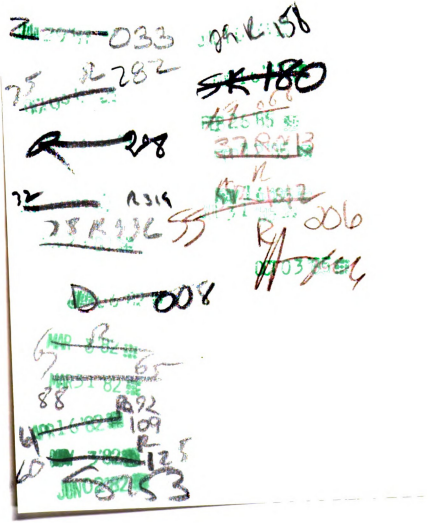

THE IMPACT OF THE THERAPIST ON THE PROCESS AND OUTCOME OF PSYCHOTHERAPY

By

Gerald Lee Gaffin

A THESIS

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

MASTER OF ARTS

Department of Psychology

1979

ABSTRACT

THE IMPACT OF THE THERAPIST ON THE PROCESS AND OUTCOME OF PSYCHOTHERAPY

By

Gerald Lee Gaffin

This study investigated the relationship between therapist personality variables, therapist behavior, and therapy outcome. Twenty-four adult clients were seen for therapy by five experienced therapists in a community mental health clinic. It was hypothesized that therapist personality needs would result in approach-avoidance behavior to client verbalization which related to therapist need areas. This hypothesis was partially confirmed. Further, it was hypothesized that the amount of approach-avoidance behavior in therapy would be related to therapy outcome especially in interaction with clients' socio-economic class. Here it was found that therapist avoidance behavior was related to therapy outcome as rated by the therapist. However, therapists did not show more avoidance of lower class clients' verbalizations as predicted even though lower class clients rated therapy as less satisfying. Implications of these findings were discussed.

ACKNOWLEDGEMENTS

I would sincerely like to thank Dr. Norman Abeles, chairman of this thesis committee. His willingness to foster my personal research ideas as well as to provide me with profound insights at times when I was "without hope", was greatly appreciated. He helped make this research a meaningful learning experience as well as a document worthy of the field.

I would also like to thank Dr. Dozier Thornton and Dr. Ralph Levine for their encouragement and helpful ideas in the planning and execution of this research.

Further thanks need to go to Dr. Rom Kriauciunas, Program Supervisor of the Ingham Community Mental Health Center, and to the therapists and intake workers there. Without their openness and cooperativeness in this research endeavor, I would dare say that this study would never have seen the light of day. Thanks also go to Polly Crisp and Miquela Rivera for their entertaining method of content analyzing this research.

Lastly, I would especially like to thank my parents and my sister. Living in a family of three M.S.W.'s could do no less than spur me on to great perfection in my research endeavors to unravel the complexities of the therapy relationship.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

The last quarter century has seen a distinct change in the focus and assessment of psychotherapy. No longer is there a strict reliance on theory alone to justify psychotherapy as a worthwhile endeavor. Consumer awareness has slowly crept into all facets of our world, and therapists are now forced to display their effectiveness to their clients, insurance companies, and to the general public in concrete, practical terms--a task not easily done.

This change was heralded by Eysenck (1952) when he summarized psychotherapy literature to date and concluded that clients treated with psychotherapy showed no more improvement than did untreated populations of clients. This study came under intense attack on both emotional and scientific grounds (Rosenzweig, 1954; Luborsky, 1954). The scientific criticism appears to have been just, that is, the criteria for improvement in the "untreated" groups were unrelated to those used for the "treated" groups, and the "untreated" groups actually received an indeterminate amount of treatment. But, from the time of Eysenck's publication on, this

controversy regarding the value of psychotherapy has continued, and probably will not be resolved by argument and counterargument (Eysenck, 1955; Strupp, 1973; Meltzoff and Kornreich, 1970). I am inclined to agree with Hans Strupp (1973, p. 511) that:

> The question in its crudest form, "does psychotherapy do any good", is largely a specious one, and most researchers have lost enthusiasm in attempting to answer it in these terms...Researchers have increasingly recognized during the last decade that there are more important questions to be answered by research...

These are questions such as the extent to which the training and experience of the therapist effect outcome.

Looking at this issue of training and experience, one way of exploring it is to assess the therapeutic effectiveness of graduate students at various levels of training in clinical or counseling psychology. This will hopefully give us an index of the role of training divorced from professional experience in effecting the outcome of therapy.

Most of the studies looking at the therapeutic effectiveness of graduate students at various levels of training do not look specifically at outcome variables. Rather, these studies look at levels of therapists' conditions such as empathy, warmth, and genuineness which have been shown to be necessary for effective therapy. Carkhuff et al. (1968) investigated the effects of the professional training of clinical graduate

students on their communication of facilitative conditions. In two studies of clinical trainees cast as counselors, one comparing first and fourth year students and the other comparing first and second year students, it was found that levels of empathy, regard, genuineness, concreteness, self disclosure, and overall conditions did not increase with level of clinical training. In fact, there was a nonsignificant trend toward decline in levels with increased training. Furthermore, in the study contrasting first and fourth year students, it was found that the ability to discriminate these conditions from tapes showed no significant difference for training level. On the other hand, Perlman (1973) found a significant increase in empathy, nonpossessive warmth, and genuineness as the training year progressed for third year clinical graduate students enrolled in a supervised practicum. While with second year graduate students, who were conducting intakes but had no supervised therapy training, there was no significant increase in those conditions.

Another line of investigation studied the issue of anxiety in therapists-in-training as a result of client responses. The importance of therapists' anxiety levels to therapy effectiveness lies in Bandura's (1956) finding that anxious therapists are rated to be less competent therapists, as well as Bandura et al.'s (1960) finding that anxiety leads to avoidance behavior of client

material which in turn leads to less effective outcome (Winder et al., 1962). Russell and Snyder (1963), in a counseling paradigm employing 2 actors role playing as clients, studied the reactions of 20 clinical graduate student counselors at various levels of training. Results revealed that hostile client behavior led to significantly greater anxiety than friendly behavior regardless of training. Furthermore, counselor's level of training had little effect on the degree of counselor anxiety for either hostile or friendly conditions. Likewise, Murphy and Lamb (1973) found that amount of anxiety displayed by therapists when confronted with a hostile client did not change as a function of training. They did find, though, that as a result of therapy training, clinical students did more "interpreting" of client behavior and less "advising" than did the control group of graduate, school psychology practicum students. This suggests that such therapy training may effect specific interview behavior of trainees as they relate to interactions with hostile clients.

As for post-therapy outcome studies for therapists-in-training, it was found by Grigg (1961) at the University of Texas Testing and Counseling Center that clinical trainees with 1 year of internship did not differ significantly from inexperienced clinical trainees with no internship or prior experience in their clients' assessments of whether counseling had been helpful to them.

From these studies, it appears that training has not shown itself to be the strongest ingredient in producing effective therapy or therapeutic conditions. Perhaps this is because training is related to therapeutic effectiveness in other than a linear fashion. Nonetheless, this would seem to leave the formal experience of the therapist as being the more crucial ingredient to therapeutic effectiveness. It is to this issue that we now turn.

At the client-centered setting of the University of Chicago Counseling Center, Cartwright and Vogel (1960) looked at the issue of therapist experience. Twenty-two clients were seen by nineteen therapists, ten of whom were considered experienced and nine unexperienced as determined by the number of past clients that therapists had seen. Outcome measurement was obtained by difference scores between pre and post-therapy application of the Butler-Haigh Q-Sort and the TAT. Results showed that an experienced therapist is effective in improving the patient's adjustment as revealed by both the TAT and by self-descriptions on the Q-Sorts while the inexperienced therapist was not as effective in improving the client's self picture and may have actually brought about a decrease in client adjustment as marked by the TAT. These results, though, were not quite significant at the .05 level, due possibly to the loose standards

used for measuring the experience of the therapists in this study.

Another study also completed at the University of Chicago Counseling Center (Barrett-Lennard, 1962) looked at the issue of experience and outcome. Eight therapists classified as experienced had completed at least two years of internship and had a minimum of three years experience at the Center while unexperienced therapists were four first year staff interns and a research assistant. Length of stay was taken as an indirect measurement of outcome and the patient-therapist relationship was measured by a questionnaire covering five relationship variables. In addition, a pre-post index of change was applied. Results showed that: 1. Length of stay was greater for clients of experienced therapists; 2. Seventy-five percent of the clients seen by the experienced therapists were rated "more changed" as opposed to 43 percent of those seen by less experienced therapists ($p < .10$); and 3. The measurement of the 5 relationship variables were higher for experienced therapists although only one reached the .05 level.

Other studies looking at therapist experience such as McNair, Lorr, and Callahan (1963) and Baum, Felzer, D'Zmura, and Shumaker (1966) have found that more experienced therapists have less dropouts from therapy.

However, not all studies have shown positive results. Fiske, Cartwright, and Kirtner (1964) found no relationship

between therapist experience and the outcome of therapy at the University of Chicago Counseling Center. The measure of experience used was the square root of the number of clients seen. And Sullivan, Miller, and Smelser (1958) found no significant relationship between therapist experience and the length of time that clients stayed in therapy or client improvement at a VA mental hygiene clinic. In this study, an experienced therapist was defined as one who had at least one year of staff work.

While the evidence is not totally positive, additional professional experience for the therapist does seem to be a factor in therapeutic effectiveness. Furthermore, research investigating experience as a factor in therapist behavior during therapy (process research as opposed to outcome research) shows that here also experience has an important influence. For instance, experience has consistently shown up as a factor in the therapist's level of warmth (Mills and Abeles, 1965; Strupp, 1973). It has also been a factor in the therapist learning to limit the direct expression of his needs in therapy and consequently be more facilitative to the client (Mullen and Abeles, 1971). And trained, experienced counselors avoid hostility less than trained, unexperienced counselors (Gamsky and Farwell, 1966). However, in addition to experience, these abilities of the experienced therapist point to another aspect of the

therapist that seems to be of importance to effective therapy, namely, the personality of the therapist. Being able to limit one's needs or give nonpossessive warmth will have a lot to do with the personality of the therapist as well as the therapist's professional experience. In fact, in those studies that failed to show better outcome for more experienced therapists, it may have been the personality factor that led to the negative results. Possibly, certain personality characteristics of the therapists allow them to be effective in therapy while others do not. Let us take a look at the research in this regard.

As far back as 1947, the American Psychological Association's report on the training of clinical psychologists (1947) recommended characteristics that psychologists should have. Among these were an interest in people, self-insight, sensitivity, and warmth. What followed from this view were studies that attempted to delineate the personality characteristics that differentiated the successful from the less successful therapists--studies such as the ones done by Holt and Luborsky (1958) and Strupp, Fox, and Lessler (1969). Holt and Luborsky looked longitudinally at the personality patterns of psychiatrists that came to the Menninger Clinic while the Strupp et al. study looked at clients' perceptions of their psychotherapy. From these types of studies, it was concluded that successful therapists tended to manifest stronger

interest in their clients than did less successful therapists, as well as being somewhat more self-insightful, warm, original, and self-controlled.

Other researchers chose not to be so global in their studies. This led to a few distinct lines of research on the personality dynamics of the therapist and how these characteristics affected the client. Three distinct lines of research in this regard seemed to be followed: 1. The Whitehorn and Betz (1954) research on "A" and "B" type therapists; 2. The Carson and Heine (1962) research on the outcome of therapy as a function of the personalities of both the client and therapist; and 3. The research of Rogers (1957) which suggested that certain personality characteristics be present for therapists to be effective in their professional work.

In their research on psychotherapy with schizophrenics, Whitehorn and Betz (1954, 1957, 1960) found that essentially two types of therapists could be discerned. They labeled these therapists "A" and "B" and found that they differed significantly. First, "A" therapists were more successful in treating schizophrenics than were "B" therapists. And secondly, "A" therapists were more able to gain the confidence of their clients, were more able to grasp the personal meaning and motivation of their clients' behavior, and were more personally involved with their clients. This personality difference translated itself using the Strong Vocational Interest

Inventory as showing that "A" therapists' interests were like those of a lawyer but not of a mathematics-physical science teacher, while "B" therapists' interests were just the opposite. This meant that "A" therapists preferred activities that involved interaction with other people. Research by McNair, Callahan, and Lorr (1962) and Berzins and Seidman (1968) additionally found that neurotics and less severely disabled patients tended to improve more with "B" therapists. However, the A-B dichotomy has been criticized as being representative of personality types. Kemp (1966) found that "A" and "B" types are not personality types but rather reflect two types of therapists' reactions to specific patient psychopathology (schizoid versus neurotic pathology). Similarily, Carson, Hardin, and Shows (1964) found "A" therapists to be more active and to be interested in the severe (severe psychopathological) patient who turns away from others.

Research on the outcome of therapy as a function of the match between client and therapist is somewhat equivocal. Carson and Heine (1962) found therapy success to vary significantly with similarity of personality characteristics as assessed from the MMPI for both clients and therapists. The relationship was curvilinear with extreme similarity or extreme dissimilarity being a block to therapeutic progress. Swensen (1971) in a review

of the research on dyadic relationships concluded that complimentarity on two main dimensions, interpersonal approach-avoidance and dominance-submission would lead to more positive relationships and hence more progress in therapy. And Dietzel and Abeles (1975) found that the most successful therapist was one who showed less complimentarity during the middle stage of therapy but showed the same amount of complimentarity as the less successful therapist during the first and last stages of therapy.

Rogers (1957, 1967) found that empathy, unconditional positive regard (warmth), and the congruence of the therapist are significantly related to successful outcome in therapy. Further research by Truax and Carkhuff (1967), Truax, Carkhuff, and Kodman (1965), and Truax and Wargo (1969) on these therapeutic conditions has found therapy to be more effective when therapists displayed high levels of these conditions. However, while the theoretical views of Rogers have tended to receive empirical support, there are several studies whose results fail to confirm a significant correlation between effectiveness of psychotherapy and levels of therapist empathy, warmth, and congruence. Garfield and Bergin (1971) found no significant relationship between the therapeutic conditions and effectiveness ratings from a variety of outcome measures. It was particularly interesting to note their finding that empathy and warmth were significantly intercorrelated with each other in a

positive direction, while congruence was negatively correlated with the other two conditions, a trend opposite to the negative intercorrelation found between empathy and warmth by Truax et al. (1966). And Gurman (1973), in his investigation of these conditions within and across sessions within the same therapist-client dyads, found that therapists varied considerably in their levels of therapeutic conditions--a result that would begin to question the direct causal link between empathy, warmth, and congruence and positive outcome in psychotherapy. In light of these findings and the recent review of the literature by Bergin and Suinn (1975) on these therapeutic conditions, it appears that there are too many negative results to describe empathy, warmth, and congruence as sufficient conditions for therapeutic personality change but that they do seem to be necessary conditions (Garfield and Bergin, 1971).

Again, as in research on training and experience, the research on personality dynamics shows some necessary conditions for personality change, but not sufficient conditions. Possibly, there is a deeper level personality dynamic that underlies such characteristics as empathy, warmth, congruence, and complementarity that would allow these conditions to be <u>sufficient</u> for personality change. This deeper level personality dynamic might be seen as the "mental health" of the therapist. It appears that how therapists are functioning (their own conflicts)

would have a profound effect on whether they can offer those therapeutic conditions to the client that would allow for personality change. If therapists are having conflicts, how can they give certain therapeutic conditions to their clients? So far, though, there seems to have been little research on the effects of therapists' conflicts on their performances. Most of the writings dealing with therapists' conflicts have been speculative and not grounded in research findings.

One area of investigation into therapists' conflicts lies in psychoanalytic theory. Conflicts of the therapists have been recognized by psychoanalytic writers, e.g., Freud, in their emphasis on the personal analysis of analysts. This awareness of conflict is further stressed by the psychoanalytic concept of countertransference. Countertransference here meaning the transference reactions of the therapist toward the client--reactions based on the unconscious needs of the therapist and his views of reality. Thus in the countertransference, the therapist uses the client through which to work out his own conflicts--a state mediating against therapy being useful to the client.

An attempt to translate the effects of this countertransference on therapy was investigated by Cutler (1958). Specifically, he investigated the countertransference reactions of therapists upon: 1. their perception of

their own behavior; 2. upon their perception of their patient's behavior; and 3. upon their effectiveness in working on problems of the client that impinge on their own self-conflicts. Of a total of 40 predictions regarding the therapists tendency to distort reports of behavior relevant to their needs, 28 were clearly confirmed. Furthermore, there appeared a strong relationship between the patient's statements of concerns which related to the conflict areas of the therapists and the judged inadequacy of the therapist's immediately following response.

Bergin and Jasper (1969), in a study of the correlates of empathy in psychotherapy, found that therapist Depression (D) and Anxiety (Pt) scores on the MMPI correlated negatively with their ability to be empathic in the therapeutic process. Likewise, Gurman (1972) found that therapists who are relatively without emotional conflict, but who are able to admit internal discomforts when present, are more able to understand, accept, and respond nondefensively to their clients. And Strupp (1973) suggests that there is a relationship between therapist attitude, clinical evaluations, and behavior in therapy mediated by the kind of personality variables that change as a result of the personal analysis of the therapist.

Therapists' conflicts would seem to be especially problematic with the high risk populations. These are

the lower socioeconomic classes as defined by levels IV and V on the Hollingshead and Redlich Index of Social Class (1958). While with the middle and upper class clients (levels I, II, and III) therapists' conflicts would possibly have less of an impact. Conceding a strong motivation and belief in therapy as well as a good amount of social-class similarity between the middle and upper class client and the therapist, there may be enough of a bond between the two to keep the client in therapy long enough to allow the therapist to resolve his conflicts so that he may provide therapeutic conditions for the client. And the realization of this situation is possible since middle and upper class clients tend to stay in therapy longer than their lower class counterparts (Myers and Bean, 1968). In fact, one could speculate that Myers and Auld's (1955) finding, that only patients seen more than ten times showed better outcome with experienced therapists, may point to the conclusion that it took these therapists up to ten sessions to work out their conflicts and attend to the needs of their clients. However, with the higher-risk populations, the poor, the therapists conflicts would seem to accentuate the problems that therapists have already in being able to work with this population. It is these clients (lower socioeconomic classes) that tend to leave therapy early (Hollingshead and Redlich, 1958) and thus won't be in therapy by the time therapists have

worked through their conflicts and are ready to attend to their clients. In addition, in a study by Nash et al. (1965) on the relationship of client "attractiveness" to therapy outcome, it was found that client attraction as defined by such social class and achievement factors as age, education, occupation, ability to relate, verbal facility, etc. was related to outcome of therapy. Consequently, it appears that conflicts in the therapist will only compound the problems that the therapist already has in being able to attend to and be attracted to the client enough to provide what the client needs. These already existing problems as Hollingshead and Redlich (1958) see it are problems arising from differences in cultural norms, values, and role expectations between psychiatrists (psychologists, social workers, etc.) and their lower socioeconomic clients. The failure of therapists to be able to attend to these lower class clients is supported by Strickland and Crowne (1963) in their finding of a correlation of .38 between socioeconomic status and satisfaction in therapy.

However, there has been no research attempts to determine whether therapists' conflicts have differential effects on outcome with different types of clients (socioeconomic levels) as the research on social class and psychotherapy might suggest. Furthermore, what studies there are on the investigation of therapist conflict areas, which I reviewed previously (Cutler, 1958;

Bergin and Jasper, 1969; Gurman, 1972; Strupp, 1973), have not controlled for the training and experience of the therapist. Therefore, it is difficult to assess how much it was the therapists' conflicts that affected therapy outcome and not the lack of training or experience of the therapists. I thus propose research, controlling for therapist training and experience, that would be aimed at studying the differential effectiveness of therapists with clients of various social class levels--a question bound up with therapists' conflicts and the effect that these conflicts have on clients of various social classes.

CHAPTER II

HYPOTHESES

The purpose of the present study is to examine the relationship between therapists' personal needs and therapy process and outcome--needs that may interfere with a therapist's effectiveness. Research has shown the personal needs of therapists to be important to the outcome of therapy. Mills and Abeles (1965) observe that counselor needs for nurturance and affiliation, as measured by the Edwards Personal Preference Schedule (Edwards, 1954), have an important effect on positive outcome. Likewise, using the Edwards Personal Preference Schedule (EPPS), Demos and Zuwaylif (1966) found that the most successful high school counselors scored higher on nurturance and affiliation while the least successful counselors scored higher on autonomy, abasement, and aggression. And Schuldt and Smee (1968) in a study of graduate psychology students, found that clinical psychology graduate students scored higher on intraception and nurturance while experimental psychology graduate students scored higher on autonomy and aggression.

Further research has related these personality needs to process and outcome and has pointed to an interaction between therapist approach-avoidance behavior to client material produced in therapy and therapists' needs and conflicts. Thus certain needs or levels of them in therapists has led to an avoidance of what information the client is producing in therapy. The importance of this approach-avoidance behavior lies in the fact that avoidance of client material is negatively indicated for positive outcome in therapy (Winder et al., 1962) and is contraindicated for the production of conditions of empathy and warmth in the therapy session. Lerman (1963) found a negative relationship between therapists' dependency anxiety and the likelihood of their responding with approach behavior toward client expression of dependency. Barnes (1963) found that therapists with conflicts in the areas of hostility, dependency, and sexuality showed less approach behavior to client material dealing with these areas than did less conflicted therapists. And Bandura et al. (1960) found that therapists who expressed little direct hostility and who showed high approval seeking needs were less likely to permit and encourage their patient's hostility. Only one study showed a positive correlation between therapist needs and approach behavior in therapy. Mills (1964) showed a positive correlation between therapist need for

nurturance and affiliation and approach to client hostility. These findings lead me to speculate that:

1. Therapists' needs, which may connote some personal conflict as measured by scores on the Edwards Personal Preference Schedule and the Tennessee Self Concept Scale (Fitts, 1965), will result in more therapist avoidance and less approach of client material that relates to these areas of therapists' conflicts. Specifically, therapists with conflicts (elevated scores in some instances and lowered ones in others) in the areas of autonomy, intraception, dominance, abasement, nurturance, heterosexuality, and aggression as measured by the Edwards and in the areas of personal self, family self, and social self as measured by the Tennessee will show less approach and more avoidance behavior of parallel client material than will less conflicted therapists. Additionally, higher therapist scores on the State-Trait Anxiety Inventory (Spielberger et al., 1970) will be related to a larger percentage of avoidance behavior while lower scores will be related to a larger percentage of approach behavior. This is in keeping with findings that anxiety in therapists inhibit their ability to approach client material (Bandura et al., 1960).

2. The greater amount of therapist avoidance of client material, the less effective therapy will be for the client as assessed from listings of problems on the Hopkins Symptom Checklist (HSCL; Derogatis et al., 1974) taken before the start of therapy and 9 sessions or 4 months later (whichever comes first--or at some earlier termination date agreed upon by both the client and therapist). Additionally, this lessened effectiveness of therapy will be found in therapists' and clients' subjective post-therapy inventories of therapy effectiveness (Strupp et al., 1969).

Research has also pointed to the conclusion that lower socioeconomic clients, as defined by levels IV and V on the Hollingshead and Redlich Index of Social Class (1958), are less likely to stay in therapy or to obtain satisfaction in therapy (Hollingshead and Redlich, 1958;

Myers and Bean, 1968; Strickland and Crowne, 1963). Further, Nash et al. (1965) found that client "attractiveness" correlated negatively with various social class indices. These findings would seem to point to the difficulties in working with lower class clients. Consequently, it would appear that therapist conflicts would compound an already difficult situation. And the fact that lower class clients tend to leave therapy early would mitigate against the therapist being able to work out their own conflicts and attend to the client as would be possible with middle and upper class (levels I, II, and III) clients who remain in therapy longer. Thus:

3. Therapist conflicts will relate to effectiveness of therapy differentially according to client's socioeconomic class (as defined by the Hollingshead and Redlich Two-Factor Index of Social Class, 1958). This means that therapist conflicts may tend to lead to less effective therapy outcome for lower class clients (levels IV and V) as measured by the Hopkins Symptom Checklist and by the Strupp et al. Post-Therapy Client and Therapist Inventories. This differential effectiveness is considered to be the result of two interacting processes. One influence is that therapists will give a larger percentage of avoidance responses to lower class clients as opposed to middle and upper class clients as a result of the therapists' difficulties in relating to lower class clients (Hollingshead and Redlich, 1958; Myers and Bean, 1968). And secondly, because of therapists' difficulties in relating to lower class clients, the lower class clients will tend to leave therapy earlier than others. Thus therapists will not have as long a time to get beyond their conflicts and attend to the client as they would with middle and upper class clients who tend to stay in therapy longer.

Specifically, it is hypothesized that:

1. Therapist scores on the Edwards Personal Preference Schedule will correlate with the percentage of therapist avoidance responses to client material relating to these need areas. Specifically, it is predicted that:
    A. The higher the score for the need areas of dominance, abasement, and aggression, the larger the percentage of therapist avoidance responses to client material relating to these need areas.
    B. The lower the score for the need areas of autonomy, intraception, and nurturance, the larger the percentage of therapist avoidance responses to client material relating to these need areas.
    C. Scores for the need area of heterosexuality will correlate with percentage of therapist avoidance responses to client material relating to this need area. However, directionality is not predicted.

2. Therapists' scores on the Tennessee Self Concept Scale for the self-concept areas of personal self, family self, and social self will negatively correlate with a larger percentage of therapists' avoidance responses to client material relating to these self-concept areas.

3. Therapists' scores on the State-Trait Anxiety Inventory will positively correlate with therapists' total percentage of avoidance responses to client material and will negatively correlate with therapists' total percentage of approach responses to client material in therapy.

4. Percentage of therapists' avoidance responses to client material will negatively correlate with therapy effectiveness as measured by the change in the clients' pre/post Hopkins Symptom Checklist and by the Client and Therapist Post Therapy Inventories of therapy effectiveness (Strupp et al., 1969). Conversely, the percentage of therapists' approach behavior will positively correlate with therapy effectiveness.

5. Clients' socioeconomic class will negatively correlate with the percentage of therapists' avoidance responses to client material in therapy--meaning that higher percentages of therapists' avoidance responses will be found in relation to lower class clients (classes IV and V). And a higher percentage of therapists' approach responses will correlate with

material from clients in the middle and upper classes (classes I, II, and III).

6. Clients' socioeconomic class will positively correlate with therapy effectiveness as measured by the change in the clients' pre/post Hopkins Symptom Checklist and by the Client and Therapist Post Therapy Inventories of therapy effectiveness (Strupp et al., 1969).

CHAPTER III

METHODS

This study was carried out in cooperation with the Ingham Community Mental Health Center. This Center is a public agency utilizing prorated fees which serves the Ingham County community.

SUBJECTS

Two groups of subjects provided data for this study--Ingham Community Mental Health Center therapists and their clients.

A. Selection of Therapists--These were chosen so as to maximize both training and experience variables. Five therapists were chosen from the agency list of therapists who consented to take part in the study. Two therapists held Masters degrees in Social Work, two therapists held Masters degrees in Counseling, and one therapist had all but the dissertation completed for the Ph.D. in Counseling. An attempt was made to balance the therapists for gender. The resulting group of therapists consisted of two females and three males. The two female therapists had 2½ and 3½ years of experience respectively. The three male therapists had 9½, 7½, and 1½ years of experience. Sex

of the therapist was not controlled for in this study. The rationale for this derives from Meltzoff and Kornreich's (1970) finding that therapist gender is unrelated to therapy outcome in a review of the literature on patient improvement.

B. Selection of Clients--These were selected from the pool of clients applying for therapy at Ingham Community Mental Health Center. Only clients meeting the following criteria were used in this study:

1. The Ss were to be between the ages of 18 and 60 years old inclusive.
2. The Ss were to be in individual therapy and to be just starting therapy with the therapists under investigation.
3. The therapy was a chosen line of endeavor for the Ss and not one forced on them through the courts, etc.
4. The Ss were functioning well enough to be able to fill out those inventories that were required of them in order to participate in the study.

Clients used in this study were clients who met the above criteria and who agreed to participate in the study. A letter explaining the purpose of the study and eliciting the clients' participation and permission for gathering inventories and tapes (see Appendix A) was given to these clients who agreed to participate in the study. It was emphasized that participation in the study would have no effect upon their right to therapy and that all material would be coded and confidential. Clients who refused to participate were dropped from the study. If a client agreed to participate, that client was considered one of the five clients being sought for

each of the five therapists under study. This procedure was followed until all five therapists had five clients each (one therapist had only four). In an attempt to obtain clients from various socioeconomic levels for each therapist, one modification of the procedure for the selection of clients was followed. If in the course of the natural assignments of cases to the therapists under study, it was found that a therapist already had three clients from the socioeconomic levels IV and V (combined) or I, II, and III (combined), then further clients referred to that therapist would not be asked to participate in the study unless they were the opposite socioeconomic level from the already acquired three. Table 1 shows a breakdown on demographic variables for the clients for each of the five therapists.

MATERIALS

A. Therapist Measures

1. Edwards Personal Preference Schedule--This schedule consists of 225 pairs of statements to which the therapists circled the one statement of the pair that is most characteristic of him or her. The EPPS purports to measure 15 personality need variables derived from a list of manifest needs presented by Murray et al. (1938). The 15 needs that it measures are: achievement, deference, order, exhibition,

Table 1

Client Demographic Information

	Level of School Completed	Client Statement of Annual Earned Income	SES Index	Client Gender	Client Race
Therapist 1					
Client 1	12+	none (medicaid)	V	F	W
Client 2	16th	9,000	II	F	W
Client 3	10th	2,300	V	F	W
Client 4	12th	10,000	III	F	W
Therapist 2					
Client 1	14th	13,500	III	F	W
Client 2	13th	20,000	II	F	W
Client 3	14th	13,000	IV	M	W
Client 4	16th	none (disabled)	IV	F	W
Client 5	14th	12,500	III	F	W
Therapist 3					
Client 1	12th	none	IV	F	W
Client 2	16th	3,400	I	F	W
Client 3	12th	18,000	IV	M	W
Client 4	13th	none (medicaid)	III	F	W
Client 5	18th	17,500	II	M	W
Therapist 4					
Client 1	16th	34,000	II	M	W
Client 2	16th	16,000	II	M	W
Client 3	15th	18,000	III	F	W
Client 4	12th	none (P.A.)	V	F	B
Client 5	12th	8,000	IV	F	W

Table 1 (cont'd.)

	Level of School Completed	Client Statement of Annual Earned Income	SES Index	Client Gender	Client Race
Therapist 5					
Client 1	12th	5,000	V	F	W
Client 2	12th	18,000	IV	F	W
Client 3	16th	3,000	II	F	W
Client 4	16th	10,000	III	F	W
Client 5	15th	10,600	III	F	H

SES = socioeconomic status
P.A. = public assistance
W = White
B = Black
H = Hispanic

autonomy, affiliation, intraception, succorance, dominance, abasement, nurturance, change, endurance, heterosexuality, and aggression. For the purposes of this study, only seven of the need variables were investigated for therapists. These seven are autonomy, intraception, dominance, abasement, nurturance, heterosexuality, and aggression.

Since this schedule can be completed by the therapist without the need of the researcher being present, a copy of the test was given to each therapist to take at their own convenience. This test takes approximately 50 minutes. Scores for the seven need areas were taken to be indicative of the therapists' levels of conflict in those need areas (see Table 2).

2. Tennessee Self Concept Scale--This scale consists of 100 self-descriptive statements which the therapists used to portray his own picture of himself. This was done by responding to these self descriptive statements as being completely false, mostly false, partly false and partly true, mostly true, or completely true. The scores that were of interest in this study were the ones relating to therapists' perceptions of their personal selves, family selves, and social selves. Scores for these three areas were considered to reflect therapists' levels of conflict in these areas (see Table 2). This scale can be completed by the therapist without assistance and was given to the therapists to

Table 2

Raw Scale Scores of Therapists on Personality Measures

	Therapists					Pop.*	Standard
	1	2	3	4	5	Mean	Dev.
Edwards Personal Preference Schedule							
Autonomy	16	15	14	10	17	13.31	4.53
Intraception	13	27	23	22	15	16.72	5.01
Dominance	18	14	26	17	14	15.83	5.02
Abasement	5	5	5	5	8	13.66	5.14
Nurturance	15	24	12	20	14	15.22	4.76
Aggression	10	8	9	11	14	11.70	4.73
Heterosexuality	16	12	15	18	16	16.01	5.68
Tennessee Self Concept Scale							
Personal Self	75	74	76	77	72	64.55	7.41
Family Self	75	71	79	78	68	70.83	8.43
Social Self	74	70	83	74	76	68.14	7.86

Table 2 (cont'd.)

	Therapists					Pop.* Mean	Standard Dev.
	1	2	3	4	5		
State-Trait Anxiety Inventory							
State Anxiety	22	31	20	27	41		
Trait Anxiety	29	39	30	28	39		

*Mean and standard deviations based on normal adult populations reported on by test authors for EPPS and TSCS.

take at their own convenience. This test takes approximately 10-20 minutes.

3. State-Trait Anxiety Inventory--This inventory is comprised of separate self-report scales for measuring two distinct anxiety concepts: state anxiety and trait anxiety. The trait anxiety scale consists of 20 statements which assess how the therapists generally feel, while the state anxiety scale consists of 20 items regarding how they feel at a particular moment in time. This inventory was designed to be self-administered and was given to the therapists to take at their own convenience. Completion of this inventory takes less than 15 minutes. Scores from this inventory are taken to be indicative of therapists' ability to approach or avoid client material (see Table 2).

B. Client Measures--Hopkins Symptom Checklist (see Appendix B)--The Hopkins Symptom Checklist is a list of problems with which people are often faced--problems relating to the areas of neurotic feelings, somatization, performance difficulty, fear-anxiety, and depression. The test consists of 58 statements of problems. The client is instructed to check those statements that are presently a problem for them. The checklist was given to the client by the experimenter either immediately prior to the first therapy session or was given to the client by the therapist at the

intake interview. The checklist takes approximately 15 minutes to complete.

C. Process Measures--Tape Recordings of Psychotherapy Sessions--Each client in the study (total of 24), depending on their length of stay in therapy, had their second session, their middle session, and their last session of therapy recorded. (In total, clients averaged 5.66 sessions each and were tape recorded an average of 1.75 times.) The second session was used rather than the first for it was believed that the first session functioned as an intake interview. The middle session was defined as the fifth session or the session that took place nearest to the end of the second month. The last session (in regard to this study and not necessarily the termination session) was defined as the ninth session or the session that took place closest to the end of the fourth month (or at an earlier agreed upon termination session). Clients who did not average at least 2 in-office sessions a month were considered terminators at that point at which 3 weeks or more had elapsed since the last session.

D. Outcome Measures

1. Therapist Measures--Therapist Form (see Appendix C)--A nineteen question therapist form (Strupp et al., 1969, shortened version) was given to therapists at the end of therapy as defined by post ninth session or post 4 months (or at an earlier agreed

upon termination date). This form tapped the therapists' subjective beliefs about the effectiveness of therapy and the movement that clients made on their problems. All answers were coded on a five point scale and effectiveness of outcome (therapists' view) was a continuous variable across clients measured as the percentage of satisfaction and change scores on the form.

2. Client Measures

a. Client Form (see Appendix D)--A twenty question client form (Strupp et al., 1969, shortened version) was given to clients at the end of the ninth session or fourth month (or at an earlier agreed upon termination date). This form tapped the client's subjective beliefs about the effectiveness of their therapy.

b. Hopkins Symptom Checklist--the Hopkins Symptom Checklist was administered once more at the end of the ninth session or fourth month of therapy (or at an earlier agreed upon termination date). Change scores on the Hopkins as a result of therapy were looked at from the standpoint of total number of complaints, total weighted score, total intensity score, symptom cluster scores, and five factor scores relating to somatization, fear-anxiety, neurotic feelings, performance difficulty, and depression. Research by Uhlenhuth and Covi (1969) and Uhlenhuth and Duncan (1968a, 1968b) has

shown the Hopkins to be sensitive to changes in the client as a result of therapy.

PROCEDURE

The procedure consisted of a four step process. The first step entailed giving the therapists copies of the Edwards Personal Preference Schedule, the Tennessee Self Concept Scale, and the State-Trait Anxiety Inventory to take at their own convenience. Each therapist was given a booklet containing the three tests. Test order was randomized in each booklet and therapists were instructed to start at the beginning of the booklet and work straight through. Therapists were informed that all tests would be coded and confidential and thus were requested to answer the questions as truthfully as possible. The total amount of time required for all three tests was under an hour and a half. Two weeks were permitted for the therapists to complete these measures. No other stage of the research progressed until these measures were completed. From these tests, the therapists' levels of need areas were determined as well as their anxiety levels (see Table 2).

Step 2 entailed obtaining clients for the study according to the procedures outlined above (see Table 1 for descriptive data on the clients). Demographic information on the clients was gathered at the time that clients called into the center to schedule an appointment.

Clients who agreed to participate in the study were requested by the experimenter to fill out the Hopkins Symptom Checklist either prior to the first session of therapy or at the intake interview.

Step 3 consisted of tape recording the second, middle, and last session of therapy for all research clients seeing each of the five therapists. Consent for this taping was obtained at the beginning of therapy when the client was enlisted into the study.

Step 4 dealt with the outcome measures. At the end of the ninth session or the fourth month (or at an earlier agreed upon termination date), clients were requested to again fill out the Hopkins Symptom Checklist. Additionally, they filled out the shortened Strupp et al. (1969) form assessing the client's satisfaction with therapy and the amount of progress they felt they made in regard to their problems. Therapists also completed the shortened Strupp et al. (1969) therapist form for assessing the therapist's satisfaction with the therapy and their view of the effectiveness of the therapy for the client.

TAPE RATING PROCEDURE

The basic system used for categorizing the therapy sessions was first used by Murray (1956) and later modified by Bandura et al. (1960) and Winder et al. (1962).

This system is one that measured therapists' approach-avoidance responses to the client during the therapy session. A scoring manual for this system, with modifications in line with the purposes of this study is presented in Appendix E.

Client statements were scored twice. Once as to whether they expressed needs relating to autonomy, intraception, dominance, abasement, nurturance, heterosexuality, and aggression; and once as to whether they expressed needs relating to the personal self, family self, or social self. Statement categories were determined empirically by the questions on the Edwards and the Tennessee that related to each of the needs (see Appendix F). There was a miscellaneous category for statements that didn't fall into any of the need areas. Multiple scoring was also possible since a single client statement could fall into more than one area.

Each therapist statement was scored as to whether the therapist approached or avoided the expressed client needs preceding it. Statements scored as approach included those in which the statement was designed to elicit further expression of feelings, attitudes, and behavior while avoidance statements included those designed to inhibit, discourage, or divert further expression of feelings, attitudes, or behavior. Therapist silence was scored in the miscellaneous category as it was found by Bandura et al. (1960) that silence was

responded to as an approach while other times it was responded to as an avoidance.

The tapes were content analyzed by two third-year graduate students in clinical psychology. Before beginning to analyze the tapes used in the study, the two raters practiced with tapes not in the study. They worked together until their agreement in scoring need categories and approach-avoidance behavior reached 75% for need categories and 80% for approach-avoidance categories.

All tapes used in the study were coded so that raters could not identify the client or therapist. Each recorded session was divided into three sections. Each section consisted of 225 calibrations on the tape recorder's counter or approximately 18 minutes of tape. For each 225-unit section a random number table was consulted to determine at what point in the first 150 units of each section rating should commence. Seventy-five consecutive units in each of the 3 sections were rated (or a total of 18 minutes for each tape). The tape sections which were to be rated were all randomly ordered so as to control for order effects. The judges made independent ratings of the same measurement units, namely, each full statement of a therapist which followed a client's statement. The total number of ratings obtained from each tape varied according to the number of times the therapist spoke following a client statement

during the three rated segments. Technical recording difficulties infrequently precluded ratings of some therapists' statements, which were marked as NR (not rated).

The resulting approach-avoidance ratios represent the proportion of times that a therapist responded with approach behavior and the proportion of times that the therapist responded with avoidance behavior to client expressions categorized in the various "need" categories. The approach and avoidance proportions used were:

$$\text{APPROACH} = \frac{\text{total no. of approaches to client expression of need studied}}{\text{total approach and avoidance to client expression of need studied}}$$

$$\text{AVOIDANCE} = \frac{\text{total no. of avoidances of client expression of need studied}}{\text{total approach and avoidance to client expression of need studied}}$$

CHAPTER 4

RESULTS*

Before proceeding to the results of this study, it may be useful to take a look at the population of clients that participated in this study. A total of 24 clients composed the population. Nineteen of the clients were females, including 1 Black and 1 Hispanic, and 5 were White males. Although there were low numbers of males and non-Whites in this study thus preventing an evaluation of gender and racial variables, they were not eliminated. This was for two reasons. One is that research on psychotherapy has not clearly established differentiated outcomes in therapy as a result of the sex or race of the client or therapist (Meltzoff and Kornreich, 1970). And two, this distribution of clients is representative of many community mental health centers and consequently it seemed justifiable to keep these individuals in the study. Of these 24 clients, 18 of them completed both the pre and post-therapy testing and had tapes of their therapy sessions made. Six clients did not complete the post-therapy testing, 3 White

---

*Statistics were considered significant if they reached the $p \leq .05$ level.

females and 3 White males. Looking at Figure 1, which depicts clients' symptom intensity scores by therapist at pre and post-therapy, it can be seen that these six non-completers did not differ in symptom intensity from their counterparts for each therapist. The six non-completers are designated by those dots lying on the abscissa since they have a pre-therapy score but no post-therapy score.

As detailed in the methods section, results for this study were obtained from three sources. These sources were therapists' personality inventories, clients' and therapists' pre and post-therapy measures, and clients' therapy tapes. Scale scores were obtained for the personality inventories and therapy measures while the therapy tapes were content analyzed. Selected taped client segments were placed into one of seven categories from the Edwards Personality Preference Schedule and into one of four (three true categories and one "non-scorable" category) from the Tennessee Self Concept Scale by two third year clinical psychology graduate students. In addition, therapists' responses to client segments were rated as approaches or avoidances to the client material. Interrater reliability for these ratings were computed using percentage agreement. Agreement for the Edwards categories was 78%, for the Tennessee categories was 79%, and for the Approach-Avoidance categories was 88%. Since the data was not ordinal, a

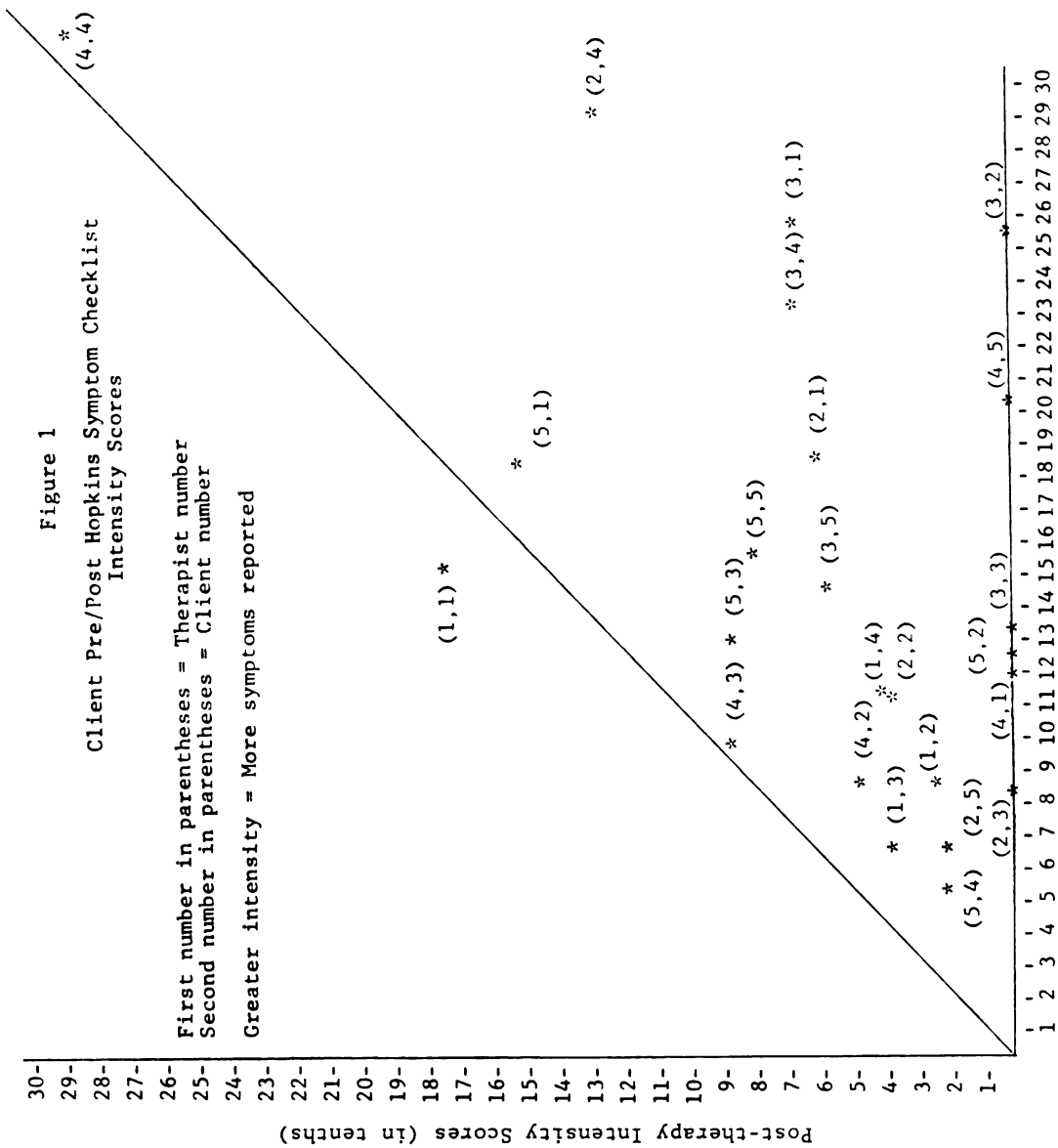
Figure 1
Client Pre/Post Hopkins Symptom Checklist
Intensity Scores
First number in parentheses = Therapist number
Second number in parentheses = Client number
Greater intensity = More symptoms reported
Post-therapy Intensity Scores (in tenths)
Pre-therapy Intensity Scores (in tenths)
(4,4)
(1,1)
(5,1)
(2,4)
(4,3)
(5,3)
(5,5)
(3,5)
(2,1)
(3,4)
(3,1)
(4,2)
(1,4)
(1,3)
(2,2)
(1,2)
(5,4)
(2,5)
(5,2)
(2,3)
(4,1)
(3,3)
(4,5)
(3,2)

Pearson Product Moment Correlation could not be computed. In addition, because of the skewness of the distributions for each of the content areas, a non-parametric correlation coefficient such as Cramer's statistic could also not be developed. The exception to this rule was with the Approach-Avoidance categories for which a phi coefficient of .75 could be computed.

HYPOTHESIS 1

Therapist scores on the Edwards Personal Preference Schedule will correlate with the percentage of therapist avoidance responses to client material relating to those need areas. Specifically, it was predicted that:

A. The higher the score for the need areas of dominance, abasement, and aggression, the larger the percentage of therapist avoidance responses to client material relating to these need areas.

B. The lower the score for the need areas of autonomy, intraception, and nurturance, the larger the percentage of therapist avoidance responses to client material relating to these need areas.

C. Scores for the need area of heterosexuality will positively correlate with percentage of therapist avoidance responses to client material relating to this need area. However, directionality is not predicted.

A. Therapists' need for dominance did not correlate with therapists' avoidance of client material dealing with dominance themes as defined by the Edwards. Although therapists ranged in their scores for this need area (see Table 2), there was little variation in therapists' expressed avoidance of this need area in therapy. What variation could be found was contributed by a spuriously high avoidance score by one therapist who avoided the one occurring instance of a client dominant theme, resulting in a 100% avoidance score. Thus this category was eliminated from further analysis.

Therapists' need for abasement was positively correlated* ($r = .5325$) with therapists' avoidance of client material dealing with abasement themes as defined by the Edwards. However, this relationship was not altogether clear since therapists' need for abasement correlated even more highly and in a positive direction with therapists' avoidance of client material dealing with themes of intraception. Regression analysis** of the relationship between therapists' need for abasement and avoidance found that the

---

*Correlations between therapist need areas and therapist approach-avoidance of client material were computed utilizing scoring categories collapsed over clients within therapists. This procedure was chosen due to the presence of zero or low frequency counts in the scoring categories for individual clients.

**Only the main variable of each regression formula and its shared variance (r^2) is reported.

therapists' need scores accounted for 28.35% of the variance in the avoidance of client abasement themes (r^2 = .2835; see Table 3).

Lastly, therapists' need for aggression showed the opposite relationship than that predicted. A strong negative correlation (r = -.7809) was found between therapists' need for aggression and therapists' avoidance of aggressive client material. This was even more powerful (r = -.9821) when one therapist's spuriously high score was eliminated when a chi-square analysis showed that elimination of the score did not significantly effect the relationship. Regression analysis showed that the therapists' need scores for aggression accounted for 96.45% of the variance in the avoidance of client aggressive themes (r^2 = .9645).

B. Therapists' need for autonomy and intraception negatively correlated (r = -.4128, r = -.4835) with therapists' avoidance of client material dealing respectively with client autonomy themes and intraception themes. Regression analysis revealed that therapists' need scores for autonomy accounted for 17.04% of the variance in the avoidance of client themes of autonomy while therapists' need for intraception accounted for 23.38% of the variance in the avoidance of client themes of intraception (r^2 = .1704, r^2 = .2338). Correlations with therapist need for nurturance could not be computed due to the infrequent

Table 3

Summary of Significant Hypothesized Correlations and Shared Variances

	Variable A	Variable B	r^2	r*
1.	Avoidance of client themes of abasement	Therapist need for abasement	28.35%	+.5325
2.	Avoidance of client themes of aggression	Therapist need for aggression	96.45%	-.9821
3.	Avoidance of client themes of autonomy	Therapist need for autonomy	17.04%	-.4128
4.	Avoidance of client themes of intraception	Therapist need for intraception	23.38%	-.4835
5.	Avoidance of client family self themes	Therapist family self concept	19.63%	-.4431
6.	Therapist Post Therapy Inventory scores	Therapist total avoidance	19.83%	-.4454
7.	Client Post Therapy Inventory scores	Client socioeconomic class	30.78%	+.5548

*All findings significant at $p \leq .05$ level.

occurrences of client material dealing primarily with nurturance themes.

C. Finally, correlations with therapists' need for heterosexuality could not be computed due to the infrequent occurrences of client material dealing primarily with heterosexual themes.

HYPOTHESIS 2

Therapists' scores on the Tennessee Self Concept Scale for the self-concept areas of personal self, family self, and social self will negatively correlate with a larger percentage of therapists' avoidance responses to client material relating to these self-concept areas.

Of the three self-concept areas, only the therapists' family self concept area showed a relationship to avoidance behavior. Therapists' scores on family self negatively correlated ($r = -.4431$) with avoidance of client material relating to family themes. Furthermore, through regression alalysis, it was found that therapists' family self concept scores accounted for 19.63% of the variance in the avoidance of client family self material ($r^2 = .1963$).

HYPOTHESIS 3

Therapists' scores on the State-Trait Anxiety Inventory will positively correlate with therapists' total percentage of avoidance responses to client material and will negatively correlate with therapists' total percentage of approach responses to client material in therapy.

Neither therapists' scores on state anxiety nor therapists' scores on trait anxiety showed a significant correlation with the percentage of therapists' total avoidance or total approach responses to client material. However, there were some significant correlations between therapists' state and trait anxiety scores and the individual avoidance percentages that comprise the total avoidance percentage. Therapists' state anxiety scores positively correlated with avoidance of client material relating to intraception ($r = .4067$) and family self ($r = .4501$), and negatively correlated with avoidance of client material relating to autonomy ($r = -.4501$) and aggression ($r = -.9567$). Approach correlations were the inverse of the avoidance correlations. Therapists' trait anxiety scores positively correlated with avoidance of client material relating to family self ($r = .6288$) and negatively correlated with avoidance of client material relating to personal self ($r = -.4605$) and aggression

(r = -.7601). Again, the approach correlations were the inverse of the avoidance correlations.

HYPOTHESIS 4

Percentage of therapists' avoidance responses to client material will negatively correlate with therapy effectiveness as measured by the change in the clients' pre/post Hopkins Symptom Checklist and by the Client and Therapist Post Therapy Inventories of therapy effectiveness (Strupp et al., 1969). Conversely, the percentage of therapists' approach behavior will positively correlate with therapy effectiveness.

Of the three therapy effectiveness measures, only the Therapist Post Therapy Inventory correlated with the therapists' percentages of <u>total</u> avoidance responses to client material (r = -.4454), and this was in a negative direction. This meant that the larger the percentage of therapists' avoidance, the less the effectiveness of therapy as rated by the therapists. Therapists' <u>total</u> avoidance accounted for 19.83% of the variance in Therapist Post Therapy Inventory scores (r^2 = .1983). In addition, although change scores from the Hopkins Symptom Checklist were not correlated overall with therapists' <u>total</u> avoidance of client material, these scores were correlated with several of the individual avoidance percentages that comprised the total avoidance percentages. Thus the Hopkins change scores positively

correlated with therapists' avoidance of client themes of autonomy (r = .5858) and aggression (r = .5299), and negatively correlated with avoidance of client themes of intraception (r = -.4038). This meant that greater positive change in therapy as measured by the Hopkins Symptom Checklist was associated with lower avoidance of client themes of intraception and higher avoidance of client themes of autonomy and aggression. All correlations with therapists' approach behavior for the Therapist Post Therapy Inventory and the Hopkins Symptom Checklist were the inverse of the avoidance correlations. Finally, as for the Client Post Therapy Inventory, there were no significant correlations with any of the approach or avoidance percentages.

HYPOTHESIS 5

Clients' socioeconomic class will negatively correlate with the percentage of therapists' avoidance responses to client material in therapy--meaning that higher percentages of therapists' avoidance responses will be found in relation to lower class clients (classes IV and V). And a higher percentage of therapists' approach responses will correlate with material from clients in the middle and upper classes (classes I, II, and III).

No correlations were found between clients' socio-economic class and any of the therapists' avoidance or approach percentages.

HYPOTHESIS 6

Clients' socioeconomic class will positively correlate with therapy effectiveness as measured by the change in the clients' pre/post Hopkins Symptom Checklist and by the Client and Therapist Post Therapy Inventories of therapy effectiveness (Strupp et al., 1969).

Of the three measures of therapy effectiveness, only the Client Post Therapy Inventory correlated with clients' socioeconomic class ($r = .5548$), and this was in a positive direction. This meant that the lower the clients' socioeconomic class, the less the perceived effectiveness of therapy as rated by the clients. Analysis of regression showed that the clients' socioeconomic class accounted for 30.78% of the variance in the Client Post Therapy Inventory scores ($r^2 = .3078$).

CHAPTER 5

DISCUSSION

This study should be viewed as a pilot study comprising a limited number of clients and therapists engaged in short-term therapy of an unspecified but generally relationship oriented nature at a community mental health center. Generalizations of the results to other client and therapist populations is therefore limited. We will examine the results of this study in terms of the therapists' personality needs, clients' outcome in therapy, and clients' socioeconomic status.

The first issue to be considered here is the relationship between therapists' personality and the process of therapy. Specifically it was asked whether there exists a relationship between the therapists' need scores, as measured by the Edwards Personality Preference Schedule, and therapists' verbal approach/avoidance to client material relating to those need areas. This would be a relationship hypothesized to be mediated by therapists' conflicted need areas. In research bearing on this point, Barnes (1963) found that therapists with conflicts in the areas of hostility, dependency, and sexuality showed less approach behavior to client material dealing with

these areas than did less conflicted therapists. Similarly, Bandura et al. (1960) found that therapists who expressed little direct hostility and who showed high approval seeking needs were less likely to permit and encourage their patients' hostility. Finally, Lerman (1963) found a negative relationship between therapists' dependency anxiety and the likelihood of their responding with approach behavior toward client expression of dependency. These studies would all seem to point to the importance of therapists' needs to the process of psychotherapy and this present study is no exception. Therapists' needs for abasement, autonomy, and intraception did relate in the predicted direction with therapists' approach/avoidance of the content areas. In addition, therapists' need for aggression related to therapists' approach/avoidance of aggressive themes but in a direction opposite to that predicted. While this last finding does not support the hypothesis, it may be a finding that is worth exploring further in future studies.

Further evidence of the relationship between therapists' personality dimensions and the therapists' approach/avoidance behaviors was found in the negative relationship between the therapists' family self concepts, as measured by the Tennessee Self Concept Scale, and their approach/avoidance of client family themes (lower the self concept, greater the avoidance). However, the final source of the therapists' personality factors, state-trait

anxiety scores as measured by the State-Trait Anxiety Inventory, showed no correlation with therapists' total approach/avoidance behaviors. There were, though, some significant correlations between the anxiety scores and certain subtotal approach/avoidance percentages. This finding regarding the anxiety scores is curious in light of past research by Bandura et al. (1960) which found that anxiety leads to avoidance behavior of client material. Possibly, all the therapists in this study fell within that range of anxiety scores that are facilitative rather than inhibitive of effective functioning. Thus as in test taking behavior, where some anxiety is useful while a lot is not, none of the therapists in this study were overly affected by their anxiety.

A second major area of findings for this research concerns the relationship of the therapists' avoidance behavior to therapy outcome. In this study it was found that of the three outcome measures, only the Therapist Post Therapy Inventory showed a direct relationship to therapists' total avoidance of client material. The Hopkins Symptom Checklist change scores for clients did not show a direct relationship to the total avoidance percentages but did correlate with subtotal avoidance percentages for specific content areas. And the Client Post-Therapy Inventory showed no correlations with any avoidance measures. Research by Winder et al.,(1962) which found that therapist avoidance of client material is negatively indicated for positive outcome in therapy would

have predicted that the relationship between all the outcome measures and therapist total avoidance should have been significant. However, this was found to be only true in part in this study. Where it was not true, interestingly enough, was with the clients. Clients' perceptions of their change in therapy did not correlate with therapists' approach or avoidance behaviors. Possibly, as seen in the research on therapists' empathy and warmth, this is because clients' views of their change are not mediated by such specific therapist behaviors as therapists' empathy, warmth, or approach/avoidance. Rather, they are tied to their more global feelings about the therapist such as whether they liked the therapist and felt that the therapist cared about them. Thus a "set" effect could result with clients rating themselves as improved or not regardless of the therapists' specific avoidance behaviors. On the other hand, the therapists do seem more atuned to their avoidance behaviors and did rate those clients that they avoided more as less improved. Again, this is in line with the research on other therapist behaviors such as empathy in which therapists rate themselves as most empathetic and warm with those clients that they rate as most improved. What is not in line with other research is the minimal relationship between the Hopkins Symptom Checklist change scores for the clients and the therapists' approach/avoidance percentages. If there is a true relationship between therapists' verbal behaviors and outcome, it seems that it should be most seen in this "objectively"

measured source of change. But this did not occur overall. Instead, the change scores correlated only with certain of the subtotal avoidance percentages, e.g., the change scores correlated in a negative direction with avoidance of client material relating to intraception and in a positive direction with client themes of autonomy and aggression. This may be because avoidance of certain content areas are more critical to change than others and consequently when all the content area avoidances are put together, the few significant individual content areas get washed out. Also, a further confounding factor is that with the exception of one client, all clients improved to some extent in this study (see Figure 1). The result of this is that the range of change scores becomes abbreviated when trying to show some relationship between these scores and therapists' approach/avoidance behaviors. With a greater range of scores, possibly the relationship may have shown itself more.

The last major finding of this study concerned the relationship of the clients' socioeconomic class to therapists' approach/avoidance behaviors and to the outcome of psychotherapy. Research has overwhelmingly pointed to the conclusion that lower socioeconomic clients, as defined by levels IV and V on the Hollingshead and Redlich Index of Social Class (1958), are less likely to stay in therapy or to obtain satisfaction in therapy (Hollingshead and Redlich, 1958; Myers and Bean, 1968;

Strickland and Crowne, 1963). Further, Nash et al. (1965) found that client "attractiveness" correlated negatively with various social class indices. And this present study was no exception to this past research. Clients' socioeconomic class did significantly relate to scores on the Client Post Therapy Inventory of therapy effectiveness, meaning that the lower the clients' socio-economic class the less effective the therapy as rated by the clients. However, what is unusual about this finding of a lessened effectiveness of therapy as rated by the lower class clients is that the effect was not seen in the Therapist Post Therapy Inventory or in the Hopkins Symptom Checklist change scores for these lower class clients. Thus therapy may have been helpful to lower class clients but they did not perceive it that way. Furthermore, this lessened effectiveness of therapy as rated by the lower class clients was not due to an inter-action effect resulting from the greater avoidance of lower class clients' material because of therapists' inability to relate to these people as was hypothesized (Hollingshead and Redlich, 1958). Rather this lessened effectiveness may have possibly resulted from the fact that lower class clients have more issues impinging on them other than psychological issues, e.g., economic factors, that may keep these clients feeling as if they got little from therapy even when change did occur. Or alternatively, lower class clients may come to therapy with more concerns

than others due to their social position and although they change, they do not reach the same end point in therapy as those who come in at more advanced levels. Thus there is a feeling that little was accomplished.

In looking over the results of this study, two concerns with the data do come up. One is that although there is a relationship between therapists' personality needs and therapists' verbal behavior in therapy, the amount of variance accounted for in therapists' verbal behavior by their personality needs is relatively small. This implies that there are other factors at work accounting for therapists' verbal behaviors that have not shown up in this study. Possibly a larger multifactorial design is needed to predict therapist behavior. And in fact, other factors such as therapist sex did at times account for a larger percentage of the variance in predicting therapist approach or avoidance to specific need areas. Sex was not dealt with as a factor in this study because an attempt was being made to look specifically at therapists' personality scores, regardless of therapists' sex, that might relate to therapy behavior. Furthermore, in a review of the research literature on the interaction effects between the sex of the therapist and the sex of the client (Meltzoff and Kornreich, 1970) no significant differences were found between male and female therapists and outcome of psychotherapy.

The second concern with the results lies in the interpretation of them. Although one may be justified in drawing some connection between the therapists' personality scores and their approach/avoidance percentages, can this connection be thought of as the result of the presence or absence of conflicts in the therapists? Specifically, can one therapist be said to show conflicts in a personality area because he or she showed a higher or lower need for that content area than did another therapist? This is an especially acute issue since the range of therapists' scores on the need areas were mainly within the normal population parameters. Thus without further verification of these conflict areas, an interpretation suggesting personality conflicts is left in question. This conclusion is all the more in question since seven out of the ten content areas measured came from the Edwards Personality Preference Schedule which is a forced choice instrument.

However, in summing up the results of this study, taking into account the foregoing reservations, three conclusions can be made. First, it appears that therapists' needs are related to therapists' verbal behaviors in therapy. Specifically, therapists' personality needs are tied to their approach and avoidance of client material relating to these needs. Secondly, the amount of therapists' avoidance behavior to client material is related to therapists' ratings of therapy outcome. And

thirdly, therapists do not avoid lower class clients' verbal content in therapy any more than they do with clients of higher socioeconomic classes even though lower class clients do feel that they benefit less from therapy.

As a final note, it would seem that these results, if further substantiated, are important to the training and selection of future therapists. If therapists' needs can influence the process and outcome of therapy, then it is important that therapists be helped in their training to deal with those parts of their personalities that can interfere of facilitate therapy. In this way, therapists can learn to be more effective in working with a greater range of client problem areas. Thus therapists can avoid client material less and bring about greater change in their clients.

APPENDICES

APPENDIX A

CLIENT CONSENT FORM

APPENDIX A

CLIENT CONSENT FORM

Dear Client,

In an attempt to study how well the Ingham Community Mental Health Center serves its clients, I am conducting some research to assess the helpfullness of the counseling offered at Ingham in meeting the needs and problems of its clients. It is hoped that through this research ways may be found to even better serve you. In order, in part, to carry out this research, I need your help. I need for you to fill out a short checklist before the first session of counseling and two short checklists after your last counseling session. These checklists look at the reasons for your coming to counseling and how useful the counseling was for you. In addition, I need your permission to tape up to three of your counseling sessions. Whether or not you decide to participate in this research, i.e., fill out the checklists and have some sessions recorded, your right to counseling will be in no way affected. You also have the right to drop out of the research at any time. If you do decide to participate, the checklists and tapes will be held in <u>strict</u> <u>confidence</u>. This means that the

APPENDIX A (cont'd.)

checklist and tapes will be seen and listened to only by those people conducting the study. All checklists and tapes will be destroyed immediately upon completion of the study.

Final results of this study, which will be anonymous, will be avaliable to the agency and all of its clients. Enclosed is a self-addressed postcard which should be mailed to me if you care to have a summary copy of the results sent to you.

If you are willing to participate, please sign your name to the statement below.

Sincerely yours,

Gerald Gaffin

****

I hereby agree to take part in this research and grant permission for up to three of my counseling sessions to be recorded. I grant this permission with the understanding that my name, the checklists, and the recorded materials will be held in strict confidence, and that the results will be available to me at the completion of the study.

_____

APPENDIX B

HOPKINS SYMPTOM CHECKLIST

APPENDIX B

HOPKINS SYMPTOM CHECKLIST

CATEGORIES: 0 - Not at all
1 - A little bit
2 - Moderately
3 - Quite a lot
4 - Extremely

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have. Read each one carefully and decide how much that problem bothered you during the past week including today. Circle the number under the column heading that best describes how that problem bothered you. For example, the first problem is headaches. If you have been bothered by that problem a little bit in the last week, you would circle "1" under the second column. Please do not skip any items. If you change your mind, erase the first mark completely. If you have any questions, please ask me.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	headaches	0	1	2	3	4
2.	nervousness or shakiness inside	0	1	2	3	4
3.	being unable to get rid of bad thoughts or ideas	0	1	2	3	4
4.	faintness or dizziness	0	1	2	3	4
5.	loss of sexual interest or pleasure	0	1	2	3	4
6.	feeling critical of others	0	1	2	3	4

APPENDIX B (cont'd.)

		Not at all	A little bit	Moderately	Quite a bit	Extremely
7.	bad dreams	0	1	2	3	4
8.	difficulty in speaking when you are excited	0	1	2	3	4
9.	trouble remembering things	0	1	2	3	4
10.	worried about sloppiness or carelessness	0	1	2	3	4
11.	feeling easily annoyed or irritated	0	1	2	3	4
12.	pains in the heart or chest	0	1	2	3	4
13.	itching	0	1	2	3	4
14.	feeling low in energy or slowed down	0	1	2	3	4
15.	thoughts of ending your life	0	1	2	3	4
16.	sweating	0	1	2	3	4
17.	trembling	0	1	2	3	4
18.	feeling confused	0	1	2	3	4
19.	poor appetite	0	1	2	3	4
20.	crying easily	0	1	2	3	4
21.	feeling shy or uneasy with the opposite sex	0	1	2	3	4
22.	a feeling of being trapped or caught	0	1	2	3	4
23.	suddenly scared for no reason	0	1	2	3	4
24.	temper outbursts you could not control	0	1	2	3	4
25.	constipation	0	1	2	3	4

APPENDIX B (cont'd.)

		Not at all	A little bit	Moderately	Quite a bit	Extremely
26.	blaming yourself for things	0	1	2	3	4
27.	pains in the lower part of your back	0	1	2	3	4
28.	feeling blocked or stymied in getting things done	0	1	2	3	4
29.	feeling lonely	0	1	2	3	4
30.	feeling blue	0	1	2	3	4
31.	worrying or stewing about things	0	1	2	3	4
32.	feeling no interest in things	0	1	2	3	4
33.	feeling fearful	0	1	2	3	4
34.	your feelings being easily hurt	0	1	2	3	4
35.	having to ask others what you should do	0	1	2	3	4
36.	feeling others do not understand you or are unsympathetic	0	1	2	3	4
37.	feeling that people are unfriendly or dislike you	0	1	2	3	4
38.	having to do things very slowly in order to be sure you are doing them right	0	1	2	3	4
39.	heart pounding or racing	0	1	2	3	4
40.	nausea or upset stomach	0	1	2	3	4
41.	feeling inferior to others	0	1	2	3	4
42.	soreness of your muscles	0	1	2	3	4
43.	loose bowel movements	0	1	2	3	4
44.	difficulty in falling asleep or staying asleep	0	1	2	3	4

APPENDIX B (cont'd.)

		Not at all	A little bit	Moderately	Quite a bit	Extremely
45.	having to check and doublecheck what you do	0	1	2	3	4
46.	difficulty making decisions	0	1	2	3	4
47.	wanting to be alone	0	1	2	3	4
48.	trouble getting your breath	0	1	2	3	4
49.	hot or cold spells	0	1	2	3	4
50.	having to avoid certain places or activities because they frighten you	0	1	2	3	4
51.	your mind going blank	0	1	2	3	4
52.	numbness or tingling in parts of your body	0	1	2	3	4
53.	a lump in your throat	0	1	2	3	4
54.	feeling hopeless about the future	0	1	2	3	4
55.	trouble concentrating	0	1	2	3	4
56.	weakness in parts of your body	0	1	2	3	4
57.	feeling tense or keyed up	0	1	2	3	4
58.	heavy feelings in your arms or legs	0	1	2	3	4

APPENDIX C

THERAPIST FORM

APPENDIX C

THERAPIST FORM

Client's name_____(to be cut off when study # assigned)

Instructions: Please rate each of the following items, comparing the client with other clients whom you see in counseling.

		Very little	Some	Mod-erate	Fairly great	Very great
1. Defensiveness	before	_____	_____	_____	_____	_____
	after	_____	_____	_____	_____	_____
2. Anxiety	before	_____	_____	_____	_____	_____
	after	_____	_____	_____	_____	_____
3. Ego strength	before	_____	_____	_____	_____	_____
	after	_____	_____	_____	_____	_____
4. Degree of distur-bance	before	_____	_____	_____	_____	_____
	after	_____	_____	_____	_____	_____
5. Capacity for insight	before	_____	_____	_____	_____	_____
	after	_____	_____	_____	_____	_____
6. Over-all adjustment	before	_____	_____	_____	_____	_____
	after	_____	_____	_____	_____	_____
7. Personal liking for client	before	_____	_____	_____	_____	_____
	after	_____	_____	_____	_____	_____
8. Motivation for therapy	before	_____	_____	_____	_____	_____

APPENDIX C (cont'd.)

		Very little	Some	Mod-erate	Fairly great	Very great
9.	Improvement expected before (prognosis)	_____	_____	_____	_____	_____
10.	Degree to which counter-transference was a problem in therapy	_____	_____	_____	_____	_____
11.	Degree to which you usually enjoy working with this kind of client in therapy	_____	_____	_____	_____	_____
12.	Degree of symptomatic improve-ment	_____	_____	_____	_____	_____
13.	Degree of change in basic personality structure	_____	_____	_____	_____	_____
14.	Degree to which you felt warmly toward the client	_____	_____	_____	_____	_____
15.	How much of an "emotional investment" did you have in this client?	_____	_____	_____	_____	_____
16.	Degree to which you think the client felt warmly toward you	_____	_____	_____	_____	_____
17.	Over-all success of therapy	_____	_____	_____	_____	_____

18. How would you characterize your working relationship with this client?

Extremely poor	Fairly poor	Neither good nor poor	Fairly good	Extremely good

19. How satisfied do you think the client was with the results of his/her therapy?

Extremely dissatisfied	Fairly dissatisfied	Neither satisfied nor dissatisfied	Fairly satisfied	Extremely satisfied

APPENDIX D

CLIENT FORM

APPENDIX D

CLIENT FORM

1. How much have you benefited from your therapy?

_____A great deal
_____A fair amount
_____To some extent
_____Very little
_____Not at all

2. How much in need of further therapy do you feel now?

_____No need at all
_____Slight need
_____Could use more

3. What led to the termination of your therapy?

_____My decision
_____My therapist's decision
_____Mutual agreement
_____External factors

4. Everything considered, how satisfied are you with the results of your therapy experience?

_____Extremely dissatisfied
_____Moderately dissatisfied
_____Fairly dissatisfied
_____Fairly satisfied
_____Moderately satisfied
_____Highly satisfied
_____Extremely satisfied

Please indicate to what extent each of the following statements describes your counseling experience. Disregard that at one point or another in counseling you may have felt differently. Use the following code and circle your answer.

APPENDIX D (cont'd.)

+2 Strongly agree
+1 Mildly agree
0 Undecided
-1 Mildly disagree
-2 Strongly disagree

+2	+1	0	-1	-2	5.	I am convinced that the counselor respected me as a person.
+2	+1	0	-1	-2	6.	I feel that the counselor was genuinely interested in helping me.
+2	+1	0	-1	-2	7.	I often felt I was "just another client".
+2	+1	0	-1	-2	8.	The counselor was keenly attentive to what I had to say.
+2	+1	0	-1	-2	9.	The counselor often used very abstract language.
+2	+1	0	-1	-2	10.	I always had the feeling that the counselor really understood my feelings.
+2	+1	0	-1	-2	11.	Nothing the counselor said or did ever decreased my self-respect.
+2	+1	0	-1	-2	12.	I felt there usually was a good deal of warmth in the way the counselor talked to me.
+2	+1	0	-1	-2	13.	I feel that the counselor often didn't understand my feelings.
+2	+1	0	-1	-2	14.	I usually felt I was fully accepted by the counselor.
+2	+1	0	-1	-2	15.	I was often uncertain about the counselor's real feelings toward me.

APPENDIX D (cont'd.)

16. How much do you feel you have changed as a result of psychotherapy?

_____A great deal
_____A fair amount
_____Somewhat
_____Very little
_____Not at all

17. How adequately do you feel you are dealing with any present problems?

_____Very adequately
_____Fairly adequately
_____Neither adequately nor inadequately
_____Somewhat inadequately
_____Very inadequately

18. To what extent have your complaints or symptoms that brought you to therapy changed as a result of treatment?

_____Completely disappeared
_____Very greatly improved
_____Considerably improved
_____Somewhat improved
_____Not at all improved
_____Got worse

19. On the whole how well do you feel you are getting along now?

_____Extremely well
_____Very well
_____Fairly well
_____Neither well nor poorly
_____Fairly poorly
_____Very poorly
_____Extremely poorly

20. How strongly would you recommend psychotherapy to a close friend with emotional problems?

_____Would strongly recommend it
_____Would mildly recommend it
_____Would recommend it but with some reservations
_____Would not recommend it
_____Would advise against it

APPENDIX E

SCORING MANUAL

APPENDIX E

SCORING MANUAL

This manual for scoring therapist approach-avoidance behavior is a partial replication of the manual developed by: Kopplin, D. A., "Eliciting Responses in Client-Therapist Interaction: A Content Analysis of Initial Psychotherapeutic Interviews". Unpublished doctoral dissertation, Michigan State University, 1965.

Scoring Unit

Definition--A unit is the total verbalization of the client followed by the total verbalization of the therapist.

I. Therapists' Approach-Avoidance Responses: Therapist responses to each scored client verbalization 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 client. Examples of approach and avoidance responses are grouped in sub-types to aid scoring.

A. Approach Responses (Ap): An approach response is any verbalization by the therapist which seems designed to elicit from the client further expression or elaboration of material relating to autonomy, intraception, dominance, abasement, nurturance, heterosexuality, aggression, personal self, family self, or social self which was scored in the client's immediately preceding statement. Approach is to the major category, not necessarily to the specific subcategories or the particular content of the client's preceding speech. The following subcategories are exhaustive.

APPENDIX E (cont'd.)

a. Exploration (probing): Includes remarks or questions that encourage the client to describe or express his feelings, attitudes, or actions further; asks for further clarification, elaboration, descriptive information, continuance; calls for details or examples; probing opinions which direct the client to reconsider by more careful thinking of a previous statement. Should demand more than a yes or no answer; if not, may be a "label".

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

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

T. Tell me more how you felt.

T. I don't completely follow that sequence.

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

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

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

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

APPENDIX E (cont'd.)

but it is a statement of fact, opinion or situation without elaboration.

C. I just don't want to talk about that anymore.
T. What I said annoyed you.

C. 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.

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

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

e. Support: Expresses sympathy, reassurance, approval, agreement or understanding of client's feelings, attitudes or behavior. Includes strongly emphasized, "Mm Hmm", "Yes"; offers explicit permissiveness.

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

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

C. But this, I don't know whether I am cheating myself or not. Well, I want to feel, you see.
T. You're feeling.

C. May I just be quiet for a moment?
T. Certainly.

C. I have my girlfriend's problems on my mind. Could we talk about them?
T. Why don't we talk about that?

APPENDIX E (cont'd.)

f. Information: Gives factual information or therapist opinion to general, direct or implied questions; includes general remarks about the counseling procedure; tells the client what to do; points out that the client's feelings are natural or common (generalizations).

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

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

C. I don't like to talk about it.
T. Mary, we have to deal with this somehow.

B. Avoidance Responses (Av): 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 material relating to autonomy, intraception, dominance, abasement, nurturance, heterosexuality, aggression, personal self, family self, or social self. The therapist attempts to inhibit the feelings, attitudes or behavior described or expressed in the immediately preceding client statement which determined its placement under the major category. Avoidance is avoidance of the major category, not specific subcategories or psychic states.

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

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

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

APPENDIX E (cont'd.)

C. 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 client verbalization. Usually fails to acknowledge even a minor portion of the statement.

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

C. 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 client response or responds to content, ignoring affect. He misses the point of the client statement. May under- or over-estimate affect. May approach the general topic but blatantly ignore the affect verbalized.

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

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

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

C. We went out for Chinese food; he's so easy to get along with.
T. It he from New York?

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

APPENDIX E (cont'd.)

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

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

C. I may drop out of Honors College.
T. You mean Arts and Letters.
C. No--Honors College.

APPENDIX F

CLIENT STATEMENT SCORING CATEGORIES

APPENDIX F

CLIENT STATEMENT SCORING CATEGORIES

I. Edwards Personal Preference Schedule--definitions from the Edwards for determining categorization of client verbalizations from tape recordings.

1. Autonomy: To be able to come and go as desired, to say what one thinks about things, to be independent of others in making decisions, to feel free to do what one wants, to do things that are unconventional, to avoid situations where one is expected to conform, to do things without regard to what others may think, to criticize those in positions of authority, to avoid responsibilities and obligations.

2. Intraception: To analyze one's motives and feelings, to observe others, to understand how others feel about problems, to put one's self in another's place, to judge people by why they do things rather than by what they do, to analyze the behavior of others, to analyze the motives of others, to predict how others will act.

3. Dominance: To argue for one's point of view, to be a leader in groups to which one belongs, to be regarded by others as a leader, to be elected or appointed chairman of committees, to make group decisions, to settle arguments and disputes between others, to persuade and influence others to do what one wants, to supervise and direct the actions of others, to tell others how to do their jobs.

4. Abasement: To feel guilty when one does something wrong, to accept blame when things do not go right, to feel that personal pain and misery suffered does more good than harm, to feel the need for punishment for wrong doing, to feel better when giving in and avoiding a fight than when having one's own way, to feel the need for confession of errors, to feel depressed by inability to handle situations, to feel timid

APPENDIX F (cont'd.)

in the presence of superiors, to feel inferior to others in most respects.

5. Nurturance: To help friends when they are in trouble, to assist others less fortunate, to treat others with kindness and sympathy, to forgive others, to do small favors for others, to be generous with others, to sympathize with others who are hurt or sick, to show a great deal of affection toward others, to have others confide in one about personal problems.

6. Aggression: To attack contrary points of view, to tell others what one thinks about them, to criticize others publicly, to make fun of others, to tell others off when disagreeing with them, to get revenge for insults, to become angry, to blame others when things go wrong, to read newspaper accounts of violence.

7. Heterosexuality: To go out with members of the opposite sex, to engage in social activities with the opposite sex, to be in love with someone of the opposite sex, to kiss those of the opposite sex, to be regarded as physically attractive by those of the opposite sex, to participate in discussions about sex, to read books and plays involving sex, to listen to or to tell jokes involving sex, to become sexually excited.

II. Tennessee Self Concept Scale--statements from the Tennessee used for empirically categorizing client verbalizations from tape recordings.

1. <u>Personal Self Statements</u>

I am a cheerful person.

I have a lot of self-control.

I am a calm and easy going person.

I am a hateful person.

I am a nobody.

I am losing my mind.

APPENDIX F (cont'd.)

I am satisfied to be just what I am.

I am as smart as I want to be.

I am just as nice as I should be.

I am not the person I would like to be.

I despise myself.

I wish I didn't give up as easily as I do.

I can always take care of myself in any situation.

I solve my problems quite easily.

I take the blame for things without getting mad.

I change my mind a lot.

I do things without thinking about them first.

I try to run away from my problems.

2. Family Self Statements

I have a family that would always help me in any kind of trouble.

I am an important person to my friends and family.

I am a member of a happy family.

I am not loved by my family.

My friends have no confidence in me.

I feel that my family doesn't trust me.

I am satisfied with my family relationships.

I treat my parents as well as I should (use past tense if parents are not living).

I understand my family as well as I should.

I am too sensitive to things my family say.

APPENDIX F (cont'd.)

I should trust my family more.

I should love my family more.

I try to play fair with my friends and family.

I do my share of work at home.

I take a real interest in my family.

I quarrel with my family.

I give in to my parents (use past tense if parents are not living).

I do not act like my family thinks I should.

3. Social Self Statements

I am a friendly person.

I am popular with women.

I am popular with men.

I am mad at the whole world.

I am not interested in what other people do.

I am hard to be friendly with.

I am as sociable as I want to be.

I am satisfied with the way I treat other people.

I try to please others, but I don't overdo it.

I should be more polite to others.

I am no good at all from a social standpoint.

I ought to get along better with other people.

I try to understand the other fellow's point of view.

I see good points in all the people I meet.

APPENDIX F (cont'd.)

I get along well with other people.

I do not feel at ease with other people.

I do not forgive others easily.

I find it hard to talk with strangers.

REFERENCES

REFERENCES

Albronda, H. F., Dean, R. L., and Starkweather, J. A. Social class and psychotherapy. Archives of General Psychiatry, 1964, 10, 276-283.

Alexander, J. F. Perspectives of psychotherapy process: Dependency, interpersonal relationships, and sex differences. (Unpublished doctoral dissertation, Michigan State University, 1967.)

Alexander, J. F., and Abeles, N. Dependency changes in psychotherapy as related to interpersonal relationships. Journal of Consulting and Clinical Psychology, 1968, 32, 685-689.

Bandura, A. Psychotherapist's anxiety level, self-insights, and psychotherapeutic competence. Journal of Abnormal and Social Psychology, 1956, 52, 333-337.

Bandura, A., Lipsher, D. H., and Miller, P. E. Psychotherapists' approach-avoidance reactions to patient's expression of hostility. Journal of Consulting Psychology, 1960, 24, 1-8.

Bare, C. E. Relationship of counselor personality and counselor-client personality similarity to selected counseling success criteria. Journal of Counseling Psychology, 1967, 14, 419-425.

Barnes, E. J. Psychotherapists' conflicts, defense preferences, and verbal reactions to certain classes of client expressions. (Unpublished doctoral dissertation, Michigan State University, 1963.)

Barrett-Lennard, G. F. Dimensions of therapist response as causal factors in therapeutic change. Psychological Monographs, 1962, 76 (43, Whole No. 562).

Baum, O. E., Felzer, S. B., D'Zmura, T. L., and Shumaker, E. Psychotherapy, dropouts and lower socio-economic patients. American Journal of Orthopsychiatry, 1966, 36, 629-635.

Beery, J. W. Therapists' responses as a function of level of therapist experience and attitude of the patient. Journal of Consulting and Clinical Psychology, 1970, 34, 239-243.

Bergin, A. E. The evaluation of therapeutic outcomes. In A. E. Bergin and S. L. Garfield (Eds.), Handbook of psychotherapy and behavior change: An empirical analysis. New York: John Wiley & Sons, Inc., 1971, 217-270.

Bergin, A. E., and Jasper, L. G. Correlates of empathy in psychotherapy: A replication. Journal of Abnormal Psychology, 1969, 74, 477-481.

Bergin, A. E., Murray, E. J., Truax, C. B., and Shoben, E. J. The empirical emphasis in psychotherapy: A symposium. Journal of Counseling Psychology, 1963, 10, 244-250.

Bergin, A. E., and Solomon, S. Correlates of empathic ability in psychotherapy. American Psychologist, 1963, 18, 393.

Bergin, A. E., and Suinn, R. M. Individual psychotherapy and behavioral therapy. In M. R. Rosenzweig and L. W. Porter (Eds.), Annual Review of Psychology. Palo Alto: Annual Reviews Inc., 1975, Vol. 26, 509-556.

Berzins, J. I., and Seidman, E. Subjective reactions of A and B quasi-therapists to schizoid and neurotic communications: A replication and extension. Journal of Consulting and Clinical Psychology, 1963, 119, 1090-1091.

Bordin, E. Research strategies in psychotherapy. New York: John Wiley & Sons, Inc., 1974.

Campbell, D., and Fiske, D. Convergent and discriminant validation by the multitrait-multimethod matrix. Psychological Bulletin, 1959, 56, 81-105.

Carkhuff, R. R., Kratochvil, D., and Friel, T. Effects of professional training: Communication and discrimination of facilitative conditions. Journal of Counseling Psychology, 1968, 15, 68-74.

Carson, R. E., Harden, J., and Shows, W. E. A-B distinction and behavior in quasi-therapeutic situations. Journal of Consulting Psychology, 1964, 28, 426-433.

Carson, R. E., and Heine, R. W. Similarity and success in therapeutic dyads. Journal of Consulting Psychology, 1962, 26, 38-43.

Cartwright, R. C., and Vogel, J. L. A comparison of changes in psychoneurotic patients during matched periods of therapy and no therapy. Journal of Consulting Psychology, 1960, 24, 121-127.

Committee on Training in Clinical Psychology, American Psychological Association. Recommended graduate training program in clinical psychology. American Psychologist, 1947, 2, 539-558.

Cowen, E. L. Social and community interventions. In P. H. Mussen and M. R. Rosenzweig (Eds.), Annual Review of Psychology. Palo Alto: Annual Reviews Inc., 1973, Vol. 24, 423-472.

Cutler, R. L. Countertransference effects in psychotherapy. Journal of Consulting Psychology, 1958, 22, 349-356.

Demos, G. D., and Zuwaylif, F. H. Characteristics of effective counselors. Counselor Education and Supervision, 1965-66, 5, 163-165.

Derogatis, L. R., Lipman, R. S., Rickels, K., Uhlenhuth, E. H., and Covi, L. The Hopkins Symptom Checklist (HSCL): A measure of primary symptom dimensions. In P. Pichot (Ed.), Psychological measurements in psychopharmacology: Modern problems in pharmopsychiatry, Vol. 7. Basel, Switzerland: S. Karger, 1974, 79-110.

Dietzel, C. S., and Abeles, N. Client-therapist complementarity and therapeutic outcome. Journal of Counseling Psychology, 1975, 22, 264-272.

Ebel, R. Estimation of the reliability of ratings. Psychometrika, 1951, 16, 407-424.

Edwards, A. L. Edwards Personal Preference Schedule. New York: The Psychological Corporation, 1954.

Eysenck, H. The effects of psychotherapy: An evaluation. Journal of Consulting Psychology, 1952, 16, 316-324.

Eysenck, H. A reply to Luborsky's note. Journal of British Psychology, 1954, 45, 132-133.

Eysenck, H. The effects of psychotherapy: A reply. Journal of Abnormal Psychology, 1955, 50, 147-148.

Fiske, D. W., Cartwright, D. S., and Kirtner, W. L. Are psychotherapeutic changes predictable? Journal of Abnormal and Social Psychology, 1964, 69, 418-426.

Fitts, W. H. Tennessee Self Concept Scale. Nashville, Tennessee: Counselor Recordings and Tests, 1965.

Fix, A. J., and Haffke, E. S. Relationship between psychotherapy skills and level of training in a psychiatric residency program. Social Science and Medicine, 1975, 9, 489-491.

Frayn, D. H. A relationship between rated ability and personality traits in psychotherapists. American Journal of Psychiatry, 1968, 124, 1232-1237.

Gamsky, N. R., and Farwell, G. F. Counselor verbal behavior as a function of client hostility. Journal of Counseling Psychology, 1966, 13, 184-190.

Garfield, S. L. Research on client variables in psychotherapy. In A. E. Bergin and S. L. Garfield (Eds.), Handbook of psychotherapy and behavior change: An empirical analysis. New York: John Wiley & Sons, Inc., 1971, 271-298.

Garfield, S. L., and Bergin, A. E. Therapeutic conditions and outcome. Journal of Abnormal Psychology, 1971, 77, 108-114.

Goldberg, L.,and Werts, C. The reliability of clinicians' judgments: A multitrait-multimethod approach. Journal of Consulting Psychology, 1966, 30, 199-206.

Gottschalk, L. A., and Auerback, A. H. (Eds.), Methods of research in psychotherapy. New York: Meridith Publishing Company, 1966.

Grigg, A. E. Client response to counselors at different levels of experience. Journal of Counseling Psychology, 1961, 8, 217-225.

Gurman, A. S. Therapists' mood patterns and therapeutic facilitativeness. Journal of Counseling Psychology, 1972, 19, 169-170.

Gurman, A. S. Instability of therapeutic conditions in psychotherapy. Journal of Counseling Psychology, 1973, 20, 16-24.

Hollingshead, A. B., and Redlich, F. C. Social class and mental illness: A community study. New York: John Wiley & Sons, Inc., 1958.

Holt, R. R. (Ed.) New horizon for psychotherapy: Autonomy as a profession. New York: International Universities Press, Inc., 1971.

Holt, R. R., and Luborsky, L. Personality patterns of psychiatrists: A study of methods for selecting residents. New York: Basic Books, Inc., 1958, Vols. 1 & 2.

Karl, N. J., and Abeles, N. Psychotherapy process as a function of the time segment sampled. Journal of Consulting and Clinical Psychology, 1969, 33, 207-212.

Kemp, D. E. Correlates of the Whitehorn Betz AB Scale in a quasi-therapeutic situation. Journal of Consulting Psychology, 1966, 30, 509-516.

Kiesler, D. The process of psychotherapy: Empirical foundations and systems of analysis. Chicago: Aldine Publishing Company, 1973, 213-231; 428-430.

Kiesler, D., Klein, M. H., and Mathieu, P. L. Sampling from the recorded therapy interview: The problem of segment location. Journal of Consulting Psychology, 1965, 29, 337-344.

Kopplin, D. A. Eliciting responses in client-therapist interaction: A content analysis of initial psychotherapeutic interviews. (Unpublished doctoral dissertation, Michigan State University, 1965.)

Lerman, H. A study of some effects of the therapist's personality and behavior and of the clients' reactions in psychotherapy. (Unpublished doctoral dissertation, Michigan State University, 1963.)

Luborsky, L. A note on Eysenck's article, 'The effects of psychotherapy: An evaluation'. British Journal of Psychology, 1954, 45, 129-131.

Luborsky, L. Perennial mystery of poor agreement among criteria for psychotherapy outcome. Journal of Consulting and Clinical Psychology, 1971, 37, 316-319.

Luborsky, L., Chandler, M., Auerbach, A., Cohen, J., and Bachrach, H. Factors influencing the outcome of psychotherapy: A review of quantitative research. Psychological Bulletin, 1971, 75, 145-185.

Meltzoff, J., and Kornreich, M. Research in psychotherapy. New York: Atherton Press, 1970.

McNair, D. M., Callahan, D. M., and Lorr, M. Therapist "type" and patient response to psychotherapy. Journal of Consulting Psychology, 1962, 20, 425-429.

McNair, D. M., Lorr, M., and Callahan, D. M. Patient and therapist influences on quitting psychotherapy. Journal of Consulting Psychology, 1963, 27, 10-17.

Miller, D. R., and Swanson, G. E. Inner conflict and defense. New York: Henry Holt and Company, Inc., 1960.

Mills, D. H. Liking as a therapist variable in the psychotherapeutic interaction. (Unpublished doctoral dissertation, Michigan State University, 1964.)

Mills, D. H., and Abeles, N. Counselor needs for affiliation and nuturance as related to liking for clients and counseling process. Journal of Counseling Psychology, 1965, 12, 353-358.

Mills, D. H., Chestnut, W. J., and Hartzell, J. P. The needs of counselors: A component analysis. Journal of Counseling Psychology, 1966, 13, 82-84.

Mintz, J. What is "success" in psychotherapy? Journal of Abnormal Psychology, 1972, 80, 11-19.

Mullen, J. A. An investigation of the variable of liking in therapy: Its relation to the variables of outcome, empathy, and therapist experience. (Unpublished doctoral dissertation, Michigan State University, 1969.)

Mullen, J. A., and Abeles, N. Relationship of liking, empathy, and therapist's experience to outcome of psychotherapy. Journal of Counseling Psychology, 1971, 18, 39-43.

Murphy, W. A., and Lamb, D. H. The effect of training in psychotherapy on therapists' responses to client hostility. Journal of Community Psychology, 1973, 1, 327-330.

Murray, H. A. Explorations in personality. New York: Oxford University Press, 1938.

Myers, J. K., and Auld, F. Some variables related to outcome of psychotherapy. Journal of Clinical Psychology, 1955, 11, 51-54.

Myers, J. K., and Bean, L. L. A decade later: A follow-up of social class and mental illness. New York: John Wiley & Sons, Inc., 1968.

Nash, E., Hoehn-Saric, R., Battle, C., Stone, A., Imber, S., and Frank, J. Systematic preparation of patients for short-term psychotherapy. II: Relation to characteristics of patient, therapist and the psychotherapeutic process. Journal of Nervous and Mental Disease, 1965, 140, 374-383.

Perlman, G. Change in "central therapeutic ingredients" of beginning psychotherapists. Psychotherapy: Theory, Research and Practice, 1973, 10, 48-51.

Rosenzweig, S. A transvaluation of psychotherapy--A reply to Hans Eysenck. Journal of Abnormal and Social Psychology, 1954, 49, 298-304.

Reissman, G., Cohen, J., and Pearl, A. (Eds.). Mental health of the poor. New York: The Free Press of Glencoe, 1964, 68-75.

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

Rogers, C. R. A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), Psychology: A study of science. New York: McGraw-Hill Book Company, Inc., 1959, Vol. 3, 184-256.

Rogers, C. R., Gendlin, E., Kiesler, D., and Truax, C. B. The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics. Madison, Wisconsin: University of Wisconsin Press, 1967.

Russell, P. D., and Snyder, W. U. Counselor anxiety in relation to amount of clinical experience and quality of affect demonstrated by clients. Journal of Consulting Psychology, 1963, 27 358-363.

Schaffer, N. D. The impact of therapist personality variables on psychotherapy process. (Unpublished doctoral dissertation, Michigan State University, 1977.)

Schuldt, W. J., and Smee, P. G. Personal needs of graduate students in psychology. Psychological Reports, 1968, 22, 916.

Spielberger, C. D., Gorsuch, R. L., and Lushene, R. E. State-trait Anxiety Inventory. Palo Alto: Consulting Psychologist Press, Inc., 1970.

Strickland, B., and Crowne, D. P. Need for approval and the premature termination of psychotherapy. Journal of Consulting Psychology, 1963, 27, 95-101.

Strupp, H. H. Psychotherapy: Clinical, research, and theoretical issues. New York: Jason Aronson, Inc., 1973.

Strupp, H. H., Hadley, S. W., and Gomes-Schwartz, B. Psychotherapy for better or worse: The problem of negative effects. New York: Jason Aronson, Inc., 1977.

Strupp, H. H., Lessler, R., and Fox, K. Patients view their psychotherapy. Baltimore: John Hopkins Press, 1969.

Sullivan, P. L., Miller, C., and Smelser, W. Factors in length of stay and progress in psychotherapy. Journal of Consulting Psychology, 1958, 22, 1-9.

Swenson, C. H. Commitment and the personality of the successful therapist. In J. Matarazzo et al. (Eds.), Psychotherapy. New York: Aldine-Atherton, Inc., 1972, 203-208.

Truax, C. B., Carkhuff, R. R., and Kodman, F. Relationships between therapist-offered conditions and patient change in group psychotherapy. Journal of Clinical Psychology, 1965, 21, 327-329.

Truax, C. B., and Carkhuff, R. R. Toward effective counseling and psychotherapy: Training and practice. Chicago: Aldine Publishing Company, 1967.

Truax, C. B., and Wargo, J. D. Antecedents to outcome in group psychotherapy with outpatients: Effects of therapeutic conditions, alternate sessions, vicarious therapy pre-training and patient self-exploration. Journal of Consulting and Clinical Psychology, 1969, 33, 440-447.

Truax, C. B., Wargo, D. G., Frank, J. D., Imber, S., Battle, C., Hoehn-Saric, R., Nash, E., and Stone, A. Therapist empathy, genuineness and warmth and patient therapeutic outcome. Journal of Consulting Psychology, 1966, 30, 395-401.

Uhlenhuth, E. H., and Covi, L. Subjective change with the initial interview. American Journal of Psychotherapy, 1969, 23, 415-429.

Uhlenhuth, E. H., and Duncan, D. B. Subjective change with medical student therapist: I. Course of relief in psychoneurotic outpatients. Archives of General Psychiatry, 1968a, 18, 428-438.

Uhlenhuth, E. H., and Duncan, D. B. Subjective change with medical student therapists: II. Some determinants of change in psychoneurotic outpatients. Archives of General Psychiatry, 1968b, 18, 532-540.

Waskow, I. E., and Parloff, M. B. (Eds.). Psychotherapy change measures. Rockville, Maryland: National Institute of Mental Health, 1975.

Whitehorn, J. C., and Betz, B. A study of psychotherapeutic relationships between physicians and schizophrenic patients. American Journal of Psychiatry, 1954, 111, 321-331.

Whitehorn, J. C., and Betz, B. A comparison of psychotherapeutic relationships between physicians and schizophrenic patients when insulin is combined with psychotherapy and when psychotherapy is used alone. American Journal of Psychiatry, 1957, 113, 901-910.

Whitehorn, J. C., and Betz, B. Further studies of the doctor as a crucial variable in the outcome of treatment with schizophrenic patients. American Journal of Psychiatry, 1960, 117, 215-223.

Williams, H. V., Lipman, R. S., Rickels, K., Covi, L., Uhlenhuth, E. H., and Mattsson, N. B. Replication of symptom distress factors in anxious neurotic outpatients. Multivariate Behavioral Research, 1968, 3, 199-212.

Winder, C. L., Ahmad, F. Z., Bandura, A., and Rau, L. C. Dependency of patients, psychotherapists' responses and aspects of psychotherapy. Journal of Consulting Psychology, 1962, 26, 129-134.