LIKING AS A THERAPIST VARIABLE IN THE PSYCHOTHERAPEUTIC INTERACTION

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ABSTRACT

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by David H. Mills

Liking for patients was thought to be a concept which might have some viability in the study of the psychotherapeutic process, because it can be derived from two of the major conflicting theories of psychotherapy (from Rogerian theory in the form of "positive regard" and from psychoanalytic theory as "positive transference"). As such, if it could be related to therapist traits and in-therapy variables, it could prove to be of great heuristic value and might in some small way effect some type of rapprochement between the two theories.

The hypotheses tested were essentially that liking for patients would relate positively to approach to dependency and to hostility (as measured by the content analysis system of Winder et al., 1962), and that liking and therapist experience, the therapist's having had a personal psychotherapy, and the therapist's facility to "hold" patients in therapy would also be positively related. Furthermore, it was predicted that the needs for nurturance and for affiliation, as measured on the Edwards Personal Preference Schedule (Edwards, 1953) would correlate positively to liking and to both the approach to hostility and to dependency measures.

The therapists used in this study were staff members and students at the Michigan State University Counseling Center and consisted of thirteen senior staff members (all with Ph.D degrees), fourteen advanced graduate students from clinical and from counseling psychology doing internships at the center, and ten beginning practicum students.

Liking for patients was derived from the semantic differential. All therapists were asked to complete a semantic differential for their "ideal" patient and then, after reading each of six two-page typescripts of actual psychotherapies of varying types of patients, to complete the same semantic differential for each of the patients. Liking scores were derived from analyzing quantitatively the differences between the "ideal" protocol and the six "actual" protocols.

The tape recordings which were analyzed using the Winder system were, for the intern and senior staff groups, fifth interviews which were drawn from the tape library at the counseling center. The tapes for the practicum group, also fifth interviews, were collected individually with the student and his supervisor's permission.

Biographical information and the Edwards Personal Preference Schedule were collected from the therapists individually.

In general, the hypotheses relating to liking were not confirmed. This was discussed as possibly meaning that what actually was being measured was a more general social liking

rather than a specific liking for patients. This discussion was supported by the findings that liking did correlate positively and significantly to the needs for nurturance and affiliation (these two needs having been called social needs) but only for the beginning practicum students. In discussing this it was suggested that the social needs which lead individuals to become psychotherapists initially are not in truth well satisfied in the psychotherapeutic situation (Grater et al., 1961) and, therefore, the correlations in general between liking and the two need areas were not significant for the intern and senior staff groups.

The need for nurturance and the need for affiliation were both significantly related to the approach to hostility but not to dependency. This was explained as being a function of (in this setting of short term therapy) therapy's having been well started by the fifth interview and, hence, the high nurturant and affiliative therapists were already "training the patient for independence" (Snyder, 1963), but still arousing some hostility by their probings.

Nurturance and affiliation were significantly and positively correlated for the practicum group only. This suggests that beginning therapists strongly associate their affiliative and nurturance needs but, with increasing experience, these needs diverge as the concurrent satisfaction of these needs in therapy is found not to be possible.

Several factors emerged from the content analysis material. Supporting the prediction of Kopplin (1963), no difference for fifth interviews was found in the approach to hostility for the various experience groups. A significant difference was found for the approach to dependency reflecting that the more experience a therapist has, the more he approaches dependency. In the light of these findings and from the predominance of other findings in this study relating to the approach to dependency and to hostility, it was suggested that the approach to dependency-was primarily a therapeutic tool which is learned with increasing experience while the approach to hostility-is much less a function of experience and more of the therapist's individual characteristics.

Despite the above results suggesting individual differences between therapists in their general approach to hostility, there was a general orderliness in the data across experience levels suggesting that the degree of training is at least of equal importance with individual differences. The data further reflect some disruptions of the satisfaction of personal needs in the doing of therapy for the interns as they are exposed to the handicaps of investing too much of their nurturant and affiliative needs in their patients. That this conflict is resolved is suggested by the fact that the senior staff members seem to be satisfying some of their personal needs in the therapeutic situation but not at the artificially high level of the beginning practicum students.

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CHAPTER I

INTRODUCTION

Many variables intrude upon the psychotherapy interaction between patient and therapist. Historically, research initially examined the patient and the effects of some of his attributes upon his psychotherapy. Slowly emphasis is shifting from patient variables to therapist variables and to the characteristics of the patient-therapist interaction. It is with a therapist variable, that of liking for patients, that the present research is concerned.

Therapists generally will admit that they like some patients and have difficulty liking others. Some therapists might well be more effective than others simply because they like a wider spectrum of types of patients and, therefore, can communicate to more patients an honest concern. This type of liking has some linkage with both psychoanalytic and client-centered theories (in the concepts of positive countertransference and positive regard respectively) though no precision alternate for it appears in either. In the context of the recent increase in research emphasis regarding therapist variables in the therapy process, we shall initially focus upon this linkage. We shall examine the attention given by the psychoanalysts to the concept of countertransference

and by the client-centered school to that of positive regard and later attempt to relate liking to the two concepts.

Countertransference

Freud's early position regaring the role of the therapist was one wherein the therapist's own feelings were not allowed to enter directly into the therapy. The therapist, he suggested, must be undistorted, cool, and without overt feeling. He wrote (1912a):

> I cannot recommend my colleagues emphatically enough to take as a model in psycho-analytic treatment the surgeon who puts aside all his own feelings, including that of human sympathy, and concentrates his mind on one single purpose, that of performing the operation as skillfully as possible . . . the justification for this coldness in feeling in the analyst is that it is the condition which brings the greatest advantage to both persons involved, ensuring a needful protection for the physician's emotional life and the greatest measure of aid for the patient that is possible at the present time (pp. 327-238).

Despite stating elsewhere (1912b) that " . . . we must reckon with the personal characteristics of the analyst . . . " (p. 351), Freud, by the above dictum and by his primary interest in transference, tended to discount research or interest which might focus on the therapist. Transference, of course, is appropriately one of the keystones of the psychoanalytic theory of therapy. Freud (1922) defines it as "a special emotional relation . . . between the patient and the physician" (p. 122), i.e., the patient's distorted attraction for the therapist. The resolution or working through of these transferences within the therapy is of utmost importance since the transferences represent unconscious,

irrational, infantile instinctual strivings (Freud, 1920) which are inappropriate and distorting the patient's current relationships (especially that with the therapist). Apparently, this interest in a patient variable, transference, tended to deemphasize the equivalent therapist variable, that of countertransference. In truth, Freud's "discovery" of countertransference came five years after that of transference (Menninger, 1958) when, as he stated (1910),

> We have noticed that every analyst's achievement is limited by what his own complexes and resistances permit . . . " (p. 289).

The initial consideration of countertransference was that it was not desirable, that it hindered the therapy situation, and that it was directly proportional to the unfinished portion of the therapist's own analysis (Fenichel, 1945). However, as Strupp (1962) and Little (1951) have pointed out, Freud actually gave little concern to the phenomena of countertransference. Recently, however, the topic has appeared much more often in psychoanalytic literature (Balint, 1939; Reich, 1947; Winnicott, 1949; Heiman, 1950; Little, 1951; Reich, 1951; Gitelson, 1952; Orr, 1954, Tower, 1956). The gist of the current feeling seems to be that countertransference is a part of the therapeutic interrelationship which is " . . . a necessary prerequisite of analysis. If it does not exist, the necessary talent and interest is lacking" (Reich, 1951). Wolstein (1959) further elaborates upon the need for omnipresent countertransference in the therapy situation:

> . . . unless the analyst were to become qualitatively rigid, stilted or immobile, he must allow the free flow of his attention to go where it will, and it cannot but hit upon the distorted as well as the rational aspects of his own personality. If he were to maintain a wholly realistic and rational attitude while his patient was in the throes of a transference distortion of unknown dimensions, he could not maintain emotional rapport. He would have to fall back on some confounded jargon about the father, the mother, and child amnesias. He would have, moreover, to sit very hard on his own distorted and irrational experience, since he had arbitrarily decided that it had no relation to his patient's at that moment and had adopted a wholly realistic and rational attitude, which is only another name for an unresponsive or nonparticipant mode of attention (pp. 5-6).

There are many definitions of countertransference almost all of which, however, stress the therapist's needs and motivations and their intrusions upon his understanding and manner of dealing with a patient. These definitions do differ in their generality, ranging from Sharp's (1947) which includes both the conscious and unconscious reactions which a therapist has towards his patients, to Menninger's (1958) which includes only unconscious reactions. Most definitions tend to be similar to Menninger's in theory, but deviate somewhat in practice to include phenomena which do enter consciousness. In the most general usage of the term, any study which relates therapist dynamics to the therapy situation can be subsumed under the rubric of countertransference. This is further emphasized by Cohen (1955) in his review of the literature on countertransference wherein he emphasizes that countertransference can be either conscious or unconscious, consist of either positive or negative feelings (or both), and arise from either real or fantasied attributes of the patient.

Becoming aware of countertransference reactions and using them positively in the therapy situation has been emphasized by Alexander (1955). Actually, Strupp (1960) credits Alexander's concept of "corrective emotional experience" with playing a major role in the increasing interest in the therapist's personality as it relates to the therapeutic process. Alexander (1958) has stated that:

> The theory of corrective emotional experience leads to still another technical conclusion. This concerns the most opaque (in my opinion) area in psychoanalysis, the question of the therapist's influence on the treatment process by virtue of being what he is: an individual personality, distinct from all other therapists (p. 311).

This theme is being restated and reemphasized continually, not only in psychoanalysis but in all areas of psychotherapy and counseling. Browning and Peters (1960) feel " . . . it might be profitable to speculate about the kinds of counselor personality traits which are likely to facilitate counseling and those which are not". In a similar vein, Strang (1953) has stated that "Counseling is an expression of the counselor's personality, not merely a technique applied at will." Frankl (1955) probably states the issue the most clearly when he says:

> The most important and unfortunately the least understood, situational variable in psychotherapy is the therapist himself. His personality pervades any technique he may use, and because of the patient's dependence on him for help, he may influence the patient through subtle cues of which he may not be aware (p. 17).

Positive Regard

Rogers (1961) in trying to determine the characteristics of a helping relationship, found himself wondering if:

> . . . I can let myself experience positive attitudes towards (a client)--attitudes of warmth, caring, liking, interest, respect; It is not easy. I find in myself, and feel that I see in others, a certain amount of fear of these feelings. We are afraid that if we let ourselves freely experience these positive feelings toward another we may be trapped by them . . . it is a real achievement when we can learn, even in certain relationships, that it is safe to care, that it is safe to relate to the other as a person for whom we have positive feelings (p. 52).

Rogers has incorporated these thoughts into his formal theory of psychotherapy under the title of "positive regard". He defines positive regard in his most current, published theoretical formulation (Rogers, 1959):

> If the perception by me of some self-experience in another makes a positive difference in my experiential field, then I am experiencing positive regard for that individual. In general, positive regard is defined as including such attitudes as warmth, liking, respect, sympathy, acceptance (p. 208).

In this theoretical schema, positive regard, per se, is treated as a generic concept with several of its derivatives being of more theoretical and practical importance. Chief among these is the concept of unconditional positive regard which, for Rogers, exists if you "prize" someone so that nothing he does will influence your positive regard for him (Rogers, 1958, pp. 212-213). He considers the presence of unconditional positive regard a *sine qua non* for therapy. Rogers gives much of the credit for the direction of his thinking in this area of positive regard to Standal (1954) who has outlined a three-stage theory of therapy utilizing positive regard. These steps are:

1. The patient perceives the therapist's (unconditional) positive regard.

2. The patient transforms this essentially external positive regard to self regard.

3. The patient generalizes this newly developed positive self regard to similar or relatedly denied or distorted experiences.

Psychotherapy is the fusion of thousands of instances of the process we have just described (p. 100).

Recent Research Relating to the Therapist

While, as mentioned above, interest in the therapist as a factor in psychotherapy has been a relatively recent phenomena, this in no way means that the therapist has been excluded from the prodding of research. Within the past ten years, many studies have entered the literature which deal with therapist variables. Almost without exception, those studies show that variables relating to the therapist do have a relationship either to what does go on in the therapy hour, the outcome of psychotherapy, or both. Strupp (1960) has shown that psychologists and psychiatrists display many differences (see also Hiler, 1958; Korman, 1960; and Strupp, 1955a). The theoretical orientation of the therapist also makes a difference as one might suspect and as Sundland and Barker (1962) have shown (see also Fey, 1958; Fiedler, 1950; Rogers, 1949; and Wolff, 1956). Degree of experience has also been shown to be an important variable (Abeles, 1962; Barnes, 1963; Chance, 1959; Strupp, 1955a, 1955b, 1960) as has the therapist's general level of competence (Bandura, 1956; Fiedler, 1951; Hiler, 1958; Holt & Luborsky, 1958; Kelly & Fiske, 1951). Other therapist dimensions which have been explored

have been anxiety level (Bandura, 1956), sensitivity (Abeles, 1961; Rosenberg, 1962), degree of conflict (Cutler, 1958; Barnes, 1963), dependency (Lerman, 1963; Winder, 1962; Caracena, 1963), sexuality (Barnes, 1963; Lerman, 1963) and hostility (Kopplin, 1963).

In general, these research studies can be dichotomized as relating the therapist variable to either the process of psychotherapy or to differential outcomes of psychotherapy. Process studies (of the type which will be included in the present study) are essentially recent phenomena. Such studies were, for the most part, forced to await the development of electronic recording devices. Following Lasswell (1929) and Covner (1942) who were the innovators in this area of transcription of psychotherapy came almost two distinct groups of researchers. Probably first came Rogers and his client-centered philosophy of psychotherapy. The bulk of the early research of all types concerned with psychotherapy came from Rogers and his adherents, culminating in the 1954 volume of research findings edited by Rogers and Dymond. Most of these studies in the 1954 volume focused primarily upon the outcome of psychotherapy with only secondary emphasis upon the process of psychotherapy. Several studies which were contemporary to those in the book (Barron, 1949; Seeman, 1949; Raimy, 1948; Snyder, 1945), however, did attempt to study process variables, primarily through categorization and analysis of interview content.

The second chief source of early process research in psychotherapy has been the learning theorists; they tend to place emphasis

upon learning and unlearning by the patient (Dollard & Miller, 1950, and Skinner, 1950) with the therapist selectively reinforcing healthy or adaptive behaviors and not reinforcing, hence extinguishing, those which are maladaptive (Ferster, 1958). Psychotherapy then is viewed as the verbal conditioning of the patient by the therapist and, as reviews of the literature in this area by Kraner (1958), Salzinger (1959), and Greenspoon (1962) have indicated, many recent articles have been published relating to verbal conditioning. Most of these studies have utilized artificial, laboratory situations and have not used the "real" psychotherapy interaction. One study which did, however, get its data from psychotherapy was done by Murray (1956). In this study, the author analyzed a published case of Rogers (that of Herbert Bryan) from a learning theory stance. He categorized statements by the therapist as being approving or disapproving, and statements by the patient according to content. He discovered that content areas which were followed by approval (i.e., by positive reinforcement) increased in occurance throughout the course of the therapy. Categories followed by disapproval decreased.

Several studies have modified Murray's initial technique and refined his procedure. Bandura, Lipsher, and Miller (1960), studying the effects of the therapist's reactions to the patient expressing hostility, changed Murray's system in that the therapist responses were classified as being approach or avoidance rather than approval or disapproval. Bandura, in this study, utilized

the interaction unit concept, that is, the therapy data were analyzed in units consisting of three parts, a patient statement, the therapist's response, and the subsequent patient statement. The final patient statement in the interaction unit then becomes the initial one in the next interaction unit. Thus, therapy was analyzed in a series of inter-locking, molecular units. Winder, et al., (1962) studied dependency utilizing a slightly modified version of the Bandura model. They report that the therapists's approach to dependence in the initial stages of psychotherapy has a positive relationship with the patient's staying in treatment and that such approach will tend to elicit a continued or increased amount of dependency statements by the patient. This model, modified from Murray (1956), has also been used by Barnes (1963), Caracena (1963), Kopplin (1963), and Lerman (1963). While it is only one of several content analysis methods (c.f., Auld & Murray, 1955), it has proven useful and reliable in the above studies and will, with some small modification, be put to use in the present study.

"Liking" as a Therapist Variable

In an attempt to minimize semantic confusion, for the remainder of this dissertation the term "liking" will be used as a therapist trait exclusively while the term "likability" will be utilized only for a patient trait.

Almost absent from the literature, however, are studies pertaining to the relationship between how well a therapist likes

his patient and the patient's subsequent therapy. Most therapists will admit to being more personally moved by some patients than by others, and to liking some patients more than others. A possible exception might be the classical psychoanalyst who still follows Freud's admonition to be like a surgeon and, hence, would admit to no feelings about the people whom he sees in psychotherapy. Most analysts, however, would probably agree with Menninger (1958) when he says that " . . . the analyst must not only be this surgeon, but he must also be the warm, human, friendly, helpful physician. He must be both" (p. 85).

An exception to this absence of studies relating in this general area of liking has been Stoler's work (1961, 1963) from a Rogerian stance, i.e., regarding likability of patients as a subdivision of positive regard. Stoler attempted two tasks, the first being to determine if likability were a concept which could be rated in a reliable manner by different raters across various patients, and the second (contingent upon the first task's being successful) was the relationship between ratings of likability of patients and the "success" of those patients in therapy. Stoler had two sets of raters, one set which had had earlier experience with the tape recorded segments which they were asked to rate and one set which had had none. The "experienced" raters were reliable across different segments for the same patient on an average of 58% of the time (significant beyond the .005 level); the average reliability for the inexperienced raters was 30% agreement (not significant). Stoler concludes this part of the study by stating

that "This degree of rater reliability may be a general characteristic on which raters can agree, that, once they have become familiar with the client" (p. 178). He also reports that the likability of patients was related to their success in therapy at beyond the .05 level. These findings do, therefore, give rather suggestive evidence for the concept of likability being isolatable and for its strong positive relationship to success in psychotherapy. In a partial replication of the part of Stoler's work relating to success in psychotherapy, Caracena (1963) found that patients rated by their therapists after the first interview as being likable remained in psychotherapy significantly longer than those rated as not being liked.

Stoler's results get some corroboration from Strupp (1960) who, as part of his rather large-scale study of the clinical functioning of psychotherapists, had his sample of psychotherapists (consisting of both psychologists and psychiatrists of varying theoretical persuasions) rate their "personal reactions" to a patient whom they had seen on film. He found that high liking, i.e., strongly positive personal reactions by the rater, was significantly related to the prediction of prognosis (the stronger the positive reaction, the better the prognostic prediction). Other significant correlates of the rated positive reactions were the rating of the therapist for "empathy" (but only significant if the therapist had had a personal therapy himself) and a trend (but not significant) towards therapists with positive reactions towards the client being rated as being more "warm".

These studies (Stoler, Strupp, and Caracena) then seem to agree in suggesting that the therapist's positive feelings about a patient would predict either a successful therapeutic outcome (Stoler), a longer psychotherapy (Caracena), or, in the absence of outcome measures, a favorably rated prognosis (Strupp). We must keep in mind, nonetheless, that no causality can be implied from such conclusions, per se, i.e., that a therapist's liking a patient or client by itself augurs well for that person's psychotherapy. While statistically this may well be true, we are not certain that therapists, to give another possible explanation, may simply learn to dislike the type of patient with whom experience has taught them they are not successful (or the converse, that they may learn to like the type of patient with whom they are successful).

The entire question of what constitutes liking for patients as a therapist trait is raised from studies like those cited above, but certainly is not answered. Stoler and Caracena focus upon the patient almost entirely. Stoler does, however, report that the ratings of patient likability of the experienced raters were significantly higher than those of the inexperienced. He feels that this may well be a function of the amount of information available to the rater at the time of rating. Given the same amount of information, his raters (in both groups) did not differ in their ratings of likability done on segments taken from "early" interviews and those taken from "late" ones.

Any discussion of Strupp's data with regard to the therapist ratings suggesting a more generalized trait of liking for patients within therapists must be done with caution. The primary reason for this caution is that there was only one patient to whom Strupp's judges responded and, hence, it would be difficult to partial out the variance relating to that particular patient from the variance intrinsically related to the judges. Strupp did find, nonetheless, that Rogerian therapists did tend to have more positive personal reactions for the patient than did analytically oriented therapists (the difference being significant at less than the .02 level). Such a difference is consistent with the theoretical stance of both Rogers and contemporary psychoanalysis; as discussed above, Rogers places great emphasis on positive regard of various types, while the analysts are much more muted in their expression of feelings towards patients.

Several other studies have some bearing on liking. Fiedler (1953) investigated some characteristics associated with therapists who had high or low levels of "feeling reaction patterns", i.e., a high pattern existed when a therapist tended to describe his patients as being quite similar to himself with the converse true for the low pattern therapists. If we can assume that therapists like patients whom they feel are similar to themselves, then the results relate to the present problem. Fiedler found that high pattern therapists were able to evoke a greater amount of feelings from their patients and were judged by their supervisors as having a high amount of therapeutic competence. Low pattern therapists

were judged low in competence and received little apparent positive transference from their patients. Generalizing from these results to liking, then, would suggest that liking might well be positively related to therapeutic competence (and possibly, experience) and to the evocation of feelings generally on the part of the patient.

Wogan (1963) suggests some personality variables which are present in therapists who easily establish favorable relationships (and are perceived as having a high degree of liking by their patients); his results suggest that favorable relationships are best set up by therapists who can tolerate "pathology" in themselves and who are expressive as opposed to repressive. This seems in some way a confirmation of Rogers' (1959) discussion of the dual importance of positive regard and congruency; that is, patients can utilize the therapist's liking for them best when they sense that he is being honest with them and that what he says is what he feels.

Statement of the Problem

The studies cited above have suggested that the ability to like patients is a "real" therapist trait, one which appears to have some relationship with therapeutic outcomes, actual or predicted. Just what this relationship is <u>within</u> the therapy hour is something which has not been explored. However, it would seem that having positive feelings or regard or reactions towards a patient enhances that patient's probability for having a "successful" therapy. To more fully understand the underlying process

involved, therefore, a rather molecular study of the therapy process as it relates to likability would be needed. Part of the present study is an attempt to do this.

We are now in a better position to elaborate on the current study. The concept of liking for patients may be rather an important one in conceptualizing or researching psychotherapy. It is something which is apparently almost universally present in therapists, something which the various studies cited above have suggested is quantifiable (hence, lending itself to research), and something which appears to have distinct correlates to some of the most important indices of therapeutic success, e.g., whether a patient stays in therapy or leaves, and, if he stays, how successful the subsequent therapy may be. The concept of liking has other advantages for the researcher, one of the major ones being that it has the potential of cutting across theoretical orientations. As such, it carries with it few negative value judgments because of origin (as, for example, congruence would for an analyst, or oceanic feelings would for the Rogerian). This does not mean that it does not have potential for theoretical linkage. This it very definitely does but it does so to both psychoanalytic and client-centered theories. As discussed above, it can be subsumed under either positive regard or countertransference, both of which are rather crucial variables in the theories in which they are found. As such, research findings relating to liking might have a more wide-spread acceptance or usability than findings relating to either countertransference or positive regard

alone. The present study will be an examination of various aspects of liking. We shall attempt to isolate the trait, differentiate between various therapists along the dimension, and attempt to determine some biographical distinctions and differences in therapeutic modus operandi between therapists possessing various degrees of the trait.

CHAPTER II

HYPOTHESES

Rogers (1959) in his discussion of unconditional positive regard writes of the optimal therapy situation as one wherein the patient "can feel more acceptance of all his own experiences, and this makes him more acceptant of all his own experiences, and this makes him more of a whole or congruent person, able to function effectively" (p. 208). According to the learning theory view of psychotherapy, for the patient to gain "acceptance of all his own experiences", such acceptance must be positively reinforced by the therapist. In other words, the therapist should be accepting of all the experiences of the patient, allowing the patient to bring all of the parts of his experiential world into the therapy. A method of studying therapy which isolates the accepting or non-accepting of the patient's experiences by the therapist is found in the content analysis techniques which have been formulated by Bandura et al. (1960) and by Winder et al. (1962). These techniques deal in detail with the therapist's approach or avoidance of the patient's verbal productions. Approach includes therapist behaviors such as exploration, support, approval, reflection, etc. Avoidance is defined as verbal behavior of the therapist designed to inhibit continuation of the content of the patient's last statement and includes such therapist

behaviors as disapproval, changing the subject, ignoring, and silence. It, therefore, is analogous to negative reinforcement. Because liking for patients can be construed as being a subdivision of unconditional positive regard (Rogers, 1959, p. 208), and, therefore, should relate to the acceptance of all of the experiences of the patient, then it should relate positively to the approach of the therapists in the therapy situation as measured by the content analysis systems as discussed above. Accordingly, the following hypotheses are suggested:

1. High-Liking Therapists (i.e., therapists who like a wide range of patients) will approach dependency statements by the patient significantly more often than will Low-Liking Therapists.

2. High-Liking Therapists will approach hostility statements by the patient significantly more often than will Low-Liking Therapists.

Dependency and hostility were chosen because, like Murray (1956), the author feels they are " . . . central conflict areas" (p. 334) and, as such, would appear in most psychotherapies in some form. Much of the content analysis research subsequent to Murray has utilized these two classes of content (Bandura, et al. (1960), Winder, et al. (1962), Barnes (1963), Caracena (1963), Kopplin (1963) and Lerman (1963).

Stoler (1963) and Caracena (1963) have both suggested that more likable patients tend to stay in psychotherapy longer than do patients who are less likable. Extrapolating from these results, leads to the following hypothesis:

3. High-Liking Therapists will have a smaller percentage of patients terminating early in therapy than will Low-Liking Therapists.

Another condition which Rogers makes for the presence of successful psychotherapy is that the therapist be congruent, i.e., open to his own experience, integrated, whole, genuine (1959). Rogers states that congruence is "a basic concept which has grown out of therapeutic experience" (p. 205) and suggests that unconditional positive regard and congruence are both necessary for therapy but that neither alone is sufficient. Possibly this dimension of congruence was in part what Strupp (1960) was tapping when he reports that empathy was only related to the having of a positive reaction to a patient when the therapist-rater had undergone psychotherapy himself. Because of this rather suggestive evidence, because of Rogers' hypotheses about the importance of congruence, and because Stoler (1963) and Caracena (1963) have strongly suggested that successful psychotherapy is related to the likability of the patient, we may well find variables such as congruence, liking, therapist experience, and the therapist's having undergone a personal psychotherapy in some way admixed. Accordingly, the following hypotheses are suggested:

4. Therapists with personal psychotherapies will reflect significantly more liking for patients than will therapists without personal psychotherapy.

5. There will be a significant positive relationship between amount of therapist experience and liking for patients.

Liking as a therapist trait should or could relate to other personality variables as mentioned above in discussing congruence. Two such variables might be the need for nurturance

and the need for affiliation which Gebhart and Hoyt (1958) have mentioned as being "social needs". Edwards (1953) has described the need for nurturance (in part) as being the need to help others, to treat them with kindness and sympathy, to show affection towards them, and to like to have others confide in you. The need for affiliation is likewise in part defined as the need to do things for friends, to form new relationships, to make as many friends as possible, to form strong attachments. From this material, therefore, the following two hypotheses are advanced:

6. There will be a significant positive relationship between the amount of a therapist's need for nurturance and his liking for patients.

7. There will be a significant positive relationship between the amount of a therapist's need for affiliation and his liking for patients.

The following two hypotheses, while not central to the study and while not relating directly to the issue of liking, follow directly from previous hypotheses and hence are included. If, as heretofore hypothesized, the trait of liking for patients is related to both approach to dependency and to hostility in the psychotherapy situation, and to the therapist's need for nurturance and for affiliation, the following two hypotheses are suggested:

8. There will be a significant positive relationship between the therapists' need for nurturance and their approach to hostility and to dependency.

9. There will be a significant positive relationship between the therapists' need for affiliation and their approach to hostility and to dependency.

CHAPTER III

METHOD

The independent variable in this study is the therapist trait of liking for patients. The dependent variables are selected biographic information about the therapists, the therapist's manner of approaching or avoiding certain classes of patient statements within the therapy situation, and certain therapist personality variables.

1. Subjects

The subjects in this study are all either staff members, interns, or practicum students at the Michigan State University Counseling Center.

A. Full-time staff N = 13.

All members of the full-time, or senior, staff of the Counseling Center were experienced psychotherapists (though there were individual differences in the absolute amount of experience) and had received a Ph.D. in either clinical or counseling psychology.

B. Interns N = 14.

The intern group was made up of advanced doctoral students from either the clinical division of the Department of Psychology or the Counseling Psychology

Program within the College of Education. All of them were working a minimum of twenty hours per week at the Counseling Center, much of this time being spent in seeing individual students in individual psychotherapy. All interns had completed all of the courses in psychotherapy offered by the departments in which they were enrolled.

C. Practicum Students N = 10.

The practicum students were graduate students who, having completed some of their initial course-work in psychotherapy, were seeing their first patients and who were, like the interns, under the supervision of the full-time staff.

2. The Measurement of Liking for Patients

A. Semantic Differential

As will be outlined below, liking will be operationally defined by a technique which utilizes the semantic differential. The semantic differential is a technique developed by Osgood, Suci, and Tannenbaum (1957) to measure the meaning of various stimuli. The subject is required to mark off on a seven point scale his response to a particular verbal, written stimuli; the scale is a bipolar one with opposite meanings at either end, e.g., "hot . . . cold". Points on the scale are then typically scored one through seven according to

their position on the scale from left to right. As exemplified in Appendix A, the differential is usually presented to the subject with the stimulus at the top of the page and any number of bipolar scales (often between twenty and thirty of them) below it. Adequate validity and reliability for the semantic differential is reported by Osgood, et al., (1957); Norman (1959) has also found rather high reliability for the differential over time. Other statistical assumptions, both implicit and explicit, have been verified (Messick, 1957), and the instrument has proven to be a highly used one. As Moss in his review of the literature and status of the differential has said, "Quite apparently, psychologists have been quick to adopt the semantic differential as a tool of broad usefulness" (p. 53).

B. Liking

Liking for patients as a therapist trait is being operationally defined utilizing the following technique:

1. Each therapist was given a semantic differential the stimulus for which was "The kind of patient with whom I like to work". There are twenty-five bipolar scales on this semantic differential, twenty of which were selected on the basis of a preliminary study to determine scales which had the most pertinence to psychotherapy and five which were taken from Howe and

Pope (1961) and are reported to have a positive relationship with the evocation of feelings.

2. Following this initial semantic differential, each therapist was given a series of two page typescripted excerpts of six different psychotherapies in random order (see Appendix B). He was instructed to read each excerpt and complete a semantic differential the stimulus for which was the name of the patient in the excerpt he had just read. Apart from the differences in stimuli, the semantic differential was identical to the one which he had completed earlier concerning the type of patient with whom he likes to work. The typescripts were taken from Bordin (1955) and from Arbuckle (1961). These particular typescripts were chosen because all but one of the patients were college students, a population with which the therapists had had experience, because there was a variety of types of problems presented in them, ranging from moderately severe disturbance to minor adjustment difficulties, and because the typescripts consisted almost entirely of statements made by the patient. This later point was deemed especially important so as to have the therapists responding only to the patient and not to the "typescript therapist" or to the quality of the typescript patient-therapist interaction.

Immediately following each of these six semantic differentials was a simple six point rating scale upon which the rater was asked to rate the typescript-patient as to likability. This scale is identical to the one used by Stoler (1963) and by Caracena (1963) and can be found in Appendix D.

3. Following rules set forth in Appendix C, each set of seven semantic differentials (one for the ideal and six for the various typescripts) was scored. The scoring consisted essentially of quantitatively determining the average deviation for each therapist-rater over the six typescript semantic differentials from the ideal one. A low score, i.e., a small deviation from the ideal for the six "actual" patients would be operationally defined as high-liking. Conversely, a large deviation between the ideal and the six "actual" patients would be defined as low-liking. All statistical analyses of these data, however, used reciprocals of the average deviation so that results could be interpreted directly, i.e., the higher the score, the higher the liking.

As further outlined in Appendix C, two liking scores were derived from the semantic differential, one which was derived directly from the average deviations and one which was derived from the average deviations and then adjusted by a factor which related to the therapist-

rater's characteristic use of the extremes on the scales or the middle scores. This score was derived because it was predicted that there might be differences between two raters who have identical average deviations but one uses the middle part of the semantic differential scales for both his 'ideal' and actual patients, and the other rater uses the extremes.

A third measure of liking was the summation of the likability ratings on the rating scales for each rater over the six typescript patients.

3. Tape Recordings

A. Tape Library.

The Counseling Center has recently initiated a tape library which will eventually include tape recordings of two complete therapy cases for each senior staff member and intern (as of the 1963-1964 school year). Accordingly, the tapes for one interview for one patient per therapist were drawn from the library. The tapes from the practicum students were obtained with both their permission and that of their supervisor. Because Stoler (1963) has reported that he found no difference in likability from early to late interviews, only one tape per therapist was necessary; for convenience (and rather arbitrarily) only fifth interviews were chosen.

The scoring of the tapes is essentially that of Winder, et al., (1962) who had in turn modified somewhat the content analysis scoring system of Bandura, et al., (1960); it is basically an analysis of therapist approaches and avoidances to various classes of patient statements (i.e., hostility and dependency bids). The unit of scoring is a triad of statements, the patient's beginning statement, the therapist's response, and the patient's subsequent response. Scoring units are inter-locking, i.e., the terminal patient statement in one sequence is the initial statement in the next sequence. The complete scoring system is reproduced in Appendix E.

C. Scoring Reliability

Two judges, the author and another advanced doctoral student (in Counseling Psychology),independently scored the tapes using the content-analysis systems described above and in Appendix E. The judges initially scored mutually a series of tape-recorded therapy interviews to establish initial familiarity with the system. Then, each scored independently another series of recorded interviews and compared results as a reliability trial. After having established reliability on the trial practice interviews, they then proceeded to score independently the tape recordings drawn from the tape library for use in this study.

The author scored all 37 tape recordings used in this study while the second scorer scored only 33 (as he had participated personally in two of the interviews, and two of the practicum interviews had been inadvertently erased). Product-moment correlations between the approach percentages to hostility and to dependency were then computed across the 33 tapes which both scorers had coded. These correlations can be found in the following chapter in Table 1.

All subsequent analyses are based upon the author's personal scorings of the tapes.

4. Biographical and other factual information concerning the therapists.

Each participating therapist was given a short biographical information inventory which is reproduced in Appendix F.

5. Therapist personality variables.

The information necessary for the evaluation of hypotheses six through nine (the hypotheses relating to the need for nurturance and for affiliation) were obtained from the Edwards Personal Preference Schedule (Edwards, 1953) which was administered to each participating therapist.

CHAPTER IV

RESULTS

This chapter will be arranged into two major sections, the first relating to general characteristics of the various sources of the data (tape scoring, liking score, Edwards Personal Preference Schedule). The second section will systematically outline the results concerning the nine hypotheses.

A. General Characteristics of the Data

1. Scoring of the Tapes.

a. Reliability. Reliability for the scoring of the tapes was established from 33 of the total of 37 tapes. For each of these 33 tapes, the global percentage of approach to dependency and to hostility was computed for each scoring, and product-moment correlations as shown in Table 1 were then computed for these two variables between the two independent scorers. Despite the fact that the basic data here are percentages, product-moment correlations were used as non-parametrics (as outlined by Pitman, 1937, and Karon, 1958) in order to take advantage of the increased power of this method over 'real' non-parametric measures. In general, this procedure was followed in the statistics throughout the

entire study. While the author did in fact score all of the 37 tapes used in the sample, four were not used in the reliability pool, two because they involved one of the scorers personally, and two because they were inadvertently erased before the second scorer could score them. The results in Table 1 are about the same magnitude as those reported in other studies which utilized the same content analysis scoring system and the same method of computing reliability (Kopplin, 1963; Caracena, 1963; Barnes, 1963).

TABLE 1

CORRELATIONS BETWEEN THE APPROACH PERCENTAGES OF THE TWO SCORERS ACROSS 33 TAPES

Area of Approach	Correlation
Approach to Dependency	+.9435
Approach to Hostility	+.8872

b. Approach Percentages as a Function of Experience. In general in the entire study, the therapist sample was broken down into three experience groupings, the senior staff of the counseling center (N-13), the interns (N-14), and the practicum students (N-10). In order to determine if there were differences between the approach percentages to aggression and to dependency between the three groups,

Kruskal-Wallis H tests were computed and are summarized in Table 2. These results suggest that there is a positive relationship between degree of experience and the approach to patient dependency bids (in fifth interviews)--the means of the three groups reflect increasing approach with increasing experience. However, despite the fact that the means of the approach to hostility suggest a similar trend, the differences are not significant as reflected in Table 2.

TABLE 2

APPROACH TO HOSTILITY AND TO DEPENDENCY AS A FUNCTION OF EXPERIENCE GROUPING

	Group Means				
	senior staff N = 13	intern N = 14	practicum N = 20	H.	P. Level
Dependency	84.77	80.79	71.90	12.50	.005
Hostility	76.92	73.50	68.80	0.67	n.s.

c. Approach to Dependency. Approach percentages to dependency were further broken down in order to determine if the approach might be a function of the sex of the patient. Both non-parametric median tests and 'robust' parametric tests (t-Test corrected for unequal variances by Welch's method as cited in Karon, 1958, pp. 113-114) were computed and are summarized in Tables 3 and 4.

TABLE 3

THE EFFECT OF THE SEX OF THE THERAPIST UPON THE APPROACH TO DEPENDENCY OVER ALL PATIENTS

Test	Value	d.f.	P. Level
Median Test	.0019	1	n.s.
t-test*	.3487	13	n.s.

* Welch's method for samples with different variances

TABLE 4

THE EFFECT OF THE SEX OF THE PATIENT UPON THE APPROACH TO DEPENDENCY OVER ALL THERAPISTS

Test	Value	d.f.	P. Level
Median Test	1.738	1	n.s.
t-Test*	2.028	14	n.s.

* Welch's method for samples with unequal variances

These tables reflect that neither the sex of the therapist nor the sex of the patient appears to relate to the approach to dependency.

d. Approach to Hostility. Approach percentages to hostility were also broken down to determine if these approaches were functions of the sex of the therapist or of the sex of the patient. Again, Median and adjusted t-Tests were

utilized, the results for which are summarized in Tables 5 and 6.

TABLE 5

THE EFFECT OF THE SEX OF THE THERAPIST UPON THE APPROACH TO HOSTILITY OVER ALL PATIENTS

Test	Value	d.f.	P. Level	Direction
Median Test	6.3645	1	.02	Female approach more than Male
T-Test*	3.5320	15	.01	Female approach more than Male

* Welch's method for samples with unequal variances

TABLE 6

THE EFFECT OF THE SEX OF THE PATIENT UPON THE APPROACH TO HOSTILITY

Test	Value	d.f.	P. Value	Direction
Median Test	5.33	1	.05	Approach male more than female
T-Test*	2.725	21	.05	Approach male more than female

* Welch's method for samples with unequal variances

These data then seem to suggest that female therapists approach aggressive bids from patients significantly more often than their male counterparts and that agressive bids of male patients are more often approached than agressive bids from female patients.

2. Edwards Personal Preference Schedule Variables (Need for Nurturance and the Need for Affiliation).

   a. Need for Nurturance and the Need for Affiliation as a Function of Experience. In order to determine if differential amounts of experience in doing psychotherapy would have significant effects upon the therapists' expressed needs for nurturance and for affiliation (as measured by the EPPS), two simple analyses of variance were computed on the raw Edwards scores for these two variables. The resulting F Scores and the group means are summarized in Table 7. As can be seen on this table, the three experience groups did not differ from each other on the need for affiliation but do differ significantly on the need for nurturance--on the latter need, the interns showed the highest scores, followed by the practicum students, and lastly, by the senior staff members.

TABLE 7

NEED FOR NURTURANCE AND NEED FOR AFFILIATION AS A FUNCTION OF EXPERIENCE GROUP

	Group Means					
	Sen. Staff	Intern	Practicum	F	d.f.	P. Value
N-Nurturance	15.00	20.21	17.77	6.30	2, 33	.01
N-Affliliation	15.23	15.57	14.78	0.11	2, 33	n.s.

b. Relationship between N-Nurturance and N-Affiliation across Experience Levels. The manual for the EEPS (Edwards, 1953) reports that the two needs studied in this experiment, need for nurturance and the need for affiliation, inter-correlated $\neq .46$ in the normative group. Similar inter-correltations (Product-Moment) were computed for the raw scores of the three experience groups in this study. As can be seen from Table 8, the above-mentioned relationship between the two needs is corroborated only for the inexperienced practicum group. The two more experienced therapist groups, the interns and the senior staff members not only failed to display the reported positive relationship between N-nurturance and N-affiliation, but produced negative, albeit non-significant, correlations.

TABLE 8

CORRELATIONS BETWEEN N-NURTURANCE AND N-AFFILIATION ACROSS EXPERIENCE LEVELS

Group	Correlation	P. of Diff. from 0.00
Total Therapist Sample (N-36)	+.2468	n.s.
Senior Staff (N-13)	-.2344	n.s.
Interns (N-14)	-.2596	n.s.
Practicum (N-9)	+.6900	.01
Edwards Normative Sample	+.46	---

3. Like Measures.

a. Relationship Between the Three Measures of Liking. As has been outlined in the Methods Section above, three separate indices of liking for patients were derived for this study. The first, or "raw," liking score was evolved from difference scores on semantic differential data between ratings of "ideal" patients and ratings of typescripts of actual patients. The "corrected" liking score is the raw score adjusted for the examinee/therapist's central tendency response pattern, and the liking rating is a summation of the six ratings of likability of the typescript patients by each examinee/therapist. These three measures were correlated in order to determine their inter-relationships and the correlations are reported in Table 9. As would be expected, the "raw" liking score and its derivitive, the "corrected" liking rating only correlates significantly with the "raw" score and then only about .40 (accounting for only about 16% of the variance). It can not be assumed, therefore, that all three of the liking scores will behave in any unitary manner; the liking rating is too dissimilar from the other two measures for such a prediction. (See Table 9 on following page).

TABLE 9

INTER-CORRELATIONS OF THE THREE MEASURES OF LIKING

Groups	Correlation	P. Value
Liking Ratings and "Raw" Liking	+.3897	.01
Liking Ratings and "Corrected" Liking	+.2383	.10
"Raw" Liking and "Corrected" Liking	+.8259	.01

b. Liking Scores as a Function of Experience Group. Simple analyses of variance were computed for the three different liking scores across experience groups in order to determine if liking were a function of gross amount of therapeutic experience. As summarized in Table 10, none of the three liking measures differed significantly over the experience groups and, therefore, liking is apparently not a function of gross experience.

TABLE 10

THE RELATIONSHIP BETWEEN THE THREE MEASURES OF LIKING ACROSS EXPERIENCE GROUPS

Liking Measure	F	d.f.	P. Level
Liking Ratings	1.95	2, 34	n.s.
"Raw" Liking	0.17	2, 34	n.s.
"Corrected" Liking	0.79	2, 34	n.s.

B. The Testing of the Hypotheses.

1. HYPOSTHESIS ONE--High-Liking Therapists (i.e., therapists who like a wide variety of patients) will approach dependstatements by their patients significantly more often than will Low-Liking Therapists. In order to test this hypothesis, product-moment correlations were computed across all 37 tapes between a therapist's approach to dependency on the tape recording and each of his three liking scores. Again, product-moment correlations were utilized in the manner suggested by Pitman (1937) and by Karon (1958) as non-parametric measures. As can be seen by referring to Table 11, this hypothesis did not find support in the data, the only significant finding being that the higher the "raw" liking scores were for female therapists, the lower their approach percentage to dependency bids in the therapy session. This is, of course, a relationship clearly in the opposite direction from that which was hypothesized.

TABLE 11

CORRELATIONS BETWEEN THE THREE INDICES OF LIKING AND THE APPROACH TO DEPENDENCY

Liking Measure	N 37 Correlation	P. Value
Liking Ratings	-.0870	n.s.
Corrected Liking	-.1169	n.s.
Raw Liking	-.2557	.07
1. Male Therapists Only	-.2520	n.s.
2. Female Therapists Only	-.6130	.05

2. HYPOTHESIS TWO--High-Liking Therapists will approach hostility statements by their patients significantly more often than will Low-Liking Therapists. Again, product-moment correlations were computed; to test this hypothesis the correlations were between the three indices of liking and the therapist's approach to hostility on the tape recordings. All correlations thus computed were zero-order and non-significant and, therefore, the hypothesis is not supported. These results are found in Table 12.

TABLE 12

CORRELATION BETWEEN THE THREE INDICES OF LIKING AND THE APPROACH TO HOSTILITY

Liking Measure	N 37 Correlations	P. Value
Liking Ratings	+.0530	n.s.
Corrected Liking	+.0195	n.s.
Raw Liking	+.0822	n.s.

A further attempt to test the theory underlying hypotheses one and two was made. The total approach percentage to all categories of patient statements was computed and this global percentage was correlated with the various liking scores. The resulting correlations were positive but failed to reach the level of significance.

3. HYPOTHESIS THREE--High-Liking Therapists will have a smaller percentage of patients terminating early in therapy than will Low-Liking Therapists. The Practicum Group (N-10) was dropped from the therapist sample for the testing of this hypothesis as for this group, the normal flow of the therapy situation might be somewhat disrupted because of the pressures on the practicum students due to their being graded for their efforts, because of the therapies being limited often by the number of quarters in which a student therapist enrolled for the practicum course, etc. Hence, the total sub-sample for the following test of this hypothesis consisted of the 13 senior staff members and the 14 interns. As has been done above, both median tests and t-Tests adjusted by Welch's method for populations with unequal variances were computed, in this case between the liking scores of the therapists who had had patients quit therapy without the therapist's approval (N-8) and the liking scores of therapists whose patients had terminated by mutual consent or were, at the time of writing still in therapy (N-19). These results, which are summarized in Table 13, are essentially negative and indicate that for this sample, a patient's remaining in therapy is apparently not a function of his therapist's liking score. (See Table 13 on following page).

TABLE 13

PATIENT'S STAYING OR QUITTING PSYCHOTHERAPY AS A FUNCTION OF THEIR THERAPIST'S LIKING SCORES

Liking Measure	Median Test	t-Test*	P. Value
Liking Ratings	.0881	.1379	n.s.
Corrected Liking	.2989	.5897	n.s.
Raw Liking	.881	1.2745	n.s.

*Welch's modification for populations with unequal variances.

In a further attempt to test this hypothesis, the 27 therapists in this sub-sample were asked to rate the therapy from which their scored tape recording was drawn as being predominantly successful or unseccussful. Thirteen of the therapies were rated as being successful and 14 were rated as being unsuccessful. Median Tests and Welch t-Tests were computed between the liking scores of the therapists in the "successful" group and the therapists in the "unsuccessful" group. As reflected in Table 14, the results were again negative and would suggest that for this sample the therapist's rating of success or failure of a therapy does not appear to be related to his liking scores. (See Table 14 on following page).

TABLE 14

THE RELATIONSHIP BETWEEN THE THERAPISTS' RATINGS OF THE SUCCESS OR FAILURE OF THE THERAPY USED IN THE TAPE POOL AND THEIR LIKING SCORES

Liking Measure	Median Test	Welch t-Test	P. Value
Liking Ratings	a	1.232	n.s.
Corrected Liking	a	0.4548	n.s.
Raw Liking	0.0344	0.222	n.s.

a - not computed

4. HYPOTHESIS FOUR--Therapists with personal psychotherapies will reflect significantly more liking for patients than will therapists without personal psychotherapies. The therapist sample was dichotomized in order to test this hypothesis into those therapists who had had a personal psychotherapy (N-27), and those therapists who had not (N-10). No attempt was made to evaluate the personal psychotherapy either in terms of duration or in any qualitative aspect. Median and t-tests were computed between the liking scores of the therapists in these two groups and are summarized in Table 15. No significant difference appeared between the groups which indicates that, for this sample of therapists, liking is not a function of the therapist's having had a personal psychotherapy.

TABLE 15

THE RELATIONSHIP BETWEEN THE THERAPISTS' HAVING HAD A PERSONAL PSYCHOTHERAPY OR NOT AND THEIR LIKING SCORES

Liking Score	Median Test	Welch t-Test	P. Value
Liking Rating	a.	0.405	n.s.
Corrected Liking	a.	1.025	n.s.
Raw Liking	0.14	1.095	n.s.

a - not computed

5. HYPOTHESIS FIVE--There will be a significant positive relationship between the amount of therapist experience and liking for patients. In order to test this hypothesis, product-moment correlations were computed between the various liking scores for the entire sample of therapists (N-37) and their respective years of experience doing psychotherapy. As the results in Table 16 indicate, no relationship was found between the years of experience and liking scores and, therefore, the hypothesis was not supported. (See Table 16 on following page).

TABLE 16

CORRELATIONS BETWEEN YEARS OF EXPERIENCE AS A PSYCHOTHERAPIST AND LIKING FOR PATIENTS

Liking Measure	Correlation	P. Value
Liking Ratings	+.0389	n.s.
Corrected Liking	+.0405	n.s.
Raw Liking	+.1154	n.s.

6. HYPOTHESIS SIX--There will be a significant positive relationship between a therapist's need for nurturance and his liking for patients. Product-moment correlations were computed between the raw nurturance scores on the Edwards Personal Preference Schedule and the various liking measures in order to test this hypothesis. The results of these computations are found in Table 17. The hypothesis is borne out only for the practicum group on the two semantic differential measures of liking. The need for nurturance and Liking for Patients seems to be related only for beginning therapists. With increasing experience, these two variables tend to diverge. (See Table 17 on following page).

TABLE 17

CORRELATIONS BETWEEN THERAPISTS' LIKING FOR PATIENTS AND THEIR NEED FOR NURTURANCE

	Therapist Sample			
	All Therapists	Senior Staff N-13	Intern N-14	Practicum N-10
Liking Rating	+.0651[a]	+.1897[a]	+.1587[a]	+.0809[a]
Corrected Liking	+.1333[a]	+.2451[a]	-.0764[a]	+.7994[b]
Raw Liking	+.0986[a]	+.2982[a]	-.1304[a]	+.6953[c]

[a]Not significant
[b]P less than .005
[c]P less than .01

7. HYPOTHESIS SEVEN--There will be a positive relationship between a therapist's need for affiliation and his liking for patients. Raw affiliation scores on the Edwards and the various liking measures were correlated (product-moment) in an attempt to test this hypothesis. These correlations are found in Table 18 and suggest that the hypothesized relationship is found only in the inexperienced therapist (i.e., practicum) group. However, there appears to be a non-significant, non-linear relationship between the need for affiliation and the Liking scores with the two variables being positively correlated for the practicum students and for the senior staff groups while the group intermediate in experience, the interns, produced a non-significant negative relationship.

TABLE 18

CORRELATION BETWEEN THERAPISTS' LIKING FOR PATIENTS AND THEIR NEED FOR AFFILIATION

	All Therapists	Senior Staff N-13	Intern N-14	Practicum N-10
Liking Rating	+.1434[a]	+.2128[a]	-.0550[a]	+.4121[b]
Corrected Liking	+.1799[a]	+.4346[b]	-.2617[a]	+.8977[c]
Raw Liking	+.1429[a]	+.2562[a]	-.1458[a]	+.6696[d]

[a] not significant
[b] P less than .10
[c] P less than .005
[d] P less than .05

8. HYPOTHESIS EIGHT--There will be a significant positive relationship between the therapists' need for nurturance and their approach to hostility and to dependency. Product-moment correlations were computed between raw nurturance scores on the Edwards and the approach percentages to hostility and to dependency across all therapists. Except for the intern group, the hypothesis was supported for the approach to hostility. That is, for the senior staff and for the practicum students, the need for nurturance and the approach to hostility in the psychotherapy situation were significantly and positively correlated. However, this positive relationship was not found between the need for nurturance and the approach to dependency in psychotherapy for any of the three therapist groups. These results are summarized in Table 19.

TABLE 19

CORRELATIONS BETWEEN THERAPISTS' NEED FOR NURTURANCE AND THEIR APPROACH TO HOSTILITY AND TO DEPENDENCY

	All Therapists	Senior Staff N-13	Intern N-14	Practicum N-9
App. Hostility	+.3659[a]	+.4908[a]	-.0391[b]	+.7520[c] [1]
App. Dependency	-.1191[b]	-.2400[b]	-.1596[b]	+.0435[b] [2]

[a] P less than .05
[b] Not significant
[c] P less than .005

[1] Rank-order correlation coef. on the same data = +.7250 (P. less than .005)
[2] Rank-order correlation coef. on the same data = -.1325 (not significant).

9. HYPOTHESIS NINE--There will be a significant positive relationship between the therapists' need for affiliation and their approach to agression and to dependency. Correlation coefficients (product-moment) were computed between the raw affiliation scores on the Edwards and the approach to hostility and to dependency as scored on the tapes. The hypothesis was borne out for the approach to hostility for all therapist groups except the senior staff. For the interns and for the practicum students, then, there was a significant positive relationship between the need for affiliation and the approach to hostility. No such relationship was found for any of the groups between the need for affiliation and the approach to dependency. These results are reported in Table 20.

TABLE 20

CORRELATIONS BETWEEN THERAPISTS' NEED FOR AFFILIATION AND THEIR APPROACH TO HOSTILITY AND TO DEPENDENCY

	All Therapists	Senior Staff N-13	Intern N-14	Practicum N-9
App. Hostility	+.3986[a]	+.1296[b]	+.4947[a]	+.6248[a]
App. Dependency	+.0927[b]	-.0347[b]	-.0955[b]	+.1894[b]

[a]P less than .05
[b]Not significant

10. For the convenience of the reader, the nine hypotheses and their results are summarized below in Table 21.

TABLE 21

SUMMARY OF THE NINE HYPOTHESES AND THEIR RESULTS

Hypothesis	Results
1. There will be a positive relationship between liking and approach to dept.	1. Not borne out except female therapists respond signif. in the opposite direction.
2. There will be a positive relationship between liking and approach to hostility.	2. Not borne out
3. High-Liking Therapists will have less patients quitting therapy.	3. Not borne out

TABLE 21.--Continued

Hypothesis	Results
4. Therapists with personal psychotherapies will have higher liking scores than those without.	4. Not borne out
5. There will be a positive relationship between years of therapy experience liking for patients.	5. Not borne out
6. There will be a positive relationship between Need for Affiliation and Liking.	6. Borne out for Practicum students on raw and on corrected liking scores.
7. There will be a positive relationship between Need for Nurturance and the approach to dependency and to hostility.	7. Borne out for Practicum students.
8. There will be a positive relationship between Need for Nurturance and the approach to dependency and to hostility.	8. Borne out for approach to hostility for senior staff and practicum. Not borne out for approach to dept.
9. There will be a positive relationship between Need for Affiliation and the approach to dependency and to hostility.	9. Borne out for approach to hostility for interns and practicum. Not borne out for approach to dependency.

CHAPTER V

DISCUSSION

"Things are seldom as they seem" (H.M.S. Pinafore)

Hypotheses

Hypotheses One and Two.--These two hypotheses were a prediction that the therapists' liking scores would relate positively to their approach to dependency and to hostility in the psychotherapy situation. Neither hypothesis was sustained, i.e., there was no significant difference between the approach rates of high-liking therapists and those of low-liking therapists.

One can subsume liking for patients under Rogers' concept of positive regard (Rogers, 1959, p. 208) and therefore the results are somewhat surprising since Rogers would predict that an acceptance of the patient's phenomenological world, i.e., having positive regard for him, would be a sine qua non for the presence of effective therapy. One could assume that one way of so accepting would be to approach or positively reinforce the various types of patient verbal productions in the therapy session and, hence, the more liking (or positive regard), the more acceptance (or approach). This does not appear to be the case. A possible explanation within the Rogerian framework would rest with the concept of congruence, the similarity between a person's experience and his self concept

(Rogers, 1959). One of the goals of therapy for Rogers is to have the patient become as congruent as possible so as to have his experiences and self-concept as similar as possible. By definition, however, for Rogers a patient is incongruent and, therefore, a portion of his verbal productions will reflect distortions of his experiences in order to maintain his unawareness of this incongruity. These expressions which arise not from the patient's phenomenological world but from his distortions thereof would not be accepted by the therapist. The therapist wishes to help the patient reorganize his self concept in order to become aware of or to assimilate experiences which have heretofore been distorted or denied awareness. Therefore, patient verbal productions which have been derived from distortions or incongruities are not accepted as they are not part of the patient's "real" experiences. Because some of the patient's dependency and hostility bids in the therapy hours may have thusly arisen from distorted experiences rather than from experiences, per se, they would as such not be accepted by the high-liking therapists. This may well acount for the negative results in the current instance. What may be happening is that high-liking therapists not only reflect their positive regard by accepting certain types of patient experiences, but also show their desire for the patient's becoming congruent by not accepting distorted experiences. Therefore, the relationship between liking and the approach percentages may not be as simple and as straight forward as was hypothesized.

Learning theory would have a similar explanation of the results. Certain classes of patient verbal responses should, for the high-liking therapists, not be reinforced for the patient's maximal growth and, hence, would be avoided. These avoidances would get admixed with the general level of acceptance or approach and, hence, the global results would reflect opposing tendencies which in some way neutralize each other.

The positive counter-transference concept of classical psychoanalytic theory would predict the opposite from that which was hypothesized in this case since liking would be considered as a therapist distortion (if it were to enter into the therapy situation). If a general high level of approach is to be considered as desirable, then positive counter-transference may in truth be negatively correlated with the approach percentages. However, since, as has been discussed above, the approach percentages seem to be a function of the avoidance of certain categories as well as the approach to other desirable ones, then such a unitary relationship seems over-simplified.

One minor finding which arose from the investigation of these two hypotheses was that the higher the liking scores for female therapists, the more the therapists avoided dependency bids from their patients. One might speculate that in our culture, the female psychotherapist having had to struggle through the rather competitive "male oriented" Ph.D program of our universities (not to speak just of the problems facing highly

educated, sensitive women) would have a greater affinity for the encouragement of independent behaviors in patients and a corresponding rejection of the aspects of dependency. A comparison on the semantic differential of the composite "ideal" patient for all the female therapists and the "ideal" patient for all the male therapists suggests, in possible corroboration of the above, that female therapists prefer more dominant, less submissive patients than male therapists (P less than .03). Since this is the only bimodal adjective pair of the 25 which reflects a significant difference between male and female therapists, however, it may well be simply a statistical artifact. If it were not spurious, though, it would suggest that female therapists prefer patients who, by their very nature, are dominant and hence, dependency would not be approached in likable patients either because it would not be appropriate or in order to keep the patient from becoming more submissive (and, therefore, less likable). It was felt that these inverse results might also hold for male therapists in the intern and senior staff groups alone since the approach to dependency was shown to be related positively to the degree of experience (See Table 2), and the mean experience level was higher for females than for males (the practicum groups being an all male group). However, this did not seem to be the case as the male therapist group, excluding the practicum students, correlated with the raw liking scores in the magnitude of -.26 which is not significantly different from zero.

Another spectre lurking behind the liking data in general might well be that the liking scores do not, in truth, measure liking for patients specifically. There are rather strong suggestions from the data as reflected in the results in Tables 17 and 18 that liking is quite strongly related to what Gebhart and Hoyt (1958) have called social needs, i.e., the needs for nurturance and for affiliation, at least for practicum students and for senior staff members. Hence, it may well be that the present liking measures, despite their source in psychotherapy typescripts, have somewhat missed their mark and are measuring rather generic social liking rather than a specific liking for patients. Assuming that the measure is one of social liking, then it is not surprising that it relates poorly with in-therapy variables since the psychotherapy situation is such a peculiar segment of human interaction.

Hypotheses Three and Four.--These two hypotheses related to there being a significant positive relationship between the therapists' liking scores and their ability to hold patients in psychotherapy, and between the liking scores and the therapist's having had a personal psychotherapy. The first of these predictions was derived from the work of Stoler (1963) and Caracena (1963), both of whom had reported that patients rated as being likable tended to stay in therapy longer than those rated by their therapist as being less likable. The second prediction was suggested by the work of Strupp (1960) who reported that in

his sample of therapists empathy was related to the therapist's having a positive reaction to a patient only when the therapist had undergone a personal psychotherapy. Neither hypothesis was confirmed. If, as the above discussion has suggested, the liking scores may be heavily weighted with social liking, then there no longer exists a theoretical reason for the liking scores to be related to either criterion variable. It just simply may not be an appropriate predictor. Therefore, the present results do not necessarily contradict those of Stoler, Caracena, and Strupp. The present data may not be comparable to their data.

Another weakness in the design of this experiment is seen rather blatantly in the testing of hypothesis three, staying or quitting psychotherapy as a function of the therapist's liking score. The analyses were run for the criterion variable along both the staying/quitting and the succes dimensions (as seen in Tables 13 and 14) only for the one patient with whom the interview scored in this study had been obtained. Accordingly, we have essentially a one item predictor, that one patient, or rather, the success of that one patient's psychotherapy. This type of analysis makes the very tenuous assumption that the therapist's success or failure with this one patient (unselected except for agreeing to have his interviews tape-recorded) is an adequate predictor of the therapist's modal success or failure with all his patients (since the liking measure is assumed to be a generalizable measure). The rating of therapeutic success or failure is fraught enough with difficulties without including

into it a one-item, hence very unreliable, predictor. The negative results are, therefore, not too surprising.

Hypothesis Five.--This hypothesis, that liking would be related to the amount of therapist experience, grows out of Rogers' (1959) discussion of the nature of psychotherapy. If doing psychotherapy is something which can be taught; if experience produces more effective psychotherapists; if unconditional positive regard (therefore, liking) is important to the success of the psychotherapist; then, liking should relate positively to experience. It must be said that classical psychoanalysis would predict the opposite since liking for patients (or any other feeling the therapist might have for the patient) would connote distortion and, therefore, would impede therapeutic progress (Freud, 1912a). Despite these contradictory predictions from Rogers and Freud, no relationship was found between liking and years of experience. The possible drawbacks of the liking measure have been discussed above. What is suggested by the present results is that liking is a personal trait/characteristic which, as far as the data will reveal, does not change significantly over experience or over training (see also Table 10). Beginning therapists do not seem to learn to like, and experienced therapists do not display great amounts of liking or, conversely, because of less distortions in their therapy method, display less. It may well be that years of experience is not the best predictor of therapeutic competence and that the negative results can be explained in this manner.

Hypotheses Six and Seven.--The needs for affiliation and for nurturance have been called social needs by Gebhard and Hoyt (1958). As such, and because Grater, et al. (1961), have called the nurturant need "almost a prerequisite and probably a necessity for job satisfaction" as a counselor (p. 10), it was felt that the nurturant need and the need for affiliation might relate positively to liking for patients, presumably another positive therapist characteristic.

A significant relationship between the need for nurturance and liking was found only for the practicum students. For the other two groups, the relationship was not significant though it was consistently in the predicted direction for the senior staff. As Grater, et al. (1961) has discussed, the area of counseling and psychotherapy attracts people with initially high nurturant needs (hence the high relationship between need for nurturance and liking--the beginning therapist needs to nurture and to like people). However, with increasing experience, the counselor is faced with a paradox--he chose to do psychotherapy because of his need to take care of and to like other people, and yet the counselor/therapist is forced "to limit the expression of his own needs and to derive his satisfactions essentially from meeting the needs of others rather than expressing his own except for nurturance . . . but his professional role limits how freely he may express his nurturant need lest he establish an unhealthy relationship" (Grater, p. 10). So, with increasing experience in doing therapy, the therapist is forced to forego

the satisfaction of his own nurturant need in order to enhance the well-being and the protection of his patient. The data suggest, though the entire trend is not significant statistically, that the beginning therapist who comes into the therapy situation expects to (and probably does) nurture patients whom he likes. With experience, however, he soon learns that too much nurturance is not good as he is exposed to "transference cures" (patients looking better only because of their relationship to the therapist) or, for the Rogerian or existentialist therapist, to the stifling of the patient's self-actualization because of too much dependence upon the therapist. At a middle point in experience (i.e., for the present sample, during the internship) the therapist foregoes much of his need for nurturance with patients whom he likes. There then occurs, as mentioned above, trends in the data which suggest that once the intern is "over the hump", he again with increasing experience is able to satisfy his needs for nurturance with patients whom he likes (though not to the degree he had in his initial stages of training).

It is interesting to note that on the Edwards findings (see Table 7) for the interns, the one group which exhibits the least nurturance with patients it likes, the absolute degree of nurturance is greater than that for the other two groups (the groups differing at the .01 level). It might well be that, because the nurturance needs are being frustrated somewhat in the therapy situation, the Edwards is picturing unfulfilled needs for nurturance. With more

fulfillment of the need in the therapy situation, the less the amount of the residual need is as reflected on the Edwards.

The relationships between the need for affiliation and the liking scores are essentially the same as those for nurturance and liking, i.e., for practicum students, the need is significantly and positively related for liking; for interns, the relationship is negative but non-significant, and for senior staff members the relationship is again positive but no quite significant (one P. level is less than .10). The similarity between the results for nurturance and for affiliation when compared with the liking scores for the practicum students is not surprising since, as reflected on Table 8, the two needs correlate for that group $+.69$. Such a relationship is suggested by the Grater paper which indicates that counseling is chosen to satisfy a need to take care of and to be close to other people (which sounds like both affiliation and nurturance needs) but once the profession is chosen it is found to be "a rather lonely kind of work . . . basically unilateral and not reciprocal" (p. 10). It is not surprising to see further on Table 8 that with experience in doing psychotherapy, the needs for affiliation and nurturance become quite dissimilar (the correlations between the two needs for the interns and senior staff members are negative and non-significant). The present data suggest that (in doing therapy) therapists beyond the practicum level of experience do not reflect a significant relationship between liking and the need for affiliation. They do not, as Grater et al. would

predict, systematically satisfy their needs to be with people simply because they have high liking scores. This is true only for the practicum students who ostensively have not yet learned that therapy is "a rather lonely kind of work" and has to be that way.

Hypotheses Eight and Nine. --These two hypotheses grew out of the already hypothesized relationships between liking and both the approach percentages and the needs for nurturance and for affiliation. Syllogistically, if liking has a positive relationship with the approach to dependency and to hostility, and if liking has a positive relationship with the needs for nurturance and for affiliation, then the approach to dependency and to hostility should relate positively to the two needs.

The results of these two hypotheses are rather puzzling (as seen in Tables 19 and 20). The need for nurturance significantly related to the approach to hostility for the senior staff and practicum groups. No relationship, however, between the need for nurturance and the approach to dependency was found. Likewise, the need for affiliation related positively for the practicum and intern groups to the approach to hostility, but, for none of the groups, to the approach to dependency. The immediate question which is raised is--why do presumably nurturant (and to a lesser degree, affiliative) therapists not approach dependency more often than less nurturant therapists? Also, why do nurturant (and to a lesser degree, affiliative)

therapists approach hostility more than dependency? It must be remembered that the interviews from which the approach percentages were obtained were fifth interviews and, since the therapeutic stress at the counseling center is towards short term psychotherapy, therapy was well started in most of the cases. Initial dependency bids had been met by the nurturant/affiliative therapists, and the quick drop-outs from therapy had already occured. The approach to hostility presumably was rising from the level where it was in the first interviews (if one can extrapolate from Kopplin (1963) who found a significant increase in the approach to hostility from the first to the second interview and predicted that this increase would continue over further interviews). The approach to dependency is, nonetheless, stable across interviews (Caracena, 1963, and Schuldt, 1964) and, hence, relatively speaking there was more approach to hostility as compared to the approach to dependency in fifth interviews than there had been earlier.

Actually, as has been suggested earlier in the discussion of the Grater paper (1961), therapists may well have to bridle the expression of the nurturant and affiliative needs in order to meet the demands of the therapy situation and of their patient appropriately. That this may be the case in the approach to dependency also is suggested by Snyder (1963) who writes

> Since the therapist is assuming in this situation a role much like that of a parent, he must be careful to avoid repeating the errors that the real parent has made in producing the excessive dependency of the (patient) . . . When the (patient) finds 'leaning on the therapist' too

> comfortable, the therapist will need to push him to make some efforts of his own. The therapist must re-condition this dependency into a striving to do things himself (p. 6).

In other words, it may make sense, after therapy is started, to find that nurturant therapists begin to train the patient for independence rather than reinforce his present dependency. This could account for the present results.

As predicted the need for nurturance and for affiliation in general related positively to the approach to hostility. This adds support to Muncie (1959) who states that apart from being nurturant one of the therapist's needs must be

> the need to uncover the damaging personality aspects in their actual workings, thereby generating additional suffering as guilt, anxiety and hostility directed against us or against self (p. 1325)

Then, as therapy progresses (at least until the fifth interview), this need to uncover also increases thus generating hostility towards the therapist and towards the self. The present data reflect that high nurturant practicum students and senior staff members are able to tolerate (i.e., approach) this hostility. As mentioned before, the intern group appears to be in a state of flux where their intense concentration on psychotherapy and their learning of the dangers of satisfying their own nurturant needs too much in psychotherapy has meant a withdrawal of the direct satisfaction of this need in psychotherapy. The practicum students have yet to be exposed to this difficulty, and the senior staff apparently have resolved it. The situation is somewhat different in looking at the need for affiliation. Here, only the

practicum and intern groups reflect significant relationships between the need and the approach to hostility. This is quite congruent with the discussion of Grater, et al. (1961) who posit for beginning therapists a high need to be with people (i.e., need for affiliation) which is progressively frustrated in the actual "lonely kind of work" of doing psychotherapy. Hence, the relationship between the need for affiliation and the approach to hostility decreases as experience increases.

General Characteristics of the Data

Approach Percentages.--As reflected in Table 2, the approach to dependency significantly increased as the experience of the therapist increased; there was no significant relationship between the approach to hostility and the experience level of the therapist. Earlier studies using the same essential content analysis method of scoring tapes found approach to dependency and to hostility both significantly related to experience (Caracena (1963), Kopplin (1963), and Lerman (1963)). The relationship between dependency and experience found in all studies is discussed by Caracena as follows:

> . . . the differences (in approach rates to dependency) suggest that explotation of a well learned habit (to follow directions, i.e., to depend) is a therapeutic technique learned through experience with the effects of approaching and avoiding dependency (p. 46).

So, it would appear that approach to dependency is an experience variable, something that is learned with increasing exposure to psychotherapy. This appears to be so much the case, that in this

entire study, the approach to dependency was related other than to experience to only one relatively minor variable (i.e., to liking for female therapists at the .05 level). It appears in great part to be a tool.

This does not appear to be the case with the approach to hostility. The present data suggest that it does not depend upon experience. Two of the other studies cited above which did find significant relationships with experience used first and second interviews (Kopplin and Caracena) and hence their data are not comparable to the fifth interviews used here. Lerman comparing the mean approach to hostility percentages of "early" (first through third) interviews with that of "later" interviews (fourth through sixth) found no significant difference. This result is clearly discrepent with the extrapolation from Kopplin's data which suggests a convergent of the approach percentages to hostility across experience levels sometime after the second interview. What appears to be happening is that the less experienced therapists "warm up" slower to hostility bids from their patients but, once they have sufficient exposure to their patient, their approach percentage to hostility is not different from that of more experienced therapists. Kopplin goes on to say that

> If a ceiling is reached in approach to hostility, the differences between experience levels may no longer be present after a series of interviews with the same patient (p. 36).

This lack of difference between experience levels has also been verified in a study of Varble (1964). So, apparently the predominance of the data suggest that the approach to hostility

depends upon things other than gross experience. In the present study, it has been seen to relate to the sex of the patient, the sex of the therapist, the therapist's liking scores, and the therapist's needs for nurturance and for affiliation in interaction with experience. The approach to hostility does not appear to be as simple and almost univariate a variable as the approach to dependency. It is much more tied to the individual therapist regardless of experience and is multiplely determined. Hence, the data suggest that the therapist can and does learn to approach dependency, but his approach to hostility is greatly determined by his own dynamics and characteristics, those of his patient, and the dyadic interaction of the two.

Liking.--In general, it can be said that the liking scores did not behave in the predicted manner, and that liking was related to very few of the other variables included in the study. As has already been noted, there appears to be suggestions from the data that what has been operationally defined in this study as liking for patients may be in truth a more generic social liking. These suggestions come mainly from two sources, the relationships between liking and the need for nurturance, and between liking and the need for affiliation (Tables 17 and 18 respectively). Liking has been shown to be related positively and significantly to both of these variables (called social needs by Gebhart and Hoyt, 1958) only for beginning therapists. These beginning therapists, as previously suggested, enter the field of psychotherapy to satisfy these needs,

only to find that the complete satisfaction of them can not be found in the therapeutic situation. Therefore, satisfaction of these needs becomes more social and less therapeutic.

Liking did not relate to either the experience grouping or to the years of experience of the therapist. As such, it would appear to be a variable much more attached to the individual therapist rather than to his degree of training. However, there may be counterbalancing factors which are causing the negative results. Rogers, it will be remembered, would predict an increase in liking for patients with an increase in therapist experience (1959), while Freud, because liking to him would be a distortion and, hence, undesirable, would predict the opposite (1912a). If, increasing experience would demand an increase in liking (i.e., positive regard) from the therapist, a concurrent increase in sensitivity (Abeles, 1961) would make the therapist more sensitive to distortions. Then two countervailing forces are set up which may cancel each other.

In general, therefore, what seems to be happening is that what is measured in this study as liking for patients may be closer to a general social liking. Because of the possible counter-balancing factors which may attenuate any experience differences for liking, it may well be that the difference between liking for people generally and liking for patients is so qualitative that the present gross quantitative measures were not able to discriminate between the two.

The Edwards Variables.--The data suggest that, in independent confirmation of the Grater paper, beginning therapists show a high relationship between the need for affiliation and the need for nurturance (this relationship even being higher than that reported by Edwards, 1953, for his normative group). However, with increasing experience, these two needs diverge as the therapist learns that gross affiliative needs are not well met by doing psychotherapy because of the unilateral nature of the interaction (and there is even some attenuation of the nurturant need as the therapist learns that too much nurturance can harm his patient). Therefore, it is not surprising that the correlations between the two needs for the intern group and for the senior staff group are not significant (Table 8).

The absolute amounts of the needs expressed bear some inspection. There is no difference between the amount of the affiliative need across the three groups. This would suggest that the affiliative needs frustrated in doing psychotherapy for the two more experienced groups have found adequate outlets (such as case conferences, supervision, professional meetings, or, as suggested in the Grater paper, by team research). This does not appear to be the case for nurturance where significant differences do appear between the groups, with the interns displaying the highest average need, followed by the practicum students and the senior staff in that order. This has been explained as reflecting some disruption in the need for nurturance for the interns as they discover the drawbacks of the luxury of their fully satisfying

their need. In some way they partially withdraw temporarily the satisfaction of this need from the doing of psychotherapy until they learn to use it more appropriately without harming their patients. The practicum students have yet to go through this stage and presumably the senior staff have resolved the issue--hence, the latter two groups reflect a lower need for nurturance since they ostensively are satisfying more of the need in the psychotherapy situation itself.

Degree of Experience.--While the degree of experience of the various therapists was a secondary issue in this study, it does merit some note. In general, apart from the liking scores and the approach to hostility, almost every variable or combination of variables in this study shows differences over the three experience groups. While individual differences within groups may be important along some dimensions, the present data suggest that degree of training is at least of equal importance. This is, of course, certainly justification (albeit unneeded) for intensive therapy training programs such as that at the counseling center where the trainee is not necessarily forced into a theoretical mold but urged and helped to use his peculiar combination of traits and dynamics.

As seen in Tables 17 through 20 especially, there is also suggested a disruption of some type occuring somewhere in the middle stages of therapy training (the intern level in the present sample). Therapists in this group appear much more dissimilar to

either beginning or experienced therapists than these latter groups do to each other. What seems to be happening is that, in the intern group, the basic needs or dynamics which bring people into the profession are being disrupted as the actual demands of the therapy situation are seen to be in part not compatible with the therapist's needs. During this period, the trainee therapist is intensely involved in learning how to do effective therapy, and it becomes a process which is rather isolated from his personal satisfactions (e.g., while there appears to be some positive relationships between the needs for nurturance/affiliation and the liking scores and the approach to hostility for practicum students and senior staff, such relationships are not present for the interns). Once through this awkward period, however, the therapist is better able to relate his own needs to the therapy situation (as can be seen in the results from the senior staff group), but never again to the degree that the beginning practicum student did (or, at least, anticipated that he would).

CHAPTER VI

SUMMARY

Liking for patients was thought to be a concept which might have some viability in the study of the psychotherapeutic process because it can be derived from two of the major conflicting theories of psychotherapy (from Rogerian theory in the form of "positive regard" and from psychoanalytic theory as "positive transference"). As such, if it could be related to therapist traits and in-therapy variables, it could prove to be of great heuristic value and might in some small way effect some type of rapprochement between the two theories.

The hypotheses tested were essentially that liking for patients would relate positively to approach to dependency and to hostility (as measured by the content analysis system of Winder et al. 1962), and that liking and therapist experience, the therapist's having had a personal psychotherapy, and the therapist's facility to "hold" patients in therapy would also be positively related. Furthermore, it was predicted that the needs for nurturance and for affiliation (as measured on the Edwards Personal Preference Schedule (Edwards, 1953)) would correlate positively to liking and to both the approach to hostility and to dependency measures.

The therapists used in this study were staff members and students at the Michigan State University Counseling Center and consisted of thirteen senior staff members (all with Ph.D. degrees), fourteen advanced graduate students from clinical and from counseling psychology doing internships at the center, and ten beginning practicum students.

Liking for patients was derived from the semantic differential. All therapists were asked to complete a semantic differential for their "ideal" patient and then, after reading each of six two-page typescripts of actual psychotherapies of varying types of patients, to complete the same semantic differential for each of the patients. Liking scores were derived from analyzing quantitatively the differences between the "ideal" protocol and the six "actual" protocols.

The tape recordings which were analyzed using the Winder system were, for the intern and senior staff groups, fifth interviews which were drawn from the tape library at the counseling center. The tapes for the practicum group, also fifth interviews, were collected individually with the student and his supervisor's permission.

Biographical information and the Edwards Personal Preference Schedule were collected from the therapists individually.

In general, the hypotheses relating to liking were not confirmed. This was discussed as possibly meaning that what actually was being measured was a more general social liking rather than a

specific liking for patients. This discussion was supported by the findings that liking did correlate positively and significantly to the needs for nurturance and affiliation (these two needs having been called social needs) but only for the beginning practicum students. In discussing this, it was suggested that the social needs which lead individuals to become psychotherapists initially are not in truth well satisfied in the psychotherapeutic situation (Grater et al., 1961) and, therefore, the correlations in general between liking and the two need areas were not significant for the intern and senior staff groups.

The need for nurturance and the need for affiliation were both significantly related to the approach to hostility but not to dependency. This was explained as being a function of (in this setting of short term therapy) therapy's having been well started by the fifth interview and, hence, the high nurturant and affiliative therapists were already "training the patient for independence" (Snyder, 1963), but still arousing some hostility by their probings.

Nurturance and affiliation were significantly and positively correlated for the practicum group only. This suggests that beginning therapists strongly associate their affiliative and nurturance needs but, with increasing experience, these needs diverge as the concurrent satisfaction of these needs in therapy is found not to be possible.

Several factors emerged from the content analysis material. Supporting the prediction of Kopplin (1963), no difference for

fifth interviews was found in the approach to hostility for the various experience groups. A significant difference was found for the approach to dependency reflecting that the more experience a therapist has, the more he approaches dependency. In the light of these findings and from the predominance of other findings in this study relating to the approach to dependency and to hostility, it was suggested that the approach to dependency was primarily a therapeutic tool which is learned with increasing experience while the approach to hostility is much less a function of experience and more of the therpist's individual characteristics.

Despite the above results suggesting individual differences between therapists in their general approach to hostility, there was a general orderliness in the data across experience levels suggesting that the degree of training is at least of equal importance with individual differences. The data further reflect some disruptions of the satisfaction of personal needs in the doing of therapy for the interns as they are exposed to the handicaps of investing too much of their nurturant and affiliative needs in their patients. That this conflict is resolved is suggested by the fact that the senior staff members seem to be satisfying some of their personal needs in the therapeutic situation but not at the artificially high level of the beginning practicum students.

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APPENDICES

APPENDIX A

Semantic Differential

(Stimulus word or words)

relating ___:___:___:___:___:___:___distant

shallow ___:___:___:___:___:___:___deep

expressive ___:___:___:___:___:___:___constricted

mature ___:___:___:___:___:___:___immature

inert ___:___:___:___:___:___:___energetic

open ___:___:___:___:___:___:___closed

aggressive ___:___:___:___:___:___:___placid

dependent ___:___:___:___:___:___:___independent

colorless ___:___:___:___:___:___:___colorful

friendly ___:___:___:___:___:___:___unfriendly

tense ___:___:___:___:___:___:___relaxed

gregarious ___:___:___:___:___:___:___solitary

potent ___:___:___:___:___:___:___impotent

calm ___:___:___:___:___:___:___agitated

vague ___:___:___:___:___:___:___precise

constrained ___:___:___:___:___:___:___free

congruent ___:___:___:___:___:___:___incongruent

happy ___:___:___:___:___:___:___sad

still ___:___:___:___:___:___:___vibrant

rational ___:___:___:___:___:___:___intuitive

frustrated ___:___:___:___:___:___:___content

impulsive ___:___:___:___:___:___:___deliberate

depressed ___:___:___:___:___:___:___expansive

strong ___:___:___:___:___:___:___weak

submissive ___:___:___:___:___:___:___dominant

APPENDIX B

Instructions Part I

The purpose of this study is to measure the meanings of certain things to various people by having them judge them against a series of descriptive scales. In taking this test, please make your judgments on the basis of what the things mean to you.

On the third page and on several pages in Part II, you will find a different concept to be judged and beneath it a set of scales. You are to rate the concept on each of these scales in order.

Here is how you are to use these scales:

If you feel that the concept at the top of the page is very closely related to one end of the scale, you should place your check-mark as follows:

fair_X_:___:___:___:___:___:___unfair

OR

fair___:___:___:___:___:___:_X_unfair

If you feel that the concept is quite closely related to one or the other end of the scale (but not extremely), you should place your check-mark as follows:

strong___:_X_:___:___:___:___:___weak

OR

strong___:___:___:___:___:_X_:___weak

If the concept seems only slightly related to one side as opposed to the other side (but is not really neutral), then you should check as follows:

active___:___:_X_:___:___:___:___passive

OR

active___:___:___:___:_X_:___:___passive

If you consider the concept to be neutral on the scale, both sides of the scale equally associated with the concept, or if the scale is completely irrelevant, unrelated to the concept, then you should place your check-mark in the middle space:

safe___:___:___:_X_:___:___:___dangerous

IMPORTANT: (1) Place your check-marks in the middle of spaces, not on the boundaries:

X

___:_X_:___:___:___:___:___

This Not this

(2) Be sure you check every scale--do not omit any.

(3) Never put more than one check-mark on a single scale.

Instructions, Part II

On the following pages, you will be reading mimeographed excerpts from psychotherapy hours. In each excerpt, what the counselor (or psychotherapist) says is prefaced by a "C"; furthermore, what the subject says is prefaced by an "S" and then appears in all capital letters, e.g.,

C. What you want is fair treatment. (Counselor Statement)

S. THAT'S ALL. I DO TRY. (Subject Statement)

There are five excerpts, each two pages long. Read each of them carefully paying primary attention to the statements of the SUBJECT, that is, everything which is in all capital letters. Immediately following each two page excerpt, on the very next page, will be a series of check lists just like those you finished on the last page. In each case, the concept at the top of the page will be the name of the subject about whom you have just read in the two page excerpt. You will complete the checklists using the same instructions which you had for Part I (concerning the type of person you would like to help) except that in this case the checklists (or scales) would, of course, refer to the subject about whom you have just read. After you complete the checklists for a subject, then go on to the next page and start reading the next excerpt, and so on.

Feel free to ask questions about anything which you do not understand.

MR. JAMES high school male

S. SOMETIMES I FIGURE THAT I SHOULDN'T WORK BECAUSE I HAVE AN AUNT WHO TOLD ME THAT SHE'D FOOT THE BILL FOR MY GOING TO COLLEGE IF I COULD GET IN. SHE'S A NUT. I LAUGHED AT HER. I KNOW SHE'S GOT THE MONEY--SHE'S ONE OF THESE OLD SPINSTERS--BUT I LAUGHED AT HER BECAUSE, BEFORE, SHE USED TO CALL ME A HOODLUM, AND NOW SHE WANTS TO GIVE ME MONEY TO GO TO COLLEGE. IT'S REALLY FUNNY--SHE'S REAL TOUGH HERSELF, BUT SHE USED TO CALL ME A HOODLUM. I WOULDN'T MIND IF SHE'D PAY MY WAY THROUGH COLLEGE--THAT WOULD BE PRETTY GOOD. SHE USED TO CALL ME A HAIRY HOODLUM, AND NOW SHE SAYS 'HELLO JOHN'. IT'S REAL FUNNY, BUT I GUESS SHE'S REALLY INTERESTED IN MY GOING TO COLLEGE. SHE'D ACTUALLY WRITE OUT A CHECK AS LONG AS I COULD GET IN. SHE'S REALLY EXCITED AT THE IDEA OF MY GOING TO COLLEGE. MY FAMILY'S OKAY, I GUESS. IF THEY KNOW I'M TRYING TO GET AHEAD, THEY'LL DO ANYTHING FOR ME.

C. You get the feeling that they're really interested in you when you're trying.

S. YEAH, I GET A PRETTY GOOD FEELING INSIDE TO KNOW THAT THEY'RE BEHIND ME. I GUESS THEY'LL GET BEHIND ME IF THEY KNOW I'M SINCERE IN WHAT I'M DOING. MY AUNT, THOUGH, SHE'S REAL FUNNY. SHE'S LOADED. SHE USED TO WANT ME TO BE A SALESMAN--SHE MADE HER MONEY SELLING THINGS--I DON'T KNOW WHAT. SHE'D SHOW ME THE TRICKS OF SELLING, AND, BOY, SHE WAS A REAL ROUGH CHARACTER. SHE DID A LOT TO HELP ME, THOUGH.

C. Uh-huh.

S. I'LL NEVER FORGET THE FIRST TIME THAT I GOT INTO TROUBLE. SHE CAME OVER TO MY HOUSE AND ASKED WHAT KIND OF TROUBLE I GOT INTO. I TOLD HER, AND MAN, SHE CALLED ME EVERY NAME IN THE HOUSE. FATHER DIDN'T MIND EITHER--BOY, WHAT A TONGUE. BUT I LIKE HER, I REALLY LIKE HER ALOT.

C. You get the feeling that she's on your side even though she does these things--she's still interested in you.

S. SHE REALLY IS. SHE HAD A HARD LIFE WHEN SHE WAS A GIRL, I GUESS. HER PARENTS HAD NO MONEY, AND WHEN SHE NEEDED SOMETHING, SHE USED TO HAVE TO GO OUT AND STEAL IT. BUT SHE'S REALLY GOT AHEAD IN THE WORLD. SHE'S SITTING PRETTY. BUT SHE HAD A ROUGH TIME GROWING UP. PEOPLE SAY I IDOLIZE HER, BUT I DON'T. THEY THINK I'D LIKE TO BE LIKE HER, BUT I WOULDN'T. I'M A LOT LIKE HER, BUT I'M NOT, IF YOU GET WHAT I MEAN. SHE'S HOT-TEMPERED AND I'M HOT-TEMPERED; SHE GOT INTO TROUBLE WHEN SHE WAS A KID AND SO DID I. OF COURSE SHE'S A WOMAN AND I'M NOT, BUT I'M DIFFERENT IN A LOT OF OTHER WAYS, AND I'M GLAD I AM. THERE ARE A LOT OF THINGS ABOUT HER . . . WELL, I WOULDN'T WANT TO BE LIKE HER.

C. On the one hand, you admire her, but still you don't want to be like her . . .

S. I'D LIKE TO HAVE THE MONEY SHE HAS, BUT I WOULDN'T WANT TO GET IT THE WAY SHE GOT IT. SHE'S OKAY, BUT I JUST DON'T CARE FOR THE WAY SHE HAS MADE HER MONEY--BUT SHE'S BEEN MORE LIKE A MOTHER TO ME THAN MY OWN MOTHER . . . I NEVER REALLY THINK OF MY MOTHER AS MY MOTHER. SHE'S TOO OLD-FASHIONED.

SHE DOESN'T BELIEVE IN MY GOING OUT WITH GIRLS. SHE DOESN'T LIKE HOCKEY. SHE DOESN'T BELIEVE IN ANYBODY HAVING A GOOD TIME. SOMETIMES I GET THE FEELING THAT I NEVER REALLY HAD A MOTHER. I MEAN, IN A WAY, MY REAL MOTHER ISN'T MY MOTHER. MY AUNT HAS DONE A LOT TO BRING ME UP, SO I FEEL CLOSER TO HER. I REALLY DO.

MR. SMITH--male college student

C. I believe that Mr. Johnson said that you had some things you would like to talk over with me.

S. YES, I THOUGHT MAYBE I COULD IRON SOME OF THE WRINKLES OUT. I'M ALWAYS WORRYING ABOUT SOME THINGS--NOT BIG THINGS, JUST LITTLE THINGS. I CAN'T GET OVER THE FEELING THAT PEOPLE ARE WATCHING ME. THEN I WORRY ABOUT PERSONAL THINGS AND OTHER THINGS. WHEN I SEE AN AD IN THE PAPER I WORRY ABOUT THE THINGS DISCUSSED IN IT ALTHOUGH I KNOW THEY AREN'T TRUE. I ALWAYS FELT THAT OTHER FELLOWS COULD ALWAYS DO THINGS, BUT I COULD NEVER COME UP TO THE OTHER GROUP. NO MATTER HOW MUCH PEOPLE SAID OTHERWISE, I DIDN'T BELIEVE THEM. I'LL WORRY ABOUT EXAMS THAT I'VE GOT EVEN THOUGH THERE'S NO POSSIBILITY OF NOT MAKING OUT WELL ON THEM. THINGS JUST CRAM UP INSIDE MY HEAD--LITTLE THINGS. THEY JUST KEEP COMING BACK. I KEEP WORRYING ABOUT THEM AND THINKING ABOUT THEM. LIKE IN ADS, LIKE LIFEBOUY ADS. WHEN I'M GOING OUT ON A DATE I'LL TAKE A BATH AND THEN AFTER THAT I'LL USE A HALF DOZEN DEODORANTS. BUT I STILL

WORRY ABOUT--WHEN JACK AND I GET TOGETHER--THAT'S MY FRIEND. HE'S A SWELL GUY. IT'S THE SAME WAY WITH HIM. THERE'S NOTHING WE CAN DO ABOUT IT. WE HAVE JUST GOT TO LET IT GO ON AND TRY TO LIVE IT OUT. IT JUST SEEMS LIKE THE WORLD IS CROWDING IN ON US. THERE'S A FEELING OF FRUSTRATION AND NOTHING YOU CAN DO ABOUT IT.

C. **You feel pretty much upset about the things and that keeps you worrying about it.**

S. YES, I KNOW I SHOULDN'T WORRY ABOUT IT, BUT I DO. LOTS OF THINGS--MONEY, PEOPLE, CLOTHES. IN CLASSES I FEEL THAT EVERYONE'S JUST WAITING FOR A CHANCE TO FIND SOMETHING WRONG. AT SCHOOL THERE WERE FELLOWS LIKE THAT WAITING FOR ME. I CAN'T STAND RIDICULE. THAT'S WHY I'M AFRAID OF KIDS. WHEN I MEET SOMEBODY I WONDER WHAT HE'S ACTUALLY THINKING OF ME. THEN LATER ON I WONDER HOW I MATCH UP TO WHAT HE'S COME TO THINK OF ME.

C. **You feel you're pretty responsive to the opinions of other people.**

S. YES, BUT IT'S THINGS THAT SHOULDN'T WORRY ME.

C. **You feel that it's the sort of thing that shouldn't be upsetting, but they do get you pretty much worried anyway.**

S. JUST SOME OF THEM. MOST OF THOSE THINGS DO WORRY ME BECAUSE THEY'RE TRUE. THE ONES I TOLD YOU, THAT IS. BUT THERE ARE LOTS OF LITTLE THINGS THAT AREN'T TRUE. AND TIME BOTHERS ME TOO. THAT IS, WHEN I HAVEN'T ANYTHING TO DO. THINGS JUST SEEM TO BE PILING UP, PILING UP INSIDE OF ME. WHEN

I HAVEN'T ANYTHING TO DO I ROAM AROUND. I FEEL LIKE--AT HOME WHEN I WAS AT THE THEATER AND NOBODY WOULD COME IN, I USED TO WEAR IT OFF BY SOCKING THE DOORS. IT'S A FEELING THAT THINGS WERE CROWDING UP AND THEY WERE GOING TO BURST.

C. You feel that it's a sort of oppression with some frustration and that things are just unmanagable.

S. IN A WAY, BUT SOME THINGS JUST SEEM ILLOGICAL. I'M AFRAID I'M NOT VERY CLEAR HERE BUT THAT'S JUST THE WAY IT COMES.

C. That's all right. You say just what you want.

S. THAT'S ANOTHER THING. WHEN I SPEAK, I KNOW WHAT I WANT TO SAY BUT I DON'T SEEM TO BE ABLE TO SAY IT. THE WRONG WORDS COME OUT AND I CAN'T EXPRESS WHAT I WANT TO SAY EVEN THOUGH I HAVE THE IDEA. SOMETIMES I'LL HAVE TO GO BACK AND RECOVER THE THREAD OF IT. I'LL FIND I'M NOT ON THE SUBJECT. SOMETIMES I CAN'T FIND WORDS TO EXPRESS WHAT I MEAN.

MR. STEWART--college male

C. One thing and another coming up, it's kind of hard to get together isn't it?

S. I GUESS IT REALLY IS. HOW LONG HAS IT BEEN NOW, ABOUT THREE WEEKS?

C. I guess it's about that time. I've been away once, and you've been away once, and that's the way it works.

S. I GUESS SO. (little laugh)

C. How are things going?

S. WELL, THINGS ARE OKAY, I GUESS.

C. Sounds like you're not too sure though.

S. WELL, I WOULD SAY I HAVE A PESSIMISTIC ATTITUDE.

C. Uh-huh.

S. I WONDER IF I--I GUESS I COULD HAVE REALLY COME IN LAST WEEK, BUT AT THE TIME I DIDN'T THINK I SHOULD, BECAUSE I HAD A--I HAD A PHYSICS TEST ON MONDAY AND I--MY FRATERNITY WAS HAVING A (lost) OVER THE WEEKEND, AND I WANTED TO STUDY.

C. Un-huh.

S. BUT FROM THE WAY IT LOOKS RIGHT NOW I SHOULD HAVE COME IN, (little laugh) BECAUSE IT DIDN'T MAKE ANY DIFFERENCE.

C. Uh-huh.

S. BUT I WAS WORKING ON THE PHYSICS TEST.

C. Yeah. You're not sure which way you're expending--if you would have expended your time more satisfactorily.

YEAH, THAT'S VERY TRUE.

C. Uh-huh.

S. DO YOU THINK MAYBE I WAS--I WAS--SUPPOSE I WAS PUTTING UP RESISTANCE OR SOMETHING? BY NOT COMING IN? MAYBE I DIDN'T FEEL THAT I HAD ANYTHING TO SAY. I DON'T KNOW.

C. Sounds like you might have some feelings concerning--What I mean is you're not really very sure of just what you're supposed to be doing or how you feel about these things.

S. MAYBE THAT'S IT. YOU KNOW WHAT I--I THINK--I CERTAINLY REMEMBER THE LAST TIME I CAME IN HERE, I--AFTER I LEFT--I HAD FEELINGS THAT I WAS--WELL, THAT EVERYTHING I SAID WAS GOING TO BE FOUND OUT BY OTHER PEOPLE AND I THINK IT SORT OF--I DON'T KNOW--IT

SORT OF MADE ME FEEL FUNNY. I MEAN--I WAS SORT OF RESISTING COMING IN HERE BECAUSE I WAS AFRAID OTHER PEOPLE WOULD FIND OUT (little lower) THESE THINGS.

C. Did you have anything particular in mind that sort of contributed to that feeling?

S. WELL, WHAT DO YOU MEAN, DID I HAVE ANYTHING PARTICULAR--

C. Well, anything that kind of--

S. WELL, YEAH, BECAUSE OF THE RECORDING OF THE CONVERSATION SORT OF (C: Uh-huh) I MEAN IT SEEMS THAT EVERYTHING IS SO PUBLIC.

C. Yeah. You were uncertain about really how personal--how intimate you can be in the situation.

S. YEAH.

C. Uh-huh. I might point out first of all that the recordings are never identified with a personality. The only one who knows that it's you talking is me. You see?

S. UH-HUH.

C. So that might offer you perhaps a little support. On the other hand, if you felt you'd rather we did have the recordings--

S. NO, IT DOESN'T MATTER. I GUESS MAYBE THAT WAS THE THING.

MR. LEWIS--college male

S. (low) IT'S GONNA RAIN. (louder) I WAS A LITTLE SCARED ABOUT THIS AFTERNOON--AFTER LAST WEEK--AFTER MISSING A WEEK. I SORT OF GOT . . . (too low). (louder) WELL, SOMETHING HAS BEEN BOTHERING ME A LOT. I GUESS IT STARTED--(Pause) I GUESS IT

STARTED LAST WEEK. IT CARRIED OVER RIGHT UP UNTIL YESTERDAY MORNING ANYWAY. BUT (louder) THE WHOLE FEELING THAT EVERYTHING IS TOO MUCH FOR ME IS COMING BACK AND (lower) I DON'T KNOW WHY, I JUST--. FROM TIME TO TIME, I FELT LIKE I'D JUST LIKE TO THROW EVERYTHING OVER AGAIN. AND (little laugh) E-E-EVEN DEATH HAS COME TO MY MIND. SOMETHING WHICH IS--IN A WAY SCARED ME, AND YET SOMETHING WHICH HASN'T AFFECTED ME AT ALL. I--I DON'T FEEL ANYTHING WHEN I THINK ABOUT IT, AND YET AT OTHER TIMES, I KNOW THAT IT'S NOT TOO PLEASANT A THOUGHT (fairly low but matter-of-fact tone). OF COURSE I REACT AGAINST IT. I MEAN (short pause) I MEAN JUST (sigh) THE IDEA FLIES THROUGH MY HEAD THAT MAYBE IT WOULD BE A GOOD THING TO GET OUT OF IT. AND IT WOULD BE AN OUT . . . (too low). AND I--I'VE TRIED MORE OR LESS TO DIG TO THE BOTTOM OF IT AND FIND OUT WHY I NEVER GET ANYWHERE WITH IT. IT SEEMS TO BE CONNECTED WITH THIS GENERAL LACK OF AMBITION, WHICH HAS SETTLED ON ME NOW. (sadly) LIKE THIS--I HAD A TEST YESTERDAY AND I HAD TO PUT IN THREE OR FOUR DAYS ON IT BEFORE I COULD GET TO THE STAGE WHERE I THOUGHT I COULD GO IN AND TAKE IT. THERE WAS A LOT OF MATERIAL BUT I COULD HAVE COVERED IT IN LESS TIME. I KNOW THAT. BUT I JUST HAD TO FORCE MYSELF TO SIT DOWN AND WORK AND CONCENTRATE AND DO IT OVER AND OVER AND OVER AGAIN JUST TO TRY TO AT LEAST GO INTO THE THING FEELING HALF WAY SECURE. AND I DON'T KNOW--JUST EVERYTHING IS--SOME DAYS SEEM TOO BIG.

C. You seem to be describing a feeling of being sort of burdened down.

S. YEAH. IT'S A COMBINATION OF BURDEN AND FEAR OF THE FUTURE.

C. You're a little bit scared (S: YEAH) of how it's all going to come out (short pause).

S. I--(short pause) I CAN'T CONNECT IT WITH ANYTHING EXCEPT JUST THIS FEELING THAT IT SEEMS FAMILIAR. IT SEEMS TO ME MAYBE I'VE HAD IT BEFORE. OR SOMETHING LIKE IT. THERE'S A CERTAIN SIMILARITY THERE BUT I--(clears throat) I HAVEN'T BEEN ABLE TO PUZZLE ANYTHING OUT OF IT. (pause)

C. You seem to have also mentioned that something came to an end? That is you went through a period of feeling overwhelmed and scared in this way and you seem to be indicating that it isn't all there right now. (short pause)

S. WELL, I GUESS IT DOES COME AND GO.

C. Uh-hum.

S. IT FLUCTUATES BUT I DON'T--IT'S NEVER BEEN EXACTLY THIS WAY BEFORE. IT NEVER BOTHERED ME JUST THIS WAY. I-I-I'VE FELT OVERWHELMED BEFORE AND MY REACTION TO THAT WAS, WELL, TO QUIT AND GO SOMEPLACE ELSE AND TRY AGAIN. BUT THIS SEEMS RATHER EXTREME. AND IT'S THE EXTREME TO WHICH THESE THOUGHTS ARE RUNNING WHICH IS SCARING ME. (C: uh-huh) AND I DON'T KNOW, IT'S--. IT GIVES ME A FUNNY FEELING. IT'S DEPRESSING. I CAN'T SHAKE IT OFF. I TRY TO DISMISS IT FROM MY MIND BUT IT DOESN'T (lower) WORK TOO GOOD.

C. You seem to be making an effort to get rid of it, but it doesn't seem to be going.

S. WELL, I TRY. YEAH. JUST TO SEE IF I CAN DO IT. (sad) AND MORE OR LESS EXPECT THAT IT'LL COME BACK (very low).

MR. BLACK-male college student

S. HOW DO YOU DO SIR? (very hearty, "salesmanish" approach).

C. How do you do.

S. WELL SORRY TO BE SAYING THIS--I--, NOBODY TOLD ME TO COME HERE, I JUST CAME ON MY OWN BECAUSE I FELT THAT--I NEED SOME HELP, BECAUSE MY MARKS HAVE BEEN GOING DOWN.

C. Uh-hum.

S. AND I THINK MY IQ ISN'T THE THING, MY IQ IS HIGHER THAN WHAT MY MARKS SHOW. EITHER (short pause) EITHER I'M FRUSTRATED, WHICH I THINK I AM IN MANY CASES, OR THERE IS SOMETHING ELSE THAT'S (lower) THE TROUBLE. I'VE, WELL, IT'S IN MANY CASES WHERE WHEN I START TO GET TESTS I GET AWFUL FRUSTRATED AND MY MIND BECOMES A BLANK. AND I'D LIKE TO HAVE YOU, IF YOU CAN, BE VERY IMPERSONAL AND OBJECTIVE AND TELL ME, IF YOU CAN, WHAT IS WRONG (little laugh). THAT'S ABOUT ALL, I MEAN, WHETHER YOU CAN OR NOT.

C. I'd like to be able to help you if you--perhaps you can tell me a little more about the situation.

S. WELL, THERE'S PLENTY OF SITUATIONS LIKE--TAKE EXAMPLES NOT OF--NOT OF JUST ONE TYPE BUT OF--OF MANY WHERE I SHOW PREJUDICE, FRUSTRATION, AND MANY TIME MAL- (lost) OF STUDENTS--OF DOING THINGS. ON MY TESTS FOR EXAMPLE. (short pause) I SAW A BASKET-BALL GAME THE OTHER NIGHT OF BRADLEY VERSUS CCNY AND FOR SOME

REASON I PUT ALL MY HOPE ON BRADLEY TO WIN AND THERE REALLY ISN'T TOO MUCH REASON WHY I WANTED BRADLEY TO WIN. BUT I HAD ALL MY--ALL MY HOPE ON BRADLEY AND WHEN THEY LOST I DIDN'T FEEL TOO GOOD ABOUT IT. I FELT PREJUDICED TOWARDS PEOPLE, ESPECIALLY WHO CAME FROM NEW YORK. NOW THAT'S COMMON, I PRESUME, BUT I WANT--I'M TELLING YOU THE TRUTH. I'M TELLING IT WITHOUT HOLDING BACK TOO MUCH YOU SEE. (pause) (C: Yeah) (pause) NOW WHETHER I'M HOSTILE TOWARDS PEOPLE IS ANOTHER--IS PROBABLY TRUE. BUT COULD YOU--MAYBE YOU COULD ASK ME MORE QUESTIONS AND I COULD BE MORE EXPLICIT IN ANSWERING THEM.

C. Uh-hum. You mentioned the ball game.

S. UH-HUM. (low)

C. When you say you have a prejudice towards people, does that imply any hostility of some sort.

S. WELL, IS IT GEOGRAPHICAL OR WHETHER IT'S GOT TO DO WITH DISCRIMINATION AGAINST ANY--(lower) ANY PEOPLE BUT IT'S PROBABLY THE MAIN REASON BECAUSE BRADLEY WAS IN THE WEST--AND CCNY WAS IN THE--IN THE EAST, BUT WHETHER THAT'S THE MAIN REASON I'M NOT SURE. AND THE MAIN REASON IS I'VE BEEN HAVING TROUBLE WITH MY TESTS, AND IT'S ALL BASED ON THIS FRUSTRATION (pause) AND, WELL, I KNOW ONE REASON. I'LL TELL YOU RIGHT NOW THAT I'M EPILEPTIC AND THAT'S, ALL OF A SUDDEN (C: uh-hum) TELLS YOU ONE THING. IT'S NOT--I DON'T HAVE MANY SPELLS, BUT I HAD ONE--OH--THREE OR SO A YEAR. BUT JUST THE SAME, IT'S IMPORTANT IN THE WAY I ACT, AND POSSIBLY YOU CAN TELL SOME THINGS.

C. When you say you have a feeling of frustration, what--

S. WELL--(long pause) WHEN I TAKE A TEST I THINK, I STUDY FOR IT AND I THINK I KNOW IT--I'M SURE I KNOW IT. BUT WHEN I--WHEN I GET UP TO TAKE THE TEST, I TRY TO CRAM SO MANY THINGS IN MY MIND, THAT I DON'T DO GOOD ON IT. (pause) FREQUENTLY, MY--MY TEACHERS--THEY SAY I KNOW IT. BUT I NEVER SEEM TO PUT IT DOWN.

MISS BROWN--college female

C. Match?

S. I SWEAR I HAVE THEM! I JUST CAN'T FIND THEM! (pause) THANK YOU. I REALIZE I WENT OFF ON A TANGENT IN THAT STORY LAST TIME. BUT THE WHOLE IDEA BEHIND MY FEELING TOWARD MY ROOMMATE--WELL, THIS SEEMS TO HAVE BROUGHT IT TO A HEAD, AND IT SEEMS TO ME IF I COULD OVERCOME IN SOME WAY THE FEAR I HAVE OF THEM, IT STANDS TO REASON I COULD OVERCOME IT WITH MY MOTHER. NOT EXACTLY OVERCOME THE FEAR. THE FEELING MIGHT REMAIN, BUT THAT MY--MY SORT OF INTELLECTUAL REALIZATION OF IT WOULD HELP ME SAY THE THING I'M AFRAID TO SAY EVEN THOUGH I'M AFRAID TO SAY IT.

C. Uh-hum.

S. AND I TRIED--SOMETHING HAPPENED SINCE THURSDAY THAT GAVE ME A LITTLE OPPORTUNITY ON THE SAME OLD ISSUE OF MY ROMMATE'S SMOKING, AND I DIDN'T DO IT. I HONESTLY DON'T KNOW HOW HER MIND WORKS! I CAN'T TALK TO HER ABOUT IT AND FIND OUT! I DON'T KNOW WHAT SHE THINKS. ABOUT WATCHING ME CLEAN UP,

PICK UP HER MESS AND NEVER--IT ISN'T LIKE HER TO TAKE AD-
VANTAGE THAT WAY, BUT THAT'S JUST WHAT SHE'S DOING. AND
SHE CALLED UP EARLY THE OTHER MORNING DOING ME A FAVOR.
SHE WAS WAKING ME UP IN TIME TO GO TO CLASS AND THE ROOM
WAS REALLY BAD. AND IT WAS ALL HERS. ONE OF THE GIRLS
THAT ENTERED SAID IT LOOKS LIKE A HURRICANE HAD ENTERED.
WELL, I DIDN'T SAY ANYTHING ABOUT IT, BUT SHE SAID USUALLY,
"DON'T LOOK AT THE ROOM. I KNOW IT'S A MESS AND I'M SORRY.
I'LL CLEAN IT UP THIS AFTERNOON". AND I USUALLY SAID, "OH,
THAT'S ALL RIGHT". WHICH IS THE LAST THING IN THE WORLD I
FEEL, BUT THE ONLY THING--I ALWAYS NATURALLY CALM DOWN WHEN
SHE APOLOGIZES. I CAME HOME IN THE AFTERNOON. SHE HAD
BEEN HOME. THE ROOM WAS STILL IN ITS ORIGINAL STATE. I
BEGAN TO GET ANGRY BUT I SAID NOTHING AGAIN. SHE WAS HOME
IN THE EVENING AND YOU CAN MAKE TIME IF YOU WANT. THAT
DOESN'T TAKE MORE THAN FIFTEEN MINUTES TO HANG AWAY YOUR
CLOTHES AND PUT YOUR BOOKS IN THE BOOKCASE. SO IT ISN'T
A QUESTION OF HER NOT BEING ABLE TO. SHE JUST DOESN'T!
AND, I DIDN'T SAY ANYTHING ABOUT IT. I DID UNBURDEN MY
SOUL TO VI, AND IN SAYING IT I FELT THAT SOMEHOW I OUGHT
TO FORCE MYSELF--(spoken rapidly and unintelligibly).
ANYWAY, THE NEXT MORNING I CLEANED UP AND THERE WAS A TIME
WHEN I WOULD HANG HER STUFF UP. I'M BEYOND THAT STAGE.
IT MAKES ME TOO MAD! I SIMPLY TAKE EVERYTHING UP AND
FLING IT ON HER BED (much feeling) IN THE BIGGEST MESS
I CAN CREATE MYSELF, BUT ALL ON HER BED, OR ON THE DRESSER,

AND THE THINGS, THE BED AND DRESSER THAT IS MINE, AND THE THINGS WE SHARE, I CLEANED. I DID IT. AND I HAD PLANNED--IT WAS SORT OF A COWARD'S WAY OUT--TO PUT A NOTE ON IT WITH SOMETHING ABOUT "I HEARD SOMEBODY SAY THE ROAD TO HELL IS PAVED WITH GOOD INTENTIONS." AND I REALIZED THAT SHE HAD HAD THE INTENTION TO DO IT. BUT BEFORE I (sigh) GOT THROUGH AND GOT OUT, I--I, IN ORDER TO LEAVE A NOTE, I'D HAVE TO GUARANTEE MY BEING OUT WHEN SHE CAME HOME AND READ IT. THEN IT WAS SILLY TO LEAVE A NOTE WHEN YOU'RE THERE TO SAY IT. WELL, IT JUST DIDN'T WORK OUT. SHE CAME HOME SOONER THAN I EXPECTED AND SHE BEGAN TO PUT HER THINGS AWAY, WHILE I WAS SO ANGRY, I HARDLY SAID, "HELLO," AND THAT'S ABOUT ALL. I DIDN'T SAY ANYTHING TO HER. SHE DIDN'T SAY ANYTHING TO ME. SILENCE OCCURS WHEN ONE OR THE OTHER OR BOTH OF US IS IN A BAD MOOD. YOU KNOW IT'S MISERABLE. I DIDN'T KNOW WHETHER THE SILENCE WAS IN RESPONSE TO MINE OR WHETHER SHE WAS DEPRESSED FOR SOME REASON. BUT SHE CLEANED UP HALF WAY.

APPENDIX C

Rules for Scoring the Semantic Differential to get the Liking Scores

1. For each rating therapist, his seven semantic differentials (one "ideal" and six from the typescripts) will be collated and his ratings on each of the 175 scales (25 scales on each of the seven differentials) scored using the following system:

adjective___:___:___:___:___:___:___adjective
SCORE 1 2 3 4 5 6 7

2. The "ideal" differential will then be compared with each of the six typescript differentials individually, item by item, and discrepencies determined quantitatively regardless of sign. For example:

IDEAL
good___:___:_X_:___:___:___:___bad Score 3

good___:___:___:___:___:_X_:___bad Score 6
discrepency 3

or

IDEAL
good___:___:___:___:___:___:_X_bad score 7

Mr. Black
good___:___:___:_X_:___:___:___bad score 4
discrepency 3

3. If a scale on the ideal differential is scored as a "4" (as being neutral, equally associated with either adjective, or completely irrelevant to the adjectives) and the same item is scored a "4" on one of the typescript differentials, then that one item for that one typescript differential will not be used in determining the total score.

4. The total discrepencies for one judge will be summed and divided by the total number of items (175 minus the irrelevant items mentioned above in part 3). This yields the average deviation per item from the ideal to the typescript patient and will be considered the raw liking score for that judge.

5. Then, for each of the rating therapists, the average deviation from the middle rank, i.e., from "4", will be determined for the ideal semantic differential only. This figure will be utilized as weighting factor and will be multiplied by the raw liking score for each therapist to obtain the therapist's corrected liking score.

APPENDIX D

Patient Likability 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 the last patient brings out in you (the patient about whom you just filled out a semantic differential).

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 patient, while a check at (6) would mean a disliking reaction to the patient. 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.

1 2 3 4 5 6

APPENDIX E

Scoring Manual

This manual is a modification of the manuals used in the following studies: Winder, et al., (1962) and Bandura, et al. (1960). It is identical with the manual used by Caracena (1963) and Kopplin (1963).

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 of 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 askedhim to help me and--

   T. Why was that?

   P. --he refused even to 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.

1. Hostility Category. The subcategories of hostility listed below are not differentiated in the scoring but are listed here to aid in the 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 acknowledgement of agreement. A statement agreeing with or acknowledging the therapist's approach towards hostility. May give example. May convey some conviction or may simply agree with the 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 anotherinitiate 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 effects 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 puset about my grades. I don't even want to go home.

   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 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 girl friend'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 patient had agreed or accepted the first therapist statement, the second therapist statement is scored as a reflection of the patient 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, 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 time.

P. I had to know if Barb thought what I said was right.
T. This is what you said earlier about you 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 towards 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 local 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. I 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 throughthis 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 advice.
T. Just say whatever you feel is important about that.

P. My 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 not 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 like to run around in blue jeans.
T. You hate your mother.

APPENDIX F

Professional Background

1. How long have you been active as a counselor, including your internship experience if any (to the nearest half year)_____?

2. How long have you been working in a counseling capacity in our Center program (to the nearest half year)_____?

3. Have you at some time received personal therapy of a personal-adjustment nature (If you are receiving counseling at this time, answer "now"--if you have received counseling from more than one counselor, answer "several")_____?

4. If your answer to question 3. was "yes" or "now" or "several," select one of the following counseling orientations which most closely approximates your most recent counselor's framework _____.

    a. Rational therapy
    b. Client-centered
    c. Eclectic
    d. Psychoanalytic
    e. Neo-analytic
    f. Learning theory
    g. Other (specify)_____.

5. Perhaps you find that you tend to operate out of one specific counseling framework more than another. Select one of the orientations offered in question 4. which most closely approximates your frame of reference_____.