# VERBAL REINFORCEMENT OF CLIENT DEPENDENCY IN THE INITIAL STAGE OF PSYCHOTHERAPY

Thesis for the Degree of Ph. D.
MICHIGAN STATE UNIVERSITY
Philip F. Caracena
1963

This is to certify that the

thesis entitled

Verbal Reinforcement of Client Dependency in the Initial Stage of Psychotherapy

presented by

Philip F. Caracena

has been accepted towards fulfillment of the requirements for

Ph.D. degree in Psychology

Charles Harley
Major professor

Date 27 August 1963

ABSTRACT

VERBAL REINFORCEMENT OF CLIENT DEPENDENCY
IN THE INITIAL STAGE OF PSYCHOTHERAPY

by Philip F. Caracena

Dependency of clients upon psychotherapists is a frequent and important occurrence in the early hours of psychotherapy. This study examines the phenomenon as an effect of therapists' approach and avoidance responses to clients' verbalizations of dependent content. The hypotheses state that when therapists approach dependency, clients continue the topic but when therapists avoid, then clients discontinue. Aside from the elicitation value of approach, these responses are assumed to reinforce discussion of the topic. Learning occurs if (1) the probability of a client's continuing the topic increases as the interview progresses and (2) the probability of a client's initiating dependency statements increases over time. Conversely, therapists' avoidance of dependency reinforces the tendency for clients to discuss non-dependent topics. The study also examines the longer-term effects of reinforcement upon staying in therapy.

Further hypotheses state (1) that therapists learn to approach dependency as an initial technique of therapy and (2) that therapists learn to reinforce selectively various types of dependent statements.

A content analysis of 72 recordings of early psychotherapy interviews with clients at a university counseling center shows that approach to dependency elicits further discussion of dependency and avoidance elicits discontinuance. For clients whose dependent statements are predominantly approached, the probability that approach elicits further discussion and that clients initiate dependency statements does not increase significantly as the hour progresses, although there are trends in the expected directions. Due to the high frequency of approach responses made to all clients, effects of avoidance are inadequately measured. Relatively infrequent approach, however, does not reinforce the competing tendency to discuss non-dependent topics. The data suggest individual differences in inhibition of each habit independent of the therapists' responses measured here.

Terminating and remaining in therapy are unrelated to the percentage of approach and avoidance therapists gave when clients discussed dependency. This fails to support previous findings. However, more "likable" clients are very likely to remain in therapy.

Staff level therapists more frequently approach than avoid dependency in contrast to practicum and interne level therapists. Approach to subtypes of dependency is not substantially affected by experience level.

Limitations inherent in the study are discussed and implications are noted for further research.

Approved Charles Hanley Committee Chairman Date 27 August 1963

# VERBAL REINFORCEMENT OF CLIENT DEPENDENCY IN THE INITIAL STAGE OF PSYCHOTHERAPY

By
Philip F. Caracena

A THESIS

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Psychology

1963

Dedication

To Virginia,

Chris and Kurt

## ACKNOWLEDGMENTS

The writer is deeply grateful to his chairman, Dr. Charles Hanley, for his proficient direction of the study and his generous personal help and encouragement. The writer wishes to express his appreciation to Dr. M. Ray Denny especially for his theoretical ideas which are evident in the study; to Dr. Harry Grater for his valuable suggestions and support; and to Dr. Bill L. Kell for his continuous belief in the writer.

Special appreciation is extended to Dr. C. L. Winder who was unable to continue direction of the study. His ideas originated and sparked this study.

Acknowledgments are made to David Kopplin for his hard work as a judge and his help throughout the study. The writer wishes to thank the therapists and clients of the Michigan State University Counseling Center for their cooperation in the collection of data.

***

TABLE OF CONTENTS

LIST OF TABLES

## LIST OF APPENDICES

APPENDIX Page

# I. INTRODUCTION

## A. Statement of the Problem

This study investigates effects of certain therapist variables upon behavioral change in clients first entering psychotherapy. The client change considered is expression of dependency as shown in two manifestations: (1) verbalization of dependent content, and (2) remaining in psychotherapy. The therapist variables include: (1) verbal approach and avoidance of client statements and (2) experience level. Our method of investigation is a content analysis of verbal interaction during psychotherapy.

Hypotheses are derived from learning theory; change in client dependency is presumed to depend upon the therapist's verbalized approach or avoidance of the client's dependency expressions. Thus, therapists' approach statements to client dependency are hypothesized as consistent elicitors of dependency. As such, they increase the probability of such further behavior from clients. Therapists' avoidant statements to dependency are considered inhibitors of this behavior.

An essential part of therapeutic skill is to retain an accepted client in treatment as long as necessary regardless of his initial state of mental health. One technique may be to approach, and thereby reinforce, dependency when it is expressed in the client's verbal repertoire. Should

approach be effective, more experienced therapists may have learned to utilize this technique more than inexperienced therapists.

If the overall therapeutic situation fits the operant conditioning paradigm, i.e., one in which the therapist selectively reinforces the client's behavior according to its proximity to the "correct" form, it follows that therapists selectively reinforce different types of dependency statements during the course of psychotherapy. Which types the therapist chooses to reinforce (approach) and which he chooses to inhibit (avoid) may vary according to the therapist's own experience with the effect of differentially reinforcing subclasses of dependency.

B. Dependency in Psychotherapy

The dynamics of dependency were described by Freud in 1905. He traced dependency motivation to feeding frustrations in the oral psychosexual stage of life. Orthodox psychoanalysts continue to theorize that adult dependency stems from the longing for relief from distress that the infant directs toward the parents. Fenichel (1945) describes a continuing dependence-independence conflict, lasting throughout the child's attempt to master his environment. Psychoanalytic treatment regenerates the original dependency conflict experienced during childhood (Fromm-Reichmann, 1950; Alexander & Ross, 1952).

Dependency is defined rather consistently in the literature. Traditionally, dependency is a learned motive

to be taken care of, helped and nurtured (e.g., Murray, 1954, 1956). Dollard & Auld (1959) distinguish a dependent relationship from a symbiotic one by stressing its unilateral character: one person relies upon another for support, maintenance or help. Wolberg (1954) describes a patient's experience of dependency as a feeling of helplessness, of wanting someone to relieve distress, give support, guidance and direction.

The importance of client dependency in the beginning phases of psychotherapy has been discussed by a number of writers. Fenichel (1945) regards dependency as a component of the more general phenomenon of transference. In describing the role of dependency in psychoanalysis, he observes that the patient enters the treatment situation with a host of repressed and partially repressed needs, among which are commonly found oral-dependent strivings. One of the first duties of the analyst is the very practical one of creating and sustaining a "workable" relationship in which the patient abandons defensive maneuvering in order to permit emergence of unconscious needs. The means by which the analyst fosters such a change is the interpretation of positive and negative transference toward himself. The patient ascribes to his therapist somewhat omnipotent powers to help, heal and protect. By interpreting the transference during treatment, the analyst makes the emergent dependent strivings explicit.

Alexander & Ross (1952) emphasize the necessity of

developing a dependent relationship to enable the patient to relive and once more face unresolved conflicts with the parents; to combat previously formed infantile reactions by reproducing them in the transference relationship. A likely consequence of failure to deal with dependency is the generation of hostility and resistance detrimental to further therapeutic contact (Wolberg, 1954).

Thus psychoanalysis regards dependent wishes, attitudes and behavior as desirable and necessary in the beginning of psychotherapy, and the role of the therapist is one of allowing dependency to emerge.

The goal of more actively eliciting client dependency early in treatment appears in other schools of therapy. Fenichel and Alexander & Ross discuss this phenomenon in non-psychoanalytic therapies, criticizing them for continuing to capitalize upon dependency far beyond the goal of uncovering. Successes are labeled "transference cures," i.e., cures maintained only through a continuing dependent relationship with the therapist. Despite the further utilization or management of dependency, therapists are commonly concerned with fostering at least its discussion in early therapy interviews.

Rogers (1942) noted the eventual disappearance of transference in his client-centered treatment. The dissipation or lack of further development of dependency on the therapist is ascribed to its being dealt with in the first place, e.g., by means of reflection, clarification of

feelings, etc. Perhaps the first two of Rogers' (1958) seven stages of therapy comprise the portion of therapy in which dependency first emerges. A general "loosening" of feelings and expression characterizes these stages.

Dollard & Miller (1950) note the desirability of inducing the patient to express more fully existing dependency needs in the early phase of treatment. Shoben (1949), in his interpretation of therapy as a learning experience, alludes to dependency, describing a part of the first step in counseling as a matter of making therapist responses which " . . . most effectively further the bringing into communicability of repressed impulses . . . " without destroying the relationship.

In most therapies, then, the emergence of dependency motive (via dependent behavior) appears to occur, whether by active, passive or unclear means. Certainly the continuation of the client-therapist relationship itself is evidence of utilization of client dependency (Dollard & Miller, 1950). Empirical identification of significant client, therapist or situational variables associated with the intentional or incidental development of client dependency has been largely neglected in light of its apparent universality to the therapeutic process and its importance to some theories of psychotherapy. Skinner (1953) theorizes, "If the patient is to return for further counsel, the psychotherapist must make sure that the behavior of coming to him is in some measure reinforced." (p. 74) Rogers (1951) tentatively

hypothesizes several general mechanisms (e.g., therapists' evaluative remarks) by which a dependent relationship may develop. But research that would allow evaluation of these hypotheses is scant. More speculative attention has been paid to techniques for the management of dependency in later stages than to the circumstances surrounding its initial appearance. Following Winder et al (1962), this study examines the first stage in which the phenomenon occurs in therapy.

C. Learning and Psychotherapy

The behaviorists Dollard & Miller (1950) and Skinner (1953) view the therapeutic process as one in which the therapist teaches and the client learns and unlearns. The therapist is assumed to have at his command a number of techniques for selectively shaping the client's behavior.

Ferster (1958) presents a similar viewpoint:

> It is possible that many of the symptoms which bring the patient to therapy are largely a by-product of inadequate positively reinforced repertoires; that the disposition to engage in the psychotic, neurotic, and pathological behaviors may seem strong when compared to weak existing repertoires but would disappear as soon as alternative effective ways of dealing with some accessible environment are generated. (p. 117)

The therapist's role, then, is to reinforce selectively.

In all "talking" therapies, what is dealt with during the therapeutic hour is verbal behavior. Implicit in our use of learning theory is the assumption that verbal response is accounted for by the same principles as are

non-verbal responses: that verbal expression, while having symbolic referents, is a behavioral response and, as such, is amenable to experimental manipulation. Skinner (1957) presents this viewpoint despite what he refers to as symbolic or "second level" characteristics. Whether verbal conditioning occurs because of cognitive mediation, as Spielberger & Levin (1962) contend, or through an automatic reinforcement of response is not put to test here. However, the dependency motive of clients in psychotherapy may generate an expectancy or learning set somewhat similar to that induced in straightforward learning experiments. Whether the client can generalize his verbal learning to other behavior is, of course, a relevant issue to be discussed later.

D. Verbal Conditioning Studies

Comprehensive reviews by Krasner (1958), Salzinger (1959) and Greenspoon (1962) indicate the deluge of recent efforts to apply conditioning procedures to language, mostly in experimental or quasi-therapeutic situations. These reviews point up a number of unsettled issues.

Our concern focusses upon whether verbal learning occurs in psychotherapy. Learning is taken to mean either (1) the strengthening of an existing (measurable) S-R bond over time or (2) the establishment of a new S-R connection. The present study attempts to demonstrate learning of the first type during the therapeutic hour, that is, an increase

in the tendency of a stimulus to elicit a response. According to elicitation theory (Denny & Adelman, 1955), the increment depends upon the consistent elicitation of the response in a given stimulus complex. Learning occurs, then, when a stimulus consistently evokes a response over a period of time. A consistent elicitor is a reinforcing stimulus. In the context of this study, verbal approach by the therapist is a consistent elicitor of dependent statements and avoidance, a consistent elicitor of non-dependent statements.

In the operant conditioning paradigm, a contingent stimulus is one which is introduced when the subject makes a desired response. The contingent stimuli may be but are not necessarily consistent elicitors.

Greenspoon's (1950, 1955) original work in the verbal conditioning field well illustrates the conditioning paradigm and clearly demonstrates learning. The experimental procedure is (1) to measure the operant level of the to-be-conditioned response (the strength or probability of some existing S-R bond), (2) to introduce the contingent stimulus, (3) to omit the contingent stimulus after repeated presentation, and (4) to measure again the operant level of the response. Positive change represents conditioning or learning: an increased probability of the response's occurrence in the absence of the eliciting stimulus. The stimulus complex which surrounded the elicitor has now acquired increased elicitation value. The contingent stimulus, through consistent elicitation of the response has been

proven to be a reinforcer.

Salzinger & Pisoni (1958) report that the contingent stimulus, "Um-hmm," is an effective "reinforcer" of affect responses in schizophrenics but, also, that its omission leads to a decrement in frequency of affect responses to the level of the control group which received no contingent stimulus. Two interpretations are possible: (1) that reinforcement occurred but was extremely short-lived, or (2) that the stimulus "Um-hmm" had no reinforcement effect but simply evoked affect responses when it was presented. It is not known whether subjects interpreted "Um-hmm" as encouragement to continue responding as they had been. Controversial findings with this particular stimulus lend support to "Um-hmm" having a number of possible meanings for different subjects in various situations (Hildrum & Brown, 1956). The factor which may determine whether or not "Um-hmm" reinforces may be the set of the subjects. Greenspoon's use of "Um-hmm" was more obviously in a context of a learning situation for the subjects. As such, "Um-hmm" may be reinforcing.

A host of studies have used contingent stimuli whose meanings are less ambiguous and less controversial than "Um-hmm." Both therapists' approach and avoidance responses have been found to be elicitors of client responses (Bandura, Lipsher, & Miller, 1960; Winder, Ahmad, Bandura, & Rau, 1962). The demonstration that they reinforce as contingent stimuli has not been made. For instance, it is quite likely

that a response similar to the previous response will be given following the stimulus: "Tell me more about that." Once this probability is established in the interview, note can be made of its becoming more likely when the client receives various proportions of approach and avoidance. That such elicitors do, in fact, reinforce can be determined in this way. Often, studies have noted only that certain contingent stimuli tend to elicit consistently without investigating whether learning occurs which can be attributed to the elicitor. In some studies, if the to-be-conditioned response is measured over time, the frequency of presentation of the elicitor is either statistically uncontrolled or it is highly correlated with the response's occurrence. Thus, it is not known whether the frequency or the probability of the response has increased.

Among the few studies of actual psychotherapy from a learning position, an investigation by Murray (1956) provides an example of the kind of ambiguity mentioned. Analyzing Rogers' case of Herbert Bryan, Murray classified therapist statements as mildly approving or disapproving and client statements according to their content. Those categories of client statements which were immediately followed by mild approval increased in frequency over the course of therapy while disapproved categories decreased in frequency. Murray reports that selective verbal reinforcement produced the changes:

> The number of approvals the therapist gave on a given hour was highly correlated with the percentage

> of the rewarded categories ($r = .97$, $p. < .01$). This was also true of disapproved categories ($r = .97$, $p. < .05$). Therefore, the behavior of the therapist was consistent with the appearance of the categories. (p. 11)

and further:

> The approvals grew more frequent and stronger as therapy progressed.

Since the elicitor was presented with increasing frequency, the concomitant increase of the response category is not evidence of learning but is evidence that approval does elicit. Needed here to show learning is a demonstration of increased probability of the S-R bond over time. This requires some kind of control over the frequency of presentation of the elicitor.

Greenspoon (1962) reviews a number of studies in which the omission of contingent stimuli immediately decreases the frequency of the desired response. Other studies show short-lived effects upon the chosen response from increasing and decreasing the frequency of the "reinforcing" stimuli. Few studies report change in operant level over time.

Waskow (1962), in a quasi-therapeutic situation, responded by selectively reflecting feeling (F), content (C) and a mixture of the two (FC). She found significant differences in the mean percentage of each type of material according to the type receiving reflection. The only conclusion which can be drawn is that an increase in frequency of reflection for each category, in effect, evoked those

categories more often. An analysis of mean percentages across time (through the first to the fourth interview and through sixths of the first interview) shows only one consistent increase in percentage of responses, this occurring for the C response category in the first interview.

> Examination of the graphs plotting sixths of other interviews suggests that the percentage of C responses for the three groups remains fairly stable within each of the interviews following the first one. (p. 15)

No indication of the internal consistency of therapist responses is given. Reflection of content may have increased in the first interview and thereafter remained constant. If this were the case, learning was not measured. If, however, the number of therapist reflections did not increase along with the rise in C, reinforcement may have occurred and reached an asymptote in the first interview.

Greenspoon (1962) concludes his discussion of the limitations and importance of verbal conditioning studies by stating:

> The research on verbal conditioning in both therapy and quasi-therapy settings generally suggest that the verbal behavior of the patient and/or subject can be modified. (p. 544)

and more specifically:

> . . . the results of the research in verbal conditioning strongly suggest that the therapist may bring the verbalization of the patient under his control by the judicious usage of certain contingent stimuli. (p. 548)

## E. Approach-Avoidance as Contingent Stimuli

Although most of the basic work guided by learning

theory has been restricted to simulated therapeutic situations, beginning application to actual therapy has been promising. Most relevant are two investigations out of which the present grew. The first deals with the effect of therapists' approach and avoidance to clients' statements of hostility (Bandura, Lipsher & Miller, 1960). Therapist approach statements are defined as " . . . verbal responses that were primarily designed to elicit from the patient further expressions of hostile feelings, attitudes, and behavior." Avoidance reactions are " . . . those verbal responses designed to inhibit, discourage, or divert the patients' hostile expressions."

In the second study, Winder, Ahmad, Bandura, & Rau (1962) analogously define approach by the therapist as " . . . the reactions of the psychotherapist which are designed to elicit from the patient further verbalization of the topic under discussion." Therapist avoidant reactions are those " . . . which are designed to inhibit, discourage, or divert the patient from further verbalization of the topic under discussion." We shall adopt Winder's definitions, making minor changes in his subclassifications. The complete operational definition of approach and avoidance used in the present study comprises all of the subcategories listed under each term in the Scoring Manual (Appendix D). Categories of patient responses similarly adopted from Winder et al are also given in Appendix D.

These categories of contingent stimuli used by

therapists are uniquely broad in that they attempt to cover most therapist statements likely to occur in the clinical setting. Furthermore, a global definition of the contingent stimuli seems apropos of the social situation. Skinner (1935) points out the generic nature of generalized stimuli and responses, conceiving of a class, members of which have certain common characteristics. In this instance, the communality is the eliciting or inhibiting effects approach and avoidance are thought to possess. These are deduced from social verbal reinforcement theory as developed by Dollard & Miller (1950) and Skinner (1957). The type of content included in each category resembles that which Murray (1956) includes under "approval" and "disapproval" and Rogers (1951) categorizes as "evaluative" therapist remarks.

The Bandura et al (1960) content analysis of early therapy interviews clearly indicates that approach responses are followed more often by the client's discussion of hostility rather than by his dropping the topic. Conversely, avoidance statements are followed immediately by fewer expressions of hostility. "Approach statements encourage the patient to express further hostility, whereas avoidance reactions serve to decrease or inhibit such expression. . . . " These client responses may well be strongly connected to approach and avoidance, the connections being learned through past social interaction. Thus approach and avoidance can be exploited by the therapist, but it is not known that they reinforce client responses. The therapist may be presenting

eliciting stimuli which trigger off ready-made response patterns in the client without strengthening S-R bonds. The data themselves do not attest to the reinforcing effects of therapist approach and avoidance since, again, no change in behavior is demonstrated over time in response to the elicitor, to the therapist himself or to the therapeutic setting.

When Winder et al examined the first two tape recorded sessions of 23 patients in therapy, they noted the same effect of approach and avoidance as found by Bandura et al for hostile and dependent statements. The therapists' approach elicits and his avoidance inhibits these same responses. The question, however, remains concerning reinforcement value.

The present study attempts to utilize two criteria for measuring the reinforcement effect of approach and avoidance: (1) increase in operant level of responses to therapist approach and (2) increase in operant level of responses to the therapeutic situation. The first of these measures the changing probability that dependent statements immediately follow approach and avoidance as the interview progresses. Clients who are more consistently approached on dependent statements and show a positive change in continuance of dependency from the first to the second segment of the therapeutic hour give evidence of reinforcement or learning in the interview. The second measure examines temporal differences in operant level of dependency statements

initiated by the client, i.e., dependency statements not in immediate response to therapist approach or avoidance. If the probability of "client initiated" dependency statements increases during the interview when the client is predominantly approached on dependency, then the stimulus complex surrounding the contingent stimuli has acquired increased elicitation value through reinforcement by therapist approach.

The Winder et al study is one of the few (c.f., Ullman, Krasner & Collins, 1961) that show behavior changes in situations outside of the laboratory or therapeutic hour as a result of verbal manipulation. Patients whose therapists approached rather than avoided dependency tended to remain in treatment, whereas patients receiving a greater avoidance more often terminated the relationship prematurely. This attests to the reinforcing effect of approach stimuli upon dependent behavior in a long-term situation. As Winder et al caution, however, there is some question of the contaminating effect of therapist personality upon continuation and termination, since three of the therapists had none but terminating patients (although three other therapists had both terminators and remainers). In the present study, the factor of therapist personality is controlled by securing both terminators and remainers from as many therapists as possible.

## F. Selective Therapist Responses

Consistent with the point of view guiding this study

is the assumption that the therapist, as a teacher, functions toward a goal, having a definite, if not explicit, purpose in his management of the client. Much has been written concerning the overall goals of psychotherapy and conclusions vary. Some overriding desideratum such as "better mental health" may be a universal aim in therapy. Should this be a therapist's ultimate goal, one might find him selectively responding to patient behavior judged more characteristic of this ideal. Not all his behavior would be consistent with this goal; to make it so would necessarily preclude his accepting everything about the unhappy client. Goals probably change according to the phase of treatment, the sophistication of the therapist, etc. That therapists have varying effects upon patients according to the therapists' level of experience is attested to by a number of investigations (e.g., Strupp, 1955a, 1955b; Fey, 1958; Sullivan, 1958).

One simple goal early in therapy is to retain the client in treatment; one method of retaining him is to reinforce (approach) dependency. Theoretically, the experienced therapist has learned the effectiveness of approach and avoidance responses to dependency, i.e., has himself been taught by experience with continuing patients. The experienced therapist with a goal of retaining a client has learned to approach dependency more, if approach does reinforce, where a less experienced therapist would approach dependency less. A second possibility is that experienced therapists,

having learned the differential values of reinforcing various types of dependency, approach different kinds of dependency expressions than do the less experienced. Sears et al (1953, 1957) present theoretical foundations for expecting various types of dependency bids to have varying potency for different people. Inspection of the Patient Statement categories found in the Scoring Manual (Appendix D) suggests a number of dimensions along which the seven types of dependency bids may vary (e.g., congruence with a concept of "good mental health," degree of social acceptance, reality adaptation, freedom from anxiety, etc.).

G. Statement of Hypotheses

Hypotheses I and II constitute the portion of this study which explores the generality of the findings of Winder et al (1962). The first hypothesis deals with the elicitation value of approach and avoidance within the therapeutic setting. The second hypothesis concerns the long-term effects of approach and avoidance upon staying in therapy.

I. If therapists approach client expressions of dependency early in treatment, then clients continue such expressions: if therapists avoid, clients tend to discontinue immediately following dependency expressions.

II. If therapists approach clients' expressions of dependency, clients remain in treatment: but if therapists avoid dependency, clients prematurely terminate.

Hypotheses III and IV bear on the reinforcement value of approach and avoidance. Both state that learning occurs within the hour.

III. Therapist approach statements to client dependency tend to increase the probability of the clients' immediately following expressions of dependency as the interview progresses whereas therapist avoidance tends to decrease the probability of immediately following dependency expressions.

IV. If the therapist approaches clients' expressions of dependency, then the probability of clients' initiating dependency statements increases over time, but if the therapist avoids, then client initiated dependency decreases.

Hypotheses V and VI deal with the effect of therapist experience upon approach and avoidance of client dependency.

V. Experienced therapists approach dependency statements more often than less experienced therapists.

VI. Experienced therapists tend to approach different types of dependency statements than do less experienced therapists.

# II. METHOD

## A. Clients

The data were obtained from tape-recorded psychotherapy interviews with clients at the Michigan State University Counseling Center. Participating psychotherapists were requested to turn in to the investigator recordings of the first and second interviews of all new therapy cases begun over a period of five school quarters.

Frequently a client's original purpose in seeing a counselor is vague. For this reason, clients were accepted for the study whether they initially requested therapy or decided to enter therapy after a number of non-therapy interviews, e.g., educational, vocational, informational. Clients were excluded if they had had previous psychotherapy, as determined by therapists' reports (see Appendix A, Data Sheet for Therapists, and Appendix B, Follow-Up Questionnaire). A total of 72 tapes from 60 clients met the criteria for inclusion in the sample.

If any characterization can be made of the sample as a whole, it might be that of a late adolescent group experiencing newly-found independence from home. Dependency problems are likely to have been precipitated by the reality of their situational separation at college. Cases with immediately apparent acting-out symptoms or severe personality disorganization are usually not seen at the

Center. The sample differs from those of Winder et al and Bandura et al, who used older patients who had been strongly urged to undergo therapy primarily because their problem children were being seen at the same clinic.

Most of the clients were assigned to therapists by the Counseling Center receptionist who had very little basis for assignment other than time availability. Selection entered into this process (1) when students requested and were able to see particular therapists, or (2) when practicum student therapists were assigned cases by their supervisors after intake interviewing.

B. Therapists

Of the therapists asked to participate, 30 contributed tapes. Six were staff members having from four to ten years of therapy experience, 12 were internes having an average of one year of supervised therapy experience, and 12 were practicum students carrying their first to fourth supervised case.

Attempts to obtain all recordings from every therapist met with practical difficulties. No fixed number of cases was set; recordings were collected whenever possible. Selective factors, therefore, may have entered into which therapists turned in cases and which cases therapists turned in. Table 1 presents the distribution of tapes and therapists.

C. Stage of Therapy

Due to the vagueness of purpose in many initial

Table 1. Descriptive Summary of the Sample

| Therapist Experience Level | Number of Therapists | Number of Clients | Sex of Clients | | Therapy Interview | | | Number of Terminators | Number of Remainers |
|---|---|---|---|---|---|---|---|---|---|
| | | | M | F | 1st | 2nd | Both | | |
| Staff | 6 | 11 | 6 | 5 | 9 | 5 | 3 | 4 | 5 |
| Interne | 12 | 29 | 11 | 18 | 25 | 10 | 6 | 11 | 15 |
| Practicum | 12 | 20 | 7 | 13 | 14 | 9 | 3 | 6 | 9 |
| Total | 30 | 60 | 24 | 36 | 48 | 24 | 12 | 21 | 29 |

interviews, the hour which comprised the first therapy interview was decided upon immediately after its conclusion by the client's therapist. Prescribed criteria were supplied to the therapists in the form of a brief Data Sheet included with the unrecorded tapes (see Appendix A). No client in the sample saw a therapist more than three times before the therapist reported that psychotherapy had begun and most therapy started the first time that a client was seen. Mutual agreement to begin therapy was usually explicit early in the relationship. A check was made on this in the Follow-Up Questionnaire (see Appendix B). If sufficient doubt appeared that the client had actually started therapy, the case was dropped from the sample.

While first and second interviews were used by Winder et al (1962), this method was impractical in the present study. Therapists often were unable to record interviews. Thus, the sample consists of 36 clients for whom only first interviews were available, 12 clients for whom only second interviews were available, and 12 clients who had both first and second interviews recorded. To justify analyzing second interviews along with first interviews, a comparison was made of first and second interview scores from the 12 clients who contributed both interviews. Of 11 scores, only the total percentage of therapist approach statements was found to increase from the first to the second interview (Sign test, two-tailed $p. < .05$). Total approach percentage, however, is not relevant to any of the hypotheses. The

sample, then, consists of an admixture of first and/or second interviews. In some analyses presented in the Results Section, certain reduced sample sizes may reflect the removal of second interview data for clients who also contributed first interviews to the sample.

D. Duration of Treatment

Counseling Center policy encourages short-term psychotherapy, suggesting that therapists, ideally, should attempt to terminate clients within 20 interviews when possible. However, treatment often exceeds this duration. While longer-term clients are accepted and continued, clients terminated after 10 to 20 interviews frequently are deemed successful cases, keeping Counseling Center goals in mind. Much of the treatment might be described as relationship therapy, other as brief psychotherapy. Considering these characteristics, "premature terminators" are those who entered treatment but who terminated before the sixth interview without their therapists' approval. The "remainer" group consists of clients still in therapy after 10 therapy interviews. Copies of the Follow-Up Questionnaire (Appendix B) were distributed to the therapists several months after treatment began in order to assess the status of their cases. In this way, clients terminating earlier than the sixth interview for reality reasons (e.g., being dropped from enrollment in the University) and those satisfactorily completing therapy before the sixth interview were eliminated from the analysis dealing with terminators and remainers.

There were 29 remainers and 21 terminators, distributed as shown in Table 1.

E. Scoring of Interviews

All recorded interviews were scored according to a modification of content analysis manuals employed by Winder et al (1962) and Bandura et al (1960) (see Appendix D). The basic unit of analysis is the "statement," generally defined as the total verbalization of one speaker, bounded by the preceding and succeeding speeches of the other speaker. An "interaction sequence" consists of three such units: a "patient statement," a "therapist response," and the following "patient response." The patient response both concludes one interaction sequence and begins a new one, thereby becoming the next patient statement.

Each scoreable patient statement is classified as one or more of the following: (1) one or more of seven types of dependency statements, (2) a hostility statement, or (3) an "other" type of expression. Each subsequent therapist response, the contingent stimulus, is classified as an approach or an avoidant statement in reference to the patient statement category preceding it. In the case of approach or avoidance of dependency or hostility, the therapist response is categorized exclusively into one or more of eight approach or five avoidance subcategories. The concluding patient responses are scored as continuing or not continuing with the dependent or hostile content of the

preceding patient statement. Additionally, the patient response is scored as a new patient statement.

In order to minimize contamination in scoring, the judges code each unit before listening to any subsequent unit. Scoring therapists' responses to the hostility and "other" categories of patient statements enables alternative hypotheses to be tested and thereby serves as a control.[1]

F. Scoring Reliability

Two judges coded interviews: Judge B for the most part unfamiliar with the therapists involved in the study, and both Judge A and Judge B ignorant of the duration of treatment each client received. The judges established familiarity with the scoring system by mutually coding a series of interviews. Several independently coded interviews were then assessed for trial agreement. None of these tapes were used subsequently.

Interjudge reliability on the scores used in the testing of hypotheses was determined as follows:

Over a period of several months, Judge A scored all 72 tapes. The reliability pool consists of a randomly selected sample of ten tapes taken from the first 35 scored by Judge A and another set of ten tapes selected at random from the last 37 scored by Judge A. Judge B coded his first ten early in the process and his last ten several months

---

[1]The hostility data are used more directly in a M.A. thesis in preparation by David A. Kopplin.

later. This procedure results in a reliability measure reduced by practice effects of Judge A and forgetting effects of Judge B. Product-moment correlations of various scores were computed to obtain interjudge reliability coefficients. They are presented under appropriate sections in the next chapter.

# III. RESULTS

To facilitate the presentation of results, each hypothesis will be dealt with separately. In the subsections dealing with each hypothesis, the first describes the scores used in the analysis, the second presents interjudge scoring reliability, and the third section comprises the analysis and outcome of the hypothesis tested.

## A. Hypothesis I

Hypothesis I states that when dependency statements are approached by the therapist, the client continues the topic under discussion, but when the therapist avoids, the client does not continue.

Scores. For this test, the percentage of dependent statements which were approached rather than avoided by the therapist (D Ap%) was determined for 72 tapes. The percentage of units in which clients continued with further dependency when they were approached was then computed (D Ap C%). The parallel percentage for continuance of dependency following therapists' avoidance (D Av C%) was also determined.

Reliability. Table 2 indicates that interjudge agreement on these percentages is reliable. All coefficients of correlation computed in this study are product-moment correlations unless otherwise noted. The variation in size of the reliability sample and the entire sample is due to the absence of units in one or more tapes.

Table 2. Interjudge Reliability for Percentage Continuance of Dependency Following Approach and Avoidance

| Score | N | r | p. |
|---|---|---|---|
| D Ap C% | 20 | .81 | <.01 |
| D Av C% | 18 | .76 | <.01 |

Outcome. The mean percentages of D Ap C% and D Av C% are 63 and 26, respectively, for 68 tapes. In 90 per cent of the tapes, D Ap C% is greater than D Av C%. The sign test shows D Ap C% to exceed D Av C% ($p. < .0001$, one-tailed test). Approach to dependency clearly elicits further dependency while avoidance inhibits continuance of the topic.

To investigate whether approach has high elicitation value and avoidance low elicitation value within experience levels of therapists, sign tests were made within staff, interne and practicum groups. The same superiority of approach in eliciting dependency holds for each level ($p. < .0001$).

## B. Hypothesis II

The second hypothesis states that approach is associated with the clients' remaining in treatment and avoidance with premature termination of the relationship.

Score. The percentage of therapist approach responses to dependency (D Ap%) was computed for each of the 29 remainers and 21 terminators seen by 27 therapists.

Reliability. The interjudge reliability coefficient of D Ap% for 20 interviews is .61 ($p. < .01$).

Outcome. The Mann-Whitney U test reveals no differences in D Ap% between the two groups (p. = .41, one-tailed test).

Winder et al (1962) had used only student therapists. Since their sample was less heterogenous than the sample of therapists in this study, analyses within experience levels were performed. Of the terminators and remainers meeting the criteria, seven were treated by staff members, 28 by internes and 15 by practicum students. D Ap% fails to differentiate terminators from remainers within any of the three levels.

It is important to mention that the above samples may have been biased by therapist personality characteristics in that 21 out of 27 therapists contributed tapes of only terminators or only remainers. The distribution of clients into the two groups, therefore, is based not only upon continuation or termination, but also upon which therapists the clients had seen. Controlling for this factor by using pairs of terminators and remainers seen by the same therapist yields only nine pairs of clients seen by six therapists. The Wilcoxin test for differences in D Ap% between the nine pairs of clients shows no trend in the expected direction.

There is still another difference between the present sample and that studied by Winder et al. Sixteen of their clients had D Ap% higher than 50 per cent and seven clients received less than 50 per cent approach to dependency.

The therapists in the present study approach dependency much more frequently (Mdn. D Ap% = 76). Only two therapists approached dependency less than 50 per cent of the time; one terminator's D Ap% was 47 and one remainer's was 43.

It is possible that differences in D Ap% are obscured by the definition of terminating and remaining in treatment, since the cut-off point in this study differs from Winder's. We set a six-interview maximum for terminators and a 10-interview minimum for remainers. Winder et al used a 10-interview maximum and a 20-interview minimum. Setting a more stringent cut-off point of not more than six and not less than 20 interviews (yielding 21 terminators and 13 remainers), however, does not differentiate the groups on D Ap% (Mann-Whitney U test).

Other percentages were examined in an attempt to separate remainers from terminators. For all 50 clients, the following scores do not make the discrimination: D Ap C%, D Av C%, H Ap% (approach to hostility), Total Ap%, and a difference score reflecting the change in D Ap C% from the first to the second segment of the interview. Reliability coefficients for all these scores are adequate and are presented under sections dealing more directly with the scores.

Using the nine pairs of clients matched for therapists, the Wilcoxin test does not separate terminators from remainers on the basis of the following scores: D Ap C%, D Av C%, H Ap%, H Ap C%, H Av C%, Total Ap%, and the difference between D Ap C% in the first and second segment of the interview.

Terminators and remainers differ on D Ap C% for the six staff members (Mann-Whitney U, $p. < .02$, two-tailed test). Terminators continue dependency more when approached than do remainers. However, three therapists had none but remainers and two therapists had none but terminators. Therapist personality differences could not be statistically controlled within experience levels because of the shrinking sample size.

## C. Hypothesis III

Hypothesis III deals with the reinforcement effect of approach; if therapists approach dependency, the probability of further discussion of dependency increases over the course of the interview. If therapists avoid dependency, continuance of dependency decreases.

Scores. Results presented under Hypothesis I confirm that therapist approach responses to dependency consistently elicit further dependency and avoidant responses elicit non-dependent statements. Hypothesis III investigates learning due to the consistent elicitation. When therapists approach dependency, then, an increment should be found in D Ap C% from the first segment of the interview to the second.

To insure that the frequency of therapist responses to dependency is held constant from segment to segment, each of the 72 interviews is divided into two equal segments on the basis of the number of dependent statements made by

clients. The Wilcoxin test shows no significant differences in central tendency of D Ap% from segment 1 to segment 2 (p. = .29, two-tailed test). In addition, the frequency of D Ap does not increase from the first to the second segment (sign test, p. = .46, two-tailed). Therefore, D Ap% and frequency of D Ap do not change but remain relatively constant over the interview. The Piersonian correlation coefficient between D Ap% in the first and second segment of the interview is .38 (p.< .01). With these controls, a change in D Ap C% cannot be attributed to changes in the number of dependent statements made, their percentage, or the frequency of approach responses from segment to segment.

D Ap C% and D Av C% were computed separately for each segment of the 72 interviews.

Reliability. Interjudge reliability coefficients of scores used in this section are shown in Table 3.

Table 3. Interjudge Reliability of Scores in the Two Segments of the Interviews

| Score | Segment 1 r | p. | N | Segment 2 r | p. | N |
|---|---|---|---|---|---|---|
| D Ap C% | .66 | .01 | 20 | .50 | .05 | 19 |
| D Av C% | .76 | .01 | 17 | .52 | .05 | 17 |
| D Ap | .63 | .01 | 20 | .43 | .05 | 19 |

Interjudge reliability for the number of dependency statements (used to divide interviews into segments) scored in the 20 reliability tapes is .90 (p. <.01). For 20 tapes,

interjudge reliability on the two control scores in Table 7, approach to hostility (H Ap%) and Other Ap%, is .87 and .70, respectively.

Outcome. D Ap C% in segment 2 does not exceed D Ap C% in segment 1 when the sign test is applied to the entire sample. Of 67 tapes, 35 decreased and 32 increased in percentage continuance following approach. Clients do not tend to continue dependency more in the second segment when the analysis ignores differences in D Ap%.

It is impossible to obtain a predominantly approached group distinct from a predominantly avoided group since, as described under Hypothesis II, the entire sample is highly approached on dependency. The restricted range, therefore, obscures differences in the following tests. The hypothesis pertains to consistent approach and avoidance rather than to consistent and inconsistent approach. Therefore, an analysis of subgroups is called for. The "High Approach" group, then, is composed of clients receiving the mean D Ap% score (73%) or greater. The "Low Approach" group are clients approached on dependency less than 73% of the time. Table 4 indicates that in comparison to the Low Approach group, the High Approach group does not change significantly in D Ap C% or D Av C% from segment to segment. The directions of changes, however, are consistent with the directional hypothesis.

Table 4. Change Over Segments in Percentage Continuance of Dependency for High and Low Approach Groups

| Score | Group | Increase | Decrease | Chi Square p.* |
|---|---|---|---|---|
| D Ap C% | High Approach | 21 | 17 | <.10 |
| | Low Approach | 11 | 18 | |
| | Total | 32 | 35 | |
| D Av C% | High Approach | 11 | 7 | <.15 |
| | Low Approach | 11 | 14 | |
| | Total | 22 | 21 | |

*One-tailed test

The data for D Ap C% are analyzed in more detail in Table 5, which presents the comparison for High and Low Approach groups when clients start out in the first segment with either low or high D Ap C% scores, i.e., D Ap C% scores above and below the mean 63%.

Table 5. Change Over Segments in Percentage Continuance of Dependency Following Approach (D Ap C%) for High and Low Approach Groups

| Seg. 1 Score | Group | Increase | Decrease | Fisher's Exact p.* |
|---|---|---|---|---|
| Low D Ap C% | High Approach | 13 | 2 | .05 |
| | Low Approach | 8 | 5 | |
| High D Ap C% | High Approach | 8 | 15 | .25 |
| | Low Approach | 3 | 13 | |

*One-tailed test (Tocher's modification)

As hypothesized, the High Approach group tends to score higher on D Ap C% than the Low Approach group when the percentage of continuance is low in the first segment. This must be interpreted as a minimal confirmation of the hypothesis because of the split imposed upon the High Approach group. In addition, without Tocher's modification of Fisher's Exact test, the difference is not significant. (The modification makes the test less conservative.)

Similarly, the Low Approach group which begins the interviews with high D Ap C% scores tends to decrease in continuance, but not significantly more than the High Approach group. The results of both tests, then, fail to confirm the hypothesis, but weak learning trends appear.

The same kind of analysis, applied to the groups when first segment D Av C% scores are low and high, i.e., above and below the mean 26% gives the results shown in Table 6.

Table 6. Change Over Segments in Percentage Continuance of Dependency Following Avoidance (D Av C%) for High and Low Approach Groups

| Seg. 1 Score | Group | Increase | Decrease | Fisher's Exact p.* |
|---|---|---|---|---|
| Low D Av C% | High Approach | 8 | 1 | .78 |
| | Low Approach | 9 | 1 | |
| High D Av C% | High Approach | 3 | 6 | .25 |
| | Low Approach | 2 | 13 | |

*One-tailed test (Tocher's modification)

While there are similar learning trends for the "high beginners," the differences are not significant. The hypothesis is not confirmed.

Both Table 5 and Table 6 show a clear tendency regardless of D Ap% for "low beginners" in continuance scores to continue more in the second segment and for "high beginners" to continue less as the interview progresses. The Chi Square test shows significant directional changes to occur for both D Ap C% and D Av C% scores ($p. < .001$, two-tailed test). The product-moment correlations between first segment scores and second segment scores of the high beginners and of the low beginners, for both D Ap C% and D Av C%, are all below .05. There is no association between magnitude of continuance scores from segment to segment when clients start low or high on continuance. Correlations of the total D Ap C% and total D Av C% scores from segment to segment are also not significant.

In interpreting the slight changes in continuance noted in the above two tables, it is relevant to investigate the relationship of the percentage continuance of dependency to therapists' approach to the category and therapists' approach to other categories of client behavior. Table 7 indicates that, as the interview progresses, only D Ap% becomes more closely associated with continuance of dependency following approach. For the entire sample, the relationship is low but significant in the second segment. Other scores remain unrelated in the second segment.

Table 7. Correlations of Percentage Continuance of Dependency Following Approach (D Ap C%) with Therapist Responses

| D Ap C% | D Ap% N | D Ap% r | H Ap% N | H Ap% r | Other Ap% N | Other Ap% r |
|---|---|---|---|---|---|---|
| Segment 1 | 72 | .02 | 72 | .04 | 72 | .00 |
| Segment 2 | 71 | .29* | 71 | .00 | 71 | .12 |

*p. $<$.01, two-tailed test

The significance of the difference between the correlations of D Ap% with the first and the second segment D Ap C% scores is at the one-tailed 5% level ($z = 1.64$). In the second segment of the interview, discussion of dependency is more related to the therapists' approach responses than it is in the first segment.

D Av C% fails to show a similar relationship with D Ap%. The correlation of D Ap% scores with D Av C% in the first segment is .09, while in the second segment it is .07. As discussed earlier, the Low Approach group, in fact, received more approach than avoidance of dependency.

Table 8 presents correlations of D Ap% scores with D Ap C% in each segment for the group which shows significant increases in continuance (clients whose continuance of dependency following approach is initially low). Although there is an increase in continuance, D Ap% is not significantly related to the change.

Table 8. Correlations of Percentage Approach to Dependency (D Ap%) with Continuance Following Approach (D Ap C%)

| D Ap C% | N* | r | p. |
|---|---|---|---|
| Segment 1 | 30 | .22 | N.S. |
| Segment 2 | 30 | .26 | N.S. |

*N includes two tapes that are not included in Table 5 because D Ap C% neither increased nor decreased.

## D. Hypothesis IV

Hypothesis IV concerns reinforcement of dependency statements initiated by the client. When therapists approach dependency, clients initiate more dependency statements, and when therapists avoid, client initiated dependency decreases during the course of the interview.

Score. Client initiated dependency (CID) statements are clients' dependency expressions which are not in immediate response to therapists' approach or avoidance. For a unit to be scored as a client initiated dependency statement, then, the interaction sequence which precedes it contains only Hostile or Other response categories. When therapists respond to these categories, and simultaneously attempt to introduce discussion of dependency, the judges score "Dependency initiated by therapist." Consequently, a succeeding dependency statement cannot be scored as CID.

CID scores are expressed as the percentage of units in which the client initiates dependent statements in comparison with the opportunity he has to initiate them.

"Opportunity to initiate" is the number of non-dependent (Hostile or Other) units which do not immediately follow therapists' D Ap, D Av, or initiation of dependency responses. In the scoring system, therefore, CID% is independent of the frequency and percentage continuance of dependency.

CID% was computed in first and second segments of interviews. Each segment of an interview contains half of the total number of dependency units in that interview. Results presented under Hypothesis III indicate, for the entire sample, that D Ap% is stable and that the frequency of D Ap does not increase from segment 1 to segment 2.

Reliability. Interjudge scoring reliability of CID%, shown in Table 9, is adequate in each segment.

Table 9. Interjudge Reliability of Percentage CID in the Two Segments of the Interviews

| CID% | N | r | p. |
|---|---|---|---|
| Segment 1 | 18 | .75 | $<.01$ |
| Segment 2 | 19 | .74 | $<.01$ |

Outcome. High and Low Approach groups were formed by dividing the sample at the mean D Ap% score (73%). Table 10 indicates no significant difference between High and Low Approach groups in the change of CID% from the first to the second segment.

Table 10. Change Over Segments in Percentage CID for High and Low Approach Groups

| Score | Group | Increase | Decrease | Chi Square p.* |
|---|---|---|---|---|
| CID% | High Approach | 19 | 20 | <.15 |
| | Low Approach | 9 | 20 | |

*One-tailed test

For the entire sample, the product-moment correlation between D Ap% scores and CID% in segment 1 is .01. In segment 2, the correlation increases to .15. However, the difference between the two correlations is not significant. CID%, then, does not appear to vary in association with D Ap%.

Table 11 presents changes in CID% scores from segment to segment for clients who received segment 1 CID% scores below and above the mean, 32%. The findings are not significant although the CID% scores of clients beginning the interview with low CID% scores tend to change in the hypothesized directions.

Table 11. Change Over Segments in High and Low Segment One Percentage CID for High and Low Approach Groups

| Seg. 1 Score | Group | Increase | Decrease | Chi Square p.* |
|---|---|---|---|---|
| Low CID% | High Approach | 16 | 8 | <.15 |
| | Low Approach | 9 | 11 | |
| High CID% | High Approach | 3 | 12 | <.20 |
| | Low Approach | 0 | 9 | |

*One-tailed test

Product-moment correlations between D Ap% and CID% scores in segment 1 and segment 2 for the high and low first segment CID% scores do not reach significance. The correlation for the total group CID% scores and D Ap% is similarly not significant.

## E. Hypothesis V

Hypothesis V states that experienced therapists approach dependency statements more than less experienced therapists.

Score. Only one interview from each therapist is included in this analysis. This procedure prevents unequal weighting of D Ap% scores by individual therapists within each experience level. The tapes from therapists were chosen on the basis of the alphabetical order of clients' names, thus giving six D Ap% scores from staff members, 12 from internes, and 12 from practicum students.

Outcome. The Mann-Whitney U test indicates that staff level therapists approach dependency statements more than either internes or practicum students. Table 12 shows the significance levels of the differences.

Table 12. Differences of Percentage Approach to Dependency Between Experience Levels

| Direction of Difference | One-tailed p. |
|---|---|
| Staff > Interne | .02 |
| Staff > Practicum | .03 |
| Practicum > Interne | .29 |

## F. Hypothesis VI

Hypothesis VI predicts that experienced and inexperienced therapists differ in the percentage of approach responses to subtypes of dependency statements made by clients.

Reliability. Interjudge scoring reliability is satisfactory for only two of the eight subcategories. Table 13 presents the reliability coefficients. Due to the small number of cases, Spearman rho coefficients are computed in this analysis.

Table 13. Interjudge Reliability for Percentage Approach to Subcategories of Dependency

| Dependency Subcategory | N | rho |
|---|---|---|
| Problem Description | 12 | .54* |
| Help Seeking | 18 | .22 |
| Approval Seeking | 18 | .32 |
| Company Seeking | 14 | .53* |
| Information Seeking | 16 | .32 |
| Agreement | 12 | .06 |
| Disapproval Concern | 13 | .00 |
| Initiative Seeking | 5 | .00 |

*$p. < .05$

Part of the difficulty in obtaining satisfactory interjudge reliability is the very low frequency of some of the subcategories in each tape. In the extreme instance, initiative seeking, units appear in only five of the 20 tapes assessed for reliability. Of these five tapes, the mean number of such units per tape was only 6 for Judge A and 2.4 for Judge B.

Interjudge disparity in scoring for approach and avoidance of subcategories is statistically magnified since scores are expressed in percentages. There were some tapes for which one disagreement about approach and avoidance affected the score by 50% or 100%.

Outcome. Mann-Whitney U tests determine differences between experience levels in per cent approach to the Problem Description and Company Seeking subcategories. There are 16 practicum, 21 interne, and 11 staff tapes included in the analysis of approach to Problem Description, while 17 practicum, 32 interne, and 13 staff tapes are used in computing approach to Company Seeking. Practicum students tend to approach Problem Descriptions more than internes, while staff therapists tend to approach Company Seeking statements more than internes. However, both of these differences fail to reach significance ($p. < .10$, two-tailed tests). No other differences were found.

When only one tape from each therapist is used, N becomes too small for a meaningful statistical test.

Sign tests show no differences between experience levels in the effectiveness of approach in eliciting further dependency (D Ap C% and D Av C%).

# IV. DISCUSSION

## Approach-Avoidance as Contingent Stimuli: Hypotheses I, V, and VI

Hypothesis I pertains to the immediate effects of therapists' approach and avoidant responses to clients' expressions of dependency. In the present study, therapists' responses that are designed to promote or to discourage discussion of dependency do have these effects upon clients. The results support Winder et al (1962). Wider generalization of the eliciting effects of approach and avoidance is justified, since the populations of clients and therapists in each investigation differ in several respects. Although no measures are available for clients in either sample, the dependency conflicts of late adolescent students coming to a Counseling Center would seem central to their stage of personality development. On the other hand, parents seen at a Child Guidance clinic are not necessarily experiencing a transition to independence. Their dependency perhaps is more situational or problem-centered, being motivated by a wish to get help for their children. Approach and avoidance effectively elicit and inhibit expressions of dependency no matter which source.

The habit of responding to approach and avoidance is not confined to dependency. Parallel results regarding the elicitation of immediately following hostility discussion

are noted by Kopplin (1963), who confirms findings of Bandura et al (1960).

Some importance is attached to the repeated confirmation with different client and therapist populations of the hypothesis that therapists have a direct and effective role in determining the course of discussion in early therapy interviews. As Murray (1956) found, even the non-directivity of Rogers is "directive" in the sense that clients are swayed by mild therapist approval and disapproval.

Therapists appear to exploit a strongly entrenched habit of the client to follow direction as early in therapy as the first hour. The habit may be generalized from ordinary social interaction or from prototypes of the dependent relationship (parent-child, teacher-pupil). The second possibility seems more likely.

Demonstrations of the leading role which therapists play, together with the resulting dependent role of clients, explicate at least one aspect of psychotherapeutic technique. Other questions arise concerning (1) the occurrence and the effectiveness of this direction in various stages of psychotherapy, (2) possible client and therapist differences determining approach and avoidance and (3) the influence of therapist's goals and values upon his manipulation of clients.

According to Hypothesis V, experience teaches therapists to approach dependency. Significant differences in the present study support the hypothesis in regard to

staff level therapists compared to internes and practicum students. The difference in D Ap% between the latter two groups is slight, as is the difference in their degrees of experience. Although these findings must be regarded with care because of the small sample size, the differences suggest that exploitation of a well-learned habit is a therapeutic technique learned through experience with the effects of approaching and avoiding dependency.

In addition to quantitative differences in percentage of approach responses, there may be substantial qualitative change occurring with increasing experience. Appropriateness of the approach response within the broad category of dependency may be one of these. There is some evidence that therapists' experience is not related to their sensitivity to clients' expressions, as rated by experts (Rosenberg, 1962). The present study finds that the effectiveness of approach responses does not differentiate experience levels. All levels were equally able to elicit dependency when they approached and to inhibit dependency when they avoided dependent statements. The elicitation value of approach and avoidance seems to lie within the verbal response itself, rather than in the experience level of therapists who use it.

It would be interesting to determine the relative potencies of subcategories of approach and avoidance in eliciting continuance. This type of analysis may disclose qualitative differences in the elicitors and in therapists'

use of them. Other dimensions of responses are not measured by this system. Therapist style, defined by Strupp (1957) and studied by Rottschafer & Renzaglia (1962) is one such factor known to influence client dependency. Throughout the scoring of the tapes, both judges were concerned with unscorable aspects of therapists' responses. For example, while one therapist's "exploration" approach was inquiring, another's was tinged with hostility.

Although differences in the tone of the therapist's responses may be crucial in their cumulative effects upon clients, the scoring manual emphasizes explicit verbal content; minor shifts in content and affect are not scored. Not all approach and avoidance responses are as mutually exclusive as the manual allows. Adhering to verbal content in scoring may increase reliability and support the approach-avoidance model at the cost of sensitivity to other important variables.

Whether manipulation of verbal expressions of dependent content is therapeutically relevant or effective is not known. The distinction between "talking about" one's own or another's dependency and "being" dependent is a problem in validity of measurement for any study utilizing content analysis. Strupp (1962) provides a thoroughgoing criticism of the technique, most of his objections pertaining to questions of validity. Janis (1943) bases his defense of content analysis upon its usefulness in establishing a set of meaningful and lawful relationships in the data to

which it is applied. As such, he regards the test of content analysis as similar to the proof of a theory; validity lies, in part, in heuristic value.

The portion of the study most hampered by low scoring reliability is Hypothesis VI. Only two subcategories of dependency can be tested for differences in approach percentage for therapists of different experience levels. The trends that were found are obscured by unequal representation of D Ap% scores within each experience level.

In an attempt to raise scoring reliability, the investigator tried to establish mutually exclusive subcategories of dependent statements. However, the criteria for each type became impractically narrow, since client verbalizations typically are complex. Consequently, subcategories were used as they had been by Winder et al, some being too inclusive and others too rare in the present sample.

Inherent in the scoring subcategories is a factor which may explain the sparseness of units in some classifications. Twelve therapists were asked to rank the dependency subcategories on a continuum of "mental health." They show strong agreement on independent rankings of most types of dependency bids, the infrequently scored Disapproval Concern and Initiative Seeking subcategories being judged least healthy. Thus, the relatively healthy student population sampled may preclude use of these categories. This appears to have happened in transfering a manual derived from a population of clients somewhat different from those studied here.

In line with the operant conditioning model, analyses of psychotherapy interviews throughout the duration of treatment may reveal that approach and avoidance become distributed according to the rankings of dependency subcategories on the continuum of "mental health." Because the present study examines only early psychotherapy, such an analysis cannot be made.

## Approach-Avoidance as Consistent Elicitors: Hypotheses II, III, and IV

Hypothesis II deals with the long-term reinforcement effects of approach and avoidance upon remaining in psychotherapy. The findings show no difference between terminators and remainers in terms of therapists' responses to dependent statements. One side of the hypothesis is not adequately tested, however, since the sample lacked clients whose dependency was avoided consistently. Rather, the Low Approach group was inconsistently approached. The data are more accurately applied to a test of the effects of consistent versus inconsistent elicitation, than to a test of two consistent elicitors of competing responses.

One might speculate about the reasons that therapists in this study predominantly approach dependency in contrast to therapists' behavior in the Winder et al study. They write:

> Further investigation suggested that the form of the expressions of dependency by terminators and remainers may differ. It is suggested that some forms of expressions may provoke avoidance if the

> psychotherapist follows conventional notions about proper psychotherapeutic technique. (p. 134)

Clients in the present study are typically self-referred adolescents experiencing conflicts about their transition from dependency. Clients studied by Winder et al were adults seeking help primarily for their children and only tangentially for themselves. Their personal problems encompassed a wide range. In conventional psychotherapy, the first type of dependency would seem to be more "approachable" than the second. In addition, therapists may recognize and want to deal with the more central problems in their clients. No comparisons are available along these dimensions in the present study.

Additionally, the means by which therapists get clients may help to explain the failure of D Ap% to differentiate terminators from remainers. Where some therapists in the Winder et al study were assigned cases following diagnostic and intake interviews by a different therapist, the staff members and internes in the present study were free to choose their own clients, to retain or terminate them, to refer them to a waiting list, or to send them to other therapists. Therapists who incur some formal obligation to see a particular client have greater reason to avoid dependency than do therapists who are free to avoid the entire relationship.

A small scale study bears on this point. During the earliest phase of data collection, the investigator asked therapists to complete a short rating scale after

seeing new clients. The scale is adapted from Stoler (1961) and is reproduced in Appendix C. Therapists rated on a scale from 1 to 6 their feelings of liking or disliking the client they had just seen and tape recorded for the present study. The scale was discontinued after the first 28 tapes were obtained. The results are shown in Table 14. The mean score is 3.2 for terminators and 1.9 for remainers.

Table 14. Client Likability and Remaining in Therapy

| Client Likability | Terminators | Remainers | Fisher's Exact p.* |
|---|---|---|---|
| Liked (1-3) | 1 | 13 | .03 |
| Disliked (4-6) | 7 | 7 | |

*Two-tailed test

Clients may remain in response to their therapists' initial liking of them, therapists may retain clients whom they like, or some third factor may affect both variables. In any case, both therapists and clients in the present study had relatively unobstructed choice regarding continuation of therapy. This may not have been true with Winder et al.

Hypotheses III and IV are not adequately tested, since they deal with two mutually contradictory elicitors. As noted earlier, consistent avoidance of dependency (D Ap% $< 50$) characterizes only two therapists in this sample. Therefore, the tests made are between effects of

consistent versus inconsistent elicitation (High and Low Approach groups).

The study fails to confirm the hypothesis that the fact that the therapist exploits a pre-existent habit (continuing a subject when approached) makes his ability to manipulate the client's verbalizations more powerful as the interview continues. Trends in the predicted directions are found with both High and Low Approach groups; as the interview progresses, continuance of dependency becomes more probable with approach, and discontinuance increases with avoidance. However, there is no significant learning effect when the High and Low groups are compared. Correlations were computed to investigate the relationship between therapists' responses and the measures which showed the slight learning trends, D Ap C% and D Av C%. The association between D Ap% and D Ap C% from first to second segments of interviews increases significantly, while therapists' approach to Hostility and Other categories of client responses remain unrelated to continuance following approach to dependency throughout the interview.

Thus, over the course of the interview, there is a small but significant build-up of association between therapists' approach responses and the degree to which clients continue the topic following approach. The number of clients for whom the probability of continuance increases, however, is not significant. The relatively low correlation coefficient obtained suggests that there are contaminating

factors being measured along with one or both of the variables. Measurement of the qualitative differences in therapists' approach responses and shifts in content within the broad category of dependency may be accountable. These unmeasured variables also may have confounded the testing of increased continuation in the second segment.

Essentially the same trends are noted between approach to dependency and client initiated dependency but low significance levels lead to the rejection of the fourth hypothesis.

An analysis of continuance scores which are low or high in the first segment of the interview reveals for both groups a general regression toward the mean in the second segment, regardless of the percentage approach clients receive. "Low beginners" increase continuance and "high beginners" decrease from the first to the second segment. The increase for low beginners may be due to clients' becoming adapted to the situation and a subsequent weakening of initial inhibition to react in a dependent manner. The decrease for high beginners may reflect stimulus-satiation to the topic or accumulating dependency anxiety resulting in a build-up of inhibition to discuss dependency. In either case, the changes are unrelated to therapists' approach to dependency as measured in this study.

Although learning is not demonstrated in this study, the consistency of trends is suggestive. Larger and more varied samples of clients and therapists, together with

more refined scoring categories are needed. Other content categories and more extensive time sampling are necessary in order to investigate the applicability of the indicated trends to psychotherapy in general.

# V. SUMMARY

Dependency of clients upon psychotherapists is a frequent and important occurrence in the early hours of psychotherapy. This study examines the phenomenon as an effect of therapists' approach and avoidance responses to clients' verbalizations of dependent content. The hypotheses state that when therapists approach dependency, clients continue the topic but when therapists avoid, then clients discontinue. Aside from the elicitation value of approach, these responses are assumed to reinforce discussion of the topic. Learning occurs if (1) the probability of a client's continuing the topic increases as the interview progresses and (2) the probability of a client's initiating dependency statements increases over time. Conversely, therapists' avoidance of dependency reinforces the tendency for clients to discuss non-dependent topics. The study also examines the longer-term effects of reinforcement upon staying in therapy.

Further hypotheses state (1) that therapists learn to approach dependency as an initial technique of therapy and (2) that therapists learn to reinforce selectively various types of dependent statements.

A content analysis of 72 recordings of early psychotherapy interviews with clients at a university counseling center shows that approach to dependency elicits further

discussion of dependency and avoidance elicits discontinuance. For clients whose dependent statements are predominantly approached, the probability that approach elicits further discussion and that clients initiate dependency statements does not increase significantly as the hour progresses, although there are trends in the expected directions. Due to the high frequency of approach responses made to all clients, effects of avoidance are inadequately measured. Relatively infrequent approach, however, does not reinforce the competing tendency to discuss non-dependent topics. The data suggest individual differences in inhibition of each habit independent of the therapists' responses measured here.

Terminating and remaining in therapy are unrelated to the percentage of approach and avoidance therapists gave when clients discussed dependency. This fails to support previous findings. However, more "likable" clients are very likely to remain in therapy.

Staff level therapists more frequently approach than avoid dependency in contrast to practicum and interne level therapists. Approach to subtypes of dependency is not substantially affected by experience level.

Limitations inherent in the study are discussed and implications are noted for further research.

## REFERENCES


Alexander, F., & Ross, H. Dynamic psychiatry. Chicago: Univ. of Chicago Press, 1952.

Bandura, A., Lipsher, D. H., & Miller, P. E. Psychotherapists' approach-avoidance reactions to patients' expressions of hostility. J. consult. Psychol., 1960, 24, 1-8.

Denny, M. R., & Adelman, H. M. Elicitation theory: an analysis of two typical learning situations. Psychol. Rev., 1955, 62, 290-296.

Dollard, J., & Auld, F., Jr. Scoring human motives: a manual. New Haven, Conn.: Yale University Press, 1959.

Dollard, J., & Miller, N. E. Personality and psychotherapy. New York: McGraw-Hill, 1950.

Fenichel, O. The psychoanalytic theory of neurosis. New York: Norton, 1945.

Ferster, C. B. Reinforcement and punishment in the control of human behavior by social agencies. Psychiat. Res. Repts., 1958, 10, 101-118.

Fey, W. F. Doctrine and experience: their influence upon the psychotherapist. J. consult. Psychol., 1958, 22, 403-409.

Fromm-Reichmann, F. Principles of intensive psychotherapy. Chicago: Univ. of Chicago Press, 1950.

Greenspoon, J. The effect of a verbal stimulus as a reinforcement. Proc. Ind. Acad. Sci., 1950, 59, 287. (Abstract).

Greenspoon, J. The reinforcing effect of two spoken sounds on the frequency of two responses. Amer. J. Psychol., 1955, 68, 409-416.

Greenspoon, J. Verbal conditioning and clinical psychology. In A. J. Bachrach (ed.), Experimental foundations of clinical psychology. New York: Basic Books, 1962, 510-553.

Hildrum, D. C., & Brown, R. W. Verbal reinforcement and interview bias. J. abnorm. soc. Psychol., 1956, 53, 108-111.

Janis, I. L. Meaning and the study of symbolic behavior. Psychiatry., 1943, 6, 425-439.

Kopplin, D. A. Hostility of patients and psychotherapists' approach-avoidance responses in the initial stage of psychotherapy. Unpublished master's thesis, Michigan State University, 1963.

Krasner, L. Studies of the conditioning of verbal behavior. Psychol. Bull., 1958, 55, 148-170.

Murray, E. J. A case study in a behavioral analysis of psychotherapy. J. abnorm. soc. Psychol., 1954, 49, 305-310.

Murray, E. J. The content-analysis method of studying psychotherapy. Psychol. Monogr., 1956, 70 (13, Whole No. 420).

Rogers, C. R. Counseling and Psychotherapy. Boston: Houghton Mifflin, 1942.

Rogers, C. R. Client-centered therapy. Boston: Houghton Mifflin, 1951.

Rogers, C. R. The necessary and sufficient conditions of therapeutic personality change. J. consult. Psychol., 1957, 21, 95-103.

Rogers, C. R. The process conception of psychotherapy. Amer. Psychol., 1958, 13, 142-149.

Rosenberg, E. H. Correlates of a concept of therapeutic sensitivity. Unpublished doctoral dissertation, Michigan State University, 1962.

Rottschafer, R. H., & Renzaglia, G. A. The relationship of dependent-like verbal behaviors to counselor style and induced set. J. consult. Psychol., 1962, 26, 172-177.

Salzinger, K. Experimental manipulation of verbal behavior: a review. J. genet. Psychol., 1959, 61, 65-95.

Salzinger, K., & Pisoni, S. Reinforcement of affect responses of schizophrenics during the clinical interview. J. abnorm. soc. Psychol., 1958, 57, 84-90.

Sears, R. R., Macoby, E., & Levin, H. Patterns of child rearing. Evanston, Ill.: Row, Peterson, 1957.

Sears, R. R., Whiting, J. W. M., Nowlis, V., & Sears, P. S. Some child-rearing antecedents of aggression and dependency in young children. Genet. psychol. Monogr., 1953, 47, 135-234.

Shoben, E. J. Psychotherapy as a problem in learning theory. Psychol. Bull., 1949, 46, 366-392.

Skinner, B. F. The generic nature of the concept of stimulus and response. J. genet. Psychol., 1935, 12, 40-63.

Skinner, B. F. Science and human behavior. New York: Macmillan, 1953.

Skinner, B. F. Verbal behavior. New York: Appleton-Century-Crofts, 1957.

Spielberger, C. D., & Levin, S. M. What is learned in verbal conditioning? J. verb. learn. verb. behav., 1962, 1, 125-132.

Stoler, N. Client likability as a variable in the study of psychotherapy. Psychiatric Institute Bulletin, Univ. of Wisconsin, 1961, 1, 1-9.

Strupp, H. H. An objective comparison of Rogerian and psychoanalytic techniques. J. consult. Psychol., 1955, 19, 1-7.

Strupp, H. H. Psychotherapeutic technique, professional affiliation and experience level. J. consult. Psychol., 1955, 19, 97-102.

Strupp, H. H. A multidimensional system for analyzing psychotherapeutic techniques. Psychiatry, 1957, 20, 293-306.

Strupp, H. H. Patient-doctor relationships: the psychotherapist in the therapeutic process. In A. J. Bachrach (ed.), Experimental foundations of clinical psychology. New York: Basic Books, 1962, 576-615.

Sullivan, P. L., Miller, C., & Smelser, W. Factors in length of stay and progress in psychotherapy. J. consult. Psychol., 1958, 22, 1-9.

Ullman, L. P., Krasner, L., & Collins, B. J. Modification of behavior through verbal conditioning: effects in group therapy. J. abnorm. soc. Psychol., 1961, 62, 128-132.

Waskow, I. E. Reinforcement in a therapy-like situation through selective responding to feelings or content. J. consult. Psychol., 1962, 26, 11-19.

Winder, C. L., Ahmad, F. Z., Bandura, A., & Rau, L. C. Dependency of patients, psychotherapists' responses, and aspects of psychotherapy. J. consult. Psychol., 1962, 26, 129-134.

Wolberg, L. R. The technique of psychotherapy. New York: Grune and Stratton, 1954.

## APPENDIX A

### Data Sheet for Therapists

Please write in and tape record the information asked for in items 1 through 5:

1. Tape SIDE NUMBER: _____

2. Client's full NAME: _____

3. Therapist's position: Staff _____ Interne _____ Practicum _____

4. DATE of this interview: _____

5. Interview number: _____

The purpose of this questionnaire is to identify tapes of the first two psychotherapy interviews which you have with new clients. This excludes only those interviews which you judge to be primarily educational, vocational or testing oriented. It may be difficult to specify just which interview you start therapy in but we would include interviews in which you were assessing the client's potential for therapy by means of "trial therapy" procedures.

If you judge your first interview as a therapy interview, then go on to record the next interview which you have with the client. If the recorded interview was not a therapy interview, please hold the tape to record a subsequent interview in which you begin therapy or to record another client.

6. By the above criteria, was this interview one in which you were primarily engaged in therapy? YES ___ NO ___

   6a. If "YES," was it the First or Second therapy interview? (Circle one)

   6b. If "NO," what was the nature of the interview?

7. Has this client had psychotherapy prior to his seeing you? YES ___ NO ___

Please return this sheet with the tape when you have collected two therapy interview recordings. If you need the tape for some reason, it will be available.

## APPENDIX B

### Follow-Up Questionnaire

We are inquiring about the status of some of the clients whom you tape recorded for study. Please fill in the appropriate information and return this form to the receptionist.

CLIENT'S NAME: _____

1. How many hours of <u>therapy</u> have you had with this client? _____

2. How many hours of "non-therapy" contacts have there been? _____ What was the nature of those hours? _____

3. Are you currently seeing him in therapy? _____ Seeing him for some other reason? _____ Explain. _____

4. Has the relationship been terminated? _____

   a. If "YES," did the client terminate despite your explicit or implicit feeling that he needed more therapy, i.e., did you regard the termination as <u>premature</u>? _____ Explain the reasons and circumstances of termination. _____

   b. Was the termination due to unavoidable situational factors? _____ What were they? _____

5. Was there an agreement made by you and the client to begin therapy? _____ When was the agreement made? (e.g., 2<u>nd</u> hour) _____ If there was no mutual agreement on therapy, please explain the basis upon which you saw him. _____

6. Has the client had psychotherapy prior to seeing you? _____

## APPENDIX C

### Client Likability Scale

Upon completion of the therapy interview, i.e., if you checked "YES" to question 6 on the data sheet attached to this form, make a rating on the continuum of liking to disliking of the client.

You may make a mark at any place along the scale: you are not confined to the points that are numbered.

Scale point (1) is for a positive liking reaction to the client, while a check at (6) would be a disliking reaction to the client. Marking any place along the scale between these two points will represent the magnitude of your liking or disliking, depending on the closeness to the end of the scale.

Often it is our experience that we have feelings and reactions to people, but do not necessarily draw our attention to these feelings. This rating task asks you to look at the specific liking or disliking feeling that this client brings out in you. Ratings made of the same client after different interviews may, of course, differ.

1 2 3 4 5 6

## APPENDIX D

### Scoring Manual

(This manual is a modification of manuals used in the following studies: Winder, C. L., Ahmad, F. Z., Bandura, A., & Rau, L. C. Dependency of patients, psychotherapists' responses, and aspects of psychotherapy. J. consult. Psychol., 1962, 26, 129-134; Bandura, A., Lipsher, D. H., & Miller, P. E. Psychotherapists' approach-avoidance reactions to patients' expressions of hostility. J. consult. Psychol., 1960, 24, 1-8.)

A. Scoring Unit and Interaction Sequence

1. Definition. A unit is the total verbalization of one speaker bounded by the preceding and succeeding speeches of the other speaker with the exception of interruptions.

There are three types of scoring units: the "patient statement" (P St), the "therapist response" (T R), and the "patient response" (P R). A sequence of these three units composes an "interaction sequence." The patient response not only completes the first interaction sequence but also initiates the next sequence and thereby becomes a new patient statement.

Example:

P. I can't understand how you can stand me. (P St)

T. You seem to be very aware of my feelings. (T R)

P. I am always sensitive to your feelings. (P R)

2. Pauses. Pauses are not scored as separate units. The verbalization before and after the pause is considered one unit. Therapist silences are scored as prescribed under Part D2e of this manual. There are no patient silences in this system.

3. Interruptions. Statements of either therapist or patient which interrupt the other speaker will be scored only if the content and temporal continuity of the other speaker is altered by the interruption. Then, the interrupting verbalization becomes another unit and is scored. A non-scored interruption is never taken into account in the continuation of the other speaker.

Interruption scored as one unit:
P. I asked him to help me and--

T. Why was that?

P. --he refused to even try.

Non-interruption scored as 3 units, one interaction sequence:
P. I asked him to help me and--

T. Why was that?

P. I don't know.

Verbalizations such as "Um hmm" or "I see" are ignored in scoring unless they are so strongly stated as to convey more than a listening or receptive attitude.

Patients' requests for the therapist to repeat his response are considered interruptions and are not scored. However, therapists' requests of this sort are scored as units (as approach or avoidance of the patient statement).

B. Categories of Patient Statements and Patient Responses

There are three categories: Dependency, Hostility, and Other. They are scored as exhaustive categories. All discriminations are made on the basis of what is explicitly verbalized by the speaker in the unit under consideration. One statement may be scored for several categories.

When dependency and/or hostility units occur, the object of the patient's behavior is also scored as either psychotherapist or other.

A coding of self (S) is given if the patient refers to his own behavior and a coding of other (O) is given if the client refers to someone else's behavior.

1. Hostility category. The subcategories of hostility listed below are not differentiated in the scoring but are listed here to aid in identification of hostility.
   a. Hostility. Hostility statements include description or expression of unfavorable, critical, sarcastic, depreciatory remarks; oppositional attitudes; antagonism, argument, expression of dislike, disagreement, resentment, resistance, irritation, annoyance, anger; expression of aggression and punitive behavior, and aggressive domination.

      1. Anger:

P. I'm just plain mad!

P. I just couldn't think--I was so angry.

P. My uncle was furious at my aunt.

2. Dislike: expresses dislike or describes actions which would usually indicate dislike
   P. I just don't get interested in them and would rather be somewhere else.

   P. I've never ever felt I liked them and I don't suspect I ever will.

   P. He hates editorials.

3. Resentment: expresses or describes a persistent negative attitude which does or might change to anger on a specific occasion
   P. They are so smug; I go cold whenever I think about having to listen to their 'our dog' and 'our son.' Boy!

   P. They don't ever do a thing for me so why should I ask them over?

   P. Dad resents her questions.

4. Antagonism: expresses or describes antipathy or enmity
   P. It's really nothing definite, but we always seem at odds somehow.

   P. There is always this feeling of being enemies.

5. Opposition: expresses or describes oppositional feelings or behavior
   P. If he wants to do one thing, I want to do another.

   P. It always seems she is against things. She is even against things she wants.

   P. No, I don't feel that way (in response to T's assertion).

6. Critical attitudes: expresses negative evaluations or describes actions which usually imply negative evaluations
   P. If I don't think the actors are doing very well, I just get up and walk out.

   P. There is something to be critical about in almost everything anyone says or does.

7. Aggressive actions: acts so as to hurt another person or persons, either physically or psychologically
   P. He deserves to suffer and I'm making it that way every way I can.

   P. I can remember Mother saying: 'We slap those little hands to make it hurt.'

b. Hostility anxiety. A statement including expression of fear, anxiety, guilt about hostility or reflecting difficulty expressing hostility
   P. I just felt so sad about our argument.

   P. I was afraid to hit her.

   P. After I hit her I felt lousy.

c. Hostility acknowledgment or agreement. A statement agreeing with or acknowledging the therapist's approach toward hostility is scored as further hostility. May give example. May convey some conviction or may simply agree with therapist's response.
   T. You were angry.

   P. Yes!

2. Dependency categories.
   a. Definition. Any explicit expression or description of help-seeking, approval-seeking, company-seeking, information-seeking, agreement with others, concern about disapproval, or request that another initiate discussion or activity.

   b. Scoreable categories: The subcategories listed below are scored exhaustively.

1. Problem Description: States problem in coming to therapy, gives reason for seeking help, expresses a dependent status or a general concern about dependency
   P. I wanted to be more sure of myself. That's why I came.

   P. I wanted to talk over with you my reasons for dropping out of school next quarter.

   P. Part of the reason I'm here is that everything's all fouled up at home.

   P. I depend on her, am tied to her.

   P. I want to be babied and comforted.

2. Help-seeking: Asks for help, reports asking for help, describes help-seeking behavior
   P. I asked him to help me out in this situation.

   P. What can you do for him?

   P. I try to do it when he can see it's too hard for me.

3. Approval-seeking: Requests approval or acceptance, asks if something has the approval of another, reports having done so with others, tries to please another, asks for support or security. Includes talk about prestige. Expresses or describes some activity geared to meet his need
   P. I hope you will tell me if that is what you want.

   P. If there was any homework, I did it so Dad would know I was studying like a good girl.

   P. Is it alright if I talk about my girl's problem?

   P. That's the way I see it, is that wrong?

   P. I asked him if I were doing the right thing.

4. Company-seeking: Describes or expresses a wish to be with people, describes making arrangements to do so, describes efforts to be with others, talks about being with others
   P. It looks as if it'll be another lonely weekend.

   P. Instead of studying, I go talk with the guys.

   P. I only joined so I could be in a group.

   P. We try to see if other kids we know are there, before we go in.

5. Information-seeking: Asks for cognitive, factual or evaluative information, expresses a desire for information from others, arranges to be the recipient of information
   P. I asked him why he thought a girl might do something like that.

   P. I came over here to see about tests you have to offer. I want to know what they say.

   P. I'm planning to change my major. I'd like to know how to do it.

6. Agreement with another: Responds with ready agreement with others, readily accepts the therapist's reflection. Often illustrates therapist's remarks with examples, draws a parallel example to indicate agreement. May accept preceding statement on authority or if preceding statement was a therapist approach to Dependency, may simply agree with it.
   P. Oh, yes! You're absolutely right about that.

   P. Immediately I felt he was right and I had never thought about it that way.

   T. Then you wanted to get some help?

   P. Yes.

7. Concern about disapproval: Expresses fear, concern, or unusual sensitivity about disapproval of others, describes unusual distress about an instance of disapproval, insecurity, or lack of support. Little or no action is taken to do something about the concern
   P. She didn't ever say a thing but I kept on wondering what she doesn't like about me.

   P. My parents will be so upset about my grades, I don't even want to go home.

   P. It seems like I always expect I won't be liked.

   P. I can't understand how you can stand me when I smoke.

   P. I'm sorry I got angry at you.

8. Initiative-seeking: Asks the therapist or others to initiate action, take the responsibility for starting something (to start discussion, determine the topic). Arranges to be a recipient of T's initiative. May solicit suggestions
   P. Why don't you say what we should talk about now?

   P. If you think I should keep on a more definite track, you should tell me.

   P. I got my advisor to pick my courses for next term.

   P. Tell him what to do in these circumstances.

3. Other category. Includes all content of patient's verbalizations not classified above

C. Categories of Therapist Responses
Therapist responses to each scored patient statement are divided first into two mutually exclusive classes, approach and avoidance responses. When both approach and avoidance are present, score only the portion which is designed to elicit a response from the patient.

1. Approach responses. The following subcategories are exhaustive. An approach response is any verbalization by the therapist which seems designed to elicit from the patient further expression or elaboration of the Dependent or Hostile (or Other) feelings, attitudes, or actions described or expressed in the patient's immediately preceding statement, i.e., the part of the preceding statement which determined its placement under Dependency, Hostility or Other. Approach is to the major category, not specific subcategories.
   a. Approval: Expresses approval of or agreement with the patient's feelings, attitudes, or behavior. Includes especially strong "Mm-hmm!", "Yes"

      P. May I just be quiet for a moment?
      T. Certainly.
      P. I have my girlfriend's problems on my mind. Could we talk about them?
      T. Why don't we talk about that?

   b. Exploration (probing): Includes remarks or questions that encourage the patient to describe or express his feelings, attitudes, or actions further, asks for further clarification, elaboration, descriptive information, calls for details or examples. Should demand more than a yes or no answer; if not, may be a "label"

      P. How do I feel? I feel idiotic.
      T. What do you mean, you feel idiotic?

      P. I can't understand his behavior.
      T. What is it about his behavior you can't understand?

   c. Reflection: Repeats or restates a portion of the patient's verbalization of feeling, attitude, or action. May use phrases of synonymous meaning. Therapist may sometimes agree with his own previous response; if the client had agreed or accepted the first therapist statement, the second therapist statement is scored as a reflection of the client statement.

      P. I wanted to spend the entire day with him.
      T. You wanted to be together.

P. His doing that stupid doodling upsets me.
T. It really gets under your skin.

d. Labeling: The therapist gives a name to the feeling, attitude, or action contained in the patient's verbalization. May be a tentative and broad statement not clearly aimed at exploration. Includes "bare" interpretation, i.e., those not explained to the patient. May be a question easily answered by yes or no

P. I just don't want to talk about that any more.
T. What I said annoyed you.

P. She told me never to come back and I really did have a reaction.
T. You had some strong feelings about that--maybe disappointment or anger.

e. Interpretation: Points out and explains patterns or relationships in the patient's feelings, attitudes, and behavior: explains the antecedents of them, shows the similarities in the patient's feelings and reactions in diverse situations or at separate times

P. I had to know if Barb thought what I said was right.
T. This is what you said earlier about your mother . . .

f. Generalization: Points out that patient's feelings are natural or common

P. I want to know how I did on those tests.
T. Most students are anxious to know as soon as possible.

P. Won't you give me the scores?
T. Many students are upset when we can't.

g. Support: Expresses sympathy, reassurance, or understanding of patient's feelings.

P. It's hard for me to just start talking.
T. I think I know what you mean.

P. I hate to ask favors from people.
T. I can understand that would be difficult for you.

h. Factual Information: Gives information to direct or implied questions. Includes general remarks about the counseling procedure

P. Shall I take tests?
T. I feel in this instance tests are not needed.

P. What's counseling all about?
T. It's a chance for a person to say just what's on his mind.

2. Avoidance responses. The following subcategories are exhaustive. An avoidance response is any verbalization by the therapist which seems designed to inhibit, discourage, or divert further expression of the Dependent, Hostile, or Other patient categories. The therapist attempts to inhibit the feelings, attitudes, or behavior described or expressed in the immediately preceding patient statement, i.e., the part of the preceding statement which determined its placement under Dependency, Hostility, or Other. Avoidance is avoidance of the major category, not specific subcategories.

a. Disapproval: Therapist is critical, sarcastic, or antagonistic toward the patient or his statements, feelings, or attitudes, expressing rejection in some way. May point out contradictions or challenge statements

P. Why don't you make statements? Make a statement. Don't ask another question.
T. It seems that you came here for a reason.

P. Well, I wonder what I do now?
T. What do you think are the possibilities? You seem to have raised a number of logical possibilities in our discussion.

P. I'm mad at him: that's how I feel.
T. You aren't thinking of how she may feel.

b. Topic Transition: Therapist changes or introduces a new topic of discussion not in the immediately preceding patient verbalization. Usually fails to acknowledge even a minor portion of the statement

P. Those kids were asking too much. It would have taken too much of my time.
T. We seem to have gotten away from what we were talking about earlier.

P. My mother never seemed interested in me.
T. And what does your father do for a living?

c. Ignoring: Therapist responds only to a minor part of the patient response or responds to content, ignoring affect. May under- or over-estimate affect. May approach the general topic but blatently ignore the affect verbalized

P. You've been through this with other people so help me out, will you.
T. You are a little uneasy.

P. You can see I don't know what to do and I want you to give me advice.
T. Just say whatever you feel is important about that.

P. My older sister gets me so mad I could scream.
T. Mm-hmm. How old did you say she was?

d. Mislabeling: Therapist names attitudes, feelings, or actions which are not present in the actual verbalization preceding the response

P. I just felt crushed when she said that.
T. Really burned you up, huh?

P. I don't know how I felt--confused, lost--
T. I wonder if what you felt was resentment.

e. Silence: Scored when it is apparent that the patient expects a response from the therapist but none is forthcoming within 5 seconds after the patient stops talking. If the therapist approaches after 5 seconds have elapsed, silence cannot be scored and the therapist's response is merely "delayed"

P. If you think I should keep on a more definite track, tell me because I'm just rambling.
T. (5 second silence)
P. It is very confusing to know what to do.

3. Dependency and Hostility initiated by therapist: Scored whenever the therapist introduces the topic of Dependency or Hostility, i.e., when the patient statement was not scored as the category which the therapist attempts to introduce

P. Last week I talked about Jane.
T. You've mentioned a number of things you have done to please her.

P. (Enters office)
T. Now, how may I help you?

P. I was late for class this morning.
T. I wonder if you dislike the teacher or the class?

P. I like to run around in blue jeans.
T. You hate your mother.