail at being a good therapy case.

35. I feel confident that if I would confide in my therapist, s/he would be able to help me.

36. I don't think therapists know any more about solving human problems than the average person would.

37. I sometimes like to do things in a new way just for the different experience.

38. It's very important to me that I change something about the way my life is going right now.

39. I believe that personal misfortune is a punishment for a sinful life.

40. No one can really make me change - I have to want to change.

41. There is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears without resorting to professional help.

42. I expect my therapist to help me to uncover things about myself, about which I am now unaware.

43. I don't like to take chances where my life is concerned.

44. I am not in need of help now.

45. If my problems are to be solved, it will have to be through my changes.

46. I never even used to think I had a problem until just recently.

47. I feel that it is helpful to tell others about one's problems, because it takes the burden off one's shoulders.

48. I would not be willing to be very inconvenienced in order to obtain therapy.

49. I like to experience new things in my life.

50. I feel that I am not in control of my life.

51. A skilled therapist could trick me into changing even if I didn't want to.

STRONGLY AGREE ..... A
AGREE ..... B
UNDECIDED C
DISAGREE ..... D
STRONGLY DISAGREE ... E

52. No one can really make another person change - they have to want to.

53. A person with a strong character can get over mental conflicts by himself/herself, and would have little need of a therapist.

54. I believe that my therapist will maintain strict confidentiality regarding our discussions.

55. I wish everything in my life would just stay as it is for awhile.

56. Things couldn't be going better for me than they are now.

57. It is best to take responsibility for your own actions.

58. I don't want to know too much about what actually makes me "tick".

59. If I have a problem or am feeling stress, my first instinct is to talk to someone about it.

60. I am doubtful that a therapist will be helpful to me.

61. I have alot to gain in life and nothing much to lose.

62. I often feel like I simply can't cope with all the hassles in my life.

63. I believe that a therapist will be able to tell me the "secret formula" for the solution of my problems.

64. I really want to change.

65. I feel uneasy about seeing a therapist because of what some people would think.

66. A skilled therapist might be able to convince me to change my mind about some things.

67. Life keeps changing too fast for my liking.

68. I feel like everything in my life is well under control.

69. I believe my problems are all my fault.

70. I know what needs to be done in my life, but I'm not sure how to go about it.

STRONGLY AGREE ..... A
AGREE ..... B
UNDECIDED C
DISAGREE ..... D
STRONGLY DISAGREE .. E

71. I enjoy opening up and confiding in others.

72. I expect to be unchanged after therapy.

73. I like to face things that scare me as soon as possible.

74. I am more distressed now than at any other time in my life.

75. Regardless of what I or my therapist might do, one cannot alter what is fate.

76. I feel confident about being a client in therapy.

77. At times I am afraid to let others know what I am really feeling.

78. I would willingly confide intimate matters to a therapist if I thought it would help me.

79. The way to survive life is to stick to a rigid schedule.

80. My life is going in the direction I always hoped it would.

81. I have a choice in everything I do.

82. I need to be encouraged to develop self-confidence but I haven't anyone to help me.

83. Therapy has become more accepted and I feel it is a wise approach to take.

84. I don't believe a therapist can know anything about me, which I don't already know.

85. The way to live is to try new things and not be afraid of change.

86. I feel like I need help with my life now.

87. I usually act the way I do because other people make me act that way.

88. I believe I am capable of succeeding in anything I do.

89. I am usually very careful about who I open up to.

90. Coming for therapy gives me hope that I will be understood.

91. It is best to avoid the unknown , if at all possible.

STRONGLY AGREE ..... A
AGREE ..... B
UNDECIDED C
DISAGREE ..... D
STRONGLY DISAGREE ... E

92. I am satisfied with the life that I have made for myself.

93. I am in control of my own life and am responsible for what happens to me.

94. I'm very unsure of what my therapist will expect from me.

95. I will share my problems with anyone who is genuinely willing to listen.

96. I don't think a therapist could help me, because s/he is not in my shoes.

97. Trying new things adds excitement to one's life.

98. I really don't think very highly of myself these days.

99. I feel quite powerless about changing my life situation these days

100. I believe that if I want to change, I will be able to change.

101. I don't feel the therapist should ask questions that are not related to my problem.

102. I believe that my therapist has my best interests in mind.

103. I have a planned schedule from which I do not deviate.

104. Nowadays, I am enjoying the simple pleasures of life.

105. I am responsible for most of the things that happen to me in my life.

106. I don't feel like I get any support for the changes I want to make in my life

107. Talking about myself to people usually makes me feel better.

108. I am only seeing a therapist so everyone will leave me alone.

109. I think I would like to sky dive or race cars.

110. I feel like I am no longer able to cope with everyday life - the slightest thing sets me off.

111. The important people in my life demand too much of me.

STRONGLY AGREE ..... A
AGREE ..... B
UNDECIDED C
DISAGREE ..... D
STRONGLY DISAGREE ... E

112. I enjoy making up my own mind about my life.

113. If I talk about me and my problems honestly, I fear that I will be regarded as less of a person.

114. I have complete confidence in therapists.

115. At times when I would like to do something new, I often don't try it.

116. Things are going smoothly in my life.

117. Everyone is responsible for their own lives.

118. Therapy would be a very strange experience for me.

119. The more someone knows you, the more they can help you.

120. I think therapy would be a waste of time.

121. I get bored easily if my life is too orderly and routine.

122. I am more distressed now than at any other time in my life.

123. I try hard to be my best, but at times people don't let me.

124. I know what I want in life.

125. People would make fun of me if they knew my secrets.

126. I think a therapist will look at my problem from an objective view and help me deal with it.

127. By taking new risks I may lose the stability that I now have.

128. I feel like all my dreams and goals are being accomplished.

129. If someone really knew what I think and feel, they would really like me.

130. A therapist isn't any more likely to help me, than a friend would be.

131. You can't succeed if you don't take big risks.

132. I feel that I'm fighting with myself on every decision I have to make.

STRONGLY AGREE ..... A
AGREE ..... B
UNDECIDED C
DISAGREE ..... D
STRONGLY DISAGREE ... E

133. I am not often wrong.

134. When I run into problems, I try to come up with solutions, and if one solution doesn't work, I try another one.

135. When I disclose intimate information about myself, I feel very vulnerable and uncomfortable.

136. I believe that professionals who have been trained to help people like me, can and do.

137. I feel energetic and happy to be alive almost every day.

138. I am eager to "tell my story" to my therapist.

139. All therapists want is to make money from other people's troubles.

140. Even though changes reflect uncertainty, I usually welcome them as challenges.

141. I feel ready to benefit from psychotherapy.

---

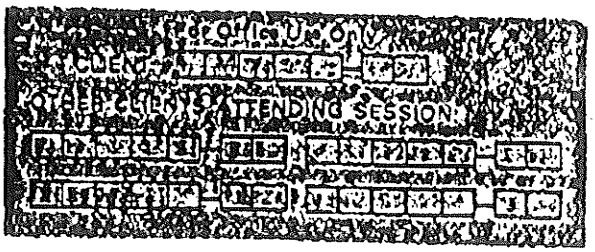
142. Your sex: Male = A Female = B

143. Have you ever been in psychotherapy/counseling before?
Yes = A No = B

144. Your age: under 20 = A
20-25 = B
26-30 = C
over 30 = D

PSYCHOLOGICAL SERVICE CENTRE

INTAKE/ASSESSMENT/THERAPY FORM



DATE: Yr. Mo. Day

WORKER: CO-WORKER:

INTAKE

CONTACT WITH: (check one)

- Individual Adult 1
- Individual Child 2
- Couple 3
- Family 4
- Social Network 5

PREVIOUS RELATED CARE: Yes 1 No 2

CONCURRENT RELATED CARE: Yes 1 No 2

CRISIS: Yes 1 No 2

PROBLEM DURATION: (check one)

- Up to One Month 1
- One to Six Months 2
- More Than Six Months 3

DISPOSITION: (check one)

- Assigned to Therapist 1
- Intake Coordinating Committee 2
- Referred Elsewhere 3
- Resolved at Intake 4
- Other 5

PRESENTING PROBLEMS (see back of form)

ASSESSMENT

TYPE OF ASSESSMENT: (check one or more)

- Behavioral 1
- Intellectual 2
- Neurological 3
- Personality 4
- Vocational 5
- Psychosocial 6
- Other 7

INITIATED BY: (check one)

- Referral Source 1
- Client/Family 2
- P.S.C. 3
- Other 4

FIRST CLIENT CONTACT: Yr. Mo. Day

TIME REQUIRED FOR ASSESSMENT: (check one)

- Less than 2 hours 1
- 2-4 hours 2
- 5-8 hours 3
- 9-16 hours 4
- More than 16 hours 5

REPORT SENT: Yes 1 No 2

TERMINATED FROM PSC: Yes 1 No 2

THERAPY

CONTACT WITH: (check one)

- Individual Adult 1
- Individual Child 2
- Couple 3
- Family 4
- Social Network 5

CONTACT TYPE/PLACE: (check one)

- Person to Person
  - PSC/University 1
  - Community Organization 2
  - Other Community Setting 3
- Telephone 4

DURATION OF CONTACT: (check one)

- Less than 45 minutes 1
- 45-74 minutes 2
- 75-104 minutes 3
- 105-134 minutes 4
- 135 minutes or more 5

SPECIAL PROGRAM: (check one)

- None 1
- Sexual Dysfunction Clinic 2
- Obesity Control Centre 3
- Community Resource Unit 4
- Manitoba Clinic 5
- Other 6

HOME CONTACT: (check one)

Is there any reason client should not be contacted at home? Yes 1 No 2

TERMINATION SESSION: (check one)

- No 1
- Mutually Agreed To 2
- Unilateral by Client 3
- Unilateral by Therapist 4
- Other 5

IF TERMINATION, REFERRAL MADE:

Yes 1 No 2

SPECIALIZED INFORMATION, IF ANY:

PROBLEMS ADDRESSED: (see back of form)

PSC: P02 8/85

CLIENT(S) ATTENDING SESSION: _____

Dear Counselor/Therapist,

Thank you for taking the time to participate in this research. I am basically trying to validate a questionnaire I have constructed, which is designed to measure a client's readiness for therapy (change). As a preliminary step, and the one you have been asked to help in, I am interested in seeing how the questionnaire your client/s has/have filled out will relate to some ratings I will ask you to make about your client/s. The rating scales shouldn't take you more than 5 minutes per client.

Naturally, your ratings will be treated confidentially, as will the questionnaires completed by clients. If you are interested in the general results of the investigation, there will be address labels at the front desk, on which you should provide your mailing address.

You can drop off the ratings at the front desk. Thanks again for your cooperation. If you're rating more than 1 client you may find it helpful to put the clients' initials on this form so you will remember which form is for which client.

Sincerely,

Cliff Berish

Your: Age: _____ Approx. length of experience

Sex: M/F (circle) _____ years _____ months

orientation: _____

I would rate this client's desire to change him/herself as:	1 very high	2	3 high	4	5 low	6	7 very low
I would predict the likely outcome in therapy with this client will be:	1 very negative	2	3 negative	4	5 positive	6	7 very positive
I would rate this client's readiness to become involved in a therapeutic relationship as:	1 very low	2	3 low	4	5 high	6	7 very high
I would rate my personal satisfaction from working with this client as:	1 very high	2	3 high	4	5 low	6	7 very low

APPENDIX G: STAGES OF CHANGE QUESTIONNAIRE

Each statement describes how a person might feel about his or her problems. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel.

There are FIVE possible responses to each of the questionnaire items:

1 = Strongly Disagree (SD)

2 = Disagree (D)

3 = Undecided (U)

4 = Agree (A)

5 = Strongly Agree (SA)

**NOTE: The scoring direction for this questionnaire is reversed (i.e., now from strongly disagree ... to ... strongly agree).

Circle the number that best describes how much you agree or disagree with each statement.

	SD	D	U	A	SA
1. As far as I'm concerned, I don't have any problems that need changing.	1	2	3	4	5
2. I think I might be ready for some self-improvement.	1	2	3	4	5
3. I am doing something about the problems that had been bothering me.	1	2	3	4	5
4. It might be worthwhile to work on my problem.	1	2	3	4	5
5. I'm not the problem one. It doesn't make much sense for me to be here.	1	2	3	4	5
6. It worries me that I might slip back on problems I have already changed, so I am ready to work on my problems.	1	2	3	4	5
7. I am finally doing some work on my problems.	1	2	3	4	5
8. I've been thinking that I might want to change something about myself.	1	2	3	4	5
9. I have been successful in working on my problems but I'm not sure I can keep up the effort on my own.	1	2	3	4	5
10. At times my problems are difficult, but I'm working on them.	1	2	3	4	5
11. Working on problems is pretty much of a waste of time for me because the problems don't have to do with me.	1	2	3	4	5

12. I'm working on my problems in order to better understand myself.	1	2	3	4	5
13. I guess I have faults, but there's nothing that I really need to change.	1	2	3	4	5
14. I am really working hard to change.	1	2	3	4	5
15. I have problems and I really think I should work on them.	1	2	3	4	5
16. I'm not following through with what I had already changed as well as I had hoped, and I'm working to prevent a relapse of my problems.	1	2	3	4	5
17. Even though I'm not always successful in changing, I am at least working on my problems.	1	2	3	4	5
18. I thought once I had resolved my problems I would be free of them, but sometimes I still find myself struggling with them.	1	2	3	4	5
19. I wish I had more ideas on how to solve my problems.	1	2	3	4	5
20. I have started working on my problems but I would like help.	1	2	3	4	5
21. Maybe someone will be able to help me.	1	2	3	4	5
22. I may need a boost right now to help me maintain the changes I've already made.	1	2	3	4	5
23. I may be part of the problem, but I don't really think I am.	1	2	3	4	5
24. I hope that someone will have some good advice for me.	1	2	3	4	5
25. Anyone can talk about changing; I'm actually doing something about it.	1	2	3	4	5
26. All this talk about psychology is boring. Why can't people just forget about their problems?	1	2	3	4	5
27. I'm working to prevent myself from having a relapse of my problems.	1	2	3	4	5
28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.	1	2	3	4	5
29. I have worries but so does the next person. Why spend time thinking about them.	1	2	3	4	5
30. I am actively working on my problems.	1	2	3	4	5

31. I would rather cope with my faults than try to change them. 1 2 3 4 5

32. After all I had done to try and change my problems, every now and again they come back to haunt me. 1 2 3 4 5

TREATMENT SUMMARY FORM

1. CLIENT NAME _____ 2. CLIENT BIRTHDATE _____

3. CLINICIAN _____ 4. DATE OF REPORT _____

5. STARTING DATE: _____ 6. DATE OF LAST SESSION: _____ mo / day / yr

7. TOTAL NUMBER OF CLIENT SESSIONS: _____ 3. TOTAL NUMBER OF SESSIONS WITH COLLATERALS (TEACHER, MINISTER, SOCIAL SERVICES WORKER, ETC. _____

9. STATUS AT TERMINATION (SEVERITY OF PRESENTING COMPLAINTS AFTER TREATMENT):

1-Minimal 2-Very Mild 3-Mild 4-Moderate 5-Severe 6-Very Severe

10. PRESENT LEVEL OF FUNCTIONING (relative to others of same age, sex, ethnic status, and socioeconomic status):

1-Excellent 2-Above Average 3-Average 4-Below Average 5-Poor

11. DISPOSITION: 1-Therapy Continuing (This is an End-of-Spring-Semester Report) 2-Transfer Within P.S.C. 3-Referral Outside P.S.C. 4-Termination

A. IF TRANSFER WITHIN P.S.C., IS ANY PARTICULAR CLINICAN REQUESTED? _____

B. IF REFERRAL OUTSIDE P.S.C., NAME OF NEW CLINICAN AND AGENCY

1-Private Referral (clinican name and city _____

2-Agency Referral (clinician name, agency, and city) _____

C. IF TERMINATION:

a. NATURE OF TERMINATION:
1-Mutually determined
2-Client determined in interview
3-Client by no-show for first interview
4-Client by no-show for other than first interview
5-Client determined outside of interview with notification
6-Therapist determined

b. REASON FOR TERMINATION:
1-Problems reduced (no further need)
2-Referral to more appropriate agency
3-Client unmotivated
4-End of School year

12. DEGREE OF NEED FOR FURTHER SHORT-TERM TREATMENT: 1-None 2-Mild 3-Moderate 4-Strong 5-Very Strong

13. DEGREE OF NEED FOR FURTHER LONG-TERM TREATEMENT: 1-None 2-Mild 3-Moderate 4-Strong 5-Very Strong

14. NARRATIVE SUMMARY: Attach a narrative summary to this page. A suggested guide for this summary is presented in the Centre Manual.

Appendix I: Residual Items (not loaded on clinical factors)

2. I assume that my therapist will know more than me about solving personal problems.....

4. This really seems like a bad time in my life for a change.....

17. I believe that a therapist will be able to tell me the "secret formula" for the solution to my problem.....

18. I would discuss my therapy with my family if they were interested.....

22. Regardless of what I do or my therapist might do, one cannot alter what is fate.....

23. I think therapy will be a shared responsibility between myself and my therapist.....

24. It is more important what one does than what one feels about what one does.....

36. It is probably best not to know everything about oneself.....

38. I can pinpoint an event which led to my decision to seek therapy.....

46. The problems I want to talk about in therapy are of relatively recent origin.....

51. What I choose to do can determine what my life will be like.....

54. I insist on knowing the details of my therapists' personal life if I am to work with him/her.....

58. I usually act the way I do because other people make me act that way.....

59. I believe that a therapist will be able to help me solve my problems.....

62. A person with an emotional problem sometimes might not solve it alone; s/he is likely to resolve it with professional help.....

64. I don't expect to feel better when I've finished therapy.....

66. I think that heredity has played the most important role in determining what I am like.....

73. A lack of physical exercise is often at the root of emotional problems.....

81. I would be prepared to make big changes in my life situation (e.g., move, change jobs, etc.) if it seemed important in therapy.....

86. I would discuss my therapy with my friends if they were interested.....

87. I have known exactly what needs to be done for my life to be better for quite a long time already.....

89. It's important to me that my therapist get to know me well, in order for me to work with him/her.....

98. I believe that personal misfortune is a punishment for a sinful life.....

99. No one can really make another person change -- they have to want to.....

107. I am willing to look at the possibility that some of the ways I have "always done things" has contributed to my problems.....

108. I feel that only a therapist near to my own age will will be effective for me.....