THERAPISTS' TRUST IN THEIR CLIENTS: INVESTIGATION OF A FUNDAMENTAL ATTITUDE

BY

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Abstract

This investigation was concerned with the Rogerian assertions that therapists' demonstration of empathy, unconditional positive regard, and genuineness is an expression of therapists' trust in their clients and that therapists' demonstration of the facilitative attitudes contributes to clients' trust in their therapists. Forty-eight therapist-client dyads involved in individual, personal therapy participated in the study by completing self-report questionnaires. Hypotheses were partially supported in that therapists' self-reported trust in their clients predicted therapists' demonstration of the facilitative attitudes but only when combined ratings of the individual attitudes were considered that were generated by therapists themselves. In addition, clients' combined ratings of therapists' facilitative attitudes predicted clients' self-reported trust in their therapists. Unexpectedly, therapists' ratings of the facilitative attitudes predicted clients' generalized trust in other people but did not predict clients' trust in their therapists. Clients' trust in their therapists predicted neither client nor therapist ratings of client global improvement. Therapists' trust in their clients, on the other hand, predicted client improvement when improvement was assessed by therapists themselves. The associations between therapist experience, the number of sessions held with clients, and therapist and client trust were also examined. The study's theoretical implications are discussed and directions for future research are suggested.

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Therapists' Trust in their Clients: Investigation of a Fundamental Attitude

According to client-centered theory, therapists' demonstration of genuineness, empathic understanding, and unconditional positive regard facilitates personality change by releasing clients' inherent tendencies towards growth and self-actualization. It can be argued that therapists' implementation of these attitudes is a direct expression of their trust in the actualizing tendency of their clients.

Clients' trust in the therapeutic relationship, in so far as it enables clients to engage in self-exploration and self-directive behaviour, is also regarded by client-centered theory as an important contributor to psychotherapeutic gain. Since it is proposed to arise primarily out of therapists' implementation of the facilitative attitudes, client trust can be regarded as an indirect corollary of therapist trust.

In what follows, the Rogerian emphasis on therapist trust and its relation to therapists' implementation of the facilitative attitudes and the development of client trust will be more thoroughly considered. In addition, the concepts of therapist and client trust will be further elucidated by considering various definitions and theoretical models of interpersonal trust that have arisen out of research in social psychology. Following this, an empirical study investigating the role of therapist trust in the therapeutic endeavour will be presented. In this study, therapists' trust, therapists' implementation of the facilitative attitudes, client trust, and clients' global improvement in therapy were assessed. The manner in which therapist trust and client trust related to each other and to therapists'

implementation of the facilitative attitudes and client improvement will be presented. Finally, the theoretical and practical implications of the study will be discussed.

Rogerian Theory

Therapists' Trust in the Actualizing Tendency

The theoretical model of "client-centered" therapy put forward by Carl Rogers has been a highly influential approach to the practice of psychotherapy since its inception in the early 1950's. Although Rogers did not intend to create a new school of psychotherapy (Rogers, 1966), his solid emphasis on the therapeutic relationship and on the authoritative role of the client has distinguished his approach from various theoretical alternatives.

A fundamental assumption that underlies Rogers' unique approach to therapy maintains that there exists in every living organism a tendency to maintain and enhance the self which can be relied upon to motivate the organism's behaviour. This inherent propensity to strive for fulfilment has been referred to as the "actualizing tendency" (Rogers, 1980, p. 118) and is postulated to continuously move organisms in the direction of greater autonomy, self-responsibility, socialization, and overall maturity (Rogers, 1951, 1977). According to Rogers (1951, 1980), it is therapists' trust and belief in their clients' actualizing tendency that comprises the most integral component of the psychotherapeutic endeavour. He states:

> Practice, theory and research make it clear that the person-centered approach is built on a basic trust in the person .... [It] depends on the actualizing tendency present in every living organism's tendency to grow, to develop, to

> realize its full potential. This way of being trusts the constructive directional flow of the human being toward a more complex and complete development. It is this directional flow that we aim to release (Rogers, 1986, p.198).

In order to understand the rationale behind Rogers' (1986) statement it is helpful to consider more closely his conceptualization of psychological disturbance and psychotherapeutic personality change. Although Rogers (1977) clearly hypothesizes that the actualizing tendency is present in every human being, he also acknowledges that its presence is not always evident and that people often do not exhibit what would be considered constructive or self-enhancing behaviour. According to Rogers (1959, 1977), the discrepancy between individuals' behaviour and their inherent capacity for growth is reflective of a fundamental state of incongruence between individuals' perceptions of themselves and their experience of their external and internal environments. He maintains that this state of incongruence has its origin in individuals' early social interactions with significant others. During their early years of development, Rogers (1959) postulates that most people receive positive responses from caregivers on a selective basis, depending on the extent to which their behaviours, feelings, and experiences are judged to be acceptable and worthy of approval. As development proceeds, individuals learn to assimilate into their awareness only those aspects of their personality and behaviour that have been responded to in a positive manner by significant others, and they distort or deny to their awareness those aspects of themselves which have been deemed less worthy of regard. Thus,

individuals acquire a selective manner of perceiving and relating to themselves that is based on the conditional positive regard that has been communicated to them by significant others. Depending on the extent and magnitude with which self-referential information is denied to awareness, people will experience varying degrees of incongruence between their perceptions of themselves and their actual experiences, and will respond to this incongruence with anxiety, defensiveness, and disorganized behaviour (Rogers, 1959).

Since an incongruent state is proposed to be the basis of all psychological and behavioural disturbance, the goal of Rogers' (1951) client-centered therapy is to enable clients to establish within themselves a sense of congruence. This is accomplished through the reorganization of the self-structure such that the whole of clients' experience is unconditionally accepted and incorporated into awareness. This process of reintegration is facilitated when therapists enter into their clients' frames of reference and communicate an accurate understanding as well as an unconditional acceptance of their clients' experiences. Within this relationship of acceptance, it is postulated that clients are able to explore aspects of themselves which were formerly too threatening to acknowledge and they are able to fully integrate these experiences into their awareness so as to arrive at a mode of experiencing that is congruent with their self-perceptions (Rogers, 1951, 1959).

As was alluded to earlier, a subtle, yet fundamentally important component of Rogers' (1951, 1959) theory of psychotherapeutic personality change is his emphasis on therapists' trust in the actualizing tendencies of the individuals

with whom they are interacting. Put simply, Rogers' theory maintains that therapists who trust in their clients' inherent capacity for growth will be most effective at creating an interpersonal environment that will facilitate its emergence. Because they trust that their clients are themselves capable of attaining awareness of their incongruent state and the nature of its origin, for example, such therapists would place primary emphasis on establishing a non-directive and accepting therapeutic relationship that would facilitate clients' personal efforts at self-exploration. Similarly, if therapists trust that clients' inherent tendencies are primarily constructive, they will promote clients' efforts to attain an accurate understanding of their deepest selves and to behave in a manner that is congruent with their inner experiences. Ultimately, client-centered theory implies that clients who experience an attitude of trust from their therapists, will be enabled to discover for themselves that their inner resources are trustworthy. As a result, these clients will begin to relate to themselves in a manner that frees them from the constraining values and perceptions of other people and moves them forward in a direction that is not only congruent with their self-experience, but is also characterized by responsible and self-enhancing behaviour.

An inference that can be drawn from the Rogerian emphasis on therapist trust is that therapists who do not trust their clients would yield less than optimal results from therapy. It can be argued that less trusting therapists would assume a more directive role in the therapeutic relationship and would thereby run the risk of imposing their own insights and precepts onto their clients. Under these conditions, clients would not be given

maximal opportunity to discover and follow their own preferences, and would possibly become further entrenched in an incongruent state, as they attempt to live by the standards of yet another significant and influential figure in their lives.

It is of interest that Rogers' delineation of psychological maladjustment and personality change resembles that of the interpersonal theorists of the neo-Freudian tradition. Similar to Rogers (1951, 1959), interpersonal theory posits that psychological maladjustment originates in individuals' early social relationships (Sullivan, 1953). Interpersonal theory maintains that an incongruent state arises when individuals learn to associate particular behaviours and aspects of their personality with the unpleasant experience of anxiety, as it is communicated to them by their caregivers. As in Rogers' (1951, 1959) theory, the client-therapist relationship is regarded as a primary facilitator of personality change. For interpersonal theorists, the emphasis is on the manner in which the relationship embodies a dynamic interpersonal exchange wherein maladaptive patterns of relating and the underlying sources of interpersonal anxiety can be actively identified and explored (Safran, 1990; Sullivan, 1953, 1954).

Although client-centered and interpersonal theory share many similarities, their positions diverge somewhat in their views of the functional role that therapists' trust in their clients' actualizing tendency plays in the therapeutic process. Sullivan (1953), the founder of interpersonal theory, states that therapists can depend on clients' "drive toward more adequate and appropriate ways of living" (p.373). His theory, however, implies that the drive towards actualization can be depended on to emerge

only after therapists help their clients to achieve insight into their problematic interpersonal styles and to foresee the benefits of enduring the considerable amount of anxiety that is an inevitable aspect of significant personality change (Sullivan, 1953, 1954). Rogers (1951), on the other hand, argues that clients' tendencies towards self-actualization must be depended on throughout the course of therapy. He maintains that, given an interpersonal environment characterized by understanding and acceptance, clients can be trusted to achieve insight into their personal difficulties and to proceed in a psychologically self-enhancing manner without the directional influence of the therapist. Rogers (1951) therefore attributes a much more fundamental role to therapists' trust in their clients than do proponents of the interpersonal approach.

Rogers' fundamental emphasis on therapists' trust in their clients was most explicitly expressed in his early work (e.g., Rogers, 1951). However, it remained a central, underlying postulate of his position throughout subsequent revisions of his theory (Bozarth, 1990). The centrality of therapists' trust in their clients' actualizing tendencies has also been emphasized by contemporary proponents of client-centered therapy. Bozarth and Brodley (1986), for example, have argued that the drive towards actualization is the basic hypothesis of client-centered therapy, and that failure to recognize this often leads therapists to inappropriately depend on therapeutic techniques and their own authority, rather than on their clients' resources and expertise in determining the direction of the therapeutic process. More recently, the same authors have similarly argued that therapists' trust in their clients' actualizing tendency operates

as an axiom in client-centered therapy and that because of this, client-centered therapists assume far less responsibility for the content and direction of the therapeutic process than do therapists from other theoretical orientations (Bozarth & Brodley, 1991). They argue further that the only role of the client-centered therapist is to create an interpersonal environment that fosters clients' own capacities for growth. Finally, Harman (1990) has discussed the manner in which therapists' "unconditional confidence" in the constructive tendencies of the human organism can be understood as a "facilitative precondition" for effective psychotherapy. She emphasizes that therapists' experience of trust or confidence in their own psychological processes is a necessary prerequisite for facilitating a similar attitude in their clients.

The Interpersonal Conditions that Generate Personality Change: A Formal Delineation

An important component of Rogerian theory that has been alluded to at several points in the previous discussion is its emphasis on the interpersonal climate of the therapeutic endeavour. In 1957 Rogers formally delineated the interpersonal conditions that he hypothesized to be both "necessary and sufficient" for generating personality change in the context of psychotherapy. Rogerian theory, as it has been discussed thus far, implies that therapists who most effectively create an interpersonal environment that is characterized by these conditions are those who do so out of a genuine trust that their clients are inherently inclined towards growth.

The first two conditions delineated by Rogers (1957) require that therapists and clients be in a relationship with one another

and that clients be in a state of incongruence, as evidenced by anxious feelings and dysfunctional behaviour. The next three conditions pertain primarily to the therapist and refer to her or his attitudinal stance in the therapeutic relationship. First, therapists are required to relate to clients in a geniune manner. Therapist genuineness is proposed to arise when therapists' awareness of the quality of their relationship with a particular client is congruent with their actual experience of it. Second, therapists are required to experience what is referred to as "unconditional positive regard" for the client. This attitude encompasses a warm acceptance of and caring for the client that is not conditional upon the client's behaviours, attitudes, or experiences. Third, Rogers maintains that therapists must experience an accurate understanding of their clients' frame of reference. This "empathic understanding" requires therapists to experience their client's subjective awareness as if it were their own, while remaining fully conscious of the fact that the experiences originate in the client. The final condition requires that, to some extent, therapists' unconditional positive regard and empathic understanding be perceived by the client.

It is Rogers' (1957) position that therapeutic relationships characterized by all of the postulated conditions will inevitably lead to positive therapeutic outcomes regardless of the theoretical orientation of the therapist. He states that "(n)o other conditions are necessary. If these six conditions exist, and continue over a period of time, this is sufficient. The process of constructive personality change will follow" (Rogers, 1957, p.96).

Research on Therapist Trust and the Facilitative Attitudes

Although Rogers' theory implies that an attitude of trust in clients' self-actualizing drive is a vital principle underlying therapeutic personality change, an extensive literature search has revealed that empirical research on therapist trust is essentially nonexistent. At the same time, research on therapists' attitudes of genuineness, empathy, and unconditional positive regard is abundant. Since therapists' demonstration of the facilitative attitudes can be regarded as an expression of therapist trust, the available literature on the these attitudes will be reviewed in order to demonstrate the degree to which they have been associated with positive therapeutic outcomes.

One of the earliest and most comprehensive studies of Rogers' (1957) "necessary and sufficient conditions" was conducted by Barrett-Lennard in 1962. This study obtained support for Rogers' (1957) hypotheses in that, generally, therapists of clients who had improved the most during therapy indicated on a self-report inventory that they had experienced higher levels of congruence, empathic understanding, positive regard, and unconditionality of regard in the therapeutic relationship than did therapists of less improved clients. Therapist ratings of relationship quality, particularly their unconditionality of regard ratings, were more closely related to client change at therapy termination than they were after five sessions of therapy. Clients' perspectives of the relationship were also assessed. In accordance with the data derived from therapists, clients who had improved the most in therapy indicated on a self-report inventory that they had perceived their therapists as demonstrating higher levels of the therapeutic conditions than did less improved

clients. In contrast to therapists' perceptions of the relationship, however, client ratings of the therapeutic conditions, especially their ratings of positive regard and unconditionality of regard, were more closely related to client change when therapy was still in progress than after therapy had terminated. Overall, after five sessions of therapy, client-rated relationship quality was more closely related to client change than was therapist-rated relationship quality. After therapy termination, however, therapist, rather than client, ratings of the relationship were more strongly associated with client change.

The fact that Barrett-Lennard (1962) assessed not only therapists' experience of the relationship attitudes but also clients' perceptions of these attitudes was important, mainly because Rogers (1957) places considerable emphasis on the client's point of view. According to Rogers (1957), the attitudes of genuineness, empathy, and unconditional positive regard can only be expected to have a facilitative influence on the therapeutic process in so far as they are perceived by the client to exist in the relationship. Thus, while therapists' assessments of their ability to implement the facilitative attitudes can provide a certain degree of insight into the therapeutic relationship, it is Rogers' position that an understanding of clients' perceptions of the presence or absence of the facilitative conditions is the more important factor for predicting changes in personality. Drawing upon these propositions, Barrett-Lennard (1962) hypothesized that client's perceptions of their therapists' response in the relationship would relate more closely to client change than would therapists' own ratings of their response. This hypothesis was supported, but only when the therapeutic conditions and client

change were assessed when therapy was still in progress.

Rogers' (1957) emphasis on the client's point of view was taken into account in an early research review which focused exclusively on studies that investigated the relationship between therapy outcome and the quality of the therapeutic relationship as it was perceived by the client (Gurman, 1977). The majority of the reviewed studies measured clients' perceptions of therapists' implementation of the facilitative attitudes using the self-report inventory that was developed by Barrett-Lennard (1962). The review concluded that "there exists substantial, if not overwhelming, evidence in support of the hypothesized relationship between patient-perceived therapeutic conditions and outcome in individual psychotherapy and counseling" (Gurman, 1977, p.523).

The enthusiastic affirmation of the Rogerian hypotheses put forward by Gurman (1977), however, was not reiterated by another important review of the relevant literature. The empirical studies considered by Lambert, DeJulio, and Stein (1978) were substantially different from those reviewed by Gurman (1977) in that a vast majority assessed the presence or absence of the facilitative conditions exclusively from the perspective of independent judges who rated audiotapes of therapy sessions. A number of research reviews by authors from various theoretical perspectives were also considered. Lambert et al. (1978) concluded that the relationship between the facilitative conditions and therapy outcome is modest at best. Even when they accounted for therapists' theoretical orientation, the level of client disturbance, and the perspective from which the facilitative attitudes or therapy outcome were assessed, Lambert et al. (1978) failed to identify a solid relationship between

specific therapeutic conditions and therapy outcome. They concluded that variables not accounted for by Rogers' (1957) hypotheses also contribute to personality change in the context of psychotherapy. They also pointed out that, in their reviews of the relevant research, proponents of client-centered therapy were much more likely than more impartial investigators to emphasize evidence in support of Rogers' (1957) hypotheses and to downplay research findings that were in opposition to the Rogerian view.

Lambert et al. (1978) identified a number of methodological issues which, in their view, were not adequately addressed in the studies they considered and may have been partly responsible for the lack of support they found for Rogers' (1957) hypotheses. Because of the apparent lack of agreement between measures of therapists' attitudes taken from the perspectives of clients, therapists, and independent judges, for example, Lambert et al. (1978) recommended the use of a variety of assessment methods. Ideally, concurrent measures taken from all three perspectives should be used. It will be noted below that this recommendation does not necessarily conflict with Rogers' (1978) primary emphasis on the client's perspective of the therapeutic relationship. Other methodological recommendations for studies employing tape-judged ratings included consideration of the role of nonverbal behaviours in the therapeutic relationship, adequate sampling across sessions, and consideration of the time and circumstances under which the facilitative attitudes are assessed.

A more recent review of process and outcome research in psychotherapy considered the relationship of each of the facilitative attitudes with therapy outcome (Orlinsky & Howard, 1986). This comprehensive review sought to include all

investigations of the facilitative attitudes that had been conducted in the context of actual therapy sessions. In addition to numerous other and more recent investigations, many of the studies reviewed by Gurman (1977) and Lambert et al. (1978) were included in this review.

The strongest empirical support was found for the positive influence of therapists' empathic understanding on therapy outcome. Here, slightly less than half of the 86 reviewed findings reported positive relationships between therapist empathy and therapy outcome. No significant negative findings were reported.

Promising, yet slightly less consistent, support for the Rogerian hypotheses was reported with respect to therapist warmth and acceptance. Of the 94 findings that were considered, more than half reported positive relationships between therapist warmth and acceptance and outcome. Two studies reported significant negative results.

The least consistent evidence in favour of Rogers' (1957) hypotheses was reported for therapist genuineness. Fifty-three findings that investigated the relationship between therapist genuineness and therapy outcome were considered. Substantially less than half of these findings reported a positive relationship between the two variables. One significant negative relationship was observed.

An important variable that emerged in Orlinsky and Howard's (1986) assessment of the relative influence of the three therapist attitudes was the perspective from which therapists' implementation of the attitudes was assessed. For each of the therapist attitudes, the highest proportion of positive results

was reported when the attitudes were measured from the perspective of the client. The next highest proportion was obtained when non-participant observers rated therapists' implementation of the facilitative attitudes. Finally, the smallest proportion of positive results was reported when therapists rated themselves. In addition, it was found that clients' ratings of therapist empathy and therapist warmth and acceptance related positively to each of four different methods of assessing outcome. These methods included outcome ratings made by clients, therapists, independent clinicians, and objective indices or tests. Positive relationships between clients' ratings of therapist genuineness and outcome were most frequently observed when clients rated outcome. However, positive results were also reported when therapists and objective indices were used for outcome assessment. When therapists' ratings of their own attitudes were considered, on the other hand, positive relationships between the facilitative attitudes and therapy outcome were observed only when evaluations of outcome were made by therapists themselves. Finally, the number of studies reporting a positive relationship between outcome and non-participant observers' ratings of both therapist empathy and therapist warmth and acceptance were higher when outcome was assessed by objective indices than when any of the three remaining criteria were used. In accordance with Rogers' (1957) theoretical position, therefore, support for his hypotheses, particularly with respect to the positive influence of therapists' empathic understanding, appeared to be strongest when the therapeutic relationship was assessed from the client's point of view.

Empirical research on the facilitative attitudes has slowed

considerably in recent years, particularly in comparison to the prolific number of studies that were conducted prior to Orlinsky and Howard's (1986) review. Overall, recent studies that have examined therapist empathy, genuineness, or unconditional positive regard, as they relate to therapy outcome, have done so within the context of larger research objectives. They have considered more varied aspects of the therapeutic relationship in a diversity of treatment approaches with a variety of client populations.

Table 1 presents 27 findings taken from 10 studies that have recently examined the association between therapy outcome and therapists' demonstration of relationship variables that correspond with, or are highly similar to, one or more of the facilitative attitudes. Of the three facilitative attitudes, it appears that unconditional positive regard has received the most research attention and the strongest empirical support. Ten of the 27 findings pertain to the association between therapists' demonstration of unconditional positive regard and therapy outcome. Seven of these findings are positive and none are negative.

Therapist empathy and therapist genuineness were examined individually in only one study. This study did not assess therapy outcome directly but compared clients who terminated therapy early or late in the therapeutic process on their ratings of numerous therapist attributes (Hynan, 1990). While clients who terminated therapy later in the process rated their therapists as warmer and more respectful than did clients who terminated earlier, the two groups did not differ in their ratings of therapist understanding or genuineness.

The remaining 14 findings pertain to the association between

Table 1
Summary of Outcome Studies on the Facilitative Attitudes Conducted after 1986

Reference	Therapy Type	Client Population	Perspective of Attitude Assessment	Attitude Assessment & Time of Assessment	Outcome Perspective	Finding[a]
Antonnucio, Davis, Lewinsohn, & Breckenbridge (1987)	Cognitive	outpatients with clinical depression	O	U-time of assessment not specified	S	0
Bennun & Schindler (1988)	Cognitive-Behavioural	outpatients with phobic disorders	C	U-before 2nd session	T	+
			C	U-before 2nd session	C	+
			C	U-before 2nd session	S	+
DeRubeis & Feeley (1990)	Cognitive	patients of unspecified status with major depression	O	Com-1st quadrant of treatment program	S	0
			O	Com-2nd quadrant	S	-
			O	Com-3rd quadrant	S	0
			O	Com-4th quadrant	S	0
Eckert, Abeles, & Graham (1988)	Psycho-dynamic	nonstudent outpatients at university clinic	C	U-at termination	S	0
			C	U-at termination	C	+
Green & Herget (1991)	Milan	outpatients at counselling centre	T	U-after each session	C	+
			T	U-after each session	T	+
			T	U-after each session	S	+
Hill, Beutler, Daldrup (1988)	Gestalt Therapy for Chronic Pain	outpatients with rheumatoid arthritis & mild depression	C	Com-time of assessment not specified	S	0
Hoogduin, de Haan, & Schaap (1989)	Behavioural	outpatients with obsessive-compulsive disorder	C	Com-after 2nd session	C	0
			C	Com-after 10th session	C	+
			T	Com-after 2nd session	C	+
			T	Com-after 10th session	C	+
Hynan (1990)	unspecified	outpatients at a university counselling centre	C	U-after termination	S	+[b]
			C	E-after termination	S	0[b]
			C	G-after termination	S	0[b]
Keijsers, Schaap, Hoogduin, & Peters (1991)	Behavioural	outpatients with anxiety disorders	C	Com-after 3rd session	S	+
			C	Com-after 10th session	S	+
			T	Com-after 3rd session	S	0
			T	Com-after 10th session	S	0
Williams & Chambless (1990)	Behavioural	outpatients with agoraphobia	C	Com-after 4th session	O	+
			C	U-after 4th session	O	0

Note. O = non-participant observer; C = client; T = therapist; S = objective indice or test score; E = empathy; G = genuineness; U = unconditional positive regard; Com = composite measure of therapist genuineness, empathy, & unconditional positive regard.
[a]Unless otherwise specified, findings are reported as "+" (therapist attitude positively correlated with outcome), "0" (no significant correlation), or "-" (therapist attitude negatively correlated with outcome).
[b]Findings reported as "+" (late terminators rated therapists higher on attitude than early terminators), "0" (no significant difference between late and early terminators), or "-" (late terminators rated therapists lower on attitude than early terminators).

composite measures of the facilitative attitudes and therapy outcome. Of these, 6 findings are positive, 7 are nonsignificant, and 1 is negative. The negative finding was obtained in a study of cognitive therapy for depression which found that therapists' demonstration of the facilitative attitudes correlated negatively with client change in depression scores in the second quadrant of the treatment program (DeRubeis & Feeley, 1990). Significant correlations between client change and therapists' demonstration of the facilitative attitudes were not obtained at any other point in the treatment process.

A slightly higher proportion of positive findings were reported when therapists rated therapists' implementation of the facilitative attitudes (5 out of 7 findings) compared to when clients rated therapists' facilitative attitudes (9 out of 15 findings). No positive results were reported in the two studies that utilized non-participant observers' ratings of the facilitative attitudes. Client and therapist ratings of therapists' unconditional positive regard related positively to outcome ratings made by clients, therapists, and objective indices or tests. Composite ratings of therapists' facilitative attitudes made by clients related positively to outcome ratings made by clients, independent observers, and objective indices. Composite ratings made by therapists related positively only to client ratings of outcome. Taken together, these observations on rater perspective, which are based on a relatively small number of studies, do not indicate as strongly as did Orlinsky and Howard's (1986) observations that support for the Rogerian hypotheses is greatest when the therapeutic relationship is assessed from the client's point of view.

The fact that none of the recent studies were conducted within the context of client-centered therapy is also worthy of consideration. The four studies that were conducted in the context of behaviour therapy yielded primarily positive findings. However, the results of the remaining studies that were conducted in a diversity of other therapy contexts were mixed. A number of the reviewed studies also indicated that intervention strategies specific to the individual therapeutic approaches, in addition to, or in lieu of, the facilitative attitudes were positively related to therapy outcome. These findings, therefore, provide only moderate support for Rogers' assertions regarding the universally positive influence of therapists' demonstration of the facilitative attitudes on therapy outcome regardless of the treatment context.

Finally, consideration must be given to the measuring instruments that were used in recent studies to assess therapists' demonstration of genuineness, empathy, and unconditional positive regard. The majority of the reviewed studies did not use well-validated measures of the facilitative attitudes. In several cases each attitude was rated by only one or two items on a larger measure of therapist attributes. In addition, of the studies that did use more adequate measures of the facilitative attitudes, none reported the association between each facilitative attitude and outcome individually. Conclusions drawn from recent studies on the facilitative attitudes should therefore be considered in conjunction with the results of previous studies wherein the facilitative attitudes have been assessed more adequately.

Taken together, then, the reviews by Lambert et al. (1978), Orlinsky and Howard (1986), and more recent studies, indicate that

Rogers' (1957) hypotheses have not been consistently supported in the empirical literature to date. On the basis of this literature it can be concluded that the facilitative attitudes of empathy and unconditional positive regard, especially when they are measured from the client's perspective, contribute to therapy outcome, but that the positive influence of genuineness is less certain. It can also be concluded that, contrary to Rogers' (1957) view, the facilitative attitudes are not "necessary and sufficient" components of effective psychotherapy. While they may be regarded as important ingredients of the therapeutic endeavour in many circumstances, other variables also contribute significantly to treatment gain, particularly when therapy is conducted from a perspective other than the client-centered approach.

Conclusions such as these have important implications for Rogers' assertions regarding the underlying role of therapist trust in the therapeutic process. Therapist trust may be important only in so far as it underlies the attitudes of unconditional positive regard and empathy when they are implemented by the therapist. In so far as other variables contribute to therapeutic gain, therapist trust may or may not be an important underlying factor. It is possible, for example, that the proper ulitilization of specific therapeutic techniques and strategies, alone, generates a certain degree of personality change, irrespective of the therapist's attitudes on these dimensions towards his or her clients.

Prior to accepting the position that therapist trust plays only a limited role in the therapeutic process, however, an alternative explanation for the lack of empirical support for the Rogerian hypotheses can be considered. One might suggest that

Rogers' (1957) assertions have not been substantially supported in the literature because many of the therapists that participated in the relevant research did not possess a genuine trust in their clients and therefore did not adequately implement the facilitative attitudes. This proposition is supported by the observations of Mitchell, Bozarth, and Krauft (1977) who found that the therapists in many of the earlier studies on the facilitative conditions demonstrated the facilitative attitudes at levels that were less than what would be defined as "minimally facilitative" by the rating scales that were utilized in these studies. Based on these observations, Mitchell et al. concluded that the hypothesis regarding the positive influence of the facilitative attitudes on psychotherapy outcome had not been adequately tested. In relation to this, the reviews cited above (e.g. Gurman, 1977; Lambert et al., 1978; Orlinsky & Howard, 1986) and recent studies also indicate that many of the therapists who participated in research on the facilitative attitudes did not adhere exclusively to the client-centered approach. It is therefore possible that many of them also did not adhere to its most basic assumptions. While Rogers' (1957) clearly states that the relevance of his hypotheses is not limited to therapy that is conducted within the client-centered framework, his theory implies that therapists' effectiveness in implementing the various techniques and procedures that lead to positive therapeutic outcome is fundamentally dependent on the degree of trust they are prepared to invest in their clients (Rogers, 1951). Although Rogers' (1957) theory maintains that therapists from various orientations are capable of implementing the facilitative attitudes, his theory also implies that the effectiveness with

which they do so is directly related to their acceptance of the more basic hypothesis regarding their clients' inherent capacity to overcome their difficulties.

Within this view, the differential degrees of empirical support that have been obtained for the individual facilitative attitudes must be accounted for. One might suggest that the mechanics of empathy and unconditional positive regard, in comparison to genuineness, can be more readily learned as basic "skills." One might expect that they would therefore be more easily demonstrated, irrespective of the therapist's attitude, even if only on an outward basis, and that it is for this reason that they have received more consistent support in the empirical literature. Given that this is the case, one might further hypothesize that even more substantial support for the positive influence of these attitudes would be obtained if they were consistently implemented by therapists who genuinely trust their clients and therefore implement the facilitative attitudes in a more complete manner.

The Client's Trust: A Corollary of the Facilitative Attitudes

In addition to his fundamental emphasis on therapist trust, Rogers (1961, 1980) placed a certain degree of importance on the development of trust in the therapeutic relationship on the part of the client. The significance of client trust is illustrated most clearly in his description of clients' experience of psychological change over the course of therapy. Rogers (1961) describes clients' initial experiences of fear as they enter the therapeutic relationship and as they contemplate sharing seemingly undesirable aspects of themselves with another person. As clients encounter the therapist's understanding and nonjudgmental

attitude, they develop feelings of trust in the therapist. These feelings enable clients to explore their experiences more deeply, and to eventually discover that their inner resources, previously unknown and therefore feared, are trustworthy and capable of providing insight and guidance for positive living.

The manner in which client trust contributes to the therapeutic process has similarly been discussed by Barrett-Lennard (1990), an advocate of the client-centered approach. In his view, clients will experience safety and trust in a therapeutic relationship when a number of conditions are met. These conditions correspond closely to therapists' demonstration of empathic understanding, unconditional positive regard, and genuineness, and are proposed to be particularly important when clients explore especially sensitive and/or unacknowledged aspects of their experience. An attitude of trust that is cultivated in such a psychological climate reduces clients' need to present themselves in a socially desirable manner and to conceal aspects of their experience that cause them pain. The presence of a trusted therapist enables clients to completely explore their inner selves so that clients ultimately arrive at a recognition of their true identity and a mode of experiencing that is congruent with it.

In sum, what can be derived from both Rogers' (1961) and Barrett-Lennard's (1990) discussions is that a client's developing trust in the therapist is of primary importance in enabling the client to explore threatening aspects of her or himself and to eventually assimilate these experiences into his or her awareness. A further proposition that can be derived, particularly from Barrett-Lennard's (1990) discussion, is that

clients' experience of trust in the therapeutic relationship is a direct consequence of therapists' demonstration of the facilitative attitudes. It is implied that clients who feel genuinely understood and wholly accepted by their therapists, regardless of the content of their experiences, will gain confidence that their therapists will remain with them as they explore even deeper and perhaps even more threatening aspects of themselves.

It has already been argued that therapists' demonstration of the facilitative attitudes depends on the degree of trust they are prepared to invest in their clients. On the basis of this argument, a further inference that can be drawn from Rogers' (1961) and Barrett-Lennard's (1990) discussions is that the extent to which therapists foster a sense of trust in their clients depends, indirectly, on the degree of trust therapists themselves have in the therapeutic relationship.

Research on Client Trust

A review of the literature suggests that empirical studies investigating the impact of client trust on the process and outcome of therapy are sparse. Similarly, it appears that research investigating the positive influence of the facilitative attitudes on client trust has also not been conducted. On the other hand, a variable that is closely related to client trust, the client's perception of the therapist's trustworthiness, has been the subject of a number of studies concerned with the social influence process of psychotherapy.

According to social influence theorists, perceived therapist trustworthiness is defined as "the counselor's sincerity, openness, and absence of motives for personal gain" (Heppner &

Heesacker, 1983, p. 32). It has generally been studied in conjunction with clients' perceptions of therapist expertness and therapist attractiveness. Perceived therapist expertness can be understood in terms of a client's belief that the therapist possesses skills and information that will assist the client in overcoming her or his difficulties. Perceived therapist attractiveness, on the other hand, refers to a client's liking, admiration, and generally positive feelings for the therapist (Heppner & Heesacker, 1983).

It has been argued that a therapist's implementation of the facilitative attitudes is a primary contributor to a client's feelings of trust in the therapeutic relationship. In so far as the qualities of sincerity and openness correspond with the attitudes of genuineness and unconditional positive regard, the association between client trust and perceived therapist trustworthiness, as it has been defined by social influence theorists, can be conceptualized in terms of Rogerian theory. One could speculate further that clients' feelings of trust, initially cultivated in a therapeutic relationship that is characterized by each of the facilitative attitudes, are further enhanced when clients perceive their therapists as experts who possess knowledge with respect to their particular difficulties and as generally pleasant or attractive people. One could therefore argue that, of the three attributes, therapist trustworthiness is most closely related to client trust, but that, to some extent, measures of perceived therapist expertness and attractiveness also reflect the level of trust that clients are prepared to invest in their therapists. Empirical research investigating any or all of these variables may therefore provide

indirect insight into the impact that the Rogerian concept of client trust has on the therapeutic process.

Table 2 presents 39 findings derived from 9 studies that have investigated the association between various dimensions of therapy outcome and clients' perceptions of therapist trustworthiness, expertness, and attractiveness. In total, 28 of these findings are positive. In so far as measures of the three therapist attributes represent indirect indices of client trust, this research offers substantial empirical support for the position that client trust is associated with therapeutic gain. In fact, one study reported that 35.2% of the outcome variance was accounted for by the three therapist attributes (LaCrosse, 1980), the largest portion (31.1%) being accounted for by therapist expertness. These generally positive conclusions are enhanced by the observation that the outcome criteria that were employed in these studies were diverse, ranging from clients' overall satisfaction with counselling to a general reduction in client symptomatology.

Given the argument that perceived therapist trustworthiness is most closely related to the Rogerian concept of client trust, it is useful to consider the research findings that pertain particularly to this variable. Overall, 9 out of 12 findings indicated that clients' perceptions of therapist trustworthiness are positively associated with therapy outcome. Again, positive findings were obtained across a wide range of outcome criteria. One study is of special interest to the present discussion in that clients' composite ratings of counsellor trustworthiness, expertness, and attractiveness were positively associated with positive changes in client self-concept, as assessed by changes in

Table 2

Summary of Outcome Studies on Therapist Trustworthiness, Attractiveness, & Expertness

Reference	Therapy Type	Client Population	Attributes Assessed[a] & Time Assessment	Outcome Perspective & Criteria for Evaluation	Finding[b]
Dorn & Day (1985)	unspecified	outpatients at a university clinic	Com- after 1st session	S positive change in client self-concept	+[c]
Grimes & Murdock (1989)	unspecified	outpatients at a university clinic	T- after 1st session E- after 1st session A- after 1st session Com- after 1st session	S symptom reduction S symptom reduction S symptom reduction S symptom reduction	+ + + +
Grimes & Murdock (1989)	unspecified	outpatients at a university clinic	T -after 1st session E -after 1st session A -after 1st session Com-after 1st session	S continuation in S therapy S beyond S 4 sessions	+ + 0 +
Heppner & Heesacker (1983)	unspecified	outpatients at a university clinic	T 2 weeks before E termination A for most clients	C client satisfaction C with C counselling	+ + +
Keijsers et al. (1991)	Behavioural	outpatients with anxiety disorders	T-after 3rd session E-after 3rd session T-after 10th session E-after 10th session	S symptom reduction S symptom reduction S symptom reduction S symptom reduction	0 0 0 0
Kokotovic & Tracey (1987)	unspecified	outpatients at a university clinic	T- after intake session E- after intake session A- after intake session	S continuation in S therapy following S intake session	+[c] +[c] 0[c]
LaCrosse (1980)	Cognitive-Behavioural, Behavioural, & Rational Emotive	substance abusing outpatients	T-after 1st session E-after 1st session A-after 1st session Com-after 1st session	S goal attainment S goal attainment S goal attainment S goal attainment	+ + + +
LaCrosse (1980)	Cognitive-Behavioural, Behavioural, & Rational Emotive	substance abusing outpatients	T-after last session E-after last session A-after last session Com-after last session	S goal attainment S goal attainment S goal attainment S goal attainment	+ + + +
McNeill, May, & Lee (1987)	unspecified	outpatients at a university clinic	T 4 weeks E after A termination	S termination of S counselling by S mutual agreement with counsellor as opposed to premature termination	+[c] +[c] +[c]
Zamostny, Corrigan, & Eggert (1981)	unspecified	outpatients at a university clinic	T-after intake session E-after intake session A-after intake session	C satisfaction C with C intake session	+[d] 0[d] 0[d]
Zamostny, Corrigan, & Eggert (1981)	unspecified	outpatients at a university clinic	T-after intake session E-after intake session A-after intake session	S return for S second S counselling session	0[d] 0[d] 0[d]

Note. T = trustworthiness; E = expertness; A = attractiveness; Com = composite measure of therapist trustworthiness, expertness, & attractiveness; S = objective indice or test score; C = client. [a]All assessments made from client's perspective. [b]Unless otherwise specified, findings are reported as "+" (therapist attribute positively correlated with outcome), "0" (no significant correlation), or "-" (therapist attribute negatively correlated with outcome). [c]Findings are reported as "+" (clients with positive outcome rated therapist significantly higher on attribute than clients with negative outcome), "0" (no significant difference between client groups), or "-" (clients with positive outcome rated therapists significantly lower on attribute) [d]Findings reported as "+" (therapist attribute contributed significantly to prediction of outcome using regression analysis) or "0" (therapist attribute did not contribute significantly to prediction of outcome).

their scores on the Tennesse Self-Concept Inventory from the beginning to the end of therapy (Dorn & Day, 1985). Regression analyses revealed that, of the three therapist attributes, only therapist trustworthiness significantly predicted change. These findings are noteworthy because they are congruent with the Rogerian position which states that positive changes in self-concept will occur for clients who are enabled to explore their inner selves in the presence of a trusted therapist.

Overall, then, empirical research on therapists' social influence attributes offers indirect support for the Rogerian assertion that clients' feelings of trust in the therapeutic relationship contribute significantly to positive therapeutic outcomes. For this reason, empirical consideration of the hypothesis that client trust is fostered by therapists' demonstration of genuineness, empathic understanding, and unconditional positive regard is warranted. Initial insight into the validity of this hypothesis can be derived from the findings reported by Keijsers et al. (1991) in a study that was conducted in the context of behaviour therapy for anxiety disorders. This study found that clients' composite ratings of therapists' demonstration of the facilitative attitudes after the 3rd and 10th therapy session were positively correlated with clients' ratings of their therapists' trustworthiness, expertise, and support. Client ratings of therapists' facilitative attitudes correlated positively with therapy outcome, as assessed by a reduction in client symptomatology, but client ratings of therapists' social influence attributes did not. In light of the argument that client trust can be represented indirectly by client ratings of therapists' social influence attributes, these findings are

consistent with the assertion that therapists' demonstration of the facilitative attitudes fosters clients' feelings of trust in their therapists, but they are not congruent with the assertion that client trust contributes to positive therapeutic outcomes. The nonsignificant findings in this study should be considered in the context of numerous other studies, however, which have shown that client ratings of therapists' social influence attributes correlate positively with therapy outcome (see Table 2).

To the extent that the Keijsers et al. (1991) findings indicate that therapists' implementation of the facilitative attitudes contribute to client trust, empirical consideration of the positive influence of therapist trust on clients' feelings of trust, as mediated by the facilitative attitudes, is also warranted. In fact, the relationship between client and therapist trust can be examined in the context of a broader argument which maintains that, in an indirect sense, clients' and therapists' trust for each other are reciprocally reinforcing. According to this view, therapists who trust their clients would demonstrate higher levels of the facilitative attitudes and therefore foster stronger feelings of trust in their clients than therapists who possess lower levels of trust. Stronger feelings of trust on the part of clients, in turn, would render them more likely to benefit from therapy and therefore more likely to confirm their therapists' initial levels of trust. It can be argued that this cycle of indirect positive reinforcement between therapist and client trust continuously reiterates itself until therapy is terminated. On the basis of the same reasoning, one could argue that a lack of trust on the part of the therapist or client would similarly be reciprocated by a sense of distrust on the part of

the other person.

Two empirical studies that were conducted in the context of relationships other than the client-therapist dyad have recently reported a reciprocal pattern of trust. In one study, professionals and their secretaries completed questionnaires that measured a number of variables including their loci of control, desires for power, and trust in the other person (Butler, 1983). Two-stage least squares regression analyses revealed that of all the measured variables, the only one that significantly predicted secretaries' trust for their bosses was the degree of trust that bosses had in their secretaries, and vice versa. The results were taken to indicate a reciprocal pattern of trust between secretaries and their bosses. Comparable results were obtained in a more recent study which investigated the relationship between a wider range of variables and the level of trust that members of engaged, married, and divorced dyads had in their partners (Butler, 1986). Again, two-stage regression analyses revealed that individuals' level of trust in their partners was one of the strongest predictors of their partners' trust in them and vice versa. In so far as these results can be taken to indicate reciprocal patterns of trust in two relatively distinct types of relationships, it is reasonable to extend these findings to the therapeutic relationship and to suggest that reciprocity would similarly characterize clients' and therapists' trust for each other, while keeping in mind the mediating influence of the facilitative attitudes and therapeutic gain.

The Therapeutic Relationship as Perceived by the Client, Therapist, and Independent Observer

The empirical literature that has been reviewed above,

particularly the literature pertaining to the facilitative attitudes, suggests that the perspective from which the therapeutic relationship is assessed is an important variable that is worthy of careful consideration. This was made especially clear in Orlinsky and Howard's (1986) review wherein increasing degrees of support for the Rogerian hypotheses were observed when the facilitative attitudes were assessed from the perspective of therapists, objective observers, and clients respectively.

Some authors (e.g., Beutler, Crago, & Arizmendi, 1986; Lambert, Shapiro, & Bergin, 1986) have suggested that inflated correlations are, in part, responsible for the relatively strong empirical support that has been obtained in studies wherein the facilitative attitudes were assessed from the client's perspective. They point out that many of these studies utilized outcome measures that were also based on the client's point of view. These authors speculate that higher correlations were obtained because clients who were satisfied with the outcome of therapy were more likely to report a good relationship with their therapists and vice versa. According to Orlinsky and Howard (1986), however, client ratings of the facilitative attitudes have also correlated positively with outcome measures that were obtained from sources other than the client. Thus, while halo effects and rating biases may account for some of the positive correlations that have been obtained in the empirical literature, they cannot account for them all.

As has already been discussed, Rogers' (1957) theoretical position emphasizes the client's view of the therapeutic relationship. It is therefore possible that the pattern of results that has been observed in the empirical literature, which

favours measurement of the facilitative attitudes from the client's perspective, reflects the validity of Rogers' (1957) position.

An argument put forward by Barrett-Lennard (1986) is also congruent with the empirical evidence and further elucidates the Rogerian view. Barrett-Lennard (1986) argues that the facilitative effect, or lack thereof, of the therapeutic attitudes can be understood in terms of three phases. Essentially, the phases represent: 1) the extent to which the therapist experiences the facilitative attitudes towards the client, 2) the degree to which the therapist's attitudes are expressed to the client, and 3) the level at which the therapist's communicated attitudes are received by the client. According to Barrett-Lennard (1986), phase 3 of the facilitative process is indirectly related to phase 1 through the mediating influence of phase 2. In accordance with Rogers (1957), he also maintains that measures of clients' reception of therapists' communicated attitudes (phase 3) will be most directly related to assessments of personality change occurring in the client as a result of therapy.

On the basis of Barrett-Lennard's (1986) arguments, one might propose that clients, therapists, and independent observers are differentially qualified to assess each of the three phases of the facilitative process because of their unique vantage points in the therapeutic relationship. Clients, for example, are likely the best candidates to assess phase 3 of the process, whereas therapists and independent observers likely offer better assessments of phases 1 and 2 respectively. Barrett-Lennard (1986) implies that reasoning such as this underlies his development of three self-report inventories that assess

therapists' implementation of the facilitative attitudes from each of the three perspectives. Ultimately, what can be inferred from Barrett-Lennard's (1986) arguments is that the facilitative attitudes and their relationship to therapy outcome and other process variables can be most fully understood when consideration is given to assessments of their implementation that have been made not only by clients, but also by therapists and independent observers. In accordance with Lambert et al.'s (1978) recommendations, then, it appears to be advisable, in any given study, to measure the facilitative attitudes from as many of the three perspectives as is practically possible. At the same time, one should keep in mind, as was pointed out by Gurman (1977), that each perspective provides unique information about the therapeutic relationship and that any one perspective does not "speak by implication for the persons who may occupy other phenomenological positions" (p. 518).

Although the impact of therapist and client trust has not been systematically researched in many studies, it can be argued that Barrett-Lennard's (1986) facilitative phases apply to therapist and client trust as they do to the facilitative attitudes. It can be argued further that therapist and client trust would be most closely related to therapists' implementation of the facilitative attitudes or to other aspects of the therapeutic process when these variables are measured from the same perspective. For example, one would expect that therapist trust, as measured from the therapist's perspective, would be more closely associated with therapist ratings of empathy, unconditional positive regard, and genuineness than with client ratings of the same attitudes.

Trust in the Therapeutic Relationship: Further Elucidation of the Concept

Definitions of Trust

Despite the fundamental importance that Rogers (1951, 1961, 1980) attributes to therapist and client trust in the therapeutic endeavour, he does not actually define trust at any point in his writing. In order to gain a better understanding of the nature of this construct, therefore, definitions from other sources will be considered. In particular, attention will be given to definitions that have arisen out of social psychological research on the more general area of interpersonal trust.

Numerous definitions of interpersonal trust have been offered in the social psychological literature. Rotter (1967), for example, has offered a widely cited definition that focuses specifically on the communicative interactions of one or more individuals. According to his view, trust is "an expectancy held by an individual or a group that the word, promise, verbal or written statement of another individual or group can be relied upon" (Rotter, 1967, p.651). A slightly more general definition of trust has been proposed by Larzelere and Huston (1980) who define trust as "the extent that a person believes another person (or persons) to be benevolent and honest" (p.596). Benevolence refers to an individual's genuine concern for the welfare of others and her or his motivation to seek common gain. Honesty, on the other hand, is regarded as an individuals' tendency to follow through on his or her stated intentions. Finally, a very general definition of trust has been offered by Deutsch (1973). Here, trust is defined as "confidence that one will find what is desired from another, rather than what is feared" (p.149).

It appears that, of the definitions cited above, the general definition of trust put forward by Deutsch (1973) can be most appropriately applied to the concept of trust in the therapeutic relationship, as considered from both the client's and therapist's perspectives. In his definition, Deutsch (1973) does not delineate what, exactly, is "desired" or "feared" by the trusting person. This lends a certain degree of flexibility to his definition, so that it can be applied to several types of relationships characterized by a diversity of goals. In the therapeutic relationship, as it is conceived by Rogerian theory, for example, "what is desired" could be understood as referring to the therapist's desire that his or her clients actively engage in self-exploration throughout the therapeutic process, or, that the client's inherently positive tendencies be released as a result of the therapeutic endeavour as a whole. Likewise, "what is feared" may be understood as referring to noninvolvement on the part of the client, or to clients' further entrenchment in incongruent modes of experiencing. From the client's perspective, on the other hand, "what is desired" may refer to feelings of acceptance and understanding resulting from the therapist's warm involvement in the relationship, and "what is feared" may allude to concerns about being judged or rejected on account of sharing seemingly inadmissible experiences. Therapists' and clients' "desires", therefore, would likely include, but would not be limited to, desires for sincere communicative interactions, previously referred to by Rotter (1967), as well as honest and benevolent intentions on the part of the other person, referred to by Larzelere and Huston (1980). Similarly, "what is feared" by the participants in the therapeutic relationship would likely include

interpersonal interactions characterized by the opposite of these qualities, but would likely encompass a whole range of other types of negative interactions as well. Overall, it should be noted that the Rogerian concept of trust, particularly therapist trust, differs from other concepts of interpersonal trust in so far as it encompasses a confidence in another person's actualizing ability that is not necessarily grounded in observable evidence. While trust in most other relationships seems to require some degree of positive interaction with the trusted person before it can be expected to develop, Rogers' concept of therapist trust seems to focus more on trusting the potential within the individual even before it becomes manifest in his or her outward behaviour.

Generalized versus Specific Trust

Although it was not referred to in the definitions cited above, an important distinction has been made in the social psychological literature between what can be termed "generalized" and "specific" trust. In essence, "generalized" trust can be understood in terms of an individual's attitudinal orientation towards other people as a whole, whereas "specific" trust can be understood in terms of an individual's attitude towards another person in particular (Johnson-George & Swap, 1982; Larzelere & Huston, 1980).

According to Rotter (1980), generalized trust represents a "relatively stable personality characteristic" (p.1) that develops out of individuals' social experiences across time. He proposes that individuals who consistently encounter other people who behave in an unreliable manner will eventually generalize these experiences across time and circumstances and will develop a generally distrusting orientation towards others. Individuals who

encounter primarily dependable and reliable others, on the other hand, will adopt a relatively trusting interpersonal stance in their general interactions with others.

This aspect of Rotter's (1980) theory coincides with an influential theory of personality development put forward by Bowlby (1969, 1973, 1980). In essence, Bowlby's theory, formally known as attachment theory, hypothesizes that when childrens' efforts to attain and maintain proximity with significant others are consistently met by caring and understanding responses, they will develop the expectation that trustworthy attachment figures will always be available during times of need, and they will approach the world in a confident, trusting manner. On the other hand, children who receive less consistent or adequate care from their caregivers will be less assured with respect to the availability of attachment figures and will develop a more distrusting and apprehensive orientation towards the world. It is Bowlby's view that individuals' construal of the personal world, as it is developed during their early years, carries forward into adulthood where it exerts an ongoing influence on individuals' social behaviours across situations and interpersonal relationships. Attachment theory has been the subject of numerous longitudinal and cross-sectional empirical studies (e.g., Ainsworth, Blehar, Waters, & Wall, 1978; Collins & Read, 1990; Hazan & Shaver, 1987; Main Kaplan & Cassidy, 1985; Waters, 1978) that have generally supported these propositions.

Unlike generalized trust, specific trust does not refer to a personality variable that exerts a stable and consistent influence on individuals' general patterns of relating. Rather, specific trust might be better understood as a relationship variable that

arises out of an individual's continued interactions with a particular other person over an extended period of time (Holmes, 1991; Johnson-George & Swap, 1982). In the context of such a relationship, researchers have argued that a number of factors contribute to the development of specific trust (Johnson-George & Swap, 1982; Holmes, 1991). These factors generally refer to the personal characteristics of both individuals involved in the relationship, including each of their levels of generalized trust. They also refer to the quality of the individuals' past interactions with one another as well as the context in which the interaction is taking place.

Overall, the combined influence of the factors that contribute to specific trust would be expected to vary from one relationship to the next for any one person. For this reason, it would appear that, within a given relationship, assessing an individual's specific trust for another person would be more conducive to understanding the dynamics of that particular relationship than would assessing an individual's generalized level of trust. Some evidence in support of this view has been obtained by Larzelere & Huston (1980). They found that measures of specific trust among dating and married couples were more strongly related to assessments of a number of relationship variables, including level of commitment, intimacy of self-disclosures, and love, than were measures of generalized trust (Larzelere & Huston, 1980).

It is interesting to note that Rotter (1971) maintained that generalized expectancies, including those related to interpersonal trust, would be most predictive of an individual's behaviour in novel, ambiguous or unstructured situations. In his view,

assessments of individuals' more specific expectancies would be required in situations that have been more clearly defined or are characterized by greater familiarity. A similar view has been discussed by Lazarus and Folkman (1984) who cite empirical evidence indicating that individuals' personality characteristics are more predictive of their coping patterns in stressful situations that are highly ambiguous than they are in stressful situations that are more clearly defined.

Indirect support for the greater utility of specific over generalized trust measures for understanding events in specific relationships can also be derived from research that has been conducted within the context of the Social Relations Model. According to this model, an individual's behaviour in a specific relationship is the function of her or his general, behavioural response to others across a variety of relationships (actor effects), the behavioural response that is generally elicited from others by her or his partner (partner effects), and the unique, behavioural adjustment that both individuals in the relationship make to each other (relationship effects; Kenny & La Voie, 1984). The Social Relations Model has been applied to the study of a number of variables within social psychology including social perception, interpersonal dominance, self-disclosure, interpersonal attraction, and nonverbal communication (Kenny & La Voie, 1984; Malloy & Kenny, 1986). Actor, partner, and relationship effects have been identified as contributing significantly to each of these aspects of interpersonal interaction. On the basis of these findings, one could hypothesize that a social relations analysis of interpersonal trust would similarly indicate that an individual's level of

specific trust for another person is influenced by each component in the social relations model. In so far as a measure of specific trust can be understood as assessing actor, partner, and relationship effects in combination, and in so far as a measure of generalized trust can be understood as assessing actor effects only, one could hypothesize that measures of specific trust would be more conducive for understanding various dimensions of individuals' relationships with particular other people, including relationships that are built up in the context of a therapeutic endeavour, than would measures of generalized trust.

As a final note, consideration must be given to the fact that specific trust is proposed to develop as a result of individuals' experiences with one another over an extended period of time (Holmes, 1991; Johnson-George & Swap, 1982). With respect to the therapeutic relationship and in terms of Rogerian theory, this proposition implies that therapists' and clients' specific trust for each other can be expected to increase with therapy duration, provided that the relationship is characterized, to a minimal degree, by therapists' demonstration of the facilitative attitudes and provided that clients generally improve as therapy progresses.

Since therapists' and clients' generalized trust are proposed to represent relatively stable personality characteristics, one would not expect them to increase or decrease greatly with the progression of a given therapeutic relationship, unless interpersonal trust is a specific issue that clients are confronting in therapy. One could argue, however, that generalized trust, on the part of therapists, would vary according to therapists' level of experience. Experienced therapists will,

over time, observe the actualizing tendency at work in a variety of individuals and situations. As a result, they will become more convinced of the generally growth-promoting influence of the actualizing tendency, and will generally trust it to manifest itself in their work with clients. To the extent that therapists' generalized trust influences their interactions with specific clients, one would expect more experienced therapists to manifest higher levels of specific trust, even during the early stages of their relationship with new clients, than less-experienced therapists. Given the argument that therapists' and clients' specific trust indirectly reinforce one another, one could argue further that clients of more experienced therapists would manifest higher levels of specific trust than clients of less experienced therapists.

Summary

Therapist trust has been discussed as a fundamental variable underlying the process of psychotherapeutic personality change. On the basis of Rogerian theory, it has been proposed that therapists who trust that their clients are inherently inclined towards growth and self-enhancing behaviour will aim to create a therapeutic environment that releases their clients' natural inclinations. In so far as the attitudes of genuineness, empathic understanding, and unconditional positive regard are the primary means by which such an environment is created, it has been argued that these attitudes will be demonstrated most fully by therapists who wholly trust in the inherent tendencies of their clients. In addition, it has been argued that trusting therapists, by implementing the facilitative attitudes, will foster feelings of trust in their clients and that clients' feelings of trust will

ultimately contribute to positive therapeutic outcomes and therefore reinforce therapists' initial level of trust.

It has been suggested that therapists, clients, and independent observers are differentially qualified to assess different aspects of the therapeutic relationship. On the basis of this reasoning, it has been argued that therapist trust, as measured from the therapist's perspective, would be most closely associated with ratings of therapists' implementation of the facilitative attitudes and other aspects of the therapeutic endeavour that are also obtained from the therapist's perspective. Similarly, it has been argued that client trust, as measured from the clients' perspective, would be most closely associated with measures of the facilitative attitudes and other variables pertaining to the therapeutic relationship that are obtained from the client's perspective.

Finally, the distinction that has been made in social psychological literature between generalized and specific trust has been considered. It has been argued that therapists' and clients' levels of specific trust would be more closely related to other aspects of their relationship than would their generalized levels of trust. In addition, it has been argued that therapists' generalized and specific trust for clients would increase as they gain experience with a variety of clients over time, and that, within a particular, functional, therapeutic relationship, therapists' and clients' specific trust for each other would increase with therapy duration.

The Current Study

In order to investigate the validity of the preceding arguments, the current study assessed the variables of therapist

and client trust, and therapists' implementation of the facilitative attitudes in the context of actual therapeutic relationships. In this study, therapist trust was measured in terms of therapists' generalized assumptions about the trustworthiness of others (generalized trust) and in terms of their specific trust for individual clients (specific trust). In addition, information was obtained on therapist experience, as indicated by their highest degree and by the number of years of practice since graduation with their highest degree. Information was also obtained on the number of sessions that were held with clients. Clients' generalized trust and their specific trust for their therapists were assessed. Clients and therapists rated therapists' level of genuineness, empathic understanding, and unconditional positive regard as well as clients' level of global improvement since beginning therapy.

Multiple regression analyses were conducted in order to assess whether therapist trust predicted therapists' implementation of the facilitative attitudes, whether therapists' implementation of the facilitative attitudes predicted client trust, and whether client trust predicted client improvement. Protected t tests and comparisons of the adjusted R^2 values from the regression analyses assessed whether ratings of therapists' and clients' specific trust were more closely related to ratings of the therapeutic conditions and client improvement than were ratings of therapists' and clients' generalized trust. Protected t tests and comparisons of R^2 values also assessed whether the trust ratings and assessments of the therapeutic conditions and client improvement were more predictive of each other when they were made from the same or opposite perspectives. Correlational

analyses tested whether therapists' and clients' generalized trust were related to therapists' level of experience and the number of sessions in which they had interacted. Finally, correlational analyses also provided a preliminary assessment as to whether therapists' and clients' specific trust for one another were mutually reinforcing.

Hypotheses

The following hypotheses were advanced:

1. Therapist trust will predict therapists' demonstration of the facilitative attitudes as follows:

    b) Therapists' specific and generalized trust will be more predictive of therapists' ratings of therapists' implementation of the facilitative attitudes than of client ratings of therapists' facilitative attitudes.

    a) Therapists' specific trust will contribute more to the prediction of therapist and client ratings of therapists' facilitative attitudes than will therapists' generalized trust.

2. Therapists' demonstration of the facilitative attitudes will predict client trust as follows:

    a) Client ratings of the facilitative attitudes will contribute more to the prediction of clients' specific and generalized trust than will therapist ratings of the facilitative attitudes.

    b) Therapist and client ratings of therapists' facilitative attitudes will be more predictive of clients' specific trust than of clients' generalized trust.

3. Client trust will predict clients' global improvement in therapy as follows:

a) Clients' specific and generalized trust will be more predictive of client ratings of clients' global improvement than of therapists' ratings of clients' global improvement.

b) Clients' specific trust will contribute more to the prediction of therapist and client ratings of clients' global improvement than will clients' generalized trust.

4. a) Therapists' generalized and specific trust and clients' specific trust will correlate positively with therapist experience.

b) Therapists' and clients' specific trust will correlate positively with the number of sessions in which they have interacted.

5. Therapists' specific trust and clients' specific trust will correlate positively with each other. This correlation will diminish once therapists' implementation of the facilitative attitudes and clients' global improvement, as assessed by therapists and clients, are controlled.

Method

Therapists and Clients

Sixty-six therapists employed in private practice, one of several hospital clinics, or one of two university counselling centres in the province of Manitoba were contacted by letter (see Appendix A) and asked to participate in the study on a voluntary basis. Twenty-one therapists agreed to participate. Of these, four were unable to return questionnaire materials or recruit client volunteers. The final sample consisted of 17 therapists, 15 of whom had obtained a Ph.D. in clinical psychology, one of whom had a Masters degree in educational psychology, and one who

had a Masters degree in social work. The mean number of years that therapists had been practising since graduating with their highest degree was 11 years. Ten therapists were male and seven were female, and their ages ranged from 37 to 63 years (M= 47). One therapist completed one of the questionnaires (Barrett-Lennard Relationship Inventory, Barrett-Lennard, 1962; see description below) in terms of his relationship with someone other than a client. In order to retain the maximum number of participating therapists, he was asked to redo the measure for the therapist-client relationship.

Therapists were informed that their participation would involve asking one or more of their clients to take part in the study on a voluntary basis. A total of 52 clients returned questionnaire materials. The number of clients seen by any one therapist ranged from one to six. Again, 16 clients completed one of the Barrett-Lennard Relationship Inventory in terms of their relationship with someone other than their therapist. They were asked to redo the measure and all but four complied. Among the final sample of 48 clients, 38 were female and 10 were male. Their ages ranged from 23 to 59 years (M= 39). All clients were seeking personal, as opposed to vocational, counselling on an outpatient basis and had attended a mean of 43 sessions.

Instruments

The Trust/Confidence Attachment Scale.

Therapists' and clients' generalized trust was measured using the Trust/Confidence Attachment Scale (TCAS; see Appendix B) developed by Brennan, Shaver, & Hazan (1989). The scale is one of seven measures that were developed in accordance with attachment theory to assess various dimensions of adults' styles of

attachment. Items on the scale consist of 10 statements that describe individuals' general feelings and attitudes towards trusting other people. The first item, for example, states, "I find it easy to trust others." Respondents are required to indicate on a seven-point Likert scale the extent to which they agreed or disagreed with each statement. Total scores on the TCAS are obtained by determining the mean of subjects' responses to the 10 statements.

The reliability of the TCAS was evaluated using two samples of undergraduate students and one sample of undergraduate students and their heterosexual partners (Brennan & Shaver, 1991). Coefficient alphas for the three samples were .87, .85, and .89. Subjects in the third sample completed the scale a second time after an interval of 8 months and the test-retest coefficient was .81.

The concurrent validity of the TCAS is evidenced by findings which indicate that the scale relates to measures of individuals' styles of attachment in a manner that is consistent with attachment theory. Brennan and Shaver (1991), for example, found a negative relationship between scores on a measure of anxious-ambivalent attachment and scores on the TCAS. A negative relationship between avoidant attachment and trust and a positive relationship between secure attachment and trust were also found. The scale's concurrent validity was further supported by correlations between subjects' and their partners' scores on the seven measures of attachment style dimensions for Brennan and Shaver's (1991) sample of heterosexual couples. For example, individuals' scores on a measure of their general feelings of frustration and a measure of their feelings of ambivalence in

relationships correlated negatively with their partners' scores on the TCAS. In a related vein, female and male subjects' scores on the TCAS correlated positively with measures of their own relationship satisfaction and with the relationship satisfaction of their male and female partners. Finally, evidence of the TCAS's construct validity was indicated by the strong negative relationship that was found between the TCAS and a measure of interpersonal distrust (Brennan & Shaver, 1991).

The Dyadic Trust Scale.

Therapists' and clients' specific trust in each other was measured using modified versions of the Dyadic Trust Scale (DTS). This scale was developed by Larzelere & Huston (1980) to measure specific trust among intimate partners. In its original form, the scale requires subjects to indicate, on seven-point Likert scales, the extent to which they agree or disagree with each of eight statements concerned with various aspects of their partners' trustworthiness. Negatively stated items on the DTS are reversed scored. Subjects' total score on the scale is derived by determining their mean rating on the 8 statements.

Larzelere and Huston (1980) found the DTS to have high item-total correlations ranging from .72 to .89 and a reliability of .93 (coefficient alpha). The concurrent validity of the scale is evidenced by the strong correlations that were found between dyadic trust scores and self-report measures of love and self-disclosure for a sample of dating, married, and divorced couples. The discriminant validity of the scale is demonstrated by the low correlations that were obtained between the DTS and a measure of social desirability (r= .00, ns) and two measures of generalized trust (r= .17, p <.05; r= .02, ns). The dyadic trust scores were

more strongly related to measures of love and self-disclosure than were either of the measures of generalized trust.

Other authors have found that, based on retrospective interviews, divorced individuals' scores on the DTS decreased significantly across three successive time periods that preceded their legal divorce, and that dyadic trust scores were among the strongest predictors of conflict during the divorce process (Ponzetti & Cate, 1986). Dyadic trust scores among divorced parents have also been negatively correlated with measures of their childrens' problematic behaviours in school (Wood & Lewis, 1990). Finally, Cahn (1989) reported that scores on the DTS were positively correlated with dating and married individuals' assessments of their partners as "ideal mates."

In the present study, the DTS was modified to measure specific trust from both clients' and therapists' perspectives. The first item in the scale, for example, which previously read, "My partner is primarily interested in his/her own welfare", was modified to read, "My client is primarily interested in his/her own welfare" (Therapist Form, see Appendix C.1) or "My therapist is primarily interested in his/her own welfare" (Client Form, see Appendix C.2). Two additionally modified forms of the DTS which measure therapists' and clients' perceptions of each other's trust (see Appendices C.3 and C.4) were also included for future analyses. For example, the first item in the scale read, "My client feels that I am primarily interested in my own welfare", and "My therapist feels that I am primarily interested in my own welfare" respectively. Prior to completing the DTS, respondents were informed that the scale was adapted from studies that were investigating relationships other than the client-therapist dyad

and that, for this reason, some of the questions may appear difficult or inappropriate to answer.

The Relationship Inventory.

Therapists' implementation of the facilitative attitudes were measured using the Relationship Inventory (RI) that was developed by Barrett-Lennard (1962). The basic form of the Relationship Inventory (RI) consists of 64 items that are evenly divided into subscales measuring four facilitative attitudes (Barrett-Lennard, 1986). Half of the 16 items in each subscale are expressed negatively and half are expressed positively. The attitude of unconditional positive regard is represented by two subscales which are respectively termed "level of regard" and "unconditionality of regard." Level of regard refers to an individual's overall positive or negative affective response to a particular other, and unconditionality of regard refers to the extent to which the response is conditional upon the other persons's specific attributes or behaviours (Barrett-Lennard, 1986). The remaining two attitudes assessed in the RI are congruence (or genuineness) and empathic understanding. Congruence refers to the "degree to which one person is functionally integrated in the context of his [or her] relationship with another, such that there is absence of conflict or inconsistency between his [or her] total experience, his [or her] awareness, and his [or her] overt communication" (Barrett-Lennard, 1962, p. 444). Empathic understanding embodies an individual's communicated understanding of the important aspects of another person's subjective awareness (Barrett-Lennard, 1986).

In the present study, clients completed the "other toward self" (OS) form of the inventory (see Appendix D.1) wherein items

are worded as statements that describe individuals' experience of another person's response to them. The first item, for example, belongs to the level of regard scale and reads, "____ respects me as a person." Respondents are instructed to mentally insert the appropriate individuals' name in the space provided, and to choose one of six numerically coded answers ranging from +3 ("Yes! I strongly feel that it is true") to -3 ("No! I strongly feel that it is not true") for each item. In the present study, clients' total scores on the RI were used in the primary analyses. These were derived by reversing the scores on negatively stated items, substituting number codes of 1 through 6 for the signed codes of -1 to +1, and by determining the overall mean of clients' responses to the 64 items. For exploratory analyses, clients' scores on the individual subscales were derived by determining the mean rating of the items belonging to each subscale.

Therapists completed the "myself to the other" (MO) form of the RI (see Appendix D.2), wherein items are worded in the first person and describe the reporting person's response to the other individual. The first item, for example, reads, "I respect ____ as a person." Scoring procedures for therapists' completion of the MO form of the RI were the same as for clients' completion of the OS form.

Gurman (1977) has reviewed 14 studies that have investigated the internal reliability of the RI, primarily in the context of analogue or actual therapy situations. In 11 studies, separate split-half or alpha coefficients were derived for each subscale on the RI. The mean coefficients for the regard, empathy, unconditionality, and congruence subscales were respectively .91, .84, .74, and .88, and the mean coefficient for the total scale

was .91.

Test-retest reliabilities of the RI were assessed in 10 studies reviewed by Gurman (1977), half of which were conducted in the context of actual therapy relationships. Test-retest intervals ranged from 12 days to 12 months and separate coefficients for each subscale were derived for eight samples. Similar to the coefficients for internal reliability, test-retest coefficients were uniformly high with mean values equal to .83 (regard), .83 (empathy), .80 (unconditionality), .85 (congruence), and .90 (total).

The validity of the RI has been discussed at length by Barrett-Lennard (1986) himself. He argues that the overall process of developing and revising the RI scales, which took into account the critical evaluations of several independent judges, demonstrates the content validity of the inventory. In addition, the structure of the RI, the item analyses used in its revision, and its high reliability coefficients demonstrate that it is metrically sound and therefore a potentially valid measuring instrument. Barrett-Lennard (1986) also cites several studies which have conducted inter-item factor analyses on the RI and have yielded factors that coincide closely with the variables of empathy, level of regard, unconditionality of regard, and genuineness.

The concurrent validity of the RI, according to Barrett-Lennard (1986), is evidenced by numerous studies which have yielded positive associations between the facilitative attitudes, as measured by the RI, and the outcome of a variety of therapeutic endeavours. Here, he draws particularly on the positive conclusions made by Gurman (1977) since the majority of studies

included in this review utilized one or more forms of the RI. Barrett-Lennard (1986) also cites studies that have demonstrated the RI's association with a number of variables inherent in relationships other than the client-therapist dyad. These variables include marital adjustment and distress, and students' level of self-esteem, anxiety, and educational achievement. He also states that a number of well-designed studies that have utilized the RI as a measure of the dependent variable have indicated that subjects' scores on the RI are affected by "factors which should convincingly influence relationship quality" (p.460). These factors include, among others, clients' "psychological mindedness," therapists' and teachers' open-mindedness, and training procedures for psychiatric residents.

Finally, Barrett-Lennard (1986) argues that maximal validity of the RI can be attained when it is completed by therapists and clients after a minimum of three therapy sessions. Under these conditions, clients and therapists would be most likely to respond in terms of the specifics of their particular relationship, rather than in terms of their initial expectations of what should be occurring in therapy, or in terms of their personal biases.

The Global Outcome Rating.

The Global Outcome Rating (GOR; Strupp & Hadley, 1979) was utilized in the present study as a measure of clients' global improvement since therapy inception. Clients and therapists completed the patient and therapist forms of the GOR respectively (see Appendix E.1 and E.2). Both forms require respondents to indicate on an 11-point scale the degree of improvement or change they perceive in the client since the beginning of therapy. The scale ranges from +5 ("very greatly improved") to -5 ("very much

worse").

The Brief Symptom Inventory.

The Brief Symptom Inventory (BSI; Derogatis, 1992; Appendix F) was included in the present study as a measure of client symptomatology. The BSI is a shortened form of the Symptom Check List-90 (Derogatis, 1977) and consists of 53 self-report items measuring nine dimensions of psychological distress (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, Psychoticism). Items in the scale constitute a list of psychological symptoms (e.g., "Nervousness or shakiness inside") and respondents are required to rate each symptom on a 5-point scale (0-4) ranging from "not at all" (0) to "extremely" (4) with reference to their experience over the previous seven days.

In the present study, the General Severity Index (GSI) of the BSI was used as the primary measure of clients' psychological adjustment. The GSI, which represents both the number of symptoms and the intensity of distress experienced by respondents, is considered the most sensitive summary measure that can be derived from the BSI (Derogatis & Melisaratos, 1983). The GSI is obtained by summing subjects' scores on each item on the BSI and dividing the grand total by 53. Norms to be used for the interpretation of the BSI for a number of respondent populations, including female and male outpatients, have been provided by Derogatis (1992). Norms for college students have also been reported by Cochran and Hale (1985).

Derogatis (1992) reported acceptable coefficient alpha estimates for each symptom dimension that ranged from .71 on Psychoticism to .85 on Depression for a large sample of male and

female outpatients. Coefficient alphas that ranged from .70 on psychoticism to .88 on depression were also reported by Broday and Mason (1991) for a sample of clients at a university counselling centre. Test-retest reliabilities over a 2-week interval for a sample of non-patient subjects ranged from .68 on Somatization to .91 on Phobic Anxiety (Derogatis, 1992). The test-retest coefficient for the GSI was .90.

The construct validity of the BSI was assessed by examining the correlations of the nine symptom dimensions with the clinical scales on the Minnesota Multiphasic Personality Inventory (MMPI; Dahlstrom, 1969), the Wiggins content scales on the MMPI (Wiggins, 1966), and the Tyron Cluster Scales on the MMPI (Tyron, 1966). Correlations ranged from .30 to .72 and seven of the nine dimensions on the BSI showed strong convergence with clinically appropriate scales on the MMPI (Derogatis, 1992). Further evidence of the scale's concurrent validity has been presented in a review of over 100 studies that have involved the BSI and have demonstrated its sensitivity to changes in individuals' psychological status as it is affected by a wide range of factors (Derogatis, 1992). Among these, several studies have shown significant changes in BSI scores for subjects undergoing psychological treatment for a variety of conditions.

Procedure

Letters of instruction (see Appendix G), client recruitment letters (see Appendix H), and questionnaire packets for clients and therapists were sent to each participating therapist. Therapists were asked to present the recruitment letter to clients whom they judged to be eligible to participate in the study, and distributed the appropriate documents to clients who agreed to

take part.

To protect confidentiality, neither clients nor therapists indicated their names on any of the questionnaire materials. Code numbers were used for purposes of identification. Therapists had the option of indicating clients' initials on the questionnaires that assessed their relationship with those particular clients. These initials were subsequently removed from the questionnaires.

Questionnaire packets for therapists were of two types and were be labelled "Therapist 1" and "Therapist 2." Therapists were instructed to complete the packet labelled "Therapist 1" first. This packet was completed only once by each therapist and contained a consent form (see Appendix I.1), and the Trust/Confidence Attachment Scale in that order. The packet labelled "Therapist 2" contained general instructions and preliminary questions pertaining to therapists' level of experience, their theoretical orientation, and the number of sessions held with clients (see Appendix J). The packet also contained, in the following order, the MO form of the Relationship Inventory, two modified versions of the Dyadic Trust Scale (measuring therapists' trust in their clients and therapists' perception of how much their clients trust them), and the therapist form of the GOR. Therapists were instructed to complete the questionnaires in the order that they appeared in the packet. They were instructed to complete one packet labelled "Therapist 2" for each of their clients participating in the study.

Client packets were labelled "Client." These packets contained, in the following order, general instructions for completing the questionnaires (see Appendix K), a consent form (see Appendix I), the Trust/Confidence Attachment Scale, two

modified versions of the Dyadic Trust Scale (measuring clients' trust in their therapists and clients' perceptions of how much their therapists trust them), the OS form of the Relationship inventory, the patient form of the GOR, and the Brief Symptom Inventory. Again, clients were instructed to complete the questionnaires in the order that they appeared in the packet.

Each questionnaire packet was accompanied by an addressed envelope. Therapists and clients were provided with postage so that the completed questionnaires could be mailed directly to the researchers. After data collection was completed, a letter of explanation was sent to therapists (Appendix L.1). Therapists were requested to distribute a similar letter to their clients (Appendix L.2).

Results

Description of Sample and Reliability of Measures

Means, standard deviations, and alpha coefficients (where applicable) for therapists' and clients' scores on the TCAS, DTS, RI, and GOR, and clients' scores on the General Severity Index of the BSI are presented in Table 3. Official norms for the TCAS, DTS, RI, and GOR have not been provided in the literature. However, an examination of the means and standard deviations in Table 3 indicates that, in the present study, therapists' and clients' scores on the DTS, RI, and GOR fell largely in the top half of the possible scoring range for each of these measures. This indicates that clients and therapists in this sample evaluated each other in primarily positive terms. In addition, clients in this sample reported a slightly lower degree of symptomatology (M= 1.03, SD= .70) on the General Severity Index (GSI) of the BSI than did the outpatient psychiatric sample (M=

Table 3

Means, Standard Deviations, and Alpha Coefficients for Therapists' and Clients' Scores on each Measure

Measure	n	Possible Scoring Range	M	SD	alpha[a]
$TCAS_T$	17	1-10	5.78	.57	.65
$TCAS_C$	48	1-10	3.72	1.08	.84
DTS_T	48	1-7	5.52	.75	.80
DTS_C	48	1-7	6.19	.58	.84
RI_T	48	1-6	4.88	.44	.94
RI_C	48	1-6	4.90	.49	.95
GOR_T	48	1-11	9.46	1.39	-
GOR_C	48	1-11	9.17	1.10	-
BSI_C	48	1-4	1.03	.70	.97

Note. DTS= Dyadic Trust Scale; TCAS= Trust/Confidence Attachment Scale; RI= Relationship Inventory; GOR= Global Outcome Rating; BSI= General Severity Index of the Brief Symptom Inventory; $_T$= scale completed by therapist; $_C$= scale completed by client.

[a]alpha coefficients could not be calculated for the GOR because it consists of only one item.1.32, SD= .72; Derogatis, 1992) on which the BSI was normed. Clients' mean score of 1.03, however, falls within one standard deviation of the normative mean for psychiatric outpatients and falls well above the mean of .30 (SD= .31) that was obtained by the normative sample of non-patient adults (Derogatis, 1992). In terms of their more generalized

feelings and attitudes in relationships, therapists' mean generalized trust score (M= 5.78) on the TCAS fell slightly above the midpoint of the possible

scoring range whereas clients' mean score (M= 3.72) fell in the lower half of the scoring range.

With one exception, each of the measures presented in Table 3 shows a high level of reliability. This includes therapists' and clients' scores on the DTS (alpha = .84 and .80 respectively) which was modified to suit the purposes of the present investigation. Although the TCAS has proven to be a highly reliable instrument in other research settings (see above discussion on the psychometric properties of the TCAS), the reliability of therapists' scores on the TCAS in the present study was relatively low (alpha= .65). For this reason, therapists' scores on the TCAS were included in subsequent analyses only when therapists' generalized trust, which was assessed by therapists' scores on the TCAS, was a primary variable of interest. Given the high correlation between therapists' scores on the TCAS and therapists' scores on the DTS (r= .67, p< .0001; see Table 4 in Appendix M), only therapists' scores on the DTS, which represented the more reliable instrument (alpha=.80), were included in analyses wherein therapist trust served as a covariate. The manner in which problems associated with multicollinearity were avoided in analyses that included therapists' scores on both the TCAS and the DTS will be described below.

Identification of Covariates

Correlational analyses and analyses of variance were conducted in order to identify characteristics of the client-therapist dyad that were not central to the research questions under investigation but were related to measures that would serve as the criterion variables (e.g., therapist and client ratings on the RI and GOR, and client ratings on the TCAS and DTS) in

multiple regression analyses. Significant characteristics were defined as covariates and their effects were partialled out of the final analyses.

Correlational analyses were conducted when the potential covariates represented continuous variables. These included clients' and therapists' ages, therapists' years of experience, the number of completed sessions, and client symptomatology. Analyses of variance were conducted when the covariates represented categorical variables. These included clients' and therapists' sex, marital status, therapists' theoretical orientation, whether ratings were made by the client or the therapist, and whether client-therapist dyads constituted the same or opposite sex dyads. Analyses of variance were also conducted to determine whether there were differences between therapists on any of the prospective criterion variables.

Although it would seem that the inclusion of more than one dependent variable in these analyses would deem multivariate analyses of variance (MANOVA) more appropriate than univariate analyses of variance (ANOVA), the relatively small number of subjects precluded the utilization of the MANOVA procedure (Tabachnik & Fidell, 1989). In addition, the large number of correlations and univariate comparisons that resulted from this procedure yielded an unacceptably high experimentwise error rate that was of concern. However, when the experimentwise error rate was set at .05 or .10, only two covariates (client symptomatology and therapist effects) were identified. Thus, covariates were ultimately defined as variables that related to prospective criterion variables at a comparisonwise error rate of .05. The disadvantage of this procedure was that some non-covariates could

be identified as covariates merely by chance. However, the assurance that the confounding influence of theoretically important covariates would be partialled out of the final analyses appeared to justify this risk.

Results of the correlational analyses are presented in Table 5. For the RI, clients' scores were negatively related to therapist age (r= -.30, p< .04), and therapists' scores were negatively related to client age (r= -.32, p< .04) and positively related to the number of completed sessions (r= .34, p< .04). On the basis of these results, therapist and client age, and the number of completed sessions were grouped together as a covariate set and partialled out of subsequent analyses wherein either therapist or client ratings on the RI served as the criterion variable. Although not all covariates in the set were related to both therapist and client ratings on the RI, they were grouped together into one covariate set and then partialled out of subsequent analyses wherein either therapist or client ratings on the RI served as the criterion variable so that legitimate comparisons between these analyses could be made.

Table 5 indicates further that clients' scores on the DTS were negatively related to the number of sessions attended (r= -.30, p< .04) and that clients' scores on the TCAS were negatively related to client symptomatology (r=-.56, p< .001). Thus, the number of completed sessions and client symptomatology were partialled out of final analyses wherein client ratings on the TCAS or DTS served as the criterion variable. Again, the same covariate set was partialled out of analyses wherein either rating of client trust served as the criterion variable so that legitimate comparisons between these analyses could be made.

Table 5

Correlations between Prospective Criterion Variables and Therapist and Client Age, Number of Completed Sessions, Therapist Experience, and Client Symptomatology

Criterion Variable	Therapist Age	Client Age	Session Number	Therapist Experience	Client Symptomatology[a]
RI_T	.02	-.32*	.34*	-.11	.04
RI_C	-.30*	.16	.14	.01	-.14
$TCAS_C$	.10	-.01	.14	.01	-.56***
DTS_C	-.06	-.13	-.30*	.19	.24
GOR_T	.22	-.13	.23	.06	-.30*
GOR_C	-.05	-.07	.14	.01	-.40**

Note. TCAS= Trust/Confidence Attachment Scale; DTS= Dyadic Trust Scale; GOR= Global Outcome Rating; $_T$= scale completed by therapist; $_C$= scale completed by client. aClient Symptomatology was assessed by clients' scores on the General Severity Index of the Brief Symptom Inventory.

*p< .05 **p< .01 ***p< .001.

Finally, therapist and client ratings on the GOR were negatively related to client symptomatology as assessed by clients' scores on the General Severity Index on the BSI (r= -.30, $p\leq$ .04 and r= -.40, $p<$ .006, respectively). For this reason, the effects of client symptomatology were partialled out of subsequent analyses wherein therapist or client ratings on the GOR served as the criterion variable.

The results of the analyses of variance are presented in Tables 6 to 12 in Appendix N. The ANOVAs for therapists' and clients' sex, age, and marital status; dyad gender composition; and rater perspective were not significant. Two ANOVAs were significant. First, clients' scores on the RI were related to therapists' theoretical orientation, $F(3,13)$= 5.41, $p<$ .01. Multiple comparisons revealed that clients working with therapists from a Cognitive-Behavioural perspective rated their therapists as higher on the facilitative conditions than did clients working with therapists from eclectic, psychoanalytic, or systemic orientations. The second significant ANOVA revealed differences between therapists on their ratings of themselves on the RI[1], $F(16,31)$= 3.54, $p<$ .001. Therapists were therefore grouped on the basis of their theoretical orientation and on the basis of their RI ratings. Therapists from a Cognitive-Behavioural perspective were coded as 1 and therapists from all other perspectives were coded as 0. With respect to therapists' RI ratings, therapists were divided into three groups on the basis of the distribution of

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[1]An additional ANOVA indicated that therapists also differed significantly on their ratings on the DTS, $F(16,31)$= 6.55, $p<.001$ (see Table 12). The implications of this finding will be discussed below.

their RI scores relative to the mean. In subsequent regression analyses, these groups were represented by two dummy variables. Therapists with RI scores greater than one standard deviation above the mean were coded as 1 on the first dummy variable (Dum1) and all other therapists were coded as 0. Therapists with RI scores within one standard deviation of the mean were coded as 1 on the second dummy variable (Dum2) and all other therapists were coded as 0. By default, therapists whose RI scores were lower than one standard deviation below the mean were represented by 0 codes on both dummy variables. Multiple comparisons revealed that therapists within each grouping did not differ significantly from one another.

Analyses of Hypotheses

Hypothesis 1.

To test the assertion that therapists' specific and generalized trust contribute to therapists' demonstration of the facilitative attitudes, two hierarchical, multiple regression analyses were conducted. The criterion variable in the first analysis was therapist ratings on the RI. The first predictor variable entered into this regression equation was the covariate set made up of client and therapist age, the number of completed sessions, and therapist groupings based on their theoretical orientation and their distribution of scores on the RI. The second and third predictor variables were therapists' scores on the TCAS and DTS respectively. The hierarchical entry of the predictor variables made it possible to determine the increase in variance of the criterion variable that was accounted for by therapists' scores on the TCAS or DTS beyond that accounted for by the covariate set. In addition, entering therapists' scores on

the two trust measures into the equation at separate steps made it possible to partial out the effects of therapists' scores on the TCAS from the effects of therapists' scores in the DTS in order to avoid problems associated with multicollinearity between these two variables (Cohen & Cohen, 1983). The second regression analysis followed an identical procedure, except that client ratings on the RI served as the criterion variable.

The results of the regression analysis wherein therapist ratings on the RI served as the criterion variable are presented in Table 13. First, these findings indicate that the covariate set contributed significantly to the regression equation, $F(6,41) = 9.84$, $p < .001$, with therapist groupings on the basis of their RI scores being the significant positive predictors within this set (Dum1: $F[1,41] = 27.88$; $p \leq .001$, $\beta = 1.06$; Dum2: $F[1,41] = 7.75$, $p \leq .008$, $\beta = .46$). In total, the covariate set accounted for 53% of the variance in therapists' RI scores. This suggests that differences between therapists that may or may not have subsumed genuine differences in their demonstration of the facilitative attitudes were strong positive contributors to the prediction of therapists' ratings on the RI.

Beyond the significant contribution of the covariate set, therapists' scores on the TCAS did not contribute significantly to the regression equation. Therapists' scores on the DTS, on the other hand, did add to the equation, $F(1,39) = 23.64$, $p < .001$, $\beta = .37$, even when the contributions of the covariate set and therapists' scores on the TCAS were controlled. Adding therapists' scores on the DTS to the equation resulted in an increase of .17 in the adjusted R^2 value. Taken together, the findings in Table 13 indicate that, beyond the strong, positive

Table 13

Regression Analyses of Therapist Trust Predicting Therapist Ratings of the Facilitative Attitudes

Criterion Variable	Predictor Variable	F	df	p	β	Adj. R^2	Incr. R^2
RI_T	Covariate Set	9.84[a]	6,41	.001	-	.53	-
	Sesno	.54	1,41	ns	.00	-	-
	Age_C	2.82	1,41	ns	.00	-	-
	Age_T	.15	1,41	ns	.00	-	-
	Theor	.45	1,41	ns	.11	-	-
	Dum1	27.88	1,41	.001	1.06	-	-
	Dum2	7.75	1,41	.008	.46	-	-
	$TCAS_T$	.12[a]	1,40	ns	.04	.52	-.01
	DTS_T	23.64[a]	1,39	.001	.39	.69	.17

Note. Adj. R^2= Adjusted R^2; Incr. R^2= increment of adjusted R^2 as a result of adding variable to regression equation; RI= Relationship Inventory; TCAS= Trust/Confidence Attachment Scale; DTS= Dyadic Trust Scale; $_T$= scale completed by therapist; $_C$= scale completed by client; Sesno= Number of completed sessions; Theor= Theoretical orientation; Dum1 & Dum2= Dummy variables representing therapist groupings based on distribution of scores on RI ratings. [a]F values presented for variable or variable set having controlled for variables or variable sets entered at prior stages in the analysis.

contribution of therapist differences, therapists' specific trust, but not their generalized trust, was a positive predictor of therapist ratings of the facilitative attitudes.

The results of the regression analysis wherein client ratings on the RI served as the criterion variable are presented in Table 14. Again, this table indicates that the covariate set contributed significantly to the regression equation, $F(6, 41) = 2.32$, $p < .05$, with therapists' age being the significant negative predictor and therapists' theoretical orientation being the significant positive predictor within this set, ($F[1,41] = 5.41$, $p < .03$, $\beta = -.03$ and $F[1,41] = 4.88$, $p < .03$, $\beta = .54$ respectively). In total, the covariate set accounted for 14% of the variance in client RI ratings. Thus, therapists who were younger and who described their orientation as Cognitive-Behavioural were rated higher on the facilitative attitudes by their clients.

Beyond the significant contribution of the covariate set, therapists' scores on neither trust measure contributed significantly to the regression equation. This indicates that therapists' generalized and specific trust did not predict clients' experience of the facilitative attitudes beyond the significant prediction that was afforded by therapists' age or therapists' theoretical orientation.

Taken together, the results presented in Tables 13 and 14 lend partial support to the first hypothesis in the study. Therapists' specific trust was a positive predictor of therapists' demonstration of the facilitative attitudes, but only when the attitudes were rated by therapists and not by clients. On the other hand, therapists' generalized trust predicted neither therapists' nor clients' ratings of therapists' facilitative

Table 14

Regression Analyses of Therapist Trust Predicting Client Ratings of Therapists' Facilitative Attitudes

Criterion Variable	Predictor Variable	F	df	p	β	Adj. R^2	Incr. R^2
RI_C	Covariate Set	2.32[a]	6,41	.05	-	.14	-
	Sesno	1.02	1,41	ns	.00	-	-
	Age_C	1.35	1,41	ns	.01	-	-
	Age_T	5.41	1,41	.03	-.03	-	-
	Theor	4.88	1,41	.03	.55	-	-
	Dum1	.60	1,41	ns	.23	-	-
	Dum2	1.08	1,41	ns	.26	-	-
	$TCAS_T$	.86[a]	1,40	ns	.16	.14	.00
	DTS_T	.06[a]	1,39	ns	.04	.12	-.02

Note. Adj. R^2= Adjusted R^2; Incr. R^2= increment of adjusted R^2 as a result of adding variable to regression equation; RI= Relationship Inventory; TCAS= Trust/Confidence Attachment Scale; DTS= Dyadic Trust Scale; $_T$= scale completed by therapist; $_C$= scale completed by client; Sesno= Number of completed sessions; Theor= Therapist groupings on the basis of therapists' theoretical orientation; Dum1 & Dum2= Dummy variables representing therapist groupings based on distribution of scores on RI ratings.

[a]F values presented for variable or variable set having controlled for variables or variable sets entered at prior stages in the analysis.

attitudes. In relation to the latter finding, it should be noted that the failure to find a significant prediction on the basis of therapists' generalized trust may have been due to the fact that therapists' scores on the generalized trust measure were relatively unreliable and therefore less likely to contribute to a regression equation (Cohen & Cohen, 1983).

Hypothesis 2.

To test the assertion that, controlling for therapist trust, therapists' demonstration of the facilitative attitudes contributes to clients' specific and generalized trust, two hierarchical, multiple regression analyses were conducted. In the first analysis, clients' scores on the TCAS served as the criterion variable. The covariate set consisting of the number of completed sessions and clients' scores on the General Severity Index (GSI) of the BSI was entered as the first predictor variable. Therapists' scores on the DTS were then entered into the equation as a covariate in the second step of the analysis. Finally, the set of therapist and client ratings on the RI was entered into the equation. Again, the hierarchical manner in which the predictor variables were entered into the equation made it possible to determine whether the set of RI ratings contributed significantly to the prediction of clients' scores on the TCAS, even when the contribution of the covariate set and therapists' scores on the DTS had been taken into account. It was especially important to enter therapists' scores on the RI and the DTS into the analysis at separate steps because these variables were highly

correlated[2] (r= .76, p< .001, see Table 4) and their simultaneous introduction into the analysis would have created problems associated with multicollinearity. The second regression analysis was identical to the first except that the criterion variable was clients' scores on the DTS.

The results of these regression analyses are presented in Table 15. With respect to the analysis wherein clients' scores on the TCAS served as the criterion variable, the results indicate, first, that the covariate set contributed significantly to the regression equation, $F(2,45)= 11.98$, $p< .001$, with clients' scores on the GSI being the significant, negative predictor within this set, $F(1,45)= 2.61$, $p< .001$, $\beta= -.89$. In total, the covariate set accounted for 32% of the variance in clients' scores on the TCAS. Beyond the contribution of the covariate set, therapists' scores on the DTS, also entered as a covariate, did not contribute significantly to the equation. Overall, these findings indicate that clients' symptomatology was a strong, negative contributor to the prediction of clients' generalized trust, such that the greater the symptomatology, the less clients trusted others, and therapists' specific trust did not contribute further to this prediction.

With respect to the primary variables of interest, the results in Table 15 indicate that, controlling for the effects of clients' scores on the GSI and therapists' scores on the DTS, the set of RI ratings contributed significantly to the prediction of

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[2] Clients' scores on the DTS and RI were also highly correlated (r=.50, $p\leq$ .001; see Table 4). The implications of the high correlations between clients' and therapists' scores on the RI and DTS will be discussed below.

Table 15

Regression Analyses of Therapists' Facilitative Attitudes Predicting Client Trust

Criterion Variable	Predictor Variable	F	df	p	β	Adj. R^2	Incr. R^2
$TCAS_C$	Covariate Set	11.98[a]	2,45	.001	-	.32	-
	Sesno	2.61	1,45	ns	.00	-	-
	BSI_C	22.47	1,45	.001	-.89	-	-
	DTS_T	.54[a]	1,44	ns	.14	.31	-.01
	RI_C & RI_T[b]	4.46[a]	2,42	.02	-	.41	.10
	RI_C	2.54	1,42	ns	.40	-	-
	RI_T	6.55	1,42	.01	-1.09	-	-
DTS_C	Covariate Set	2.87[a]	2,45	.07	-	.07	-
	Sesno	4.24	1,45	.05	-.01	-	-
	BSI_C	1.09	1,45	ns	-.12	-	-
	DTS_T	.30[a]	1,44	ns	.06	.06	-.01
	RI_C & RI_T[b]	9.43[a]	2,42	.001	-	.39	.33
	RI_C	18.75	1,42	.001	.63	-	-
	RI_T	.08	1,42	ns	.07	-	-

Note. TCAS= Trust/Confidence Attachment Scale; DTS= Dyadic Trust Scale; RI= Relationship Inventory; BSI_C= clients' scores on the General Severity Index of the Brief Symptom Inventory; $_T$= scale completed by therapist; $_C$= scale completed by client; Sesno= number of completed sessions.

[a]F values presented for variable or variable sets having

controlled for variables or variable sets entered at prior stages in the analysis. [b]Variables entered into regression equation as a set.

clients' scores on the TCAS, $F(5,42)= 4.46$, $p< .02$, with therapist ratings on the RI being the significant, negative predictor within this set, $F(1,42)= 4.46$, $p< .01$, $\beta= -1.09$. The addition of the set of RI ratings to the regression equation resulted in an increase of .09 to the adjusted R^2 value. These findings indicate that, beyond the contribution of clients' symptomatology, therapist ratings of therapists' facilitative attitudes are a moderate, negative contributor to the prediction of clients' generalized trust such that the more positive the facilitative attitudes, the less the client's trust for others.

Turning to the prediction of clients' scores on the DTS, the results in Table 15 indicate, first, that the covariate set contributed marginally to the regression equation, $F(2,45)= 2.87$, $p< .07$, with the number of completed sessions being the significant, negative predictor within this set, $F(1,45)= 4.24$, $p< .05$, $\beta= -.01$. Overall, the covariate set accounted for 7% of the variance in clients' scores on the DTS. Beyond the contribution of the covariate set, therapists' scores on the DTS did not add to the regression equation. Taken together, these findings suggest a trend towards more therapy sessions being associated with less reported specific trust in the therapist by the client and do not provide evidence that therapists' specific trust for the client is directly related to clients' specific trust for their therapists.

However, Table 15 indicates that, controlling for the effects of clients' scores on the GSI and therapists' scores on the DTS, the RI rating set did contribute significantly to the prediction of clients' scores on the DTS, $F(2,42)= 9.43$, $p< .001$, with client ratings on the RI being the positive predictor within this set, $F(1,42)= 18.75$, $p< .001$, $\beta= 63$. Adding clients' scores

on the DTS to this model resulted in an increase in the adjusted R^2 value of .33. These findings, therefore suggest that clients' experience of their therapists' facilitative attitudes was a strong, positive contributor to the prediction of clients' specific trust, even when the significant contribution of the number of completed sessions and therapists' specific trust was taken into account.

In sum, the results presented in Table 15 lend partial support to the second hypothesis in the study. Therapists' demonstration of the facilitative attitudes predicted clients' specific trust when the attitudes were assessed from the client's, but not the therapist's, point of view. A rather unexpected finding was that therapists' demonstration of the facilitative attitudes, as rated by the therapist, was a negative predictor of client's generalized trust.

Hypothesis 3.

To test the assertion that client trust contributes to clients' global improvement in therapy, two hierarchical, logistic regression analyses were conducted. Logistic regression, as opposed to linear regression, was used because the criterion variables, clients' and therapists' scores on the GOR, were based on single item ratings and therefore represented categorical rather than continuous data (Hosmer & Lemeshow, 1989). Whereas linear regression predicts the value of the response or criterion variable, logistic regression predicts the probability that a criterion variable will take on a given value. In addition, logistic regression is based on the binomial, rather than the normal, distribution which also describes the distribution of error terms in the logistic regression. The statistic that is

used to determine the extent to which a given variable contributes significantly to a logistic regression equation is called the Generalized Likelihood Ratio (G). This ratio follows the χ^2 distribution and compares the probability of obtaining the observed data set from models with and without the variable of interest. Finally, in logistic regression, positive predictors are indicated by β values greater than 1 and negative predictors are indicated by β values less than 1.

The criterion variable in the first logistic regression was therapists' scores on the GOR. Similar to previous analyses, the predictor variables were entered into the regression equation in a hierarchical manner in order to control for the effects of variables or variable sets that were entered at prior stages in the analysis. The first predictor variable entered into this analysis as a covariate was clients' scores on the General Severity Index (GSI) of the BSI. The second predictor variable entered into the equation was therapists' scores on the DTS, also entered as a covariate, and the third predictor was the covariate set of therapist and client ratings on the RI. The final predictor variable, which was also the variable of interest, was the set of clients' scores on the TCAS and DTS. The second logistic regression followed an identical procedure except that clients' scores on the GOR served as the criterion variable.

The results of these regression analyses are presented in Table 16. They indicate that clients' scores on the GSI were negative predictors of client global improvement, as rated by therapists and clients (decrease in $G= 4.91$, $p< .03$, $\beta= .88$, and decrease in $G= 7.79$, $p< .005$, $\beta= .33$, respectively). In the model wherein therapist ratings on the GOR served as the criterion

Table 16

Logistic Regression Analyses of Client Trust Predicting Client Improvement

Criterion Variable	Predictor Variable	G	Decrease in G	df	p	β[a]
GOR_T	intercept	131.38	-	-	-	-
	BSI_C	126.47	4.91[b]	1	.03	.88
	DTS_T	122.59	3.88[b]	1	.02<p<.05	2.03
	RI_T & RI_C[d]	122.31	.28[b]	2	ns	-
	RI_T	122.55	.04	1	ns	.89
	RI_C	122.36	.23	1	ns	.61
	$TCAS_C$ & DTS_C[d]	120.34	1.97[b]	2	ns	-
	$TCAS_C$	121.14	1.22	1	ns	1.45
	DTS_C	121.43	.93	1	ns	.59

Table 16 (continued)

Criterion Variable	Predictor Variable	G	Decrease in G	df	p	β[a]
GOR_C	intercept	148.17	-	-	-	-
	BSI_C	140.38	7.79[b]	1	.005	.33
	DTS_T	138.22	2.16[b]	1	ns	.58
	RI_T & RI_C[d]	135.59	2.63[b]	2	ns	-
	RI_T	138.03	.19	1	ns	1.49
	RI_C	135.72	2.53	1	ns	2.38
	$TCAS_C$ & DTS_C[d]	133.40	2.19[b]	2	ns	-
	$TCAS_C$	133.80	1.79	1	ns	1.55
	DTS_C	133.61	1.98	1	ns	1.38

Note. G= Generalized Likelihood Ratio; GOR= Global Outcome Rating; BSI= General Severity Index on the Brief Symptom Inventory; DTS= Dyadic Trust Scale; RI= Relationship Inventory; TCAS= Trust/Confidence Attachment Scale; $_T$= ratings made by therapist; $_C$= ratings made by client.

[a]positive predictors are indicated by β values greater than 1 and negative predictors are indicated by β values less than 1.

[b]decrease in G presented for variable or variable set having controlled for variable or variable sets entered at prior stages in the analysis.

[d]variables entered into regression equation as a set.

variable, therapists' scores on the DTS also served as a positive predictor of client improvement (decrease in G= 3.88, .02<p<.05, β= 2.03) even when the effects of clients' scores on the GSI were controlled. No other covariates contributed significantly to either model. Taken together, these covariate analyses indicate that clients with lower levels of symptomatology were more likely to be rated by therapists and clients as having made global improvements in therapy. When client symptomatology was controlled for, therapists with higher levels of trust for their clients were more likely to rate their clients as having improved.

With respect to the primary variables of interest, the client trust set did not contribute significantly to either logistic model once the contribution of the covariates had been taken into account. This indicates that the third hypothesis was not supported. Neither clients' generalized nor their specific trust predicted therapists' or clients' assessments of client global improvement.

Hypothesis 4.

Correlational analyses indicated that therapist experience correlated positively with therapists' scores on the TCAS (r= .30, p< .04) but did not correlate significantly with therapists' or clients' scores on the DTS. On the other hand, the number of completed sessions did correlate positively with therapists' scores on the DTS (r= .33, p<.02) and negatively with clients' scores on the DTS (r= -.30, p< .04).

Taken together, these results lend partial support to the fourth hypothesis. They indicate that more experienced therapists reported higher levels of generalized trust than did less experienced therapists. Therapist experience did not, however,

relate to therapists' specific trust for individual clients or to clients' specific trust for their therapists. Therapists' and clients' specific trust for one another did relate to the length of time over which they had been interacting. Contrary to expectations, however, therapists' specific trust for their clients appeared to increase with the length of therapy, whereas clients' specific trust for their therapists appeared to decrease.

Hypothesis 5.

Therapists' and clients' specific trust, as assessed by their respective scores on the DTS, did not correlate significantly (r= -.04, ns). Thus, contrary to what was expected, evidence for the reciprocal reinforcement of therapists' and clients' trust for one another was not obtained.

Exploratory Analyses

In light of the finding that therapists' specific trust predicted therapist ratings of the facilitative attitudes when therapists' generalized trust was controlled, exploratory analyses were conducted to determine whether therapists' specific trust predicted any of the individual facilitative attitudes (i.e., level of regard, unconditionality of regard, empathy, and congruence), as rated by the therapist, more strongly than it did the others. Four multiple regression analyses were conducted such that therapist ratings on each of the subscales of the RI served as the criterion variable in one analysis. As in previous analyses, the predictor variables were entered into the regression equations hierarchically. The covariate set consisting of client age, therapist age, number of completed sessions, and therapist groupings based on therapists' theoretical orientation and their ratings on the RI, was entered into each equation first and was

followed by therapists' scores on the TCAS. Therapists' scores on the DTS were entered into each equation last.

The results of these analyses are summarized in Table 17. (A more detailed presentation of the results can be examined in Table 18 in Appendix O.) Overall, when the effects of the covariate set and therapists' scores on the TCAS were controlled, therapists' scores on the DTS contributed to the prediction of three of the four RI subscales: Level of Regard, Unconditionality of Regard, and Congruence, but not Empathy. The nonsignificant prediction of the Empathy subscale may be related to the fact that therapist ratings on the Empathy subscale were the least reliable (alpha= .70) among the otherwise highly reliable subscales (see Table 19). A comparison of the increment in R^2 values that resulted from adding therapists' scores on the DTS to each equation suggests that therapists' specific trust was most predictive of therapists' ratings of their level of regard for clients (increment in R^2= .37).

In light of the finding that therapist ratings of the facilitative attitudes predicted clients' generalized trust and client ratings of the facilitative attitudes predicted clients' specific trust, further exploratory analyses were conducted in order to compare the individual contributions of therapists' and clients' ratings of the four facilitative attitudes as they predicted clients' generalized and specific trust respectively. Two sets of multiple regression analyses were conducted. In one set of four analyses, clients' scores on the TCAS served as the criterion variable. The covariate set consisting of the number of completed sessions and clients' scores on the GSI was entered into each regression analysis first, followed by therapists'

Table 17

Regression Analyses of Therapists' Specific Trust Predicting Therapist Ratings of Individual Facilitative Attitudes

Criterion Variable	Predictor Variable	F[a]	df	p	β	Adj. R^2	Incr. R^2
Level of Regard	CovSet[b]	3.61	6,41	.006	-	.25	-
	$TCAS_T$	1.08	1,40	ns	.19	.25	.00
	DTS_T	39.86	1,39	.001	.75	.62	.37
Uncond Regard	CovSet[b]	16.56	6,41	.001	-	.67	-
	$TCAS_T$	.09	1,40	ns	-.04	.66	-.01
	DTS_T	13.46	1,39	.001	.42	.74	.08
Empathy	CovSet[b]	5.46	6,41	.001	-	.36	-
	$TCAS_T$	.18	1,40	ns	-.05	.35	-.01
	DTS_T	1.06	1,39	ns	.11	.35	.00
Congruence	CovSet[b]	9.00	6,41	.001	-	.51	-
	$TCAS_T$	.17	1,40	ns	.06	.50	-.01
	DTS_T	1.06	1,39	.02	.28	.55	.05

Note. Uncond Regard= Unconditionality of Regard; CovSet= Covariate Set; TCAS= Trust/Confidence Attachment Scale; DTS= Dyadic Trust Scale; $_T$= ratings made by therapist; $_C$= ratings made by client.

[a]F values presented for variable or variable set having controlled for variables or variable sets entered at prior stages in the

regression. [b]Covariate set consisted of client age, therapist age, number of completed sessions, and therapist groupings on the basis of theoretical orientation and ratings on the RI. See Table 18 in Appendix O for *F* values, degrees of freedom, and significance level of each component in the covariate set.

Table 19

Reliabilities (coefficient alpha) of Therapist and Client Ratings on the RI

Subscale	Therapist Ratings	Client Ratings
Level of Regard	.91	.92
Unconditional Regard	.70	.85
Empathy	.91	.82
Congruence	.83	.84

scores on the DTS. The final predictor variable entered into each equation was therapists' scores on one of the four RI subscales such that a different subscale was included as the final predictor in each of the four analyses. Following this, a comparison of the increment in $\underline{R}^2$ values that resulted from adding therapists' scores on the RI subscales to each equation made it possible to compare the amount of variance in clients' scores on the TCAS that was accounted for by therapists' scores on each subscale. The second set of four analyses followed an identical procedure except that, in each analysis, clients' scores on the DTS served as the criterion variable and client ratings on one of the four RI subscales served as the final predictor variable.

While it would seem that entering therapists' scores on the four subscales as predictor variables into the same equation would have allowed for a more direct comparison of their individual contributions, high correlations among therapist ratings on the four subscales (see Table 20, Appendix O) would have created problems associated with multicollinearity and would have yielded ambiguous results (Cohen & Cohen, 1983). Given the high correlation among the four subscales, the $\underline{R}^2$ values that resulted from the four regression analyses can not be considered pure indices of the amount of variance in clients' trust scores that can be attributed to each subscale. However, comparing the $\underline{R}^2$ values would represent an initial indicator as to which subscales are more or less predictive of clients' scores on either of the trust scales.

The results of these analyses are presented in Table 21. Controlling for the effects of the covariate set and therapists' scores on the DTS, Table 21 indicates that therapists' scores on

Table 21

Regression Analyses of Individual Facilitative Attitudes Predicting Client Trust

Criterion Variable	Predictor Variable	F[a]	df	p	β	Adj. R^2	Incr. R^2
$TCAS_C$	Covariate Set[b]	11.98	2,45	.001	-	.32	-
	DTS_T	.80	1,44	ns	.28	.31	-.01
	$LevelReg_T$	5.58	1,43	.02	-.78	.38	.07
	$UncondReg_T$	5.55	1,43	.02	-.63	.38	.07
	$Empathy_T$	1.06	1,43	ns	-.37	.31	.00
	$Congruence_T$	.17	1,43	ns	-.27	.31	.00
DTS_C	Covariate Set[b]	2.87	2,45	.07	-	.07	.07
	DTS_T	.30	1,44	ns	.06	.06	-.01
	$LevelReg_C$	16.38	1,43	.001	.55	.30	.24
	$UncondReg_C$	20.38	1,43	.001	.40	.35	.29
	$Empathy_C$	15.89	1,43	ns	.001	.30	.24
	$Congruence_C$	9.46	1,43	ns	.61	.21	.15

Note. Each of the RI subscales served as the final predictor variable in separate regression analyses. In each analysis, the covariate set and therapists' scores on the DTS were entered into the equation prior to therapists' or clients' scores on the RI subscale; Adj. R^2= Adjusted R^2; Incr. R^2= increment in adjusted R^2 as a result of adding variable to equation; TCAS= Trust/Confidence Attachment Scale; DTS= Dyadic Trust Scale; LevelReg= Level of Regard; UncondReg= Unconditionality of Regard; $_T$= ratings made by

therapist; $_c$= ratings made by client.

[a]*F* values presented for variable or variable set having controlled for variables or variable sets that were entered at prior steps in the regression equation. [b]the covariate set consisted of the number of completed sessions and clients' scores on the General Severity Index of the Brief Symptom Inventory. See Table 15 for *F* values, degrees of freedom, and significance level of each component in the covariate set.

two of the four subscales (Unconditionality of Regard and Level of Regard) were significant, negative predictors of clients' scores on the TCAS. An examination of the increment in the adjusted $\underline{R}^2$ values that resulted from adding therapists' scores on the RI subscales to the regression equations suggests that neither therapists' unconditionality of regard nor their level of regard accounted for a very large portion of the variance in client generalized trust ($\underline{R}^2$= .07 for both subscales). The subscales that did not contribute significantly to the prediction of client generalized trust (Empathy and Congruence) were the least reliable of the four subscales (see Table 19).

Table 21 also indicates that, controlling for the effects of the covariate set and therapists' scores on the DTS, client ratings on each of the four RI subscales contributed to the prediction of clients' scores on the DTS. An examination of the increments in the adjusted $\underline{R}_2$ values that resulted from adding clients' scores on each subscale to the regression equation indicates that each RI subscale accounted for approximately 25% of the variance in clients' specific trust scores. The exception was the Congruence subscale which accounted for 15% of the variance.

A third set of exploratory analyses was conducted in order to determine whether clients' generalized or specific trust would predict clients' level of symptomatology. These analyses were conducted in light of the fact that clients' self-reported symptomatology on the GSI, after a mean of 43 sessions, correlated negatively with client and therapist ratings of client global improvement on the GOR ($\underline{r}$=-.31, $\underline{p}$<.03 and $\underline{r}$=-.30, $\underline{p}$<. 04, respectively, see Table 4). The post hoc hypothesis was that higher levels of generalized or specific trust would predict lower

levels of symptomatology. To test this assertion, a hierarchical multiple regression analysis was conducted wherein clients' scores on the GSI served as the criterion variable. The first predictor variable entered into the equation was therapists' scores on the DTS which was followed by the set of RI ratings, also entered as a covariate. The final predictor variable entered into the equation was the set of clients' scores on the TCAS and DTS.

The results of this analysis are presented in Table 22. They indicate that neither therapists' scores on the DTS nor the RI rating set contributed significantly to the prediction of clients' scores on the GSI. On the other hand, the client trust set contributed to the prediction of clients' scores on the GSI, $F(2,42)= 10.92$, $p< .002$, with clients' scores on the TCAS being the significant, negative predictor within this set, $F(1,42)= 21.07$, $p< .001$, $\beta= -.40$. Adding the client trust set to the regression equation resulted in a substantial increment in the adjusted R^2 value equal to .32. Taken together, the results suggest that, after a mean of 43 sessions, clients' generalized trust was a strong, negative contributor to the prediction of clients' symptomatology. This indicates that clients who had difficulty trusting others were more likely to report symptoms.

Finally, client ratings on the TCAS correlated significantly with measures of client functioning: the GSI, as rated by the client ($r= -.56$, $p< .001$, see Table 4), and the GOR, as rated by therapist and client ($r= .30$, $p< .04$ and $r= .31$, $p< .03$, respectively, see Table 4). This pattern of correlations suggests the possibility that the TCAS also measures client functioning as an index of interpersonal adjustment. For this reason a final exploratory analysis was conducted to determine whether, after a

Table 22

Regression Analyses of Client Trust Predicting Client Symptomatology

Criterion Variable	Predictor Variable	F	df	p	β	Adj. R^2	Incr. R^2
BSI_C	DTS_T	.22[a]	1,45	ns	.11	-.02	-
	RI_T & RI_C[b]	.42[a]	2,44	ns	-	-.04	-.02
	$TCAS_C$ & DTS_C[b]	10.92[a]	2,42	.002	-	.28	.32
	$TCAS_C$	21.07	1,42	.001	-.40	-	-
	DTS_C	.25	1,42	ns	.09	-	-

Note. BSI= General Severity Index on the Brief Symptom Inventory; DTS= Dyadic Trust Scale; RI= Relationship Inventory; TCAS= Trust/Confidence Attachment Scale; $_T$= ratings made by therapist; $_C$= ratings made by client.

[a]F values reported for variable or variable set having controlled for variables or variable sets entered at prior steps in the regression equation. [b]variables entered into equation as a set.

mean of 43 sessions, clients' specific trust predicted clients' level of interpersonal adjustment. The analysis was identical to the first regression analysis that tested hypothesis 2 except that clients' scores on the DTS was added as a predictor variable. The first predictor variable in this analysis, then, was the covariate set consisting of the number of completed sessions and clients' scores on the GSI. Next, therapist ratings on the DTS and the RI rating set were entered, also as covariates. Finally, the last predictor variable was clients' scores on the DTS, the variable of interest. The results for hypothesis 2 (see Table 15) already indicate the extent to which each of the covariates in the analysis under discussion contributed to the prediction of clients' scores on the TCAS. With respect to the present variable of interest, clients' scores on the DTS did not contribute significantly to the regression equation once the covariates had been taken into account, $F(1,41) = .02$, ns. Thus, in so far as clients' scores on the TCAS can be regarded as an index of interpersonal adjustment, clients' specific trust did not predict clients' interpersonal adjustment after a mean of 43 sessions.

Discussion

Despite the substantial influence that client-centered theory has had on clinical theory and practice, the current study is among the first to provide empirical evidence in support of its most central proposition: therapists' trust in the actualizing tendency of their clients is a fundamental aspect of the therapeutic process. Using a sample of experienced therapists practising in variety of treatment settings, the study found that therapists' self-reported trust for their clients was a strong predictor of therapists' attitudes of unconditional positive

regard, empathy, and genuineness when these attitudes were assessed in composite by therapists themselves. Also consistent with Rogerian theory, therapists' demonstration of the facilitative attitudes, as perceived by clients, was a strong predictor of clients' trust in their therapists. An anomalous finding was that therapist ratings of the facilitative conditions did not predict clients' trust in their therapists, but was a negative predictor of clients' trust for other people in general. Finally, an aspect of Rogers' theory that was not supported was the assertion that clients' trust in their therapists would predict client global improvement. Therapist and client ratings of therapists' attitudinal response in their relationship also did not predict client progress. An unexpected finding was that therapists', rather than clients', trust in the therapeutic relationship predicted client global improvement but only when improvement was assessed by therapists themselves.

In what follows, the major findings in the study will be considered more extensively in the context of the study's hypotheses and in the context of Rogerian theory as a whole. Following this, the overall conclusions of the study will be integrated into a model of the therapeutic process and their general implications for therapeutic practice and theory will be discussed. Finally, the methodological limitations of the study will be considered and directions for future research will be offered.

Therapist and Client Trust and the Facilitative Attitudes

Therapist and client trust were assessed at two levels in this study. On the one level, a measure of generalized trust assessed therapists' and clients' confidence in other people as a

whole. This measure was designed to appraise a relatively stable aspect of personality that exerts a steady and consistent influence on individuals' willingness to depend on and render themselves vulnerable to other people in a variety of relationships (Brennan & Shaver, 1991). On the other level, a measure of specific trust assessed therapists' and clients' feelings about trusting each other in particular. This measure, which was modified to suit the present sample, rated the extent to which therapists and clients viewed each other as honest, considerate, and generally dependable people (Larzelere & Huston, 1980).

Both measures of trust can be understood as assessing respondents' confidence that other people in general or other persons in particular are inclined towards behaving in a responsible and constructive manner in their relationships with others. This confidence in other people's social behaviour is a crucial aspect of Rogers' (1977; 1961) concepts of therapist and client trust. At the core of Rogers' notion of therapist trust is a belief in clients' capacity to self-actualize. One of the primary manifestations of this actualizing tendency, in Rogers' (1977) view, is positive social behaviour. Thus, even though the measures of therapist trust do not assess therapists' confidence in their clients' actualizing ability directly, they do make reference to one of its most immediate corollaries. Another corollary of clients' actualizing tendency that is implied in Rogerian theory and is more immediately relevant to therapy is the client's successful resolution of psychological difficulties. Therapists' confidence in this aspect of client behaviour was not explicitly assessed by either measure of therapist trust.

However, the measure of specific trust does make reference to the therapeutic relationship, and, by implication, can be understood as assessing therapists' perceptions of their clients as they engage in the work of therapy. Of the two measures of trust then, the index of specific trust seems to assess the Rogerian concept of therapist trust most closely. In light of the relatively strong support for the Rogerian emphasis on therapist trust that was derived in the current study (see discussion below), it seems that the development of an even more fitting index of therapist trust for use in future research would be a worthwhile activity.

In comparison to their assessment of therapist trust, the indices of generalized and specific interpersonal trust seem more directly applicable to the measurement of client trust. This is because the Rogerian concept of client trust explicitly encompasses an expectation for positive social behaviour by referring to the client's belief that her or his therapist will behave in a consistent and caring manner throughout their interaction in therapy. Again, the measure of specific trust appears to assess client trust most closely because of its immediate reference to the therapist-client relationship.

Given that the Rogerian concepts of trust were adequately assessed, the findings of the study, when considered from the therapist's point of view, provide support for Rogers' (1951; 1980) assertion that therapists' trust in their clients exerts a primary influence on the extent to which therapists will demonstrate the attitudes of genuineness, empathy, and unconditional positive regard in the therapeutic relationship. Indeed, therapists' specific trust for their clients accounted for 17% of the variance in therapists' perceptions of their

attitudinal stance in their relationship with clients. Another assertion that received strong support was that clients' perception of their therapists as genuine, understanding, and unconditionally accepting contributes fundamentally to the degree of trust clients are willing to invest in their therapists. Here, clients' perceptions of their therapists' relationship attitudes accounted for 33% of the variance in clients' scores on the measure of specific trust for their therapists.

With one exception, it was the specific not the generalized trust of therapists and clients that contributed significantly to the above analyses. Although the nonsignificant predictions generated by the generalized trust scores were not anticipated, the overall pattern of results is consistent with the hypotheses and with previous research which found greater predictive validity for specific rather than generalized indices of trust (Larzelere & Huston, 1980). These findings indicate that the dynamics of the therapeutic relationship can be understood most adequately, not by considering therapists' and clients' general manner of relating to and perceiving other people, but by considering specifically their perceptions of each other within the context their unique relationship. The findings are also congruent with Moos and Clemes' (1967) assertion that therapists' and clients' behaviours and perceptions in the therapeutic setting are the product of their mutual influence on each other as well as their respective personality characteristics considered in isolation. As will be noted below, the exception within this overall pattern of results - the finding that therapist ratings of the facilitative attitudes predicted clients' generalized, but not their specific, trust - requires further empirical clarification before its significance

can be adequately understood. When one considers the relatively long period of time over which therapists and clients had been interacting, and when one considers Rotter's (1971) assertion that generalized expectancies are most predictive of individuals' behaviours in novel or ambiguous situations, the otherwise nonsignificant predictions that were afforded by the generalized trust scores are, perhaps, not surprising. One must, however, be cognizant of the fact that the measure of therapists' generalized trust was relatively unreliable and was, on that basis alone, less likely to contribute to a regression equation.

Another aspect of the study that coincides with previous research (Orlinsky & Howard, 1986) is the finding that the perspective from which therapist and client trust and therapists' demonstration of the relationship attitudes were assessed was important. In particular, therapists' self-reported trust for their clients predicted their own, but not their clients', assessments of the facilitative attitudes. Similarly, clients', but not therapists', assessments of the therapeutic conditions predicted clients' self-reported trust for their therapists. Taken together, this pattern of results lends credence to Barrett-Lennard's (1986) view that therapists and clients approach their relationship from different vantage points and, in accordance with arguments put forward by Gurman (1977), it suggests that therapists' and clients' experiences in the relationship and the factors that contribute to their experiences can best be understood by considering their respective viewpoints directly, rather than by inferring one person's perspective from that of the other. In fact, the nonsignificant correlation between therapist and client ratings of the facilitative attitudes indicates that

their perspectives in the relationship were quite diverse and relatively uninformative of each other. This finding coincides with the low concordance rate that has been observed among therapist and client ratings of the therapeutic conditions and other process variables in previous research (Barrett-Lennard, 1962; Caskey, Barker, & Elliott, 1984; Gurman, 1977; Lacrosse, 1977).

Even if therapists' and clients' perceptions of their interaction were substantially different, this does not imply that they were operating in separate vacuums, completely unaware of and unaffected by each other's presence. A recent study suggests that therapists, at least, are highly cognizant of their clients' experiences (Dill-Standiford, Stiles, Rorer, 1988). Relatively high levels of agreement among ratings of the therapeutic process made from opposite perspectives were obtained when therapists' impressions of their clients' viewpoints, rather than therapists' own perceptions of the interaction, were correlated with indices of client experience. Consideration of clients' awareness of therapists' viewpoints, however, made little difference in agreement levels among ratings. The authors speculated that clients have less information about the therapist on which to base attributions of her or his experience. Similar results were obtained in another study which, in the context of analogue peer-counselling interviews, found a strong, positive correlation between student volunteer ratings of their interviewers' level of empathic understanding and interviewers' predictions of what these ratings would be (Harman, 1986). The rating scales that were utilized in the study were the Empathy subscale on the OS form of the Barrett-Lennard Relationship Inventory (Barrett-Lennard,

1962), also completed by clients in the current study, and a parallel form of this subscale intended to measure interviewers' perceptions of the other person's assessment of their interaction (i.e., interviewers' metaperceptions). In terms of the current investigation, these results suggest that significant predictions among trust ratings and ratings of therapists' facilitative attitudes that were made from opposite perspectives may have been obtained if therapists' and clients' awareness of the other person's viewpoint, in addition to, or in lieu of, their own perceptions of the interaction had been taken into account.

In the absence of data confirming these speculations, the possibility that the significant predictions are indicative of rater biases that have little to do with therapists' and clients' actual experiences in their relationship also needs to be considered. Rater bias in psychotherapy research, especially as it pertains to therapists' and clients' assessments of their relationship, is a relatively new area of study. Nevertheless, evidence for bias in client ratings of therapeutic relationships was recently reported by Johnson and Neimeyer (1993). Using the Social Relations Model (Kenny & LaVoie, 1984) as a theoretical and statistical base, this study found that interpersonal ratings made by members of a psychotherapy group for incest survivors reflected the individual characteristics of the rater and ratees rather than the quality of their dyadic relationships. Elsewhere, Hill, O'Grady, and Price (1988) found that objective observers' perceptions of therapists as likable, competent, and similar to themselves biased their ratings of therapists' facilitative attitudes but not their ratings of therapists' directiveness, clinical management, or adherence to cognitive-behavioural and

interpersonal treatment strategies. In a subsequent study, rater bias was also associated with observer ratings of therapists' and clients' dominance and affiliativeness (Mahalik, Hill, O'Grady, & Thompson, 1993). Here, judgments of affiliativeness were most affected by rater biases and were associated with raters' perceptions of themselves as dominant or affiliative, their gender, and their liking for and perceived similarity with the ratees. The authors of the latter study suggested that ratings of the therapeutic conditions or therapist and client affiliativeness involve greater subjectivity and are therefore more vulnerable to bias than are ratings of other process variables. Similar conclusions were drawn from a study which found that observer ratings of therapist actions were less reliable than ratings of client actions (Weiss, Marmar, & Horowitz, 1988). The authors attributed this pattern of results to the higher levels of inference that are required in rating therapists' behaviours.

Taken together, the studies on rater bias in psychotherapy research, though not directly applicable to the current investigation, would suggest that, because of their subjective nature, the current self-report ratings of client and therapist trust and therapists' attitudinal stance in their relationship were vulnerable to distortion. To the extent that these distortions arose out of systematic differences between clients and therapists on variables that were extraneous to the actual therapeutic interaction, ratings made from the same perspective may have been related to one another solely because of their shared biases, rather than because of genuine associations between their underlying constructs. It is possible, for example, that therapists, because of their training in psychology, were more

familiar with completing questionnaires than were clients and that this greater familiarity, alone, lead to systematic differences in their manner of responding. Alternatively, response differences may have arisen out of the fact that therapists completed anywhere from one to six questionnaire packages pertaining to as many relationships whereas clients completed only one set of questionnaires pertaining to one relationship. Therapists, therefore, in an effort to promote efficiency, may have adopted a manner of responding that was different from that of clients. Indirect support for these propositions can be derived from Landy and Farr's (1980) review of the literature on performance rating in industrial settings which cites rater experience with rating forms, and the number of rating requests as variables that significantly influence rating behaviour. Several psychological characteristics of the rater, including her or his self-confidence level and her or his level of anxiety, were also cited as influential variables. Here, raters low in self-confidence and raters high in anxiety were cited as offering more lenient appraisals and appraisals that utilized more extreme response categories respectively. Given that psychotherapy frequently focuses on alleviating problems related to anxiety management or self-concept formation, it is possible that therapists and clients differed significantly in either or both of these areas. In the end, further research would be required to determine whether these, or other, variables contributed to systematic biases in rating behaviour in the current study and whether these biases confounded the significant results.

Although, for the most part, significant predictive relationships were observed when ratings were made from the same

perspective, one anomalous finding was that therapist ratings of the facilitative attitudes was a negative predictor of clients' self-reported, generalized trust. At first glance, these results might be interpreted as indicating that clients who were involved in a positive relationship with their therapists refrained from generalizing this experience to other relationships, and actually grew to trust others in the aggregate less. This interpretation seems counterintuitive and contradicts a number of outcome studies which have found a positive, though inconsistent, association between therapists' demonstration of the facilitative attitudes and various indices of client adjustment at therapy termination (see review Orlinsky & Howard, 1986). One could propose, however, that clients, at this stage in therapy, were becoming aware of the extent to which their therapists' warm and empathic stance contrasted with the relative non-acceptance they had experienced or were experiencing in other relationships, and they regarded their experience in therapy as an exception to an otherwise negative interpersonal environment. Had clients' generalized trust been assessed at therapy termination, it is possible that clients would have had greater opportunity to establish more constructive relationships outside of the consulting room and, as a result, they may have adopted a more positive worldview. This explanation is supported by the finding that, at the time of assessment, clients' average generalized trust scores were, in absolute terms, quite low and that they contrasted sharply with their highly positive ratings of the therapeutic relationship (see Table 3). However, it is not supported by the finding that only therapist ratings of the therapeutic relationship predicted clients' generalized trust and that these ratings were not even

correlated with clients' perception of their therapists' attitudinal stance.

An alternative explanation for the atypical finding might propose that the causal relationship between therapists' demonstration of the facilitative attitudes and client generalized trust was the opposite of what would be suggested by the regression analysis. It is possible that therapists perceived themselves as working harder at establishing a warm and understanding relationship with clients who had had especially negative interpersonal experiences than they did with clients who had less reason to be apprehensive of the interpersonal world. This explanation, however, is not supported by the finding that therapist ratings of their attitudes and clients' generalized trust were not significantly correlated. Also, one would anticipate that greater efforts on the part of therapists to establish an accepting and empathic relationship would translate into more positive experiences for the client. Again, the nonsignificant correlation between therapist and client ratings of the facilitative attitudes suggests that this was not the case. In the end, it appears that the significant, negative prediction of client generalized trust by therapists' ratings of the facilitative attitudes requires further empirical clarification before it's implications can be understood.

The evidence for a strong therapist effect in the prediction of therapists' demonstration of the facilitative conditions also needs to be considered. Overall, differences between therapists accounted for 53% of the variance in therapists' ratings of themselves on the facilitative attitudes. This indicates that therapists' appraisal of their attitudinal response in their

relationship with clients was, to a very large extent, associated with individual differences between therapists that may or may not have arisen out of their respective experiences in the therapeutic interaction. To the extent that these differences embodied variations between therapists in their specific trust for clients, the strong association between these differences and therapist ratings of their relationship attitudes, would uphold the Rogerian assertion that therapist trust is a foremost determinant of therapists' attitudinal stance in the therapeutic relationship. Evidence that this was indeed the case can be derived from the fact that analyses of variance indicated that therapists differed significantly, not only on their ratings of themselves on the facilitative attitudes, but also on their self-reported levels of specific trust. In addition, therapists' specific trust and therapists' ratings of the therapeutic conditions were very highly correlated indicating that therapists who scored high or low on one measure tended to score similarly on the other. Thus, it is possible that therapists differed on their ratings of the facilitative attitudes, largely because they also differed on their levels of specific trust and that the "therapist effect" in the present investigation reflects this phenomenon.

Although the preceding interpretation would be consistent with Rogerian theory, other explanations for the therapist effect and for the overall pattern of results cannot be ruled out. It is possible, for example, that differences between therapists on their ratings of the therapeutic conditions were contingent on differences between therapists on variables other than their specific trust for clients. In relation to this, Keijsers et al. (1991) reported that therapists' ratings of themselves on the

therapeutic conditions correlated significantly with their perception of clients as actively participating in the therapeutic process, their feeling that clients were oriented towards attaining their goals, and their overall liking for clients. Thus, the therapist effect in the current study may have represented variations in therapists' perceptions of their clients on these or other dimensions. Given that the therapist effect accounted for a greater amount of variance in therapists' assessments of the relationship attitudes than did therapists' specific trust, this explanation would challenge the fundamental emphasis that Rogerian theory places on therapist trust. The explanation does not, however, account for the very strong correlation that was observed between therapist ratings of the relationship attitudes and therapist trust.

Another explanation for the current pattern of results is that the therapist effect represents differences between therapists in their rating behaviours and therefore has relatively few implications for actual therapeutic practice. The high correlation between therapists' ratings on the measure of the facilitative attitudes and the measure of specific trust may illustrate that therapists who endorse high or low scores on one rating scale tended to do so on others as well. The studies on rating biases in psychotherapy research (e.g., Hill et al., 1988; Johnson & Neimeyer, 1993; Mahalik et al., 1993) support this explanation by illustrating that assessments of the therapeutic relationship are frequently influenced by factors inherent in the individuals doing the rating that are otherwise unrelated to the actual therapeutic interaction. On the other hand, this explanation is not supported by the fact that therapists did not

differ significantly in their ratings on any of the other measures that were utilized in the study.

A final explanation is that therapist ratings of the facilitative attitudes and specific trust were highly correlated because they represent one and the same construct and that the therapist effect represents differences between therapists on this construct. Some authors have, in fact, argued that, to a large extent, ratings of therapists' facilitative attitudes and related constructs actually assess some "global 'good' quality" (Rappaport & Chinsky, 1972, p. 401) more so than the specific attitudes or characteristics of the therapist (Mahalik et al., 1993). These speculations are supported in the present study by the findings that client ratings on the measure of specific trust and therapists' facilitative attitudes were also highly correlated, and that both therapists' and clients' average ratings on these measures were, in absolute terms, very positive. Clearly, these propositions, if proven true, would confound the entire results of the study.

The design of the present study renders it impossible to discern which, if any, of these interpretations underlies the substantial therapist effect that was uncovered in the analyses. In light of the fact that Rogers' (1961; 1980) regarded therapists' trust for their clients as their most fundamental contribution to the therapeutic endeavour, empirical consideration of any other factors that exert a significant influence on the process of psychotherapy and the manner in which these factors relate to therapist trust would provide important insight into the validity of Rogers' (1961; 1980) propositions. Regardless of the factors that would be identified in such an analysis, however, one

should be aware that, in the present study, therapists' trust in their individual clients accounted for 17% of the variance in therapist ratings of the facilitative attitudes beyond that which was accounted for by differences between therapists on other factors. As research demonstrates that the measure of therapist trust and especially the measure of the therapeutic conditions are reliable and valid (Barrett-Lennard, 1986; Larzelere & Huston, 1980), one can state with some confidence that therapist trust is a significant predictor of the therapeutic process even if other variables also play a role.

In addition to the therapist effect, the age and theoretical orientation of the therapist were significant covariates in the multiple regressions. Together they accounted for 14% of the variance in client ratings of therapists' facilitative attitudes. Therapists who were younger or who were from a Cognitive-Behavioural perspective were perceived by clients as more facilitative than therapists from an eclectic, psychoanalytic, or systemic orientation. Therapist age and therapist theoretical orientation did not correlate with therapists' ratings of their relationship attitudes or therapists' trust ratings for individual clients. In addition, therapists' trust for their clients did not predict client ratings of therapists' attitudinal stance in the relationship beyond the prediction that was afforded by the covariates. Taken together, these findings suggest that therapist variables associated with their age or with their general approach to doing therapy but not their actual experiences in the therapeutic relationship determined the extent to which they were perceived by clients as genuine, empathic, and unconditionally accepting.

With respect to therapist age, the current findings contradict those of an earlier study wherein clients, using the Empathy subscale on the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962), rated older therapists as more empathic than younger therapists (Fish, 1970). Therapist age, however, may have been confounded with therapists' level of training since some therapists had completed their doctoral degrees whereas others were in their first or second year of graduate training. A more recent study, using clients' total scores on the same inventory, found that neither therapist nor client age was significantly related to client ratings of their therapists' facilitative presence when therapist experience was controlled (Robiner & Storandt, 1983). This study, however, was conducted in the context of analogue interviews with non-professional crisis workers and client volunteers who were not otherwise involved in therapy. For this reason, the findings may not be comparable to those of the current investigation. Other research on the influence of therapist and client age on the therapeutic endeavour in general has increasingly found that therapist-client age similarity, rather than their respective ages considered in isolation, is positively associated with a number of process variables and with therapy outcome (Beutler et al., 1986). Given that therapists in the current study were, on average, older than clients (47 years vs. 39 years), it is possible that younger therapists, because they were closer to clients in age, were assumed by clients to possess a more similar outlook on life, and were, on that basis alone, perceived as demonstrating greater understanding, acceptance, and genuineness, irrespective of the attitudes that were actually experienced by therapists themselves.

Alternatively, younger therapists may have been less formal in their approach to clients than older therapists, possibly because of their age similarity, and this relative informality may have been experienced by clients as a warmer or more empathic interpersonal style even if therapists' underlying attitudes did not actually differ. These propositions, along with any others that might explain the significant effect of therapist age, should be considered more extensively in future empirical studies.

Turning to the significant association between therapists' theoretical orientation and client ratings of the therapeutic conditions, some insight into the higher ratings that were given therapists from a Cognitive-Behavioural (CB) perspective may be derived from a study recently conducted by Bachelor (1988). Based on a content analysis of client and non-client descriptions of the experience of being empathically understood, Bachelor (1988) identified four different styles of perceiving empathy. In the context of perceived "Cognitive" empathy, individuals described feeling understood when they perceived another person as accurately conceptualizing their inner experiences (e.g., the therapist restates the client's experiences in accurate terms). Individuals whose perceptual style was labelled "Affective" felt understood when they perceived another person as actually partaking in their experiences on an affective level (e.g., the therapist's eyes water when the client relates a sorrowful event). The third, "Sharing," perceptual style characterized individuals who felt understood when another person disclosed to them an experience similar to their own. Finally, individuals whose perceptual style was labelled "Nurturant" indicated that they felt understood simply by another person's supportive and attentive

presence. Of the four perceptual styles, Bachelor (1988) reported that clients utilized the "Cognitive" style most frequently. In terms of the present study then, it is possible that the CB therapists, because of their emphasis on cognitions as determinants of experience and behaviour (e.g., Beck, 1976), had a manner of communicating that was most suited to clients' predominantly cognitive manner of perceiving. In fact, Bachelor (1988) argued that Barrett-Lennard's (1962) Empathy subscale, because of its frequent use of verbs such as "thinks," "sees," and "realizes," favours therapists who are prone to giving cognitive empathic responses.

Other explanations for the CB therapists' high scores on client ratings of the facilitative attitudes can also be offered. Some studies have found that CB therapists are more verbally active than are therapists from other orientations (Hill, Thames, Rardin, 1979; Luborsky, Woody, McLellan, & Rosenzweig, 1982). It is possible that because of their higher levels of activity, CB therapists were perceived by clients as more involved in the relationship and were therefore rated as more facilitative, even if therapists' underlying attitudes were not significantly different. This proposition is supported by Bennun and Schindler's (1988) finding that client ratings of therapists' positive regard correlated strongly with their perceptions of their therapists' as providing active guidance. In a similar vein, Keisjers et al. (1991) found that clients' overall ratings of their therapists' facilitative attitudes correlated strongly with their perceptions of therapists as demonstrating active expertise. When one considers that one component of therapists' activity might involve the verbal and nonverbal expression of

their perceptions of the therapeutic interaction to the client, these findings may also lend support to the proposition that CB therapists were regarded as more facilitative than the others because they possessed better skills in communication. This proposition is congruent with Barrett-Lennard's (1986) view that therapists' ability to express their attitudes to their clients is an important mediating variable in the facilitative process.

Ultimately, the factors that, in the eyes of clients, differentiated the CB therapists from the others who participated in the study require further empirical investigation. In light of the relatively small sample of CB therapists (n= 2), the possibility exists that the present findings are not representative of therapists from this theoretical orientation as a whole. At any rate, further investigation of the factors that underlay clients' experiences of the therapeutic conditions, as they relate to therapists' personal characteristics and their approach to doing therapy, would be an important area of study, especially when one considers that Rogers (1957) regarded the client's experience as a pivotal component in successful psychotherapy.

Client and Therapist Trust and Client Improvement

An assertion of Rogerian theory that did not receive empirical support was that clients' trust in their therapists contributes to clients' global improvement in therapy. For both client and therapist ratings of client improvement, neither clients' generalized nor their specific trust was a significant predictor of client progress when the significant contribution of client symptomatology was taken into account. The finding that clients' symptomatic functioning predicted client improvement is,

perhaps, not surprising, given that one would expect assessments of client recovery to take their current level of adjustment into account. On the other hand, the finding that neither client nor therapist ratings of the facilitative attitudes predicted client improvement was more surprising in light of research which has demonstrated a positive, albeit irregular, association between the therapeutic conditions and therapy outcome (see review by Orlinsky & Howard, 1986). Overall, the results can be taken to indicate that, as important as clients' trust for their therapists and therapists' demonstration of warmth, empathy, and genuineness may be for the therapeutic relationship, they are not associated with the changes that clients make as a result of their involvement in therapy. It is important to note that client improvement was assessed during therapy and not at termination. While it is possible that factors that do or do not relate to client improvement when therapy is still in progress bear a similar relationship to therapy outcome, this speculation requires empirical validation. Nevertheless, additional, although less convincing, evidence that clients' trust for their therapists does not contribute to client improvement can be derived from the exploratory analyses which revealed that, after a mean of 43 sessions, clients' specific trust did not predict their level of symptomatology or their level of interpersonal adjustment (assuming that clients' scores on the generalized trust measure provided a valid assessment of the latter variable).

From the perspective of the therapist, a factor that did predict client global improvement was therapists' specific trust. It is difficult to account for this finding given that, according to Rogerian theory, any significant impact of therapist trust on

client change should be mediated by therapists' ability to establish a facilitative relationship with their clients and by clients' tendency to respond in a trusting manner. Evidence demonstrating the influential nature of these mediating variables was not obtained. One explanation for the unexpected prediction of client improvement by therapist trust might draw upon the argument that therapist and client trust indirectly reinforce one another. The causal direction between therapist trust and client improvement may have been the reverse of what would be implied in the regression analysis, and therapists may have been more likely to trust clients who, as a result of their trust in their therapists, were progressing in therapy. However, the correlations between therapist trust and client trust, and between therapist trust, client trust and either rating of client improvement were not significant. An alternative explanation might argue that therapists were exhibiting what social psychologists have labelled the "confirmation bias" (Taylor & Crocker, 1981) in that therapists who invested higher levels of trust in their clients may have been more likely than less trusting therapists to interpret changes in their clients' functioning as indicators of psychological growth. Empirical evidence that confirmatory biases influence the manner in which therapists test hypotheses regarding their clients' personal characteristics has been reported by Dallas and Baron (1985). Other studies, however, have reported contradictory results (Strohmer & Newman, 1983; Strohmer & Chiodo, 1984). Whether or not confirmatory biases influence therapists' perceptions of therapy outcome remains to be investigated.

Returning to the nonsignificant prediction of client global

improvement by client trust, this finding is incongruent with the consistent, positive association that prior research has demonstrated between clients' perception of their therapists' trustworthiness, a variable that relates closely to client trust, and a wide range of outcome criteria (see Table 2). Given that clients' trust for their therapists was assessed more directly in the current study, one would have anticipated similar, or, perhaps, even more convincing, results in the same direction. For this reason, an effort will be made to account for the nonsignificant findings by considering more closely the manner in which client progress was evaluated.

The rating scale that assessed client improvement was a single-item index of the overall degree of change clients had manifested since beginning therapy. Therapists' and clients' average ratings on this index indicated that clients had made substantial progress even though therapy had not yet terminated. The lower symptom status of clients in the present sample in comparison to clients in normative samples of psychiatric outpatients may have been a further indicator that significant change had taken place even at this point in therapy. It is possible, however, that client trust contributes most substantially to a specific type of client change and that the relatively simple ratings of global improvement did not adequately reflect this dimension of change.

According to Lambert et al. (1986), psychotherapy outcome research clearly demonstrates that therapeutic gain occurs on several dimensions. These authors argue that change on each of these dimensions needs to be assessed before the impact of a particular approach to therapy can be fully understood. For this

reason, they recommend that, whenever possible, a variety of instruments and rating perspectives be used to assess change in three primary areas of client adjustment: clients' intrapersonal functioning, their interpersonal functioning, and their ability to contribute to society as a whole. Lambert et al. (1986) recommend further, that global indices of progress be used sparingly and that more individualized indices of improvement be utilized that would reflect meaningful change in client's specific presenting problem in any one of these areas. They point out that global indices of improvement, have, in some studies, been more indicative of clients' final status at therapy termination than of the actual change in clients' condition that had taken place over the course of therapy.

Taking Lambert et al.'s (1986) recommendations into account, and considering the specific role that client trust is hypothesized by Rogerian theory to fulfil in the therapeutic endeavour, an aspect of client adjustment that may have been important to monitor more closely in the current study is the integrity with which they perceive their own behavioural and emotional processes. According to Rogerian theory, client trust, cultivated in the context of an empathic, genuine, and accepting relationship, liberates the client to engage in an active process of self-exploration that contributes first and foremost to a more integrated perception of the self. Thus, a more adequate, and theoretically meaningful, test of the therapeutic importance of client trust may have been attained if changes in clients' self-perceptions, rather than more global improvements, had been assessed. Indirect evidence that this assessment of change would have yielded significant results can be derived from the study

that was conducted by Dorn and Day (1984). Here, clients' perceptions of their therapists as trustworthy predicted positive changes in clients' self-concepts, as measured by the Tennesse Self-Concept Inventory at the beginning and end of therapy. In terms of Lambert et al.'s (1986) tri-partite categorization of change, improvements in self-concept fall in the intrapersonal realm. However, changes in client self-concept are regarded by Rogerian theory as the primary building blocks for improvements in other areas of functioning. For this reason, it is possible that precise estimates of change in clients' intrapersonal functioning would have related to more exact assessments of change in their functioning at interpersonal and societal levels as well. Overall, then, a multidimensional assessment of change, as it was conceived by Lambert et al. (1986), may have provided a better understanding of the impact that client trust, and indirectly therapists' facilitative attitudes, do or do not have on client adjustment than did the global estimate of improvement that was utilized in the current study.

Client and Therapist Trust, Treatment Duration, and Therapist Experience

Consistent with the hypotheses of the study and with theoretical formulations of interpersonal trust (Holmes, 1991; Johnson-George & Swap, 1982), therapists' and clients' trust for one another were related to the length of time over which they had interacted. Contrary to expectations, however, therapist trust correlated positively with the number of sessions whereas client trust correlated negatively with the number of sessions. One could hypothesize that the discrepant findings arise out of the different expectations that therapists and clients bring with them

as they enter into the therapeutic endeavour. Therapists, for example, may enter the therapeutic relationship, expecting, on the basis of their experience, that difficult and painful issues will be confronted. As they observe their clients successfully confronting and resolving these issues, their trust grows. Clients, on the other hand, may enter the relationship with an unrealistically high level of confidence in their therapists' "healing" ability and may subsequently lower their confidence level as they proceed in therapy and confront increasingly difficult issues. One could speculate further that the clients in the present sample, who, after an average of 43 sessions, had almost certainly confronted emotionally difficult issues yet maintained a relatively high level of trust, were able to do so because of their therapists' facilitative presence. Clearly, these speculations require empirical validation, especially since the cross-sectional design of the study prevents conclusions about the temporal development of trust in therapeutic dyads. Nevertheless, therapist and client expectations for how therapy will proceed and what can be accomplished through therapy have been cited as influential variables in therapy process and outcome by a number of researchers (Beutler, Crago, Arizmendi, 1986; Frank, 1959; Garfield, 1986; Goldstein, 1962). None, however, have specifically examined the association between these expectations and the development of client or therapist trust.

The dissimilar processes by which therapist and client trust appear to develop may also explain why they were not correlated with one another and, for this reason, did not appear to be mutually reinforcing. It is also possible that the study's relatively small sample size did not provide adequate power to

detect the association between therapist and client trust since they were hypothesized to reinforce one another only indirectly through the mediating influence of therapists' demonstration of the facilitative attitudes and client improvement.

With respect to the role of therapist experience in the development of therapist trust, it is difficult to discern why therapists' trust for other people in general correlated positively with their level of experience when their level of trust for individual clients did not. Again, the small sample size may have precluded detection of a significant association between therapist specific trust and therapist experience because, again, these variables were hypothesized to relate to one another indirectly. Therapist experience was postulated as contributing to therapists' generalized confidence that clients are capable of overcoming psychological difficulties. This generalized confidence, in turn, was hypothesized as contributing to therapists' trust for individual clients. The fact that the variables in the separate steps of this three-level process were significantly correlated offers some support for the hypothesized order of events even though an indirect association between therapist experience and therapist specific trust was not indicated. Finally, the small sample size may also account for the failure to uncover a significant association between therapist experience and clients' specific trust, given that client trust was also hypothesized to arise indirectly out of therapist experience through the mediating influence of therapists' specific trust and their demonstration of the facilitative attitudes.

The Facilitative Attitudes: Their Individual Contributions

The conclusions that can be drawn from the exploratory

analyses that compared the associations between therapist or client trust and each individual facilitative attitude are limited because of the multiple comparisons that were conducted, the disparate levels of reliability that pertained to each subscale measuring the therapeutic conditions, and the high degree of intercorrelation that existed among the subscales. Nevertheless, these analyses indicated that therapists' specific trust was a relatively strong predictor of therapist ratings of their level of regard for clients and a relatively weak predictor of therapist ratings of their unconditionality of regard, congruence, and empathic understanding. While Rogerian theory does not portray therapists' trust as underlying one or more of the facilitative attitudes to a greater degree than any others, the strong prediction of therapists' level of regard on the basis of therapist trust is perhaps not surprising when one considers the scales that were utilized to assess each of these variables. As discussed earlier, the index of therapist specific trust, while making particular reference to the therapist-client relationship, measured therapists' confidence that their clients are prone to behave in a responsible and positive manner in their relationship with others. The Level of Regard subscale was designed to assess therapists' overall affective response to their clients, be it positive or negative (Barrett-Lennard, 1986). Assuming that therapists' trust in their clients' social behaviour arises primarily out of their personal experiences with their clients, it makes intuitive sense that therapists' trust would predict therapists' personal response to their clients. To the extent that the Unconditionality of Regard subscale assesses the constancy of therapists' response, irrespective of their personal

experiences with their clients, the weaker association between this subscale and therapist trust also makes intuitive sense. Likewise, the connection between therapists' experience of their clients as more or less prone towards positive social behaviour and therapists' ability to understand their clients and interact with them in a genuine manner seems less direct, on an intuitive level, and may explain the weaker association between therapist specific trust and therapist genuineness and empathic understanding. With respect to the latter variable, it has already been suggested that the nonsignificant prediction of therapist empathy by therapist specific trust may also be related to the Empathy subscale's lower reliability in comparison to the other subscales completed by therapists. At any rate, had an index of therapist specific trust been utilized that focussed more extensively on therapists' confidence in their clients' ability to overcome psychological difficulties, one may have obtained a different pattern of results since this aspect of therapist trust may have been less contingent on the quality of therapists' personal experiences with their clients and more focussed on the actual work of therapy.

When clients' generalized trust served as the criterion variable, only therapist ratings of their level of regard and unconditionality of regard for clients contributed significantly to the negative prediction of client trust and then only a small amount. This substantiates the view that further research is required in order to understand the factors that underlie the anomalous, negative prediction of client generalized trust based on therapists' facilitative attitudes. Nevertheless, in light of the argument that the anomalous prediction indicates that clients

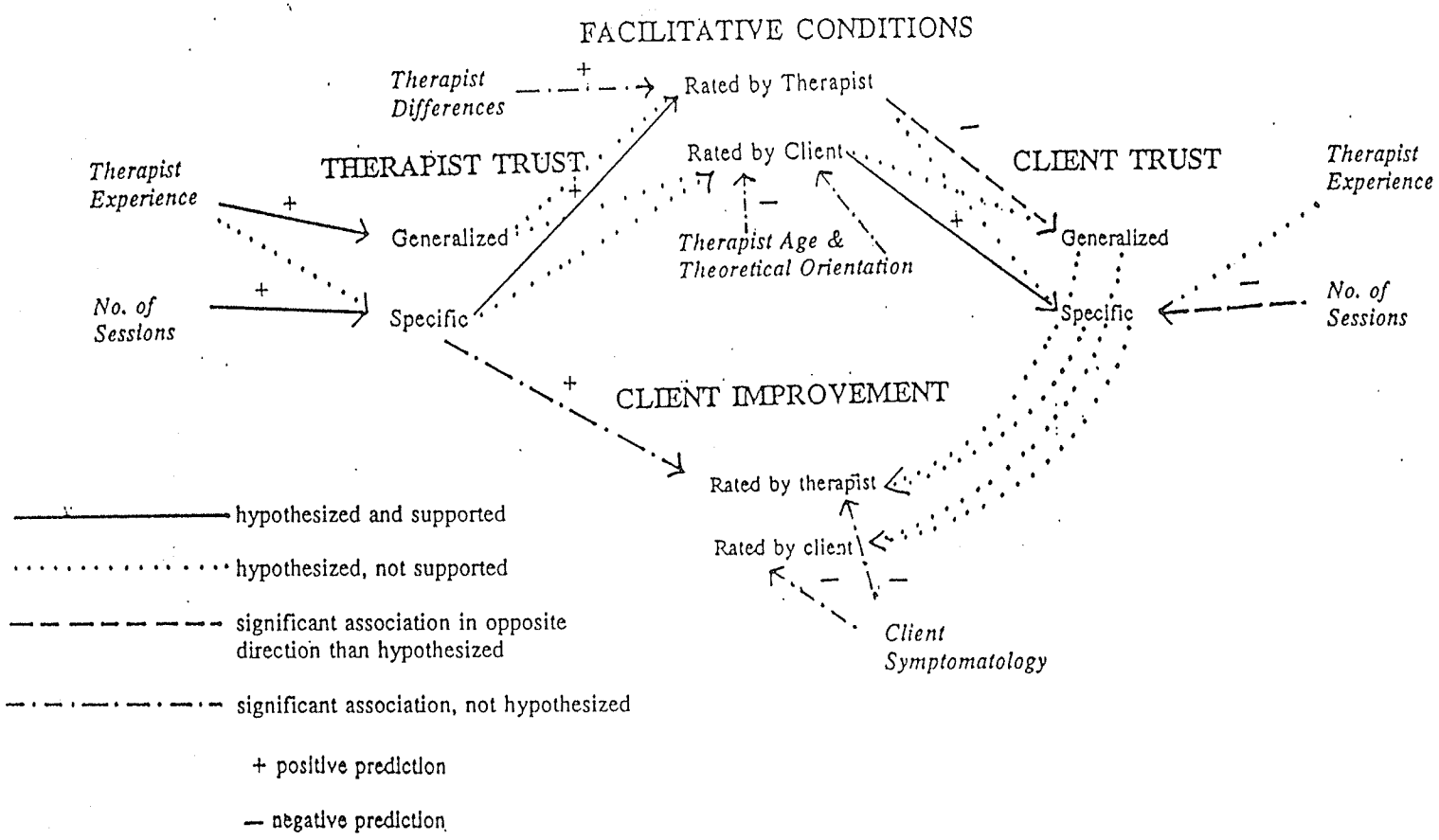
viewed the therapeutic relationship as different from their other relationships, these findings may suggest that therapists' unconditional acceptance of their clients, more so than their level of understanding or their genuine manner of relating, was the aspect of the therapeutic relationship that contrasted most sharply with clients' other interpersonal experiences. Given the alternative explanation for the atypical finding - that therapists worked harder at establishing a positive relationship with clients who came from a negative interpersonal environment - the findings may also indicate that, from the therapist's point of view, unconditional acceptance is more crucial to establishing such a relationship than are the other facilitative attitudes.

Finally, with respect to the prediction of clients' specific trust, client ratings of their therapists' level of regard, their unconditionality of regard, and empathy were more predictive of clients' trust for their therapists than were client ratings of therapist genuineness. Given that, in theory, clients' specific trust is hypothesized to be a direct contributor to therapeutic gain, these findings coincide with the review put forward by Orlinsky and Howard (1986) wherein, of the individual attitudes, therapist genuineness received the least consistent support with respect to its positive association with therapy outcome.

Summary of Conclusions and Implications for Theory and Practice

To summarize the major conclusions of the present investigation and to integrate them into a general understanding of therapy, a model of the therapeutic process is depicted in Figure 1. According to this model, therapists' specific trust for their clients is a significant predictor of therapists' experience of empathy, unconditional positive regard, and genuineness in

Figure 1. Summary of Major Conclusions



their relationship with clients. Therapists' trust in their clients is depicted as arising primarily out of the quality of their interactions with their clients over repeated sessions. In addition to therapists' trust for clients, other factors that differentiate individual therapists may relate to their experience of the therapeutic conditions. These factors, however, cannot be specified on the basis of the current findings. Though related to therapists' perception of their attitudinal stance in the therapeutic interaction, the findings suggest that therapist trust is not significantly related to clients' assessments of their therapists' attitudinal response. Here, other, as yet unspecified, factors associated with therapists' age and their theoretical orientation appear to play an important role. To the extent that clients do perceive their therapists as demonstrating the facilitative conditions, the model proposes that clients trust their therapists to remain with them throughout therapy, even though clients' trust may decrease somewhat as they proceed and confront increasingly difficult and painful issues. The negative prediction of client generalized trust by therapist ratings of relationship quality requires further clarification. However, it may indicate that clients' positive experiences in the therapeutic relationship increase their awareness of their negative experiences in other relationships. With respect to clients' specific trust for their therapists, it is not depicted in the model as contributing to client global improvement, whether rated by therapists or clients. Client trust may relate to other changes in client experience that were not assessed in the study. Finally, the model proposes that the extent to which therapists perceive clients as demonstrating improvement is related to

clients' symptomatic adjustment at the time that improvement is assessed. The findings also suggest that therapists' perception of their clients as making progress relates to the degree of trust therapists are willing to invest in their clients. For clients, their perception of themselves as making global improvements is related primarily to their current level of symptomatic functioning.

In terms of Rogerian theory, the findings depicted in Figure 1 are consistent with its most fundamental assertions. In general, the model places central importance on therapists' and clients' experience of each other in the therapeutic endeavour. More specifically, it emphasizes the role of trust in the therapeutic relationship by depicting a significant association between therapist and client trust and their perception of therapists as demonstrating genuineness, empathic understanding, and unconditional acceptance. The findings of the study expand the Rogerian view by suggesting that therapist variables other than their trust for clients also relate to therapists' experience of the facilitative attitudes. In addition, the findings suggest that greater importance should be placed on factors other than therapists' actual experiences of the facilitative attitudes that determine the level at which therapists' attitudes are perceived by clients. At the same time, Rogers'(1957) emphasis on the client's point of view demonstrates his recognition that therapists' experience of any or all of the therapeutic conditions does not presuppose their accurate communication or even their existence in the eyes of clients. With respect to the association between client trust and client improvement, the model of Figure 1 is tentative, given the nonsignificant results that were obtained

in this study. Further empirical investigations utilizing other indices of improvement would be required before Rogers' assertions about therapy outcome can be fully evaluated. Overall, the fact that the model is based on information obtained from a relatively diverse sample of therapists can be cited as evidence in support of Rogers' (1957; 1980) basic assertion that therapist and client trust are important aspects of any therapeutic endeavour, regardless of the therapists' theoretical orientation.

Several implications for the training and practice of psychotherapists can be derived from the findings of the study. Among these, greater awareness among therapists of their attitudinal stance towards their clients, particularly in terms of their assumptions regarding their clients' inherent trustworthiness, is encouraged. Given the important underlying influence that therapists' trust in their clients may play in therapists' demonstration of the facilitative attitudes, the study implies that training programs would do well to cultivate this attitude early on in the training process. This might be done by ensuring that student clinicians gain exposure to a wide range of clients and that they have adequate opportunity to observe other, perhaps more experienced, therapists interacting with clients of varying levels of disturbance in a manner that contributes to successful outcomes. In addition to cultivating the attitude of trust and the attitudes of empathy, unconditional positive regard, and genuineness, the present study also implies that therapists must constantly keep in mind that their own experiences in the therapeutic relationship do not necessarily coincide with those of the client. Because, in theory, clients', rather than therapists', experiences ultimately determine the outcome of

therapy, the study implies further that clinicians may benefit from instruction in how their attitudes can be communicated such that they would contribute to their client's experience. Again, skills in communication might be learned through individual practice and through direct observation.

Methodological Limitations of the Study

Several aspects of the study's methodology limit the conclusions that can be drawn from it's findings. First, support for a causal model of the linkages between therapist or client trust and therapists' demonstration of the facilitative attitudes or client improvement is tentative because of the study's cross-sectional, correlational design. A time-series design with repeated assessments of the therapeutic relationship and client improvement from beginning to end of therapy would provide a better understanding of the manner in which these variables interact and the factors that contribute to their development across time. In the event that continuous assessments of client improvement are not possible, evaluation of client improvement at therapy termination rather than when therapy is still in progress, would, in and of itself, enhance the study's suitability for commenting on the overall effect that the therapeutic relationship has on client functioning.

A second aspect of the study's methodology that should be considered is the self-report method by which therapists' and clients' perceptions of their interaction were assessed. The possibility that systematic biases unrelated to therapists' and clients' actual experiences in the therapeutic relationship confounded their ratings has already been discussed. Another limitation posed by the self-reported database is that the study,

though appropriately designed to comment on therapists' and clients' self-reported experiences in the therapeutic endeavour, can provide relatively little insight into more objective components of the interaction including the manner in which therapists' and clients' experiences were or were not outwardly communicated to one another. According to Barrett-Lennard (1986), the communicative elements of the therapeutic process are assessed most appropriately by independent observers.

The third and perhaps most obvious aspect of the study's methodology that limits its generalizability is the manner in which therapists and clients were selected to participate in the study. In accordance with the ethical guidelines set out by the Canadian Psychological Association (CPA, 1986), therapists and clients were asked to take part in the study on a voluntary basis and therapists were instructed to solicit the participation of only those clients whose involvement would not hinder their progress in therapy. This nonrandom recruitment procedure may have introduced a "selection bias" into the study by yielding a sample of therapists and clients who perceived each other and the therapeutic endeavour in primarily positive terms. The selection of a positively biased sample implies that generalization of the results is limited to clients and therapists whose relationships are basically intact. Indeed, one could argue that the assertion regarding the positive impact of therapist and client trust on the therapeutic endeavour was not adequately tested because low-trusting therapists and clients did not participate in the study. In this respect, the study encountered a problem opposite to the one that, according to Mitchell et al. (1977), limited the implications that could be drawn from early studies on the

facilitative conditions which utilized samples of therapists, who in absolute terms, could not be considered minimally facilitative. While one could speculate that a more inclusive sample would have yielded similar, and perhaps even more convincing support for the Rogerian hypotheses, than did the sample in the present investigation, this speculation would require empirical validation. Contrary to the Rogerian assumptions, it is possible that, when working with highly disturbed clients, lower levels of therapist trust, and hence greater directiveness in therapy, would actually produce greater overall improvement. Similarly, it is possible that for clients whose primary problem manifests itself in an excessive dependence on other people, lower levels of client trust in the therapeutic relationship would actually coincide with psychological growth. At the same time, it is difficult to imagine that extremely low levels of trust on the part of either participant in a therapeutic dyad would contribute to therapeutic gain, regardless of the client's presenting problem or level of disturbance.

Another limitation, which may also be a result of selection bias, stems from the fact that participating clients were predominantly female and were engaged in relatively long-term therapy. Although client gender did not relate significantly to any of the variables of interest, greater representation on the part of male clients may have yielded a different pattern of results. In addition, the fact that client and therapist trust were related to the number of sessions over which therapists and clients had been interacting raises the possibility that different findings may have been obtained if the study had included a greater number of therapeutic dyads who were interacting on a

short-term basis. At any rate, the conclusions that can be drawn must be limited to therapeutic dyads consisting of therapists working with predominantly female clients on a long-term basis.

As a final note, the selection bias in the present investigation was, to some extent, unavoidable due to the ethical concerns that were involved in recruiting participants for the study (CPA, 1986). The limitations introduced into the study by the selection bias, however, may have been offset by the fact that experienced therapists working in a variety of clinical settings were included in the sample. Whereas much of the prior research on the facilitative attitudes and on the psychotherapeutic process in general has been based on the work of student clinicians practising at university counselling centres, the sample of therapists and clients who participated in the present study might be considered more representative of the general psychotherapeutic population.

Directions for Future Research

Numerous recommendations for future research follow from the current study. To begin with, the study needs to be replicated so as to ensure the reliability of its major findings. Given the relatively large number of comparisons that were conducted, a replication of the study's unexpected findings, such as the negative prediction of clients' generalized trust based on therapist ratings of the facilitative attitudes, would be especially important in order to verify that they were valid occurrences. At the same time, a replication of the nonsignificant results would increase confidence that these findings were also valid. However, a second administration of the current methodology using a larger sample and more suitable

indices of therapist and client trust may, in fact, yield greater support for the present hypotheses. Of course, the development of a reliable and valid measure of therapist and client trust, as they are conceived by Rogers (1951; 1961; 1980), comprises an important area of study in and of itself.

As indicated earlier, a better understanding of the causal relationships in the therapeutic process would be afforded by a time-series design characterized by repeated assessments of the therapeutic relationship from therapy inception to therapy termination. Depending on the factors that are assessed, this procedure could also provide valuable insight into how therapists' and clients' underlying attitudes influence their interaction. For example, consideration could be given to clients' internalization over time, or lack thereof, of therapists' attitudes of trust, empathy, genuineness, and unconditional positive regard.

The fact that relationship quality and client improvement were assessed from the perspective of both therapists and clients is a strength of the current study. However, in accordance with Lambert et al.'s (1978) recommendations, future research would provide a more comprehensive understanding of the impact of therapist or client trust on the therapeutic process by considering objective observer ratings of the therapeutic interaction as well. As was alluded to above, objective observer ratings could provide valuable insight into the specific verbal and nonverbal behaviours by which therapists' and clients' underlying attitudes are outwardly expressed. The importance of investigating these variables and their relative neglect in the empirical literature was identified by Gurman as early as 1977.

Therapist and client perceptions of each other's verbal and nonverbal behaviours would also be useful in this regard. In addition, further investigation of the phenomenology of each perspective and the biases that systematically influence the ratings that are made from the three viewpoints would enhance understanding of the factors that underlie their lack of concordance in this and other studies (e.g., Barrett-Lennard, 1962; Gurman, 1977; LaCrosse, 1977). In relation to this, data have already been collected on therapists' and clients' perceptions of each other's trust (e.g., the therapist's perception of the client's trust in the therapist and vice versa). It is possible that incorporation of this information as well as data on therapists' and clients' metaperceptions of their relationship into the current research model would yield greater levels of concordance between the two perspectives and would determine the extent to which therapists and clients are aware of each other's experiences even if they are uniquely different from their own.

Given the nonsignificant association between client trust and client global improvement, future studies could examine other outcome variables that may relate more directly to client trust. Positive change in client self-concept has already been suggested as one example. Here again, an assessment of change as it occurs across time and particularly as it manifests itself at therapy termination would be recommended.

Finally, research in the area of client and therapist trust would benefit from examining these variables in the context of a more diverse sample of therapeutic dyads. Greater variability in the sample might be attained by recruiting therapists who are

working with more disturbed clients on an inpatient basis, provided that voluntary participation and minimum interference with the therapeutic process could be assured. In addition, an effort might be made to achieve greater representation on the part of therapists and clients working together for only a limited period of time.

In closing, the current investigation, being one of the first to empirically test fundamental aspects of a very influential approach to therapy, opens a promising new area of research. Limitations notwithstanding, the study supports the client-centered emphasis on trust in the therapeutic relationship by demonstrating a strong association between therapists' trust in their clients and therapists' attitudes of empathy, genuineness, and unconditional positive regard, and by demonstrating a strong association between therapists' attitudinal stance and clients' trust in their therapists. The nature of these associations, however, was more complicated than anticipated, primarily because rater perspective and several covariates played an important role in the overall pattern of results. Replication and further refinement of the study's methodology would aid to clarify the implications of these and other findings. The association between client or therapist trust and client improvement also needs empirical clarification. Thus, several avenues of research are suggested by the study's findings, all of which could potentially contribute to a better understanding of the successful therapeutic endeavour.

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Appendix A
Therapist Recruitment Letter

Wiebke Peschken
Department of Psychology
University of Manitoba
Winnipeg, Manitoba
R3T 2N2
August 21, 1992

Dr. So-and-so
street address
city, province
postal code

Dear Dr. So-and-so,

I am presently enroled in the Clinical Psychology Training Program at the University of Manitoba. I am in the process of developing a study for my Masters' thesis which will examine the manner in which therapists' relationship with their clients contributes to the therapeutic process. I would very much like to utilize a sample of experienced therapists in my study and am therefore writing to request your participation.

Realizing that your time is limited, I have sought to minimize the amount of time that participation in the study would require. Therapists who agree to take part would be asked to complete one short questionnaire which focuses on therapists' general attitudes and feelings towards other people, and three questionnaires which assess more specific attitudes and perceptions you have towards a particular client. Together, the four questionnaires are estimated to take no more than 30 minutes per client to complete and would be filled out after a minimum of 5 sessions with the client in question.

I would also like to measure clients' perceptions of the relationship and, for this reason, your participation would also involve asking clients to take part in the study. Again, the time required for clients' participation is kept to a minimum. After a minimum of 5 sessions in therapy, they would be asked to complete one short questionnaire assessing their general attitudes towards others, three questionnaires pertaining to their perceptions of the therapeutic relationship and their level of improvement as a result of therapy, and one measure of their psychological adjustment. It is estimated that the total amount of time that would be required by clients to participate would be less than 40 minutes. While I would like to maximize the number of clients participating in the study, the number that you ask to take part would be left to your discretion. For this reason, the total amount of time that you would be committing to the study would also be left to your discretion since it would depend on the number of clients that you approach and the number that agree to participate.

An important component of the study will be the assurance of confidentiality and the acquisition of informed consent for both therapists and clients. Prior to their participation, therapists and clients will be asked to sign a consent form which will delineate the general purpose of the study and the exact nature of their involvement. At no point in the study will clients or

therapists be requested to indicate their names on the questionnaires since code numbers, known only by myself and my supervisor, will be utilized for purposes of identification. Also, identifying information with respect to clients, therapists, and clinics, etc. will be omitted from any written report of the study. In order to obtain honest and carefully considered responses on the questionnaires, I feel it is important to assure clients that their therapists will not have access to their responses. While you would be welcome to look over any measures that would be used in the study prior to their completion, clients would be requested to mail the completed questionnaires in stamped, self-addressed envelopes (provided by myself) directly to me. In a similar vein, clients will not have access to their therapists' responses to the questionnaires. No aspect of the study will be used as a means of job evaluation by employers or other individuals.

The study will be completed under the supervision of Dr. Marianne Johnson who is an Assistant Professor in clinical psychology at the University of Manitoba and has obtained C. Psych. certification. My other committee members are Dr. David Martin, Director of Clinical Training in the department of psychology, and Mr. Walter Driedger, Associate Professor in the faculty of social work. In addition, the study will be approved by the Department of Psychology Human Ethical Review Committee. It is anticipated that data collection will begin in the fall of 1992 and be completed by the end of December, 1992.

Please consider your involvement in this study carefully as your participation would be greatly appreciated. Unfortunately, I am not in a position to offer a monetary reward for participants, however I would be more than willing to share my findings with you and/or your clients in either a written or presented form once the study is completed.

Since I am presently in the process of developing a detailed account of the research proposal, I need to have an approximate idea of the number of therapists and clients that would be willing to participate in the study. For this reason I will be contacting you in the next two weeks in order to determine your level of interest in taking part. I realize that it would be difficult for you, at this point, to know how many of your clients would be willing to participate in the fall, however, I would appreciate it if you could give an estimate of the number of clients that you are presently working with that you would be willing to approach and the number that you think would be willing to take part.

Thank you very much for your time and consideration. If you have any questions regarding the study, please do not hesitate to write or call me. I will return messages left for me through the Department of Psychology at 474-9338 or you can contact me directly at 275-1858.

I am looking forward to talking with you soon.

Sincerely,

Wiebke Peschken

Appendix B
Trust/Confidence Attachment Scale

Instructions: The following statements concern how you feel in relationships with other people. We are interested in how you generally experience relationships, not just in what is happening in any one current relationship. Please try to answer each question carefully. Respond to each statement by indicating how much you agree or disagree with it. Circle a letter or letter-pair to indicate which of the following best describes your feelings: DS = disagree strongly; D = disagree; d = disagree slightly; m = mixed, not sure; a = agree slightly, A = agree moderately; AS = agree strongly.

DS	D	d	m	a	A	AS
Disagree Strongly	Disagre moderately	disagree slightly	mixed, not sure	agree slightly	Agree moderately	Agree Strongly
1 . . .	2 . . .	3 . . .	4 . . .	5 . . .	6 . . .	7

1. I find it easy to trust others.

DS 1 . . . D 2 . . . d 3 . . . m 4 . . . a 5 . . . A 6 . . . AS 7

2. I think most people are trustworthy.

DS 1 . . . D 2 . . . d 3 . . . m 4 . . . a 5 . . . A 6 . . . AS 7

3. It's easy for me to trust romantic partners.

DS 1 . . . D 2 . . . d 3 . . . m 4 . . . a 5 . . . A 6 . . . AS 7

4. You can't trust most people.

DS 1 . . . D 2 . . . d 3 . . . m 4 . . . a 5 . . . A 6 . . . AS 7

5. Most people are well-intentioned and good-hearted.

DS 1 . . . D 2 . . . d 3 . . . m 4 . . . a 5 . . . A 6 . . . AS 7

6. It's best to be cautious in dealing with most people.

DS 1 . . . D 2 . . . d 3 . . . m 4 . . . a 5 . . . A 6 . . . AS 7

7. I find it difficult to depend on others.

DS 1 . . . D 2 . . . d 3 . . . m 4 . . . a 5 . . . A 6 . . . AS 7

8. Often, just when you think you can depend on someone, the person doesn't come through.

DS		D		d		m		a		A		AS
1	. . .	2	. . .	3	. . .	4	. . .	5	. . .	6	. . .	7

9. It's risky to open up to another person.

DS		D		d		m		a		A		AS
1	. . .	2	. . .	3	. . .	4	. . .	5	. . .	6	. . .	7

10. My romantic partners have generally been trustworthy.

DS		D		d		m		a		A		AS
1	. . .	2	. . .	3	. . .	4	. . .	5	. . .	6	. . .	7

*****

Appendix C

Dyadic Trust Scale

Appendix C.1 - Therapist's Trust in Client

Client's Initials _____

This is a questionnaire to determine the attitudes and feelings you have in your relationship with your client. We are interested in your relationship as it is, not in the way you think it should be. Thus, there are no "right" and "wrong" answers. Please be honest and truthful in all your answers to the statements.
Please circle one answer for each statement. Please answer every statement.

ANSWERS:
VSA - Very Strongly Agree
SA - Strongly Agree
MA - Mildly Agree
N - Neutral
MD - Mildly Disagree
SD - Strongly Disagree
VSD - Very Strongly Disagree

VSA	SA	MA	N	MD	SD	VSD	1. My client is primarily interested in his/her own welfare.
VSA	SA	MA	N	MD	SD	VSD	2. There are times when my client cannot be trusted.
VSA	SA	MA	N	MD	SD	VSD	3. My client is perfectly honest and truthful with me.
VSA	SA	MA	N	MD	SD	VSD	4. I feel that I can trust my client completely.
VSA	SA	MA	N	MD	SD	VSD	5. My client is truly sincere in his/her promises.
VSA	SA	MA	N	MD	SD	VSD	6. I feel that my client does not show me enough consideration.
VSA	SA	MA	N	MD	SD	VSD	7. My client treats me fairly and justly.
VSA	SA	MA	N	MD	SD	VSD	8. I feel that my client can be counted on to help me.

*****

Appendix C.2 - Client's Trust in Therapist

This is a questionnaire to determine the attitudes and feelings you have in your relationship with your therapist. We are interested in your relationship as it is, not in the way you think it should be. Thus, there are no "right" and "wrong" answers. Please be honest and truthful in all your answers to the statements.
Please circle one answer for each statement. Please answer every statement.

ANSWERS:
VSA - Very Strongly Agree
SA - Strongly Agree
MA - Mildly Agree
N - Neutral
MD - Mildly Disagree
SD - Strongly Disagree
VSD - Very Strongly Disagree

VSA	SA	MA	N	MD	SD	VSD	1. My therapist is primarily interested in his/her own welfare.
VSA	SA	MA	N	MD	SD	VSD	2. There are times when my therapist cannot be trusted.
VSA	SA	MA	N	MD	SD	VSD	3. My therapist is perfectly honest and truthful with me.
VSA	SA	MA	N	MD	SD	VSD	4. I feel that I can trust my therapist completely.
VSA	SA	MA	N	MD	SD	VSD	5. My therapist is truly sincere in his/her promises.
VSA	SA	MA	N	MD	SD	VSD	6. I feel that my therapist does not show me enough consideration.
VSA	SA	MA	N	MD	SD	VSD	7. My therapist treats me fairly and justly.
VSA	SA	MA	N	MD	SD	VSD	8. I feel that my therapist can be counted on to help me.

*****

Appendix C.3 - Therapist's Perception of Client's Trust

Client's Initials _____

This questionnaire is similar, but slightly different from the previous one. It is concerned with how you think **YOUR CLIENT** has perceived **YOU** over the course of your relationship in therapy. Again, we are interested in your relationship as it is, not in the way you think it should be. Remember that there are no "right" and "wrong" answers. Please be honest and truthful in all your answers to the statements.
Please circle one answer for each statement. Please answer every statement.

ANSWERS:
VSA - Very Strongly Agree
SA - Strongly Agree
MA - Mildly Agree
N - Neutral
MD - Mildly Disagree
SD - Strongly Disagree
VSD - Very Strongly Disagree

VSA	SA	MA	N	MD	SD	VSD	1. My client feels that I am primarily interested in my own welfare.
VSA	SA	MA	N	MD	SD	VSD	2. There are times when my client feels that I cannot be trusted.
VSA	SA	MA	N	MD	SD	VSD	3. My client feels that I am perfectly honest and truthful with him/her.
VSA	SA	MA	N	MD	SD	VSD	4. My client feels that he/she can trust me completely.
VSA	SA	MA	N	MD	SD	VSD	5. My client feels that I am truly sincere in my promises.
VSA	SA	MA	N	MD	SD	VSD	6. My client feels that I do not show him/her enough consideration.
VSA	SA	MA	N	MD	SD	VSD	7. My client feels that I treat him/her fairly and justly.
VSA	SA	MA	N	MD	SD	VSD	8. My client feels that I can be counted on to help him/her.

Appendix C.4 - Client's Perception of Therapist's Trust

This questionnaire is similar, but slightly different from the previous one. It is concerned with how you think **YOUR THERAPIST** has perceived **YOU** over the course of your relationship in therapy. Again, we are interested in your relationship as it is, not in the way you think it should be. Remember that there are no "right" and "wrong" answers. Please be honest and truthful in all your answers in the statements.
Please circle one answer for each statement. Please answer every statement.

ANSWERS:
VSA - Very Strongly Agree
SA - Strongly Agree
MA - Mildly Agree
N - Neutral
MD - Mildly Disagree
SD - Strongly Disagree
VSD - Very Strongly Disagree

VSA	SA	MA	N	MD	SD	VSD	1. My therapist feels that I am primarily interested in my own welfare.
VSA	SA	MA	N	MD	SD	VSD	2. There are times when my therapist feels that I cannot be trusted.
VSA	SA	MA	N	MD	SD	VSD	3. My therapist feels that I am perfectly honest and truthful with him/her.
VSA	SA	MA	N	MD	SD	VSD	4. My therapist feels that he/she can trust me completely.
VSA	SA	MA	N	MD	SD	VSD	5. My therapist feels that I am truly sincere in my promises.
VSA	SA	MA	N	MD	SD	VSD	6. My therapist feels that I do not show him/her enough consideration.
VSA	SA	MA	N	MD	SD	VSD	7. My therapist feels that I treat him/her fairly and justly.
VSA	SA	MA	N	MD	SD	VSD	8. My therapist feels that I can be counted on to help him/her.

*****

Appendix D.1

Relationship Inventory - MO Form

Code or name: ..... Today's date: .....

BARRETT-LENNARD RELATIONSHIP INVENTORY–Form MO–64

Below are listed a variety of ways that one person may feel or behave in relation to another person.

Please consider each statement with reference to your present relationship with _____, mentally adding his or her name in the space provided. If, for example, the other person's name was John, you would read the first statement as "I respect *John* as a person".

Mark each statement in the left margin, according to how strongly you feel that it is true, or not true, in this relationship. Please be sure to mark every one. *Write in a plus number (+3, +2, or +1) when your answer is affirmative, and a minus number (-1, -2, or -3) when your answer is a 'no'.* Here is the exact meaning of each answer number:–

+3: Yes(!), *I strongly feel that it* is true.

+2: Yes, *I feel it is true.*

+1: (Yes) *I feel that it is probably true, or more true than untrue.*

-1: (No) *I feel that it is probably untrue, or more untrue than true.*

-2: No, *I feel it is not true.*

-3: No(!), *I strongly feel that it is* not true.

_____ 1. I respect _____ as a person.

_____ 2. I want to understand how _____ sees things.

_____ 3. The interest I feel in _____ depends on what he/she says and does.

_____ 4. I feel at ease with _____.

_____ 5. I really like _____.

_____ 6. I understand _____'s words but do not know how he/she actually feels inside.

_____ 7. Whether _____ is feeling happy or unhappy with him/herself does not change *my* feeling toward him/her.

_____ 8. I am inclined to put on a role or front with _____.

_____ 9. I do feel impatient with _____.

_____ 10. I nearly always know exactly what _____ means.

_____ 11. Depending on _____'s actions, I have a better opinion of him/her sometimes than I do at other-times.

_____ 12. I feel that I am genuinely myself with _____.

_____ 13. I appreciate _____, as a person.

_____ 14. I look at what _____ does from my own point of view.

_____ 15. The way I feel about _____ doesn't depend on his/her feelings toward me.

_____ 16. It bothers me when _____ tries to ask or talk about certain things.

_____ 17. I feel indifferent to _____.

_____ 18. I usually sense or realise how _____ is feeling.

_____ 19. I would like _____ to be a particular kind of person.

_____ 20. When I speak to _____ I nearly always can say freely just what I'm thinking or feeling at that moment.

_____ 21. I find _____ rather dull and uninteresting.

_____ 22. My own feelings can stop me understanding _____.

(Continues.....Page 2)

_____ 23. Whether _____ criticises me or shows appreciation of me does not (or, would not) change how I feel inside toward him/her.

_____ 24. I would rather that _____ *think* I like or understand him/her even when I don't.

_____ 25. I *care* for _____ .

_____ 26. Sometimes I think that _____ feels a certain way, because that's the way I feel myself.

_____ 27. I like _____ in some ways, while there are other things about him/her that I do not like.

_____ 28. I don't feel that I have been ignoring (or putting off) anything that is important for our relationship.

_____ 29. I do feel disapproval of _____ .

_____ 30. I can tell what _____ means, even when he/she has difficulty in saying it.

_____ 31. My feeling toward _____ stays about the same; I am not in sympathy with him/her one time and out of patience another time.

_____ 32. Sometimes I am not at all comfortable with _____ but we go on outwardly ignoring it.

_____ 33. I put up with _____.

_____ 34. I usually catch and understand the whole of _____'s meaning.

_____ 35. If _____ gets impatient or mad at me I become angry or upset too.

_____ 36. I am able to be sincere and direct in whatever I express with _____.

_____ 37. I feel friendly and warm toward _____.

_____ 38. I ignore some of _____ 's feelings.

_____ 39. My liking or disliking of _____ is not altered by anything that he (she) says about himself (herself).

_____ 40. At times I just don't know, or don't realise until later, what my feelings are with _____ .

_____ 41. I value our relationship.

_____ 42. I appreciate just how _____'s experiences feel to him/her.

_____ 43. I feel quite pleased with _____ sometimes, and then he/she disappoints me at other times.

_____ 44. I feel comfortable to express what is in my mind with _____, including any feelings about myself or about him/her.

_____ 45. I really don't like _____ as a person.

_____ 46. At times I *think* that _____ feels strongly about something and then it turns out that he/she doesn't.

_____ 47. Whether _____ is in good spirits, or is bothered and upset, does not make me less or more appreciative of him/her.

_____ 48. I can be quite openly myself in our relationship.

_____ 49. Somehow _____ really irritates me (gets 'under my skin').

_____ 50. At the time, I don't realise how touchy or sensitive _____ is about some of the things we discuss.

_____ 51. Whether _____ is expressing "good" thoughts and feelings, or "bad" ones, does not affect the way I feel toward him/her.

(Continues.....Page 3)

_____ 52. There are times why my outward response to_____ is quite different from the way I feel underneath.

_____ 53. In fact, I feel contempt toward _____.

_____ 54. I understand _____.

_____ 55. Sometimes _____ seems to me a more worthwhile person than he/she does at other times.

_____ 56. I don't sense any feelings in relation to _____ that are hard for me to face and admit to myself.

_____ 57. I truly am interested in _____.

_____ 58. I often respond to _____ rather automatically, without taking in what he/she is experiencing.

_____ 59. I don't think that particular things _____ says or does alter the way I feel toward him (her).

_____ 60. What I say to _____ often would give a wrong impression of my full thought or feeling at the time.

_____ 61. I feel deep affection for _____.

_____ 62. When _____ is hurt or upset I can recognise just how he/she feels, *without* getting upset myself.

_____ 63. What other people think and feel about _____ does help to make *m e* feel as I do toward him/her.

_____ 64. I feel there are things we don't talk about that are causing difficulty in our relationship.

Please add the following information about yourself and the other person:

	Myself	*Other*
Age:	_____ years	_____ years (known or estimated)
Sex:	_____ (M or F)	_____(M or F)
Occupation:	_____	_____

Your Marital Status_____

Positions in this relationship

Examples:	Mother	<—/—>	Son
	Counsellor	<—/—>	Client
	Personal Friend	<—/—>	Personal Friend
Actual:			
(Please fill in)	_____	<—/—>	_____

This printing on 16 Jun 1991

Appendix D.2

Relationship Inventory - OS Form

Code or name: ..... Today's date: .....

BARRETT-LENNARD RELATIONSHIP INVENTORY- Form OS--64

Below are listed various ways that one person might feel or behave in relation to another person. Please consider each numbered statement with reference to your present relationship with _____, mentally adding his or her name in the space provided. For example, if the other person's name was John, you would read statement #1, as "John respects me as a person".

Mark each statement in the answer column on the right, according to how strongly you feel that it is true, or not true, in this relationship. *Please be sure to mark every one.* Write in a plus number *(+3, +2, or +1)* for each 'yes' answer, and minus numbers *(-1, -2, or -3)* to stand for 'no' answers. Here is the exact meaning of each answer number:-

+3:	Yes (!), *I strongly feel that it* is true.	*-1:*	(No) *I feel that it is probably untrue, or more untrue than true.*
+2:	Yes, *I feel it is true.*	*-2:*	No, *I feel it is not true.*
+1:	(Yes) *I feel that it is probably true, or more true than untrue.*	*-3:*	No(!), *I strongly feel that it is* not true.

ANSWER

1. _____ respects me as a person. .....
2. _____ wants to understand how I see things. .....
3. _____'s interest in me depends on the things I say or do. .....
4. _____ is comfortable and at ease in our relationship. .....
5. _____ feels a true liking for me. .....
6. _____ may understand my words but he/she does not see the way I feel. .....
7. Whether I am feeling happy or unhappy with myself makes no real difference to the way _____ feels about me. .....
8. I feel that _____ puts on a role or front with me. .....
9. _____ is impatient with me. .....
10. _____ nearly always knows exactly what I mean. .....
11. Depending on my behaviour, _____ has a better opinion of me sometimes than he/she has at other times. .....
12. I feel that _____ is real and genuine with me. .....
13. I feel appreciated by _____. .....
14. _____ looks at what I do from his/her own point of view. .....
15. _____ 's feeling toward me doesn't depend on how I am feeling toward him/her. .....
16. It makes _____ uneasy when I ask or talk about certain things. .....
17. _____ is indifferent to me. .....
18. _____ usually senses or realises what I am feeling. .....
19. _____ wants me to be a particular kind of person. .....
20. I feel that what _____ says expresses exactly what he/she is feeling and thinking at that moment. .....
21. _____ finds me rather dull and uninteresting. .....
22. _____'s own attitudes toward things I do or say prevent him/her from understanding me. .....

Please turn to page 2

Relationship Inventory Form OS--64 - *Page 2*

- Answer choices -

+3: Yes(!). *I strongly feel that it is true.*

+2: Yes. *I feel it is true.*

+1: (Yes) *I feel that it is probably true, or more true than untrue.*

-1: (No) *I feel that it is probably untrue, or more untrue than true.*

-2: No. *I feel it is not true.*

-3: No(!). *I strongly feel that it is* not true.

ANSWER

23. I can be (could be) openly critical or appreciative of _____ without making him/her feel differently about me. _____

24. _____ wants me to think that he/she likes or understands me more than he/she really does. _____

25. _____ cares for me. _____

26. Sometimes _____ thinks that *I* feel a certain way, because that's the way *he/she* feels. _____

27. _____ likes certain things about me, and there are other things he/she does not like in me. _____

28. _____. does not avoid anything that's important for our relationship. _____

29. I feel that _____ disapproves of me. _____

30. _____ realises what I mean even when I have difficulty saying it. _____

31. _____'s attitude toward me stays the same: he/she is not pleased with me sometimes and critical or disappointed at other times. _____

32. Sometimes _____ is not at all comfortable but we go on, outwardly ignoring it. _____

33. _____ just tolerates me. _____

34. _____ usually understands the whole of what I mean. _____

35. If I show that I am angry with _____ he/she becomes hurt or angry with me, too. _____

36. _____ expresses his/her true impressions and feelings with me. _____

37. _____ is friendly and warm with me. _____

38. _____ just takes no notice of some things I think or feel. _____

39. How much _____ likes or dislikes me is not altered by anything that I tell him/her about myself. _____

40. At times I sense that _____ is not aware of what he/she is really feeling with me. _____

41. I feel that _____ really values me. _____

42. _____ appreciates exactly how the things I experience feel to me. _____

43. _____ approves of me sometimes, or in some ways, and plainly disapproves of me at other times/in other ways. _____

44. _____ is willing to express whatever is actually in his (her) mind with me, including personal feelings about himself (herself) or me. _____

45. _____ doesn't like me for myself. _____

46. At times _____ thinks that I feel a lot more strongly about a particular thing than I really do. _____

47. Whether I happen to be in good spirits or feeling upset does not make _____ feel any more or less appreciative of me. _____

48. _____ is openly himself/herself in our relationship. _____

Please turn to page 3

Answer choices as shown on previous pages

ANSWER

49. I seem to irritate and bother _____. _____
50. _____ does not realise how sensitive I am about some things we discuss.. _____
51. Whether the ideas and feelings I express are "good" or "bad" seems to make no difference to _____'s feeling toward me. _____
52. There are times when I feel that _____'s outward response to me is quite different from the way he/she feels underneath. _____
53. _____ feels contempt for me. _____
54. _____ understands me. _____
55. Sometimes I am more worthwhile in _____'s eyes than I am at other times. _____
56. _____ doesn't hide from himself (herself) anything that he (she) feels with me. _____
57. _____ is truly interested in *me*. _____
58. _____'s response to me is usually so fixed and automatic that I don't really get through to him/her. _____
59. I don't think that anything I say or do really changes the way _____feels toward me. _____
60. What _____ says to me often gives a wrong impression of his/her total thought or feeling at the time. _____
61. _____ feels deep affection for me. _____
62. When I am hurt of upset _____ can recognise my feelings exactly, without becoming upset too. _____
63. What *other* people think of me does (or would, if he/she knew) affect the way _____ feels toward me. _____
64. I believe that _____ has feelings he/she does not tell me about that are causing difficulty in our relationship. _____

Additional Information*

Please fill in the spaces below, about yourself and the other person

	Myself	*Other*
Age:	_____ years	_____ years (known or estimated)
Sex:	_____(M or F)	_____(M or F)
Occupation:	_____	_____

Your Marital Status_____

--Positions in this relationship--

	Mother	<—/—>	Son
Examples:	Counsellor	<—/—>	Client
	Friend	<—/—>	(Best) Friend
Actual: *(Please fill in)*	_____	<—/—>	_____

Thank you for filling in this questionnaire!

*Additional Information items are not part of the RI proper, and may be varied --GTB-L)

Appendix E.1
Global Outcome Rating - Therapist Form

Client's Initials _____

How much improvement or change has there been in how the patient is feeling or getting along since beginning therapy?

+5_____ Very greatly improved

+4_____

+3_____ Moderately improved

+2_____

+1_____ Slightly improved

0_____ No change

-1_____ Slightly worse

-2_____

-3_____ Moderately worse

-4_____

-5_____ Very much worse

*****

Appendix E.2
Global Outcome Rating - Patient Form

How much improvement or change has there been in how you are feeling or getting along since beginning therapy?

+5_____ Very greatly improved

+4_____

+3_____ Moderately improved

+2_____

+1_____ Slightly improved

0_____ No change

-1_____ Slightly worse

-2_____

-3_____ Moderately worse

-4_____

-5_____ Very much worse

*****

Appendix F

Brief Symptom Inventory

INSTRUCTIONS:

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

SEX

MALE ○

FEMALE ○

NAME: _____

LOCATION: _____

EDUCATION: _____

MARITAL STATUS: MAR___SEP___DIV___WID___SING___

DATE			ID NUMBER	AGE
MO	DAY	YEAR		

VISIT NUMBER: _____

EXAMPLE HOW MUCH WERE YOU DISTRESSED BY:	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Bodyaches	0	1	2	(3)	4

HOW MUCH WERE YOU DISTRESSED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Nervousness or shakiness inside	1	0	1	2	3	4
2. Faintness or dizziness	2	0	1	2	3	4
3. The idea that someone else can control your thoughts	3	0	1	2	3	4
4. Feeling others are to blame for most of your troubles	4	0	1	2	3	4
5. Trouble remembering things	5	0	1	2	3	4
6. Feeling easily annoyed or irritated	6	0	1	2	3	4
7. Pains in heart or chest	7	0	1	2	3	4
8. Feeling afraid in open spaces or on the streets	8	0	1	2	3	4
9. Thoughts of ending your life	9	0	1	2	3	4
10. Feeling that most people cannot be trusted	10	0	1	2	3	4
11. Poor appetite	11	0	1	2	3	4
12. Suddenly scared for no reason	12	0	1	2	3	4
13. Temper outbursts that you could not control	13	0	1	2	3	4
14. Feeling lonely even when you are with people	14	0	1	2	3	4
15. Feeling blocked in getting things done	15	0	1	2	3	4
16. Feeling lonely	16	0	1	2	3	4
17. Feeling blue	17	0	1	2	3	4
18. Feeling no interest in things	18	0	1	2	3	4
19. Feeling fearful	19	0	1	2	3	4
20. Your feelings being easily hurt	20	0	1	2	3	4
21. Feeling that people are unfriendly or dislike you	21	0	1	2	3	4
22. Feeling inferior to others	22	0	1	2	3	4
23. Nausea or upset stomach	23	0	1	2	3	4
24. Feeling that you are watched or talked about by others	24	0	1	2	3	4
25. Trouble falling asleep	25	0	1	2	3	4
26. Having to check and double check what you do	26	0	1	2	3	4
27. Difficulty making decisions	27	0	1	2	3	4
28. Feeling afraid to travel on buses, subways, or trains	28	0	1	2	3	4
29. Trouble getting your breath	29	0	1	2	3	4
30. Hot or cold spells	30	0	1	2	3	4
31. Having to avoid certain things, places, or activities because they frighten you	31	0	1	2	3	4
32. Your mind going blank	32	0	1	2	3	4
33. Numbness or tingling in parts of your body	33	0	1	2	3	4
34. The idea that you should be punished for your sins	34	0	1	2	3	4
35. Feeling hopeless about the future	35	0	1	2	3	4

Please continue on the following page ▶

HOW MUCH WERE YOU DISTRESSED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
36. Trouble concentrating	36	0	1	2	3	4
37. Feeling weak in parts of your body	37	0	1	2	3	4
38. Feeling tense or keyed up	38	0	1	2	3	4
39. Thoughts of death or dying	39	0	1	2	3	4
40. Having urges to beat, injure, or harm someone	40	0	1	2	3	4
41. Having urges to break or smash things	41	0	1	2	3	4
42. Feeling very self-conscious with others	42	0	1	2	3	4
43. Feeling uneasy in crowds, such as shopping or at a movie	43	0	1	2	3	4
44. Never feeling close to another person	44	0	1	2	3	4
45. Spells of terror or panic	45	0	1	2	3	4
46. Getting into frequent arguments	46	0	1	2	3	4
47. Feeling nervous when you are left alone	47	0	1	2	3	4
48. Others not giving you proper credit for your achievements	48	0	1	2	3	4
49. Feeling so restless you couldn't sit still	49	0	1	2	3	4
50. Feelings of worthlessness	50	0	1	2	3	4
51. Feeling that people will take advantage of you if you let them	51	0	1	2	3	4
52. Feelings of guilt	52	0	1	2	3	4
53. The idea that something is wrong with your mind	53	0	1	2	3	4

Appendix G
Letter of Instruction to Therapists

Wiebke Peschken
Department of Psychology
University of Manitoba
Winnipeg, Manitoba
R3T 2N2
November 10, 1992

Dr. So-and-So
Street Address
City, Province
Postal Code

Dear Therapist,

A few months ago, I contacted you regarding a study that I am conducting for my Master's thesis on the therapeutic relationship. Thank you very much for your interest in taking part. Your willingness to participate is greatly appreciated.

Enclosed, please find questionnaire packets for both you and your clients. I have also enclosed letters to your clients that outline the general purpose of the study and the exact nature of their involvement in it. Please present these letters to your clients when inviting them to take part in the study. May I remind you that clients should be 18 years of age or older, and they should be seeking individual, personal, as opposed to group or vocational, counselling. Also, clients' participation should be sought on a voluntary basis after a minimum of 5 sessions of therapy. Clients should not be asked to participate in the study if their involvement would interfere with the therapeutic process in any way.

The questionnaire packets have been labelled "Therapist 1", "Therapist 2", and "Client." As the labels imply, the "Therapist" packets are to be completed by yourself, and the "Client" packets are to be completed by your clients. You should have received only one "Therapist 1" packet which you are requested to complete first. The first item in this packet is a consent form. Please read this form and sign your name at the bottom of the page if you agree with its conditions and still wish to participate in the study. Following this, you are requested to complete one "Therapist 2" packet for **each** of your clients that are participating in the study.

You will notice that the questionnaire packets have been identified with code numbers. **It is very important that you and your clients complete questionnaire packets with matching code numbers.** To help you keep track of which client corresponds to which code number, you may choose to indicate your client's initials in the appropriate space on the materials in packet 2. These initials will be removed before the materials are used for research purposes.

Each questionnaire packet is accompanied by an addressed, manilla envelope. You are requested to mail the completed questionnaires in the sealed envelope directly to me with the postage that I have provided. Your clients will be asked to do the same.

Once again, thank you for taking the time to participate in this study. Once I have received the completed questionnaires

from yourself and from your clients, I plan to send you a letter which will delineate the purpose of this study more clearly. As I indicated in my previous letter, the results of the study will be made available to you and your clients when the entire study is completed. If you have any questions, please write or call me at 474-9338 (Department of Psychology) or 275-1858.

Sincerely,

Wiebke Peschken

Appendix H
Client Recruitment Letter

Wiebke Peschken
Department of Psychology
University of Manitoba
Winnipeg, Manitoba
R3T 2N2

Dear Client,

I am presently enroled in the Clinical Psychology Training Program at the University of Manitoba and am in the process of developing a study for my Masters' thesis which will examine the manner in which the relationship between therapists and clients contributes to the therapeutic process. I would very much like to obtain genuine responses from clients in my study and am therefore asking you to participate. Your therapist will also be taking part in the study.

Realizing that your time is limited, I have tried to minimize the amount of time that participation in the study would require. It is estimated that the total amount of time that your participation would require is less than 40 minutes. If you agree to participate, you will be asked to complete one short questionnaire that is concerned with your general feelings and attitudes towards other people, and four questionnaires that ask about how you see your relationship with your therapist and how much you think you have improved since beginning therapy. You will also be asked to complete a questionnaire that is concerned with the extent to which you are experiencing a number of problems that sometimes bring people to therapy. You may complete the questionnaires in your therapist's waiting room, or you may take them home and work on them there.

It is important for you to know that your responses will be kept confidential. At no point in the study will you be asked to indicate your name on the questionnaires. Your therapist may choose to indicate your initials on his/her materials that correspond to his/her assessment of your relationship, however these initials will be removed before the materials are used for research purposes. Also, identifying information with respect to clients, therapists, and clinics, etc. will be omitted from any written or published report of the study. In order to obtain honest and carefully considered responses on the questionnaires, I feel it is important to assure you that your therapist will not have access to your responses. You will be asked to mail the completed questionnaires direclty to me in a stamped, addressed envelope (provided by myself). No one other than myself and my research supervisor will have access to the information you provide. Your responses on the questionnaires will have no direct effect on how you are treated by your therapist. Similarly, your treatment will not be affected if you decide not to participate in the study.

The study will be completed under the supervision of Dr. Marianne Johnson who is an Assistant Professor in clinical

psychology at the University of Manitoba and has obtained C. Psych. certification. The study has also been approved by the Department of Psychology Human Ethical Review Committee at the University of Manitoba.

Please consider your involvement in this study carefully as your participation would be greatly appreciated. The study is designed to acquire information about the therapeutic relationship that may, in the long run, lead to improved understanding of the factors that enable people to benefit from therapy. Unfortunately, I am not in a position to offer an honorarium for participants, however the results of the study will be made available to you once the study is completed.

Thank you very much for your time and consideration. If you have any questions regarding the study, please do not hesitate to call me. I will return messages left for me through the Department of Psychology at 474-9338 or you can contact me directly at 275-1858.

Sincerely,

Wiebke Peschken

Appendix I.1
Therapist Consent Form

Investigator: Wiebke Peschken
Supervised by: Dr. Marianne Johnson
Assistant Professor of Psychology
University of Manitoba

The purpose of this study is to investigate the manner in the therapeutic relationship contributes to the therapeutic process. The study has been approved by the Human Ethical Review Committee of the Department of Psychology, University of Manitoba.

Taking part in the study will involve filling out five questionnaires that are concerned with your general feelings and attitudes towards other people, and your attitudes and perceptions of one or more specific clients with whom you have been working. Your participation will also involve asking one or more of your clients to take part in the study.

Your participation is completely voluntary and you are free to withdraw or refuse to participate at any time. If you wish to refrain from answering any of the questions in the questionnaire packet, you are free to do so. In order to ensure confidentiality, you will not be requested to indicate your name on any of the questionnaires. This consent form will be kept completely separate from the questionnaires and it will not be possible to connect your name to your responses on the questionnaires, except by the researchers cited above. Any identifying information with respect to therapists, clients, clinics, etc. will be ommited from any written or published report of the study. No one other than the researchers cited above will have access to the information you provide in the questionnaires. The information you provide in the questionnaires will not be made available to your clients, your employers or any other individuals with whom you are involved. You will not have access to the information that is provided by your clients who are participating in the study.

The results of the study will be made available to you when the study is completed. At this time, only the general results of the study, rather than individual questionnaire scores, will be provided. Aside from contributing to research that may be of value to the scientific community, there are no benefits to the individuals participating in the study. There are no known risks resulting from the procedures in this study. The cost to you will be the time that it requires to participate.

****

I have read and understood the above, and I agree to participate in the study. A copy of this agreement has been provided to me.

_____
(print name)

_____ _____
(signature) (date)

_____ _____
(researcher) (date)

Appendix I.2
Client Consent Form

Investigator: Wiebke Peschken
Supervised by: Dr. Marianne Johnson
Assistant Professor of Psychology
University of Manitoba

The purpose of this study is to investigate the manner in which therapists' relationship with their clients contributes to the therapeutic process. The study has been approved by the Human Ethical Review Committee of the Department of Psychology, University of Manitoba.

Taking part in this study will involve filling out one questionnaire that is concerned with your general feelings and attitudes towards other people, and four questionnaires that ask about how you see your relationship with your therapist and how much you think you have improved since beginning therapy. You will also be asked to complete a questionnaire that is concerned with the extent to which you are experiencing a number of problems that sometimes bring people to therapy.

Your participation is completely voluntary and you are free to withdraw or refuse to participate at any time. If you wish to refrain from answering any of the questions in the questionnaire packet, you are free to do so. Your responses will be kept confidential as you will not be asked to indicate your name on any of the research questionnaires. Your therapist, as a means of organizing her/his materials, may record your initials on the forms that correspond to her/his assessment of your relationship. These initials will be removed from the materials before they are used for research purposes. This consent form will be kept separate from the questionnaires and it will not be possible to connect your name to your responses, except by the researchers cited above. Any identifying information with respect to therapists, clients, counselling centres, etc. will be omitted from any written or published report of the study. The information you provide in the questionnaires will not be made available to your therapists or other individuals with whom you are involved. You will not have access to the information that will be provided by your therapists. The information you provide will have no direct effect on how you are treated by your therapist.

The results of the study will be made available to you when the study is completed. At this time, only the general results of the study, rather than individual questionnaire scores, will be provided. Aside from contributing to research that may be of value to the scientific community, there will be no benefit to the individual participating in the study. There are no known risks resulting from the procedures in this study. The cost to you will be the time it requires to participate.

****

I have read and understand the above and agree to participate in this study.
A copy of this agreement has been provided to me.

_____
(printed name)

_____ _____
(signature) (date)

_____ _____
(researcher) (date)

Appendix J
General Instructions to Therapists

Client's Initials:____

The following questionnaires were designed to measure a number of aspects of your relationship with your client over the course of therapy. Please answer them as carefully and thoughtfully as you can. You may fill them out as time permits, however it is recommended that you work on them soon after a session with your client is completed. Please complete the questionnaires in the order that they appear in the packet.

Since the questionnaires were adapted from studies that were investigating relationships other than the therapist-client relationship, some of the questions may seem difficult or inappropriate to answer for your particular client. In those cases, please consider the questions very carefully and give the best answer you can.

Before completing the questionnaires, please answer the following questions.

Your general theoretical orientation_____

Your theoretical orientation in therapy with this particular client

_____

Your highest degree_____

Years of experience since graduating with highest degree_____

When did you first start seeing this client?

_____

Was there an interruption in therapy at any point in time?

_____ If yes, for how long?_____

What is the total number of sessions that you have completed with this client?

_____

Appendix K
General Instructions to Clients

Thank you very much for agreeing to take part in this study. Your willingness to participate is greatly appreciated.

Before completing the following questionnaires, please read the consent form on the following page. If you agree with its conditions and still wish to take part in the study, sign your name and indicate the date at the bottom of the page. You may keep one copy of the consent form for your own records.

If you sign the consent form, please go on to complete each of the questionnaires as carefully and thoughtfully as you can. You may fill them out in the waiting room of your therapist's office or at home. It is recommended that you work on them soon after a session with your therapist is completed. Please complete the questionnaires in the order that they appear in the packet.

Since the questionnaires were adapted from studies that were looking at relationships other than the therapist-client relationship, some of the questions may seem difficult or inappropriate to answer for your particular therapist. In those cases, please consider the questions very carefully and give the best answer you can.

When you have completed each of the questionnaires, mail them directly to the researchers in the accompanying, addressed envelope with the postage that has been provided. **Please do not return your questionnaires to your therapist.**

*****

Appendix L.1
Letter of Explanation to Therapists

Wiebke Peschken
Department of Psychology
University of Manitoba
WINNIPEG, Manitoba
R3T 2N2

May 1, 1993

Dr. So and So
Street Address
City, Manitoba
Postal Code

Dear Dr. So and So,

Thank you very much for completing and returning the questionnaires for my study. I am writing to give you a brief account of the study's overall purpose. Please give one of the enclosed letters to each of your clients who participated.

The study is based on a theory of psychotherapy put forward by Carl Rogers. A unique aspect of Roger's theory is his argument that every human being has an inherent capacity to grow and to behave in a constructive and positive manner. He calls this inner capacity for growth the "actualizing tendency" and argues that therapists' trust or belief in the actualizing tendency of their clients is the most essential component of psychotherapy. Rogers' theory argues further that therapists who trust their clients will demonstrate the attitudes of genuineness, unconditional positive regard, and empathy. Therapists demonstrate genuineness when what they say and do in their relationship with their clients coincides with what they are actually experiencing. Unconditional positive regard refers to a therapist's acceptance and caring for the client regardless of the client's behaviours, attitudes, and experiences. Finally, empathy refers to the therapist's ability to completely understand and communicate the client's feelings and perceptions. According to Rogers, clients will inevitably benefit from therapy when their therapists establish a relationship with them that is characterized by these "facilitative attitudes." While a substantial amount of research has investigated the link between therapists' demonstration of the facilitative attitudes and whether or not clients benefit from therapy, no studies have tried to determine whether therapists' trust in their clients influences the degree to which they communicate these attitudes in the first place.

In addition to his emphasis on therapists' trust for their clients, Rogers placed a considerable degree of importance on clients' trust for their therapist. His theory argues that clients will trust therapists who demonstrate the attitudes of genuineness, empathy, and unconditional positive regard, and that clients who trust their therapist will feel more confident in talking and working through difficult issues in therapy. For this reason, Rogers argues that clients who trust their therapist will be more likely to benefit from therapy than clients who do not

trust their therapist. Again, research has not investigated the link between therapists' demonstration of the facilitative attitudes and client trust or the link between client trust and client improvement in therapy.

In my study, I asked you and your clients to complete a number of questionnaires. The questionnaires were designed to measure how much you and your clients trust other people in general (generalized trust) and how much you trust each other in particular (specific trust). The questionnaires also measured how much you and your clients think that you demonstrate the facilitative attitudes (ie., genuineness, unconditional positive regard, empathy) and how much each of you think that your clients have improved since beginning therapy. In line with Rogers' theory, my hypotheses for the study are that therapists' trust for their clients will predict therapists' demonstration of the facilitative attitudes, that therapists' demonstration of the facilitative attitudes will predict client trust, and that client trust will predict client improvement in therapy. More specifically, I am hypothesizing that therapists' and clients' specific trust for each other will be better predictors of therapists' demonstration of the facilitative attitudes and client improvement than will clients' and therapists' generalized trust for other people. I am also hypothesizing that ratings of therapist trust and client trust will be better predictors of therapists' demonstration of the facilitative attitudes and ratings of client improvement when these ratings are made from the same perspective (e.g., the perspective of the client or therapist). Finally, I will look for evidence that therapists' level of experience and the number of sessions that therapists and clients have interacted with each other influences how much therapists and clients trust each other.

If you are interested in reading a more detailed account of the study's objectives, a full proposal of my study is available for your perusal in the Department of Psychology at the University of Manitoba. Please do not hesitate to call me (Department of Psychology: 474-9338) if you have any further questions or concerns.

If you are interested in reading more about Rogers' theory, the following books and articles are recommended:

Rogers, C. R. (1951). Client-centered therapy: Its current practice, implications, and theory. Boston: Houghton Mifflin.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting and Clinical Psychology, 21, 95-103.

Rogers, C. R. (1980). A way of being. Boston: Houghton Mifflin.

Thank you again for taking the time to participate in my study. The results will be made available to you when the entire study is completed.

Sincerely,

Wiebke Peschken

Appendix L.2
Letter of Explanation to Clients

Wiebke Peschken
Department of Psychology
University of Manitoba
WINNIPEG, Manitoba
R3T 2N2

May 1, 1993

Dear Client,

Thank you very much for completing and returning the questionnaires for my study. I am writing to give you a brief account of the study's overall purpose.

The study is based on a theory of psychotherapy put forward by Carl Rogers. A unique aspect of Roger's theory is his argument that every human being has an inherent capacity to grow and to behave in a constructive and positive manner. He calls this inner capacity for growth the "actualizing tendency" and argues that therapists' trust or belief in the actualizing tendency of their clients is the most essential component of psychotherapy. Rogers' theory argues further that therapists who trust their clients will demonstrate the attitudes of genuineness, unconditional positive regard, and empathy. Therapists demonstrate genuineness when what they say and do in their relationship with their clients coincides with what they are actually experiencing. Unconditional positive regard refers to a therapist's acceptance and caring for the client regardless of the client's behaviours, attitudes, and experiences. Finally, empathy refers to the therapist's ability to completely understand and communicate the client's feelings and perceptions. According to Rogers, clients will inevitably benefit from therapy when their therapists establish a relationship with them that is characterized by these "facilitative attitudes." While a substantial amount of research has investigated the link between therapists' demonstration of the facilitative attitudes and whether or not clients benefit from therapy, no studies have tried to determine whether therapists' trust in their clients influences the degree to which they communicate these attitudes in the first place.

In addition to his emphasis on therapists' trust for their clients, Rogers placed a considerable degree of importance on clients' trust for their therapist. His theory argues that clients will trust therapists who demonstrate the attitudes of genuineness, empathy, and unconditional positive regard, and that clients who trust their therapist will feel more confident in talking and working through difficult issues in therapy. For this reason, Rogers argues that clients who trust their therapist will be more likely to benefit from therapy than clients who do not trust their therapist. Again, research has not investigated the link between therapists' demonstration of the facilitative attitudes and client trust or the link between client trust and client improvement in therapy.

In my study, I asked you and your therapist to complete a number of questionnaires. The questionnaires were designed to measure how much you and your therapist trust other people in

general (generalized trust) and how much you trust each other in particular (specific trust). The questionnaires also measured how much you and your therapist think that your therapist has demonstrated the facilitative attitudes (ie., genuineness, unconditional positive regard, empathy) and how much each of you think that you have improved since beginning therapy. In line with Rogers' theory, my hypotheses for the study are that therapists' trust for their clients will predict therapists' demonstration of the facilitative attitudes, that therapists' demonstration of the facilitative attitudes will predict client trust, and that client trust will predict client improvement in therapy. More specifically, I am hypothesizing that therapists' and clients' specific trust for each other will be better predictors of therapists' demonstration of the facilitative attitudes and client improvement than will clients' and therapists' generalized trust for other people. I am also hypothesizing that ratings of therapist trust and client trust will be better predictors of therapists' demonstration of the facilitative attitudes and ratings of client improvement when these ratings are made from the same perspective (e.g., the perspective of the client or therapist). Finally, I will look for evidence that therapists' level of experience and the number of sessions that therapists and clients have interacted with each other influences how much therapists and clients trust each other.

If you are interested in reading a more detailed account of the study's objectives, a full proposal of my study is available for your perusal in the Department of Psychology at the University of Manitoba. Please do not hesitate to call me (Department of Psychology: 474-9338) if you have any further questions or concerns.

If you are interested in reading more about Rogers' theory, the following books and articles are recommended:

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Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting and Clinical Psychology, 21, 95-103.

Rogers, C. R. (1980). A way of being. Boston: Houghton Mifflin.

Thank you again for taking the time to participate in my study. The results will be made available to you when the entire study is completed.

Sincerely,

Wiebke Peschken

Appendix M

Table 4

Correlations among Therapists' and Clients' Scores on Major Research Measures

Measure	$TCAS_T$	$TCAS_C$	DTS_T	DTS_C	RI_T	RI_C	GOR_T	GOR_C
$TCAS_C$	.12							
DTS_T	.67***	.11						
DTS_C	.06	.20	-.04					
RI_T	.42***	-.08	.76***	-.02				
RI_C	.15	.28*	.16	.50***	.14			
GOR_T	.09	.31*	.21	-.08	.08	.05		
GOR_C	-.19	.30*	-.23	.27	-.11	.22	.43	
BSI_C	-.05	-.56***	.07	-.17	.04	-.14	-.30*	-.39**

Note. TCAS= Trust/Confidence Attachment Scale; DTS= Dyadic Trust Scale; RI= Relationship Inventory; GOR= Global Outcome Rating; BSI= General Severity Index on the Brief Symptom Inventory; $_T$= scale completed by therapist; $_C$= scale completed by client.

*p< .05. **p< .01. ***p< .001.

Appendix N

Table 6

Means and Analyses of Variance for Criterion Variables as a Function of Therapist or Client Sex

	Therapist Sex				Client Sex			
Criterion Variable	Male	Female	F	p	Male	Female	F	p
RI_T	5.07	4.76	2.49	ns	4.77	4.91	.82	ns
RI_C	4.80	4.97	1.08	ns	4.73	4.95	1.60	ns
DTS_C	6.37	6.15	1.56	ns	6.03	6.23	.98	ns
$TCAS_C$	3.58	3.68	.09	ns	3.68	3.73	.02	ns
GOR_T	9.32	9.07	.33	ns	9.00	9.21	.56	ns
GOR_C	9.74	9.28	1.07	ns	9.30	9.50	.10	ns

Note. df= 1,15 for analyses involving therapist sex; df= 1,46 for analyses involving client sex; RI= Relationship Inventory; DTS= Dyadic Trust Scale; TCAS= Trust/Confidence Attachment Scale; GOR= Global Outcome Rating; $_T$= ratings made by therapist; $_C$= ratings made by client.

Table 7

Means and Analyses of Variance for Criterion Variables as a Function of Therapist Marital Status

Criterion Variable	Therapist Marital Status: Married n=12	Divorced n=1	Not Reported n=4	F	p
RI_T	4.88	4.82	4.96	.07	ns
RI_C	4.90	4.84	4.80	.14	ns
$TCAS_C$	3.55	3.57	3.86	.29	ns
DTS_C	6.33	5.94	6.21	.63	ns
GOR_T	9.18	8.67	9.44	1.36	ns
GOR_C	9.45	9.67	9.33	.65	ns

Note. df= 2,14 for all analyses; RI= Relationship Inventory; TCAS= Trust/Confidence Attachment Scale; DTS= Dyadic Trust Scale; GOR= Global Outcome Rating; $_T$= ratings made by therapist; $_C$= ratings made by client.

Table 8

Means and Analyses of Variance for Criterion Variables as a Function of Client Marital Status

	Client Marital Status						
Criterion Variable	Single n=10	Married n=13	Sep/Div n=16	Widow n=1	Not Reported n=8	F	p
RI_T	5.15	4.81	4.72	4.80	5.00	1.77	ns
RI_C	5.14	4.88	4.75	5.33	4.87	1.18	ns
$TCAS_C$	3.34	4.02	3.56	4.50	3.94	.85	ns
DTS_C	6.41	6.25	6.18	5.50	5.91	1.25	ns
GOR_T	8.90	9.54	8.94	9.00	9.38	.70	ns
GOR_C	9.30	10.15	9.13	8.00	9.38	1.38	ns

Note. df= 4,43 for all analyses; Sep/Div= separated or divorced; RI= Relationship Inventory; TCAS= Trust/Confidence Attachment Scale; DTS= Dyadic Trust Scale; GOR= Global Outcome Rating; $_T$= ratings made by therapist; $_C$= ratings made by client.

Table 9

Means and Analyses of Variance for Criterion Variables as a Function of Therapist Theoretical Orientation

Criterion Variable	Therapist Theoretical Orientation				F	p
	Eclectic n=8	Cog/Beh n=2	Psydyn n=3	Systemic n=4		
RI_T	4.77	5.19	5.10	4.85	.79	ns
RI_C	4.87	5.41	4.52	4.89	5.41[a]	.01
$TCAS_C$	3.75	3.85	3.39	3.44	.32	ns
DTS_C	6.38	6.69	6.02	6.08	2.72	ns
GOR_T	9.38	9.00	9.29	9.00	1.16	ns
GOR_C	10.00	9.00	8.86	9.13	2.99	ns

Note. df= 3,13 for all analyses; Cog/Beh = Cognitive-Behavioural; Psydyn= Psychodynamic; RI= Relationship Inventory; DTS= Dyadic Trust Scale; TCAS= Trust/Confidence Attachment Scale; GOR= Global Outcome Rating; $_T$= rating made by therapist; $_C$= rating made by client.

[a]multiple comparisons indicated that clients rated therapists reporting a Cognitive-Behavioural Perspective significantly higher on the facilitative attitudes than they did therapists from other perspectives.

Table 10

Means and Analyses of Variance for RI and GOR Ratings as a Function of Rater Perspective

Criterion Variable	Client Ratings	Therapist Ratings	F	p
RI	4.90	4.88	.05	ns
GOR	9.17	9.45	1.29	ns

Note. RI= Relationship Inventory; GOR= Global Outcome Rating.

Table 11

Means and Analyses of Variance for Criterion Variables as a Function of Gender Constitution of Dyads

Criterion Variable	Same Sex Dyads	Opposite Sex Dyads	F	p
RI_T	4.93	4.81	.80	ns
RI_C	5.00	4.77	2.56	ns
$TCAS_C$	3.67	3.80	.14	ns
DTS_C	6.26	6.13	.60	ns
GOR_T	9.00	9.53	1.83	ns
GOR_C	9.33	9.73	.97	ns

Note. df= 1,46 for all analyses; RI= Relationship Inventory; DTS= Dyadic Trust Scale; TCAS= Trust/Confidence Attachment Scale; GOR= Global Outcome Rating; $_T$= ratings made by therapist; $_C$= ratings made by client.

Table 12

Means and Analyses of Variance for Criterion Variables as a Function of Differences between Individual Therapists

Therapist	RI_T	RIC	$TCAS_C$	DTS_C	GOR_T	GOR_C	DTS_T[a]
1	4.59	4.83	3.80	5.85	9.20	8.20	5.43
2	5.73	4.83	4.20	6.25	11.00	10.00	6.63
3	4.73	4.58	3.70	5.83	9.33	9.67	4.96
4	4.82	4.84	3.57	5.94	8.67	9.67	4.85
5	4.18	4.65	4.00	6.06	9.00	11.00	4.13
6	4.68	4.83	2.10	6.75	9.00	10.00	5.13
7	5.37	4.73	3.66	5.68	9.40	8.80	6.60
8	4.80	4.55	4.17	6.67	10.00	9.33	5.67
9	4.91	4.84	4.00	6.13	9.00	11.00	5.13
10	5.25	5.31	2.70	6.69	8.00	9.00	5.56
11	4.62	5.05	3.45	6.63	9.50	11.00	4.81
12	4.37	4.76	4.20	6.00	9.50	11.00	4.88
13	4.69	5.40	3.55	6.75	9.50	8.50	5.75
14	4.95	5.30	4.74	6.28	9.40	10.40	6.08
15	4.83	4.96	3.12	6.40	8.80	9.20	5.50

Table 12 (continued)

Therapist	RI_T	RIC	$TCAS_C$	DTS_C	GOR_T	GOR_C	DTS_T[a]
16	5.02	4.34	2.50	6.25	9.00	7.00	6.38
17	5.69	5.41	4.15	6.63	8.50	9.50	6.31
F	3.54	.96	.77	1.14	.52	1.31	6.55
p	.001	ns	ns	ns	ns	ns	.001

Note. *df*= 16,31 for all analyses; RI= Relationship Inventory; TCAS= Trust Confidence Attachment Scale; DTS= Dyadic Trust Scale; GOR= Global Outcome Rating; $_T$= ratings made by therapist; $_C$= ratings made by client; Dum1 & Dum2= Dummy variables representing therapist groupings based on distribution of scores on RI ratings. [a]Therapists' scores on the DTS did not serve as the criterion variable in any analyses in the study. However, differences between therapists on this measure are presented because they are relevant for the discussion of results.

Appendix O

Table 18

Regression Analyses of Therapists' Specific Trust Predicting Therapist Ratings of Individual Facilitative Attitudes

Criterion Variable	Predictor Variable	F	df	p	β	Adj. R^2	Incr. R^2
Level of Regard	CovSet	3.61[a]	6,41	.006	-	.25	-
	Sesno	2.10[a]	1,41	ns	.00	-	-
	Age_C	.60	1,41	ns	-.01	-	-
	Age_T	.45	1,41	ns	-.01	-	-
	Theor	.64	1,41	ns	.22	-	-
	Dum1	10.61	1,41	.003	1.06	-	-
	Dum2	8.48	1,41	.006	.81	-	-
	TCAST	1.08[a]	1,40	ns	.19	.25	.00
	DTS_T	39.86[a]	1,39	.001	.75	.62	.37

Table 18 (continued)

Criterion Variable	Predictor Variable	F	df	p	β	Adj. R^2	Incr. R^2
Uncond Regard	CovSet	16.56[a]	6,41	.001	-	.67	-
	Sesno	1.65	1,41	ns	.00	-	-
	Age_C	-1.11	1,41	ns	.00	-	-
	Age_T	.74	1,41	ns	.00	-	-
	Theor	.01	1,41	ns	-.02	-	-
	Dum1	38.28	1,41	.001	1.60	-	-
	Dum2	3.84	1,41	.06	.42	-	-
	$TCAS_T$	.09[a]	1,40	ns	-.04	.66	-.01
	DTS_T	13.46[a]	1,39	.001	.42	.74	.08
Empathy	CovSet	5.46[a]	6,41	.001	-	.36	-
	Sesno	3.87	1,41	ns	.00	-	-
	Age_C	4.80	1,41	.03	-.01	-	-
	Age_T	1.45	1,41	ns	.01	-	-
	Theor	4.85	1,41	.03	.39	-	-
	Dum1	.23	1,41	ns	.10	-	-
	Dum2	3.60	1,41	.06	-.34	-	-
	$TCAS_T$	.18[a]	1,40	ns	-.05	.35	-.01
	DTS_T	1.06[a]	1,39	ns	.11	.35	.00

Table 18 (continued)

Criterion Variable	Predictor Variable	*F*	*df*	*p*	β	Adj. R^2	Incr. R^2
Congr	CovSet	9.00[a]	6,41	.001	-	.51	-
	Sesno	.62	1,41	ns	.00	-	-
	Age_C	1.90	1,41	ns	.00	-	-
	Age_T	4.87	1,41	.03	-.02	-	-
	Theor	.54	1,41	ns	-.15	-	-
	Dum1	34.81	1,41	.001	1.46	-	-
	Dum2	21.96	1,41	.001	.96	-	-
	$TCAS_T$	.17[a]	1,40	ns	.06	.50	-.01
	DTS_T	1.06[a]	1,39	.02	.28	.55	.05

Note. Uncond Regard= Unconditionality of Regard; Congr= Congruence; CovSet= Covariate Set; TCAS= Trust/Confidence Attachment Scale; DTS= Dyadic Trust Scale; $_T$= ratings made by therapist; $_C$= ratings made by client; Sesno= Number of completed sessions; Theor= Theoretical orientation; Dum1 & Dum2= Dummy variables representing therapist groupings on RI ratings.

[a]*F* values presented for variable or variable set having controlled for variables or variable sets entered at prior stages in the regression.

Table 20

Correlations among Therapist and Client Ratings on the Four RI Subscales

	Unconditional Regard	Level of Regard	Empathy
Therapist Ratings			
Level of Regard	.69**		
Empathy	.44*	.20	
Congruence	.66**	.66**	.22
Client Ratings			
Level of Regard	.70**		
Empathy	.68**	.79**	
Congruence	.74**	.79**	.81**

*p< .002. **p<.001.