A STUDY OF SOME EFFECTS OF THE THERAPIST'S PERSONALITY AND BEHAVIOR AND OF THE CLIENTS' REACTIONS IN PSYCHOTHERAPY

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ABSTRACT

A STUDY OF SOME EFFECTS OF THE THERAPIST'S PERSONALITY AND BEHAVIOR AND OF THE CLIENTS' REACTIONS IN PSYCHOTHERAPY

by Hannah Lerman

The attempt was made to study whether the therapist's behavior and his personality as they are observed outside of the therapy situation could predict his reactions in therapy to his presentation by the client of certain specific content areas, those dealing with dependency, hostility and sex. Whether the therapist behavior and personality as this is perceived by the client has an impact upon the client's subsequent behavior was also studied.

The hypotheses tested were that the greater therapist anxieties were in the areas of dependency, hostility and sexuality, the less likely they were to approach expression in these areas by the clients. A relationship between greater affectivity in the therapist and increasing likelihood of his approaching dependency expressed by the client was also postulated. It was also hypothesized that greater therapist anxieties about the three content areas studied

would cause clients to be less likely to continue to express content dealing with these areas.

Seventeen advanced graduate students who worked in the Counseling Center at Michigan State University were the therapists studied. They were rated on eleven five-point scales by three senior staff members who knew them well.

The content of therapy interviews early in the therapeutic series conducted by these therapists, a total of thirty-eight interviews, was studied and analyzed according to a system adapted slightly from that used by Bandura et al. (1960) and Winder et al. (1962).

The hypotheses relating the therapist's dependency anxiety to his behavior and to the behavior of his clients were partially confirmed. The therapist's rating on the dependency inhibition scale was related both to his behavior in relationship to his clients' expression of dependency, especially when he was not its object, and to his clients' reaction to his behavior.

A nonlinear relationship between sexual anxiety and therapist approval to sex was suggested. This was discussed in terms of the probability that extreme overt interest in sex might represent another kind of anxiety about sex than

extreme inhibition of overt sexual interest and not represent sexual ease at all.

The hypotheses concerning hostility and the affectivity level of the therapist were not confirmed. The relationship between the therapist's approach to sexuality expressed by his clients and his ratings on the scales dealing with his sexual expression proved to be significant in the opposite direction from that predicted. The clients were more likely to continue to express sexual material after the therapist approached sex if he was rated as being less overtly interested in sexual matters. This finding was discussed in terms of the meaning it might have for clients to perceive their therapist as being interested in sex when this was expressed early in the therapeutic series.

Support was reported for the differential effects upon the client of the therapist's approaching and avoiding hostility and dependency content expressed by the client, as found previously by Bandura et al. (1960) and Winder et al. (1962). A similar result was also found for the difference in the client's continuation of expression of sexual material after approach and avoidance by the therapist.

Differences in therapist behavior toward males and

females was found for the areas of dependency and hostility, but not for sexual material. This was discussed in terms of its possible relevance for the areas which were probably most problematic for males and females in the population studied.

Differences were also found between therapist behavior in first and second interviews and fifth interviews in the extent to which they approached dependency. This was discussed in terms of its implications for changes in therapist behavior being related to different requirements of different phases of therapy.

Implications were stated as to the possible relationship of the therapist's experience and training in therapy to his behavior and the possible action of this variable in masking or obscuring the relationship of his behavior to personality variables.

Some implications of the present study for further research were also discussed.

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By

Hannah Lerman

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Dedicated with love

to those who have helped me grow

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I. INTRODUCTION

The Participants' Contribution to the Therapeutic Process

Transference is the focal concept in the psychoanalytic theory of psychotherapy. It is classically defined as that special emotional attachment which a patient develops toward his analyst (Freud, 1922). It is the occurrence of the transference that is said to make the analysis possible. The emotional involvement of the patient with his analyst arises out of the unconscious tendencies and fantasies which the analytic process activates and brings into consciousness. The impulses thus aroused come to be directed to the person of the analyst rather than toward some persons, usually his parents, who were important in the patient's earlier life (Freud, 1905).

The psychoanalytic treatment process revolves around the resolution of this artificially acquired transference neurosis (Freud, 1924). The patient's reactions to the analyst are continually interpreted to him as a re-experience of emotions which originated in his earliest object-attachments during childhood (Freud, 1925). The

transference phenomenon itself, however, was considered by Freud to be universal. He saw it not only as occurring in the patient with regard to the analyst but as playing some part in all other human relationships as well (Freud, 1915). In all cases, what is said to be involved, however, is the compulsion to repeat in the present the unconscious irrational infantile instinctual strivings from the past (Freud, 1920).

Neo-Freudians and other later theorists outside the orthodox psychoanalytic camp now ignore, where they do not overtly reject, the Freudian energistic concept of libido. Other Freudian concepts such as transference have often been retained although they have been divorced from their relationship to libidinal energy. Transference, even where it has not remained central in later theoretical discussions, has usually been retained as important even where greatly modified in form and meaning. Orr (1954) points out that the basic premise that something is transferred to the person of the analyst or lived through in the course of psychotherapy has generally been accepted. The modifications which have taken place in the classical Freudian view of transference revolve around the issue of what it is that is transferred to the therapist and what mechanism is involved in accomplishing this transfer.

Theorists now commonly see the development of personality as related to the interplay of interpersonal relationships rather than to the vicissitudes of libidinal energy. They prefer also to think of what is transferred not as infantile instinctual derivatives but as the generalization of behavior learned in the context of previous relationships. Statements to this effect may be found in the works of the learning theory therapists (Dollard & Miller, 1950) and in the theories of the Neo-Freudians. Karen Horney (1939), for example, states her position thusly:

> Neuroses are ultimately the expression of disturbances in human relationships; the analytical relationship is one special form of human relationships and existing disturbances are bound to appear here as they appear elsewhere; the particular conditions under which an analysis is conducted render it possible to study these disturbances here more accurately than elsewhere and to convince the patient of their existence and of the role they play. If the concept of transference is thus disentangled from the theoretical bias of the repetition compulsion, it will in time yield the results which it is intrinsically capable of producing.

Wolstein (1954) goes even further in stating his position. In his view:

> The repetition compulsion, in Freud's conceptual system, denies the fact of emergence, novelty and reconstructability, since its mechanistic formulation located the possibilities for change in the initial events of a developmental series. It was construed as being solely a property of a traumatic event or set of events located

> at single points in time in a particular era of personality development - the oedipal phase or earlier. This deterministic view makes the very possibility of psychoanalytic therapy theoretically dubious; it seems, moreover, to reverse the actualities of the case, since the compulsion to repeat, as we know today, evolves very gradually and continually undergoes some modicum of change, if only the slightest, in each of the multiple situations in which it occurs. The compulsion to repeat need no longer be analyzed as a mechanical repetition. It may be conceived as a habitual interpersonal pattern whose future is open-ended, as a dynamic mode of reaction which has evolved, perhaps lost its original reason for being, and emerged with new and different functions requiring independent examination. For the emergence of a repetition, being woven into a variety of dissimilar situations over widely distributed periods of time, acquires new features which must also be treated in their own terms.

Wolstein's statement that each situation produces a reaction that is somehow new despite its similarity to past reactions leads us to another aspect of the classical Freudian concept of transference besides its energistic base and mechanistic form that is also not very well accepted currently, the idea that the emotional reactions of the patient to his analyst are totally irrational and completely based in his, the patient's, past history (Freud, 1915). A more currently acceptable view is that the obvious real sociocultural and personal characteristics of the analyst which are apparent to the patient serve as stimuli and are the springboards for the patient's reactions and fantasies

(Wolstein, 1960). That is, the transference phenomena are seen not as a result solely of the patient's psychodynamics; rather they are regarded as being a result of a very complex interplay between the patient's dymanic personality structure and the therapist's overt and subtle cultural and personality characteristics. Each patient is assumed to be likely to exhibit somewhat different transference behaviors with different therapists, the differences, of course, being the result of variables associated with the therapist while the similarities would be more revealing of the patient's psychological life.

When we begin to consider those variables which are associated with the therapist rather than the patient, we are moving into the less clearly charted area of counter-transference. Although transference has been a key concept of psychoanalytic theory, counter-transference has been a peripheral concept until quite recently. Freud's original statements about counter-transference were quite ambiguous (Wolstein, 1959). He projected an image of the analyst as an undistorted reflecting surface on the one hand (Freud, 1912). This implied that the analyst ideally experienced no feelings or, if he did, was able to keep them from being seen by the patient or from affecting his behavior toward

the patient (Freud, 1915). On the other hand, Freud pictures the resolution of the transference as a struggle by the analyst with the patient in which he was active in overcoming resistance and guiding the direction of the analysis (Freud, 1915). At another time, he indicated that the analyst was to be a model and a teacher (Freud, 1937). These images presuppose involvements with the patients that seem to contrast sharply with the cool detachment of a surgeon or the unchanged reflections of a mirror.

Orr (1954) notes that a distinction between two aspects or components of counter-transference was implicit even in the work of the earliest writers on this subject who followed Freud. A differentiation was made even then between the analyst's reaction to the patient's transference and the analyst's own transference to the patient arising from his own unresolved neurotic difficulties. Whether both aspects are included within the framework of the concept of counter-transference is still very much a matter of dispute.

Definitions of counter-transference abound. They range all the way from considering it to include all the emotional reactions which a therapist has toward his patients, both conscious and unconscious (Sharpe, 1947), to definitions restricting it to the effects of the therapist's unconscious

needs and conflicts upon his understanding and his technique (A. Reich, 1951). This last definition is perhaps the most well accepted of those which are available.

From Freud onward, there have been many statements about the therapist's need to be completely non-neurotic (i.e., fully analyzed) and to completely eliminate any vestiges of unconscious distortions and manifestations of neurotic needs from his behavior. While there is little question that this ideal is desirable, the frequency with which it has been set forth as a perscription for a long time prevented anyone from looking at what kinds of effects residual distortions and even fully blown neurotic manifestations by the therapist actually had upon the process of therapy.

Snyder (1961), reacting to the implications of the perpetual statement of the ideal, has this to say:

> It seems to us that available research results are tending to indicate that therapists are people, rather than minor gods of some sort, and consequently that their behavior is subject to the same laws of learning as the rest of mankind. Actually it should not be necessary to make such a statement, and yet the theoretical implications of several schools of therapy are such that they would seem to make almost superhuman requirements of the therapist. For example, we do not feel that it is reasonable to expect the therapist to have no adjustment problems at all, to maintain therapeutic distance by admitting to very few positive feelings toward his clients, or to have nothing <u>but</u> positive

> feelings toward them, to make no evaluations of his clients, or to be able to play all roles with equal facility.

If therapists are people, as Snyder suggests (and even the psychoanalysts have dropped hints that they agree), they are never fully non-neurotic or free of residues, at the very least, of former irrational needs. On the other hand, recalling Orr's distinction (Orr, 1954) between analyst reactions to patients' transference and the analyst's own transference to the patient, it is easy to see that the neurotic and non-neurotic elements of the therapist's emotional reactions would not be simple to differentiate from one another if we hypothesize, as we must, a state of near-normality at least in the therapist rather than one of extreme aberration.

A large part of the importance of the counter-transference lies in its relationship to the transference of the patient. Alice and Michael Balint (1939) point out that because the analyst is a human being, it is absolutely impossible for him to keep himself out of sight or not to exist as a stimulus for his patients. He has a name, a sex, an age, an office, a certain physical appearance, a particular taste in clothes and distinct personal mannerisms in his walk, his stance, his facial expressions, his voice

and his choice of language, among other things. In the broadest sense in which the concept can be used, all of these aspects of the analyst's personality and behavior are seen by them as being transferred onto his patients and then re-transferred back to the analyst, i.e., seen as stimuli for the patients for whatever purposes they consciously and unconsciously choose to use them. The stimuli the patients are presented with are seen as integral factors in forming the transference reactions of the patients. If a patient chooses (consciously or unconsciously) to be covertly hostile, his way of doing this will vary depending both upon what stimuli he is presented with as well as upon the meaning these stimuli have for him (i.e., his emotional reactions to them).

In addition to the therapist's stimulus value <u>per se</u>, we have already noted the importance of the therapist's reactions to the behavior and stimulus value of his patients. In their more abstract form, these are apparent in the therapist's adaptations of technique and behavior to various kinds of patients (e.g., children and psychotics) and in the individuation which is said to occur with each patient in response to his particular needs. At the more individual and personal level, the therapist's reactions are affected by his

transference to the patient--his counter-transference. Here the term is used in its broadest sense and is meant to refer to all the personal behavioral reactivity of the therapist.

It would include such behavioral reactions as his habitual, or at least frequently used, ways of responding to various ways patients may initially greet him, the fact that he may encourage silent patients to speak or that he usually does not, a discernable rhythm or pattern in what he chooses to respond to among the possibilities presented and particular phrasings of his reactions to certain areas of behavior in his patients as well as behavior which is more clearly and closely related to his own anxieties and conflicts and arises as these are triggered by particular behaviors by his patients. Like the continuing and relatively static stimulus value he presents, the therapist's continual reactivity to the patient is also seen as providing the patient with stimuli which play their parts in determining the nature of his transference reactions.

Statement of the Problem

There is a large volume of literature which deals theoretically with the effect of the therapist upon the

patient or client and some which discusses the reciprocal effects of the client upon the therapist. As will be illustrated in the following chapter, however, there is only a very small amount of research literature which explores these ideas empirically. The purpose of the present study is to contribute to the empirical investigation of the relationship between the therapist and his client.

The general question under study is whether the therapist's behavior toward his patients or clients possesses a generality which somehow expresses something about himself as well as expressing something about each of his clients. In addition, how the impact of the therapist's behavior and personality causes the client to react will also be studied.

More specifically, can the therapist's personality and behavior as they are observed outside of therapy predict his reactions in therapy to the stimuli presented by the client? Aspects of his personality connected with his methods of dealing with dependency, hostility, and sexuality outside the therapy situation will be looked at as will aspects of his level of comfort in dealing with feelings. How his reactions in therapy to client expression of content dealing with dependency, hostility and sex relates to his personality will be studied.

Secondly, does the therapist's behavior and his personality as this is perceived by the client affect what the client will do subsequently? The client's behavior with regard to the expression of need or anxiety about the areas of dependency, hostility and sexuality after certain kinds of therapist reaction to these areas will be looked at in conjunction with several aspects of the therapist's personality.

Although the theoretical basis for the present study lies in the Freudian concepts of transference and counter-transference and the subsequent modifications these concepts have undergone, these terms themselves will seldom be mentioned beyond this point. They are being defined here in terms of stimulus and reaction and it is these terms which will be used instead. It is recognized, however, that this investigation will be dealing with somewhat limited aspects of the very complex phenomena of transference and counter-transference.

II. FORMULATION OF HYPOTHESES

The History of Research Interest in the Therapist

The literature dealing with the therapist has proliferated greatly since 1950. A wide variety of therapist variables have been singled out either for study or for theoretical comment. Many of the variables whose effects have been investigated can be classified as readily observable. These include the study of the professional affiliation of the therapist (Hiler, 1958; Korman, 1960; Strupp, 1955b, 1960), his professed theoretical orientation (Fey, 1958; Fiedler, 1950, 1953; Strupp, 1955a; Sundland & Barker, 1962), and his degree of experience (Abeles, 1962; Chance, 1959; Fey, 1958; Fiedler, 1953; Strupp, 1955a, 1955b, 1960). Attempts have also been made, however, to study less tangible and less easily quantified contributions of the therapist to the therapeutic interaction such as: his level of competence (Bandura, 1956; Fiedler, 1951, 1953; Hiler, 1958; Holt & Luborsky, 1958; Kelly & Fiske, 1951; Peterson et al., 1958), his sensitivity (Abeles, 1961; Holt & Luborsky, 1958; Rosenberg, 1962), and various aspects of himself even more closely associated with his personality (Bandura, 1956;

Bandura et al., 1960; Cutler, 1958; Holt & Luborsky, 1958; Kelly & Goldberg, 1959; Rosenberg, 1962; Strupp, 1960). Surprisingly, the highly visible variable of sex of the therapist has been virtually ignored until recently (Hiler, 1958; Ivey, 1960).

These varied explorations of the therapist clearly indicate that his identity and personal characteristics do matter. To put it another way, who and what he is do seem to affect the client and the course of therapy. This seems to hold whatever dimension you choose to define the "who." Psychiatrists and psychologists differ (Strupp, 1960). Psychologists differ among themselves according to the orientation they profess to hold (Sundland & Barker, 1962), despite the findings of the earlier well-known but less well controlled study by Fiedler (1953). Amount of experience changes how therapists view prognosis and influences their diagnostic formulations (Chance, 1959; Strupp, 1960) but seemingly is one factor among many in its relationship to the therapist's judged sensitivity (Rosenberg, 1962) and level of anxiety (Russell, 1961; Bandura, 1956). Therapists who are judged to be less competent are more conflicted (Cutler, 1958) and more anxious (Bandura, 1956).

The availability of any research material at all

dealing with phenomena in and around the psychotherapy situation goes back only a very few years. While Freud early recognized the need for research (1919), he thought mainly in terms of the use of the analytic observation as a means to further knowledge about psychopathological functioning rather than as being useful in the study of psychotherapy as a process unto itself (Freud, 1912).

The study of this latter initially neglected area began with attempts to preserve the ephemeral events of psychotherapy by the use of electrical recording equipment (Frank, 1961). The political scientist and psychoanalyst Harold Lasswell (1929) and the psychologist Bernard Covner (1942) were the pioneers in this endeavor.

Covner's work was done within the framework of the client-centered school of psychotherapy which, from its inception, has been deeply committed to research activity (Rogers, 1942). Until quite recently, the major portion of the psychological research literature dealing with psychotherapy has originated within this group (see Cartwright, 1957). Their important early work, however, as typified and exemplified in the Rogers and Dymond (1954) volume, focused primarily upon the investigation of the outcome of psychotherapy and only secondarily and tangentially upon

the actual process of therapy. Where the study of process was attempted through the analysis of interview content and its categorization (Raimy, 1948; Seeman, 1949; Snyder, 1945), the primary focus was upon client variables and change in these over time. These attempts were among the earliest content systems developed, having been preceded only by Lasswell's (1938) outside the client-centered school.

It was only later that general recognition began to be given, both by the client-centered group (Rogers, 1961) and increasingly by others (e.g., Grinker et al., 1961), to those factors apart from technique per se which the therapist carried with him, consciously and/or unconsciously, into his behavioral interactions with persons seeking his help.

Content-Analysis as a Means of Studying Process

With the advent of recording techniques and their application to therapy, as mentioned above, one of the major difficulties in the way of process research was greatly alleviated. A great many systems were devised by which the content of therapeutic hours could be analyzed. The aim of the earliest systems was mainly to objectify the data of psychotherapy. They succeeded in objectifying but also succeeded in losing the "full height and depth of the

material, its full meaning (Dittes, 1959)." Later systems are more closely related to a theroretical position and contain a great deal more of what their particular theory considers meaningful material. They, too, however, may be criticized for what they omit. Auld and Murray (1955), in their review of the content-analysis literature discuss this criticism and present what may be taken to be an apologia for the methods of science in dealing with complex phenomena such as are present in psychotherapy:

> The practicing clinician often feels that the measured part of the therapeutic transaction is pitifully small alongside the complex of stimuli that he senses as a participant observer. Yet it seems unfair to expect any single content-analysis system to describe all of this complex situation. We would probably make a fairer appraisal of content systems if we expected each system to deal with only a part of this complexity. An adequate descriptive and causal analysis of psychotherapy will most likely require a large number of measures, each of them shown to be reliable and valid for its limited purpose. Measures of the content of clients' and therapists' utterances will undoubtedly be supplemented by measures of other, nonverbal responses of client and therapist. By the combination of a variety of measures, each useful in its own domain, we may in time construct an adequate study of psychotherapy.

The content-analysis system chosen for use in the present study is essentially that used by Winder et al. (1962). It is a modification of a system originally developed by E. J. Murray (1956), later modified by Bandura et al.

(1960). Murray, influenced by both psychoanalytic theory and learning theory, devised a system that was designed to be objective and non-inferential in its rules for scoring. Client statements were designated as expressing a need, expressing anxiety about a need or frustration of a need. Therapist statements were also categorized.

Bandura's revision of Murray's system essentially retains his method of categorizing client statements (eliminating only the categorizations for need frustration) but categorizes therapist statements differently, as approach and avoidance of the need expressed by the client. Approach includes any therapist statements which seem designed to elicit further expression of feelings, attitudes and behavior from the client. It encompasses such behaviors as approval, reflection, support, exploration and interpretation. Avoidance covers statements which seem designed to inhibit, discourage or divert further expressions of feelings, attitudes and actions and includes such therapist behaviors as disapproval, topical transition, ignoring and mislabeling.

Bandura's major contribution, however, is his conception of the interaction unit. Each unit has three parts: a client statement, a therapist response, and the client's subsequent statement, each of which are scored separately.

The final client statement of one unit is also the initial one of the succeeding unit. It is, therefore, possible, using such a form, to discuss client behavior and therapist behavior individually, as has been done heretofore, but also to discuss the effect the behavior of each exerts upon the behavior of the other.

Besides the system for analyzing the content of therapy hours, several of the specific hypotheses which will be tested in this study also arise out of the work of Bandura et al. (1960) and Winder et al. (1962). Hypothesis one is a replication of Bandura. The other hypotheses have not been tested previously although several of the relationships involved were suggested in the work of Winder et al. (1962) and Bandura et al. (1960).

The Hypotheses of this Study

Research such as that of Cutler (1958) and Bandura et al. (1960) provide support for the assumption that a therapist's anxieties about particular areas of experience will affect his responsiveness to client expressions which deal with these areas. Bandura's work dealt specifically with anxiety about hostility and a need for approval in the therapist. He found some support for his hypothesis that

therapists with anxiety about hostility were less likely to respond with approach behavior to patient expressions of hostility. We shall attempt to replicate this finding and also learn whether therapist anxiety about other areas of experience will yield similar findings. The following hypotheses about therapist anxiety will be tested:

1. The higher the level of therapists' anxiety about hostility, the less likely they are to respond with approach reactions to client hostility expression and expressions of anxiety about hostility.

2. The higher the therapists' anxiety about dependency, the less likely they are to respond with approach reactions to client expression of dependency and dependency anxiety.

3. The higher the therapists' anxiety about sexuality, the less likely they are to respond with approach to client expressions of sex and sex anxiety.

Besides therapist anxieties about particular content areas, there are other aspects of himself that could also be suggested as factors which influence his behavior toward his clients. The other aspect of therapist personality which will be considered is the habitual cognitive-affective level at which the therapist operates in interpersonal relationships outside the therapy situation. As envisioned here, this concept is composed of three aspects, one of which is the affectivity of his responsiveness to others, another his degree of revelation of his own feelings and

third, his ability to understand or feel with the feelings of others. What relationship would these factors have to the behavior of the therapist in therapy?

Winder et al. (1962) have suggested that patients

> tend to remain (in therapy) if the treatment relationship provides gratification of dependency need, but tend to avoid treatment which involves relatively much frustration. Further, if psychotherapy involves distress and discomfort, e.g., through arousal of personal feelings and thoughts which are anxiety and guilt provoking, gratifications in the treatment would be necessary to permit the patient to remain.

They implicitly define therapist gratification of client needs as being manifest in his approach responses to the dependency expressed by his clients. But, in order to gratify client needs, the therapist must possess the ability to perceive and to react to them. If we assume that greater affective freedom in the therapist permits him to perceive feelings in others to a greater extent and define this perception operationally in terms of his approach to dependency, we can thus hypothesize that:

4. The more affective the therapists the more likely they are to respond with approach behavior to client expressions of dependency need and anxiety.

Until now we have been talking about being able to predict the stimulus value that the therapist has for the client. The preceding discussion has implied client reactions

but we have not yet specified any particular client reactions.

Bandura et al. (1960) and Winder et al. (1962), investigating specific client reactions, have found that clients are likely to react differentially to verbal approach and avoidance behavior of the therapist for the areas of dependency and hostility. The behavior of the therapist thus has been shown to influence the behavior of the client. His personality manifests itself in his verbal behavior, as Bandura et al. (1960) has shown and as the present study also hopes to demonstrate. Non-verbal cues must also be available, however. If the client is able to perceive something about the personality of his therapist, this is likely to cause him to react in some fashion. If the client perceives what he is talking about as causing the therapist to become anxious, it seems likely that it will cause him to become anxious also and to stop and begin to talk about other topics instead. We will thus hypothesize the existence of relationships between the nature and level of a therapist's anxieties and the likelihood of the client continuing to talk about a particular topic area. Specifically, the hypotheses testing these interactions are:

5. The higher the level of therapists' anxiety about hostility, the less likely his clients are to continue to express hostility or anxiety about hostility.

6. The higher the therapists' anxiety about dependency, the less likely his clients are to continue to express dependency and dependency anxiety.

7. The higher the therapists' anxiety about sex, the less likely his clients are to continue to express sexual content.

The relationship between the affective level of the therapist and the client's continuation of discussion of each of the three content areas combined will also be looked at.

III. METHOD

The Subjects

The therapists who were studied were seventeen advanced graduate students. At the time at which they had recorded the interviews studied here, all seventeen were employed as Assistant Instructors at the Counseling Center at Michigan State University. These positions are half-time staff positions and are reserved for advanced graudate students who have already had practicum experience in psychotherapy prior to their employment by the Center. The therapists were all enrolled in either the clinical psychology program in the department of psychology at Michigan State University or in one of the various counseling and counseling psychology programs administered by the College of Education of Michigan State University. Seven of these students were clinical psychology students and the remaining ten were students of counseling and counseling psychology. Four of the group were female.

The bulk of the clients who come to the Counseling Center and enter into personal counseling or psychotherapy come from the undergraduate student population at Michigan

State University. This is so also in the clients represented among the tape recordings used here. In two cases, both for the same therapist, the clients are graduate students. Occasionally also, wives or husbands of students who are not themselves students are seen at the Counseling Center. Three of the clients recorded on the tapes used in this study fall into this category. All other clients of whom recordings were studied were enrolled as undergraduates at Michigan State University at the time the interviews were recorded.

Procedures

Collecting the Tape Recordings

Two sources of tape recordings were used in the present study. In both cases, this involved the use of recorded material collected in connection with other ongoing studies at the Counseling Center. One source was a collection of tapes of interviews very early in the therapeutic series, usually either the first or second interview and occasionally the third. The other source was a collection of tapes which were primarily of fifth interviews, including also occasional tape recordings of sixth and seventh interviews as well. Not all the therapists studied were represented in both groups of tape recordings. Both groups were

used because this permitted study of the work of more therapists than could be studied if either one of the two sources of tape recordings had been used alone for this study.

A total of thirty-eight recordings were studied. All but two of the therapists are represented in this total by at least two tapes each. For two persons, only one tape each was available. Most of the other therapists are represented by two tapes, although three tapes are included for six persons. Where more than a single tape was available for a therapist, an attempt was made to include recordings of him with both male and female clients. This was possible for all but four of the fifteen therapists for whom there were more than one single case available. In two cases, both clients in the available tapes were male while for the other two, the two clients were female.

Content-Analyzing the Tape Recordings

As previously mentioned, the basis system used for categorizing the interviews was that first used by Murray (1956) and later modified both by Bandura *et al.* (1960) and Winder *et al.* (1962). A coding manual for this basic system, wlthough modified somewhat in line with the purposes of the present study, may be found in Appendix A.

Client statements are scored as to whether they express need for or anxiety about expression of dependency, hostility and sexuality. There is a miscellaneous category for statements whose content does not fall into one of these three areas. Multiple scoring is possible, i.e., a single statement may be scored as containing content in more than one area. Notation is also made as to whether the client is oriented toward the therapist or toward another object in his eneed for or anxiety about a scorable content area.

Each therapist statement is scored as to whether the therapist approaches or avoids the expressed client needs and anxieties immediately preceding it. Statements scored as approach include those which seem to be designed to elicit further expression of feelings, attitudes and behavior from the client while statements scored as avoidance include those seemingly designed to inhibit, discourage, or divert further expressions of feelings, attitudes, or actions. Although the scoring manual makes provision for categorizing separate types of approach and avoidance behavior, separation into subcategories was not attempted. Therapist statements were categorized only as to whether they were approach or avoidance without consideration of the type of approach or avoidance manifested. Therapist silence was not scored as

avoidance but was included in the miscellaneous category on the basis of the finding of Bandura et al. (1960) that it seemed sometimes to be responded to as approach and at other times as if it were avoidance.

A related investigation was being conducted at the same time as the present study which also involved the content-analysis of many of the same tape recordings as were being used here. The two investigators collaborated in the analysis of the tapes. Both investigators were part of the sample of therapists studied here. Since all of their interviews were among the group which was coded by both investigators independently, it was felt that the achievement of adequate reliability between the two on the tapes coded by both investigators would be sufficient to counteract the bias introduced by tapes of their own interviews being included among those coded.

Thirty-three tape recordings of the thirty-eight used in this study were also used in the companion study. However, a total of thirty-nine tapes were coded independently by each of the two investigators and many of the reliability coefficients which follow (see Table 1) were computed for this number. The six additional tapes are being used solely in the other study and the results of the coding of these

do not enter into any other calculations in this study beyond the reliability data. When both investigators coded the tapes, it was the average of their judgments which was used in testing the hypotheses. In five instances, the tapes were coded by one investigator only and these judgments alone were used in subsequent computations using these tapes.

Before beginning to analyze the tapes used in the two studies, the two investigators pracitced with tapes that were not in either sample. Originally, they worked together and later coded separately after it was felt that they both were interpreting the instructions in the coding manual in a common fashion. When adequate agreement on tapes not in either sample was reached, independent coding of the tapes in the overlapping tape pool was begun.

In the previous studies which used the same content-analysis system, the fact that the coding could be performed reliably by different individuals was reported in terms of the percentages of agreement achieved among raters on the clients and therapist categories. Because the present study did not use the information about categories <u>per se</u> in its raw form but used ratios derived from these, it was felt that the reliability of scoring could better be demonstrated

through comparisons of the approach and continuance ratios that would actually be used in testing the hypotheses. It was the reliability coefficients for these which were computed.

The approach ratios represent the proportion of times that a therapist responded with approach behavior to client expression of need or anxiety about the expression of dependency, hostility and sex. For example, the approach ratio for dependency was computed as follows: first, those client statements categorized as either expression of dependency or dependency anxiety were counted. Next, the therapist response to each client statement categorized as dependency was looked at. Those therapist responses classified as approach and as avoidance were tallied. The approach proportion used was: therapist approach to dependency divided by therapist approach plus avoidance of dependency. Those client statements for which the therapist response was classified as silence, inaudible or irrelevant (see Coding Manual in Appendix A) were not included in computing the ratio. The total approach ratio represents the proportion of times the therapist approached rather than avoided for the three content areas combined.

The total continuance ratios and continuance ratios for the therapist's approach and avoidance for each of the

three areas were also computed. The approach and avoidance continuance ratios present the proportion of times that the client continues to express material in the same area after the therapist has responded with approach or avoidance to the client's immediately prior statement dealing with this content area. The total continuance ratio for each of the three content areas presents the proportion of times the client followed a statement scored for a content area with another, regardless of the kind of response the therapist made in the interim. Computation of the continuance ratios contains an additional step beyond the approach ratio related to it. For computing the continuance ratios for dependency, for example, all client statements to which the therapist had responded with either approach or avoidance to dependency (all the therapist statements included in computing the approach ratio) were looked at to see if the next client statement also was categorized as dependency. Three ratios were computed, one where the nature of the intervening therapist response was ignored (therapist approach and avoidance were included), one where only client statements to which the therapist had approached were included and one where only client statements which the therapist had avoided were included.

In Table 1 below, the reliability of the individual codings and of the reliability of the average of the two codings are shown for the approach and for the continuance ratios. These were computed in accord with the method suggested by Ebel (1951). In general, the reliabilities were judged to be adequate for the purposes of the present study. The two investigators did not, however, agree very well on the continuance ratios for hostility, particularly that following after avoidance of this area by the therapist.

Rating the Therapists' Personality

Each of the seventeen therapists studied was rated on a number of five-point rating scales by the judges. Nine scales were used of which six were the same as those used by Bandura et al. (1960). A scale designed to measure the habitual cognitive-affective level of the therapist was substituted for the warmth scale used by Bandura et al. (1960). In addition, Bandura's sex inhibition scale was subdivided into two scales, one measuring sexual anxiety when the subject is not the referent (sexual inhibition: general) and other measuring sexual anxiety when the subject's own sexuality is involved (sexual inhibition: personal). The six scales adopted unchanged were designed to provide

Table 1. Inter-judge reliability in coding the approach and continuance ratios.

	Coefficient of Correlation	Coefficient of Average Correlation
Approach Ratios		
Dependency	.847	.917
Hostility	.828	.906
Sex	.745	.854
Total Approach[1]	.829	.906
Continuance Ratios		
Total[1]		
Dependency	.760	.864
Hostility	.373	.543
Sex	.791	.883
following Approach		
Dependency	.728	.840
Hostility	.483	.651
Sex	.732	.846
following Avoidance		
Dependency	.572	.727
Hostility	.316	.481
Sex	.902	.949

[1]N = 33 for the Total Approach and Total Continuance Ratios but N = 39 for all the other ratios tabled here.

measures for the therapists of direct hostility, help seeking, indirect hostility, hostility inhibition, approval seeking and dependency inhibition. Later, the raters were asked to rerate each of the therapists on the help seeking and dependency inhibition variables and to rate each of them on three scales which were developed out of the original cognitive-affective level scale--cognitive affective level, verbalization of feelings and empathic expression. This was done because adequate agreement among judges was not attained on the help seeking, dependency inhibition and the original cognitive-affective level scales. For the rerating task, the judges were provided with additional instructions on the distinction to be made between the help seeking and dependency inhibition scales.

The three raters were also asked to rank the seventeen therapists according to how well each of them felt he knew each person. They also indicated in what sorts of circumstances (i.e., therapy, supervision, social contact, etc.), they had come to know each person and which persons and which scales had been especially difficult to rate. Copies of all the rating scales and instructions to the raters may be found in Appendix B. Three of the scales appear there with different names than they are given in

this discussion. They were renamed after the judges performed the second rating task. This was done so that the titles would tell about the scales' directionality more clearly. The renamed scales were originally called inhibition of feeling expression, ease with sexual topics and demonstration of sexual interest. They are being referred to now as verbalization of feelings, sex inhibition: general and sex inhibition: personal.

Three members of the senior full-time staff of the Counseling Center served as raters for this portion of the study. They were Dr. B. L. Kell, Assistant Director of the Counseling Center for Training, Dr. H. Grater, Assistant Director of the Counseling Center for Counseling Services, and Dr. Josephine Morse. They were chosen because it was felt that they had observed each of the seventeen therapists studied in a variety of situations and had sufficient knowledge of each of them to be able to perform the rating task adequately. Dr. Morse and Dr. Grater indicated, however, that they did not feel comfortable in rating four and six of the seventeen persons respectively. Their ratings for these persons were then omitted from consideration and only their ratings of the other therapists were used. The therapists omitted were different ones for Dr.

Morse and Dr. Grater except in one instance. Dr. Kell indicated that he knew each of the seventeen sufficiently well to feel comfortable in rating all of them and his ratings of all seventeen persons were used. There was thus at least two sets of ratings for all but one of the therapists studied.

Table 2. Inter-judge reliability in rating therapist personality variables.

	Coefficient of Correlation	Coefficient of Average Correlation
Rating Scales		
Direct Hostility	.412	.627
Help Seeking	.092	.196
Indirect Hostility	.560	.753
Cognitive-Affective Level	.647	.815
Verbalization of Feelings	.656	.821
Empathic Expression	.430	.644
Hostility Inhibition	.485	.693
Approval Seeking	.470	.680
Dependency Inhibition	.445	.658
Sexual Inhibition: General	.590	.775
Sexual Inhibition: Personal	.732	.868

Table 2 contains the correlation coefficients for the agreement among raters, both for the individual ratings

and for the average of their ratings. These were computed according to the method given by Ebel (1951) for establishing reliability of ratings where there are more than two judges and there is incomplete data from some judges. The reliability coefficients obtained are considered to be adequate for the purposes of this study, except for the help seeking scale upon which the judges did not agree in their ratings of the therapist subjects even after rerating them. Pearson correlation coefficients computed separately between pairs of raters revealed zero-order correlations in all three instances. The low overall correlation thus was not due to any one of the three raters disagreeing with the other two but was an instance of a general disagreement.

Correlation coefficients were also computed between the first and second ratings on the three variables which were rated twice. It is to be noted that the help seeking and dependency inhibition scales remained unchanged for both rating tasks but that the original cognitive-affective level scale was subdivided into three separate scales at the second rating. One of the three new affectivity scales still deals with the therapist's cognitive-affective level. It is here compared with the original compositive cognitive-affective level scale. Moreover, instructions for

differentiating the help seeking and dependency inhibition scales were given for the second rating. Table 3 shows the results of these computations of intra-judge consistency.

Table 3. Intra-judge consistency.

	Grater	Kell	Morse
Rating Scales			
Help Seeking	.793	.683	.260
Dependency Inhibition	.787	.798	.640
Cognitive-Affective Level	.540	.848	.820

The judges revealed themselves to be reasonably consistent over time in their judgments with the exception of Dr. Morse in her ratings on help seeking. Dr. Morse has told the author that she felt her set for the task of rating to have been different at the time the rerating was done than it had been earlier.

In order to see if a difference in set was a factor for all three judges, comparisons were made of the relationship between the dependency inhibition and the help seeking scales for the first rating and the relationship between them on the second rating. It is to be remembered that the judges did not agree on their ratings of dependency inhibition the first time they rated it and that the instructions for

the second rating task were designed to provide clearer differentiation between help seeking and dependency inhibition. For none of the three judges, however, was the difference significant. The relationship between the two scales for all the judges must be said then not to have been different at the time of each rating despite Dr. Morse's comments about her perception of the task as different at the two times.

IV. RESULTS

Hostility

Table 4 below shows the correlations which were obtained between the approach and continuance ratios for hostility content in their interviews and the ratings the therapists received on the scales which deal with their hostility and their affectivity.

No hypotheses were stated about the relationship of the likelihood of the therapist's approaching client hostility statements or of the client's continuing to express hostility in his subsequent statements and the therapist's ratings on the affectivity scales. Table 4 shows a significant negative relationship to exist between the likelihood of the client's continuing to express hostility after the therapist has avoided it and the extent to which the therapist talks about his own feelings. The less the therapist reveals his feelings, the more likely the client is to continue hostility expression after the therapist has avoided it. None of the other correlations between the affectivity scales and the hostility ratios and the total approach ratio are significant.

Table 4. Correlations between the therapist rating scales and the approach and continuance ratios for hostility.

	Approach/Hostility			Total Approach	Continuance		
		Object				after	
	Total	Therapist	Other		Total	App.	Av.
Rating Scales							
Direct Hostility	-.139	-.071	-.123	-.121	-.063	-.006	.171
Indirect Hostility	-.022	-.109	.053	.192	.089	-.119	.221
Hostility Inhibition	-.086	-.120	-.064	-.148	.216	.238	-.058
Approval Seeking	-.087	.136	.029	.028	.262	.220	-.052
Cognitive Affective Level	.206	-.146	.188	.296	-.058	.022	-.151
Verbalization of Feelings	.248	.078	.221	.075	-.110	.083	-.483*
Empathic Expression	-.097	-.001	-.032	-.126	-.231	-.108	-.256

*Significant at .05 level.

Hypotheses 1 and 5 which stated that there would be a negative relationship between a therapist's ratings on hostility anxiety and the likelihood of his responding with approach to client content dealing with hostility and a negative relationship to the likelihood of the client's continuing to express content dealing with hostility are not confirmed by the data. None of the hostility ratios show any significant relationship to any of the three hostility scales.

Bandura et al. (1960) found a significant positive relationship between therapists' ratings on the direct hostility scale and the likelihood of their responding with approach to hostility when the therapist was not the object of the hostility expression. They also found a negative relationship between the therapist's rating on the approval seeking scale and his approach behavior to hostility. Neither of these finds was replicated here.

Also, no support was found for Bandura's finding that therapists were less likely to approach hostility when they themselves were the objects than when they were not the objects. This was not found to be true in the present study. The result obtained in the Wilcoxon matched-pairs signed-ranks test comparing the therapist's approach behavior toward

hostility when he was its object and when he was not was not significantly different from one expected by chance. The number of therapists used in this test was twelve rather than seventeen because the recordings for five of the therapists did not contain any content which was coded as hostility expressed toward the therapist.

The tapes studied here, it is to be remembered, come from two sources within the Counseling Center and represent two different time-segments of the therapy process. One group is the first and second interviews and the other is of the fifth through seventh interviews. The sample of tapes used by Bandura et al. (1960) represented a random selection from a pool which included tapes of the patients over a series of time in therapy. The present sample differed in that all the tapes used here were from very early in the therapy process. It was thought that this difference in the sample of therapy which was available might have contributed to the failure here to replicate Bandrua's finding. The two groups of tapes (subsequently to be referred to as early and later tapes) were compared with reference to the hostility approach and continuance ratios by means of the Mann-Whitney test. The results are stated in Table 5.

Table 5. Comparison of the hostility ratios in the early and later tapes.

	p
Ratios	
Approach/Hostility	N.S.
Continuance	
Approach/Hostility	N.S.
Avoidance/Hostility	N.S.
Total Hostility	N.S.

There are, however, no significant differences between the ratios in the two groups of tapes.

Bandura et al. (1960) had also found that the likelihood of a client's continuing to express hostility was significantly greater when the therapist had approached the prior expression of hostility than when it had been avoided by the therapist. The data were available in the present study to test whether this was true also for the clients studied here. The ratios for the clients' continuance of hostility after it was approached by the therapist and after it was avoided were compared for the 38 interviews studied by means of the Wilcoxon matched-pairs signed-ranks test. The results repeated those found by Bandura with $p < .0001$ (two-tailed

test). The finding that the client's behavior is influenced by the therapist was replicated here. Bandura's population of clients was made up of parents in a parent-child clinic. The population here is made up of college students. The finding thus is a replication but is also a new finding as well since it was demonstrated for a different population of clients.

In order to see if any difference in the therapist's reaction to the verbal content presented by his clients could be related to the stimulus presented by the sex of the client, a comparison of the male therapists' approach ratios for hostility for males and females was made. (A comparison of male and female clients of female therapists was not made because data from only four female therapists were available.) The number of therapists available for this comparison was eight. Besides the four female therapists and one male therapist for whom only one client was available in the sample, four more therapists could not be included because the two clients represented in the sample for each of them were either both male or both female. A Wilcoxon test was computed. The difference between the approach ratios for hostility for male and female clients failed to be significant at the .05 level. For seven of the

eight cases, the approach ratio was larger for males than for females. In the one case which was a reversal, the difference between the two ratios was the largest of all eight cases. It is felt that, despite the test's failure to reach statistical significance, a strong tendency seems evident in the data for male therapists to be more likely to approach hostility when it is expressed by males than when it is expressed by female clients.

For the same data, a sign test was also computed. The p value reached (two-tailed test) was .07, revealing the same tendency as shown by the Wilcoxon test.

Dependency

Table 6 below shows the correlations which were found between ratios related to dependency behavior and the ratings of the therapists on the scales dealing with dependency and affectivity.

Three hypotheses were stated about relationships connected with dependency behavior. Hypothesis 2 posited a negative relationship between a therapist's dependency anxiety and the likelihood of his responding with approach behavior toward clients' expressions of dependency. This hypothesis is partially confirmed by the data. Significant

Table 6. Correlations between the therapist rating scales and the approach and continuance ratios for dependency.

	Approach/Dependency Object			Total Approach	Continuance		
	Total	Therapist	Other		Total	App.	after Av.
Rating Scales							
Help Seeking	.543*	.130	.296	.129	.312	-.057	.046
Approval Seeking	.191	.284	.041	.028	.087	.134	.253
Dependency Inhibition	.644**	.295	.652**	-.007	.429	.145	.202
Cognitive Affective Level	.269	.127	.286	.296	.173	-.010	.171
Verbalization of Feelings	-.159	.029	-.189	.075	.249	-.063	.414
Empathic Expression	-.025	.206	-.104	-.126	-.237	-.302	-.158

*Significant at .05 level.
**Significant at .01 level.

positive correlations were found between the dependency total approach ratio and both the help seeking and dependency inhibition scales. In addition, a relationship was found between dependency inhibition and approach to dependency when the therapist is not the object of the client's dependency. High scores on both the help seeking and dependency inhibition scales go toward the direction of increased ease in asking and accepting help from others and less anxiety about this. Where the therapist is anxious about dependency, he seems less likely to approach this kind of content when it is expressed by his clients.

It is somewhat surprising that one of the significant findings involved the help seeking scale. This was the one scale upon which reliability of ratings among the judges was not achieved. The meaning of its being significantly related to the therapist's approach to dependency remains unclear. It may be a chance occurrence.

Hypothesis 4, which suggested a relationship between greater therapist affectivity and the likelihood of his responding with approach to dependency is, however, not confirmed by the data in the present study. None of the correlations between the affectivity scales and the ratios for the therapist's likelihood of approaching dependency

suggest that any such relationship exists in the data of the present study.

Hypothesis 7 suggested a relationship between the therapist's anxiety about dependency and the client's continuance of dependency expression after the therapist's response. This hypothesis too is not supported by the data. None of the relevant correlations reach a significant level. The correlation between the client's total continuance of dependency, regardless of the intervening therapist response, and the therapist's rating on dependency inhibition while not significant is nevertheless high. It suggests that there is some tendency for increased freedom of dependency expression in the therapist to correlate with the client's willingness to continue to express or talk about dependency.

No significant relationship to any of the dependency ratios was found for the approval seeking scale. An attempt to understand this was made by looking at the relationship of this scale to the other dependency rating scales. The relationship of this scale to the hostility rating scales was also studied. Bandura, it may be remembered, found a relationship between approval seeking and therapist appraoch to hostility (this was not substantiated here, however). The intercorrelations of the approval seeking scale and the

other dependency and hostility scales are shown in Table 7.

Table 7. Correlation of approval seeking with the other dependency and hostility rating scales.

Help Seeking	.445
Dependency Inhibition	.364
Direct Hostility	.508
Indirect Hostility	-.143
Hostility Inhibition	.551

While the differences between the relationships of approval seeking to the other dependency scales and its relationships to direct hostility and hostility inhibition are probably not large enough to be significant, the correlations with help seeking and dependency inhibition are lower. This suggests that the approval seeking scale may not be a measure of dependency behavior alone but may also reflect some degree of hostility in the persons rated. Its use in testing hypotheses about dependency may, therefore, not be completely justified.

Winder et al. (1962) found a positive relationship between the client's continuance of content related to dependency and approach to such content by the therapist. This

relationship was also tested in the present study. A Wilcoxon test of the difference between continuance of dependency expression by the client after therapist approach and therapist avoidance yielded a result which was significant at less than $p = .0001$ (two-tailed test). As with the similar result for hostility, this finding of Winder's was replicated here with a different client population.

The approach and continuance ratios for dependency were compared for the early and later interview tapes by the Mann-Whitney test. These results are shown in Table 8.

Table 8. Comparison of the dependency ratios in the early and later tapes.

	p
Ratios	
Approach/Dependency	.02
Continuance	
Approach/Dependency	N.S.
Avoidance/Dependency	N.S.
Total Dependency	N.S.

The two groups of tapes are different with regard to the behavior of the therapist when the clients express

dependency. The therapists are more likely to approach dependency in the early interviews than they are in later interviews.

A comparison was made with the Wilcoxon test to see if there were any differences in therapist behavior in response to client expressions of dependency when the therapist was the object of this expression and when he was not. There was a significantly greater likelihood of therapists' approaching dependency when he was the object of the clients' expression than when the expression was not related to him ($p < .01$).

As with the data related to hostility, a comparison was made with the Wilcoxon test between therapist approach ratios for dependency for male and female clients. As before, only data for male therapists for whom both male and female clients were represented in the sample were used ($N = 8$). The difference was significant with $p = .05$. Male therapists were more likely to approach dependency in this sample when it was expressed by male clients than when it was expressed by females. The direction of this difference is somewhat surprising. Presumably it is more acceptable in our society for males to respond protectively and warmly to

females than to do this with males. As members of our society, the male therapists should be expected to act similarly, but they do not.

The sample used in this analysis was looked at to see if the result could be an artifact related to the number of early and later tapes included for the female and male clients. There are more early tapes for the female clients than there are for the males. Since more approach to dependency by the therapist was found in the early tapes than in later ones, the result here that male therapists approach dependency more in male clients would not seem to be due to the numbers of early and later interview tapes included in the groups of male and female clients.

It was thought that perhaps the male therapists' greater hesitancy to approach dependency with females than with males might be related to the level of their anxiety about sex. This possibility was tested by computing Pearsonian correlations between the approach ratios for dependency for all tapes of female clients of male therapists and the ratings which the therapists of these clients had received on the sex inhibition: general and sex inhibition: personal scales. These relationships were tested separately for male clients. Not all therapists were represented in the two

groups of tapes. In addition, some therapists were represented in one of the groups by more than one tape. In the computation of the correlations then, the ratings of these therapists would receive undue weight. Before computing the correlations, therefore, it was first ascertained that the therapists whose clients were represented in the groups of male and female clients were not significantly different in their ratings on the sex inhibition: general and sex inhibition: personal scales. The correlations for the relationships between the sex scales and approach to dependency for male and female clients separately appear below in Table 9.

Table 9. Correlations between therapist approach to dependency and his ratings on the sex scales for males and for females.

	Sex Inhibition: General	Sex Inhibition: Personal
Approach/Dependency		
Males	.192	.233
Females	-.128	-.122

None of the correlations indicate that there are any significant relationships present in the data for either male

or female clients. It is unlikely that the relationships here differ for males and females.

Sex

The remaining hypotheses deal with the likelihood of relationships existing between sex anxiety in the therapist and his approach to sexual material and the likelihood of his client's continuing to express sexual material after the therapist's response. Table 10 below contains the correlations relevant to hypotheses 3 and 7 as well as correlations relating the affectivity scales to the approach and continuance ratios for sexuality.

There is no support in the data for hypothesis 3. Significant linear relationships were not found between the therapist's approach to sexual content and the level of his sexual anxiety. It was not possible to test this relationship separately for those instances when the therapist is the object and those when he was not. In only one case in the sample used was sexual content scored with the therapist as object. In addition, only one of the coders scored T as object in that instance.

For the same data, however, correlation ratios were computed for the relationships of the ratings on sex anxiety

Table 10. Correlations between the therapist rating scales and the approach and continuance ratios for sexual content.

	Total Approach/ Sex	Total Approach	Continuance after Total	App.	Av.
Rating Scales					
Sex - Inhibition: General	-.134	-.033	-.218	.443	-.076
Sex - Inhibition: Personal	-.074	-.009	-.172	.492*	.057
Cognitive - Affective Level	.185	.296	.150	-.354	.092
Verbalization of Feelings	-.200	.075	-.089	-.455**	.238
Empathic Expression	.417	-.126	.116	-.766**	.228

*significant at .05 level

**significant at .01 level

and the approach ratio to sexual content. For sex inhibition: general, the eta coefficients were .16 and .55, for sex inhibition: personal, the eta coefficients were .18 and .51. In both cases, the higher correlation ratios represent the regression curves of the ratings to the approach ratios. F tests for the difference of each of the two higher correlation

ratios from zero did not reveal that either of these was significant. That the correlation ratios are so much larger than the Pearson rs computed previously strongly suggests, however, the possibility that the ratings on sex anxiety do not bear a linear relationship to approach to sex, as had been hypothesized, but may instead be in some kind of non-linear relationship to the therapist's response to sexual expression by his clients.

Hypothesis 7 posited that a negative relationship would exist between therapist sexual anxiety and the likelihood of his client's continuing to express sexual material after the therapist's response. No relationship is found in the data for this relationship for either the client's continuance of sexual material regardless of the nature of the intervening response by the therapist or his continuance in this area after the therapist had avoided it. A significant relationship was found, however, for the client's continuance of sexual material after it has been approached by the therapist and the therapist's rating on the sexual inhibition: personal scale. In addition, a correlation was found between continuance after approach and the sex inhibition: general scale which, while it does not reach a significant level, is high enough to suggest a relationship. Both of

these correlations, however, have a positive sign and suggest relationships which go in the opposite direction to those hypothesized. The data here suggests that the likelihood of the client's continuing to express sexuality increases the more sexual inhibition or sexual anxiety his therapist manifests.

Whether these correlations between the sex anxiety rating scales and continuance by the client after approach to sex by the therapist might also suggest nonlinear relationships was also investigated. The Pearson r coefficients shown in Table 10 were higher in value than the eta coefficients computed for the same data. The possibility of a nonlinear relationship here must, therefore, be rejected.

A significant negative relationship was also found between the likelihood of the client's continuing with sexual material after it has been approached by the therapist and the therapist's level of empathic expression. The likelihood of the client's continuing to express sexuality increases the lower the therapist is rated on empathic expression.

Negative correlations with continuance after approach which are high but not significant were found for the ratings of the therapist on the cognitive-affective level and

verbalization of feelings scales. The likelihood of the client's continuing to express sexuality seems to increase the more cognitive and the less verbal about his own feelings the therapist is rated as being.

The same comparisons were made for the sexual area as had been made for the other two content areas. A Wilcoxon test between the continuance of sexual material after approach and after avoidance revealed a significant difference ($p < .005$), with approach behavior by the therapist to sexual content resulting in an increased likelihood of the client's continuing in this area.

Comparison of the early and later tapes revealed no significant differences with regard to sexual content but did suggest some tendencies. These data are reported in Table 11 below.

Table 11. Comparison of the sex ratios in the early and later tapes.

	p
Ratios	
Approach/Sex	>.10
Continuance	
Approach/Sex	>.10
Avoidance/Sex	N.S.
Total Sex	N.S.

There is some tendency suggested for the therapist to be more likely to respond with approach to sexual content in the later tapes. There is, however, a suggestion that the client is more likely to continue to express sexual material after the therapist has approached it in the early interviews than he is to continue this content in the later series of interviews.

When the male and female clients of male therapists were compared as to the likelihood of the therapist's approaching sexual material for the two groups, the differences were not significant. Male therapists in this sample did not differ in the extent to which they responded with approach to sexual material with male and female clients.

V. IMPLICATIONS OF THE DATA

Discussion

The hypotheses tested in this study are stated again below. They are:

1. The higher the therapists' anxiety about hostility, the less likely they are to respond with approach reactions to client hostility expression and expressions of anxiety about hostility.

2. The higher the therapists' anxiety about dependency, the less likely they are to respond with approach reactions to client expression of dependency and dependency anxiety.

3. The higher the therapists' anxiety about sexuality, the less likely they are to respond with approach to client expressions of sex and sexual anxiety.

4. The more affective the therapists, the more likely they are to respond with approach behavior to client expressions of dependency and dependency anxiety.

5. The higher the therapists' anxiety about hostility, the less likely his clients are to continue to express hostility or anxiety about hostility.

6. The higher the therapists' anxiety about dependency, the less likely his clients are to continue to express dependency or dependency anxiety.

7. The higher the therapists' anxiety about sex, the less likely his clients are to continue to express sexual content.

Hypotheses 1 and 5 were not confirmed in this study. None of the correlations between the hostility scales and the

hostility ratios were significant. As has been previously noted, Bandura et al. (1960) had found a relationship between the therapist's approach to hostility when he was not the object of the hostility and the direct hostility scale. Therapists' approach to hostility was also found by Bandura to be related to the approval seeking scale. Neither of these findings were confirmed here. While the therapists in Bandura's study were student therapists, as were the therapists in this study, the population of clients was quite different. More importantly, however, the time sample of the therapy process differed. Bandura did not specify precisely from where in the course of therapy the tapes were selected. The implication, however, was that interviews were randomly selected from tapes available over a long time series. The sample of interviews in the present study was restricted essentially to first, second and fifth interviews. It was not found that the early and later interviews in this sample differed either in the extent to which the therapist approached hostility or in the extent the client continued expressing hostility after the therapist's response to his previous statement. The therapist's behavior with respect to hostility is not different in the early and later interviews. Possibly, fifth interviews

are too early still in the series to show a difference.

In contrast, there is support for the idea that therapists tend to approach dependency more in early interviews than in later ones. Winder et al. (1962) have suggested gratifications of some sort (approach to dependency) are necessary so that the client will remain despite the arousal of anxiety provoking feelings. Thus, there might be motive behind the therapist's approach to dependency in early interviews, especially when it was directed at him as object. In addition, however, the expression by the client of need for him, the therapist, is also gratifying to the therapist. He seemingly attempts to induce the client to express need for help from him. This serves to begin to bring about an emotional tie between the client and his therapist, gratifying both of them. It would seem, however, that more would be necessary from the therapist's view to cause the client to be firmly committed to participation in the therapeutic process. If he responds initially to the hostility expressed by the client, before the client is committed to therapy, he runs the risk of causing the client to leave therapy precipitiously. Just as approach by the therapist to hostility expressed by the client is probably not gratifying to the client, it is not gratifying either

to the therapist, especially early in therapy.

All the therapists studied here, in relative uniformity, did not reach much with approach behavior to the hostility of their clients in these early therapy interviews. Their behavior toward hostility contrasts greatly with their reactions to dependency expression. This fact of a uniform low level of approach to hostility makes it difficult to relate approach to hostility to variables other than the stage of therapy in which it occurs and possibly explains the failure here to replicate Bandura's finding. He was studying time segments of therapy in which the structure of the situation perhaps permits more choice (conscious or unconscious) by the therapist and thereby could demonstrate a relationship which would not be seen, given the limits of the present sample.

The possibility exists that there is also a difference in the sample of therapists which might be related to the difference in the findings of this study's and of Bandura's. It is unlikely that the focus of the training which the two groups of therapists have received would have been the same. Speculation as to just how their training was different is difficult, partly because Bandura's study of therapist behavior was limited to hostility and

contrasts of the two populations on dependency and sexuality thus cannot be made. With regard to hostility, however, the present sample of student therapists seemingly does not tend to avoid hostility expression when they are the objects of it any more than they do when they are not its objects. This may be a result of their training or it may not be.

No relationship was found either in the data of the present study to support Bandura's finding that therapists' approach reactions to hostility were related to their ratings on the approval seeking scale. In testing the hypotheses of this study, the approval seeking scale was first regarded here as a dependency scale. No relationship was found, however, between approval seeking and any of the ratios related to dependency behavior, although relationships were found for other dependency scales. That approval seeking behavior might bear some relationship to hostility and ways of expressing it as well as or even instead of relating to dependency behavior was a possible explanation for the lack of relationship. This is implied, although not fully confirmed by the data. The theoretical basis for such an assumption lies in the possibility that overanxiety to please someone may be rooted in fear of that person and that extreme fear of someone's disapproval may represent a projection of one's own hostile feelings toward that person.

The raters, it must be remembered, stand in positions of authority in relation to the student therapists. Eagerness to please them may well be less threatening than other forms of hostility which would be more manifest and therefore more likely to invite retaliation. The person who seeks to please has learned that this behavior has an incapacitating effect upon the other; it prevents him from perceiving the hostility clearly and reacting in terms of this. The association of approval seeking with hostility may be illustrated, in its most extreme forms, in the classic sycophant and flatterer and modern-day "yes men."

Hypotheses 2 and 6 were partially confirmed. Both the help seeking and dependency inhibition scales were significantly related to the likelihood of the therapist's approaching dependency expression by the client for the total approach to dependency. Dependency inhibition was also significantly related to therapist approach to dependency when he was not the object. It was also shown by the data that the therapists were more likely to approach dependency when they were its object. This has been touched upon above as being part of the therapists' attempts to induce commitment to therapy in their clients. However, if all the therapists or most of them approach dependency expressed by

their clients when they are the objects, there is little variance left which can be related to their personality structures. On the other hand, it is not clear what contributions to therapy is made by approaching dependency when the therapist is not the object. Those therapists who are more at ease with their own dependency needs will seemingly, in addition to responding with approach to dependency when directed toward them, be more likely to respond also to other-directed dependency expression by their clients.

There is some suggestion too that clients are likely to continue to express dependency when the therapist is more at ease with his own needs in this area. The tendency did not appear in the continuance ratios for either therapist approach or avoidance separately but appeared with the total continuance ratio. Seemingly, then, the clients did not perceive greater freedom or permission to talk about dependency in the specific immediate approach or avoidance verbal reactions of the therapists. Perhaps then, non-verbal behavior by the therapist, such as might be apparent say in a physical attitude suggesting ease, might be suggested as contributing to this result.

Hypothesis 4 was not confirmed by the data. No relationship was found between any of the affectivity scales

and the therapists' approach ratios for dependency.

Hypothesis 3 was partially confirmed by the data. No linear relationship was found between either of the sex scales and the therapists' approach ratios for sex. There were suggestions, however, of the possibility of a nonlinear relationship between the therapist's sex anxiety and his willingness to approach sexual expression in the client. The difficulty may, however, lie in the scales. If high ratings are indicative of sexual inhibition, low ratings may not necessarily indicate ease regarding sexuality. The way the points on the scales are determined, low ratings describe persons who have a high overt and socially apparent interest in sexual matters. Perhaps this is not ease with sexuality but is another kind of manifestation of anxiety about it.

Hypothesis 7, also related to sex, was not only not confirmed by the data of this study but a significant relationship in the opposite direction from that predicted was found. Clients seem likely to continue to express sexual content after it is approached by the therapists when the therapists are rated as having greater sexual inhibition. This is a strange finding. Perhaps it means that a client will try to be helpful when he perceives that the therapist is

struggling, i.e., when he attempts to approach their expression of sexuality although he is feeling uncomfortable about doing this and somehow manages to communicate this along with his overt verbal approach response. The clients here were college students, for many of whom sexuality presented some sort of problem. Perhaps they were either made anxious or angry if they perceived the therapist as highly interested in sexual material. Perhaps to them this implied the existence of pathology in the therapist. Whether fearful of the therapist or angry at the intrusiveness of his interest in sex material (remember, the interviews studied were all quite early in therapy), in either case, this perception would have been likely to cause them not to continue in the same vein as before.

The continuance ratio for the expression by the client of sexual material following approach by the therapist shows some interesting relationships to the affectivity scales, although no hypotheses about such relationships were stated. It is negatively related to all three, significantly so with the empathic expression scale. That is, the more cognitive the therapist, the less expressive of his own feelings and the less empathic he is, the more likely the client is to respond with more sex material after the

therapist has approached sexuality. The first two of these relationships go along with the findings for the sex scales. If the therapist's attitude is more cognitive, he is less emotionally involved with the sexual content expressed by his clients and may seem to the client to be less interested in the material although he has attempted overtly at least to encourage its further expression. For the moment, let us consider the verbalization of feelings scale as it may be related to whether the therapist expresses himself affectively about sexuality. If the therapist does not verbalize his feelings about sexuality or express his own sexuality in the presence of his client, the client will not react with the anxiety or hostility postulated above.

The negative relationship of the approach continuance ratio to the empathic expression scale allows for some interesting speculations. The customary expectation would be that understanding and empathy on the part of the therapist would serve to encourage expression of material in an area which is likely to be problematical for many clients. The reversal here may again be due to the fact that this study used early interviews only. The manner of approach by the more empathic therapists might be somewhat different from the approach behavior of the others (this could not be

tested here because the subcategories of approach were not scored separately). It might be that the more empathic therapists are inclined to perceive and respond to the material on a different level than the clients are willing or able to deal with in the initial stages of therapy and they react to this by changing the topic.

Another interesting finding peripheral to the hypotheses was that there are differences in the ways male therapists act with male and female clients. This was found for both the therapist approach ratios for dependency and for hostility. In both cases, the therapist tended to approach these areas more with his male clients than with females. It is possible that what is happening is that therapists are more likely to approach in those areas in which they perceive the clients to have problems. Female clients are probably less likely to have problems with dependency which would be apparent in their early interactions with male therapists than male clients would in this area. This would probably be true also for hostility. Male college students as a group would seem to be very much involved in problems arising out of their feelings about dependency and also about impulse control. This possibility of a difference in therapist behavior based upon differences

in the problem areas of male and female clients would seem to be borne out by the fact that there was no difference in the extent to which therapists approached sexual material for males and females. It could safely be assumed that this area is problematic for both male and female college students, at least among those who have come to seek help through counseling.

Conclusions

The general question which preceded the specific hypotheses which were studied here was whether the therapist's behavior toward his clients possessed some generality which expressed something about him as well as something about his clients. Insofar as the data reveal, the answer is a qualified "yes." His own feelings about dependency influence his reactions to dependency when this is expressed by his clients. How he feels about his own sexuality affects his responsiveness to sexual expression by his clients. His affectivity and his feelings about hostility seemingly do not relate to his behavior. Bandura's finding about hostility and the failure to replicate this here suggests the possibility that those anxieties and other aspects of the therapist's personality which influence what he does may change at

different points in the process of therapy. What would be needed to learn if this were so would be studies which analyzed the behavior of therapists over the entire course of psychotherapy.

The only way the therapist's behavior was related here to variables associated with the client was for the sex of the client. This was found to have some influence upon the behavior of the therapist, but it may not have been sex per se. The data suggest that the problem areas presented by the clients might influence the therapist's behavior. This is worth investigating further. It is in accord with the theoretical formulations, such as that of the Balints (1939) and many others, which speak of the individuation of therapy in terms of the needs of the client or patient.

Now, as to whether the therapist's behavior and personality has an impact upon the behavior of the client. Here, the answer as suggested by the data of this study is most clearly positive. First, there are the differences between how the client acts in response to approach versus avoidance for all three content areas studied. These results replicated those of Bandura et al. (1960) and Winder et al. (1962) and supported the conditioning paradigm suggested by them. In addition, the anxiety of the therapist

with regard to dependency and his affectivity and sexual anxiety were found to be related to the client's reactions to him.

The data here seem to suggest yet another contributing factor besides the therapist's reactions to his clients being based in the stimulus value that the clients present to him and in his own psychodynamic structure. It seems that the fulfillment of certain goals, such as keeping a client in therapy, means that certain behaviors are required of the therapist, i.e., he "ought" to approach dependency especially if he is its object and to avoid hostility initially. It is probably appropriate for him to respond to those areas which he perceives as being problems for his clients. There is evidence that the therapists in this study did some of these things. This serves to mask or obscure the influence of the therapist's personality upon his behavior.

At any one time, therapists may be presented by their clients with a choice of two, three or more possibilities from which they then usually choose one or two to which to react. It is likely (and this could be tested) that less experienced therapists would be more likely to react in terms of their own anxieties and personality idiosyncracies,

partly at least because they have not yet learned about other alternatives. The more experienced the therapist, the smaller would the variance be which could be related to his personality.

If this is not so and it is not possible for therapists to choose to behave in certain ways and, to some extent at least, to be able to learn to choose to behave in certain ways, there would seem to be little point in providing neophyte psychotherapists with any training or guidance from their more experienced elders and expecting them to benefit from it.

The data of this study strongly suggest a good deal about what the therapists studied here know about psychotherapy and also something about what they do not know. They know, it seems, how to begin therapy, i.e., approach dependency and avoid hostility. This has been mentioned above. The fact that their behavioral reactions to their clients' sexual expressions do not have the desired effects (if we assume continuance by the client of expression in an area to be desirable), suggests that they may be less certain about how and when to deal with expression in this area than in the other content areas studied.

Note must be made at this point that the therapy

tapes used were subject to the self-selection of the therapist. He chose which interviews to tape, which tapes to give the investigators, etc. The probable result of this is that the available tapes were ones that the therapists were somewhat pleased about, tapes perhaps in which he did approach dependency and avoid hostility rather than ones in which he did not do what seemed to be required of him. The influence of this selection upon the meaning of the results found is interesting. If this study does not actually represent what these therapists at this level of experience actually did most of the time, it probably represents what they can do and do do--sometimes, the best they are capable of at this point in their experience. This fact would not change the implications suggested about what the therapist knows or does not know.

This study has contributed in its small measure to increasing attempts to illuminate theprocess of therapy. It has served to suggest several directions which further research into the therapeutic interaction might take.

Information on how the behavior of the therapist (and also of the client) changes over theprocess of therapy would be valuable in itself as well as in relationship to client and therapist personality variables.

It has also been suggested that the relationship between the experience level of the therapist and the influence of his personality upon his behavior might bear investigating further.

How the problem areas presented by the client influence how the therapist behaves and whether he indeed reacts individualistically to each client would have significant theoretical implications.

A part of the present study dealt with client perceptions of his therapist's personality. That he perceived the therapist in the same manner as did the senior staff members who rated him is unlikely. This inference was, however, made in this study. The hypotheses about the client's continuance behavior might better be tested with more direct means of ascertaining the client's perceptions of his therapist.

The present study may provide some comfort for supervisors of therapists in that it implies that to some extent at least therapists can be taught to modify their behavior. Its only direct relevance for the training of therapists, however, lies in the fact that any increased knowledge of the psychotherapy process contributes to everybody's comfort in dealing with the complicated intriguing unknown and often anxiety provoking psychotherapy situation.

VI. SUMMARY

The attempt was made to study whether the therapist's behavior and his personality as they are observed outside of the therapy situation could predict his reactions in therapy to his presentation by the client of certain specific content areas, those dealing with dependency, hostility and sex. Whether the therapist behavior and personality as this is perceived by the client has an impact upon the client's subsequent behavior was also studied.

The hypotheses tested were that the greater therapist anxieties were in the areas of dependency, hostility and sexuality, the less likely they were to approach expression in these areas by the clients. A relationship between greater affectivity in the therapist and increasing likelihood of his approaching dependency expressed by the client was also postulated. It was also hypothesized that greater therapist anxieties about the three content areas studied would cause clients to be less likely to continue to express content dealing with these areas.

Seventeen advanced graduate students who worked in the Counseling Center at Michigan State University were the

therapists studied. They were rated on eleven five-point scales by three senior staff members who knew them well.

The content of therapy interviews early in the therapeutic series conducted by these therapists, a total of thirty-eight interviews, was studied and analyzed according to a system adapted slightly from that used by Bandura et al. (1960) and Winder et al. (1962).

The hypotheses relating the therapist's dependency anxiety to his behavior and to the behavior of his clients were partially confirmed. The therapist's rating on the dependency inhibition scale was related both to his behavior in relationship to his clients' expressions of dependency, especially when he was not its object, and to his clients' reaction to his behavior.

A nonlinear relationship between sexual anxiety and therapist approach to sex was suggested. This was discussed in terms of the probability that extreme overt interest in sex might represent another kind of anxiety about sex than extreme inhibitions of overt sexual interest and not represent sexual ease at all.

The hypotheses concerning hostility and the affectivity level of the therapist were not confirmed. The relationship between the therapist's approach to sexuality

expressed by his clients and his ratings on the scales dealing with his sexual expression proved to be significant in the opposite direction from that predicted. The clients were more likely to continue to express sexual material after the therapist approached sex if he was rated as being less overtly interested in sexual matters. This finding was discussed in terms of the meaning it might have for clients to perceive their therapists as being interested in sex when this was expressed early in the therapeutic series.

Support was reported for the differential effects upon the client of the therapist's approaching and avoiding hostility and dependency content expressed by the client, as found by Bandura et al. (1960), and Winder et al. (1962). A similar result was also found for the difference in the client's continuation of expression of sexual material after approach and avoidance by the therapist.

Differences in therapist behavior toward males and toward females was found for the areas of dependency and hostility, but not for sexual material. This was discussed in terms of its possible relevance for the areas which were probably most problematic for males and females in the population studied.

Differences were also found between therapist behavior

in first and second interviews and fifth interviews in the extent to which they approached dependency. This was discussed in terms of its implications for changes in therapist behavior being related to different requirements of different phases of therapy.

Implications were stated as to the possible relationship of the therapist's experience and training in therapy to his behavior and the possible action of this variable in masking or obscuring the relationship of his behavior to personality variables.

Some implications of the present study for further research were also discussed.

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APPENDIX A

CODING MANUAL FOR TAPE RECORDINGS

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General Scoring Instructions

1. The Scoring Unit

A unit consists of three parts: the client's remarks, the therapist's total subsequent response, and the next statement of the client (this last not only completes the first interaction unit but also initiates the next).

C: I cannot understand how you can stand me now when I smoke.

T: You seem to be very aware of my feelings.
C: I am always sensitive toward your feelings.

2. Interruptions

Statements of either the client or therapist which are interrupted by the other will be coded as one response if the continuity is not altered by the interruption. "Um hmm," etc. responses of the therapist even when closely followed by topic changes by the client are not to be considered as breaking the continuity.

one response

C: I asked him to help me out and . . .
T: Why did you ask for help?
C: . . . he refused to do anything about it.

two responses

C: I don't understand why he does not help me . . .
T: Did you ever ask him to help you?
C: Yes I did, but it did not work on him.

3. Scoring the Client's Initial Statement and Response

All client statements are scored both for the need or behavior systems which are being expressed (as defined below) and for the objects (persons) toward whom the client is oriented in his statement. The scorable objects are therapist and other. For therapist to be scored object, the reference has to be to him as a person rather than as a representative of the Counseling Center.

Sometimes the client will finish a sentence for the therapist. In those cases, the whole idea is scored as a client statement:

T: . . . understanding it now . . .
C: will make a change.

4. Scoring the Therapist's Response

For every therapist statement scored as approach or avoidance (see below), the client need systems relevant to the therapist statement are to be noted. A therapist response may be a generalized approach:

T: Tell me more about your difficulties.

or be specific to a given need system. If the therapist

explicitly approaches one client need system, he implicitly avoids any other applicable needs and this is to be scored wherever relevant. Approach - Misc. is scored when the therapist approaches a need not here categorized.

"Um hmmm" statements by the therapist are to be ignored completely in scoring unless they are followed by further verbalizations or if their meaning is clearly "yes" or "no" in response to a question by the client.

Scoring of Client Statements

1. Hostility categories

a. Hostility

Includes description of and expression of unfavorable, critical, sarcastic, depreciatory remarks, opposition, antagonism, argument, expression of dislike, resistance, irritation, annoyance, anger, expression of aggression and punitive behavior; may be scored when the voice quality of the client is indicative of irritation or anger, apart from the nature of the content of his statement; includes the following kinds of hostile statements:

Anger - indications that the client is angry.

C: I am just plain mad!
C: I couldn't think - I was so angry.

Dislike - expressions of dislike or description of actions which usually indicate dislike

C: I just don't get interested in them. I would always rather be somewhere else.
C: I've never ever felt that I liked them. I expect I never will.

Resentment - expression or description of persistent negative attitude which does or might change to anger on specific occasions.

C: They are always so smug. Boy!
C: They don't do a thing for me so why should I ever ask them over.

Antagonism: - expression or description of antipathy or enmity.

C: We always seem to be at odds, somehow.
C: There is always this feeling of being enemies.

Opposition - expression or description of oppositional feelings or behavior.

C: If he wants to do one thing, I want to do the other. It's lousy!
C: It always seems that she's against things, even the things she wants.

Critical Attitudes - expression of negative evaluations or description of actions which usually imply negative evaluations.

C: If I don't think the actors are doing very well, I just get up and walk out.
C: There is something to be critical about in almost everything anyone says or does.

Aggressive Actions - actions designed to hurt another person or persons, either physically or psychologically.

C: He deserves to suffer and I'm making it that way every way I can.

b. Hostility Anxiety

Includes expression of fear, anxiety or guilt about hostility and statements reflecting difficulty in expressing hostility.

C: I just felt so sad about our argument.
C: I was afraid to hit her.
C: After I hit him, I felt sick.

2. Dependency categories

a. Dependency

Includes description of and expression of behavior seeking help, seeking approval, demanding initiation of behavior by someone else, demanding company, seeking information, describing support, as well as that asserting agreement with others' (including the therapist's) statements; includes the following kinds of dependent statements:

Help-seeking - requests for help or description of help-seeking behavior

C: I asked him to help me out when that came up.
C: I try to do it when he can see that it's too hard for me.

Approval-seeking - requests for approval or acceptance or reports and descriptions of approval-seeking behavior.

C: I hope you will tell me if that is what you want.
C: When I had any homework, I'd do it so dad would know I was studying like a good girl.

Company-seeking - expressions of a wish to be with others or descriptions of efforts to be with others.

C: I just want us to spend a whole day together.
C: I only joined so that I'd be in a group - with other people.

Information-seeking - requests for information, expressions of a desire for information from others or descriptions of arrangements to be the recipient of information primarily because of the relationships involved.

C: Please explain something to me - anything! Just tell me something.

Agreement with another - expression of or description of very ready agreement.

C: Oh yes! You are absolutely correct about that. (In response to tentative interpretation by therapist).
C: Immediately I felt that he was right and I'd never thought about it that way before.

Seeking Initiative from the Therapist - requests of the therapist that he start the discussion, select the topic or take responsibility upon himself.

C: Why don't you say what we should talk about now?
C: Whenever I start, I think you should tell me what to talk about.

b. Dependency Anxiety

Includes expression of fear, anxiety and guilt about dependency, including expression of fear of or unusual

sensitivity about disapproval or description of unusual distress about an instance of disapproval and statements reflecting difficulty in expressing dependency.

C: I just felt so bad after that (asking a friend for help).
C: I just could not ask him to help me out with my studies.
C: It seems like I always expect not to be liked.

3. Sex categories

a. Sex

Includes description of and expression of behavior concerned with seductiveness and its frustration and behavior of a general sexual nature; includes all statements referring to a positive or approach component of the sexual drive; direct expression of sexual needs and wishes, description of sexual attraction and arousal, sexual activity not mixed with fear or guilt, planning for sexual satisfaction, courtship and dating among unmarried people where the erotic element is present but institutionalized, description of homosexual feelings and other perversions, descriptions of masturbation, discussion of normal sex education.

C: My boyfriend and I kiss and pet very freely.
C: I talked over my affair with my father.
C: He wanted to have sexual relations with me.
C: I have dreams about having intercourse with a faceless woman.
C: I like to watch stripteasers.
C: I value sex highly.

b. Sex Anxiety

Includes fear, anxiety and guilt about sex and statements reflecting difficulty in expressing sexual feeling; nervousness, irrational fears, phobias, compulsions, depression, hopelessness, confusion, helplessness, conflict, tension, blocking, avoidance behavior, denial of a sex drive, negative attitude toward sex, rationalizing one's behavior, depreciating self; feelings of inadequacy, somatic symptoms, impotence, frigidity.

C: I feel so guilty about going out with her.
C: I am always so afraid to even kiss her.
C: I'm frightened by my sexual feelings toward you.
C: I was afraid someone would discover us.
C: My breasts didn't grow until after all my girl friends had fully developed.

4. Other Client Responses

a. Silence

Includes client silences of more than 9 seconds following a remark by the therapist.

b. Misc.

Includes statements which do not belong to any of the above mentioned categories.

c. Generalized Anxiety

Includes all psychological and somatic expressions of anxiety which are not related to a drive nor related to

any specific person or object; general "free floating" anxiety and guilt.

d. Inaudible

Includes client statements that cannot be heard clearly enough to be categorized with regard to content.

3. Irrelevant

Includes all general opening and closing remarks, discussion of technical details as "Tuesday at 10" and other irrelevant remarks; may be scored once for several interactions at the beginning or end of the session where it is most likely to be scored.

Scoring of Therapist Statements

1. Approach categories

Includes any statements by the therapist which seem to be designed to elicit further expression of feelings, attitudes and behavior from the client; includes the following categories of responses:

Approval - the therapist's explicit approval of or agreement with the client's attitudes, feelings or behavior.

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

Reflection - the therapist's repetition and/or restatement of the client's expressed feelings, attitudes and behavior.

C: I just want us to spend a whole day together.
T: Today, you feel, is the day for us to be together.

C: I don't like that at all.
T: Your reaction is definite dislike.

Support - the therapist expresses sympathy with or understanding of the client's feelings

C: I have covered about everything.
T: I think I know what you mean.

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

Exploration - therapist remarks and questions that encourage the client to describe or express his feelings, attitudes or actions further, statements that ask for further clarification, elaboration, and descriptive information and which call for details and examples.

C: You ask me how I feel? I feel . . . idiotic.
T: Idiotic? Why?

C: Mostly, I cannot understand my behavior.
T: What is it about your behavior that you cannot understand?

Instigation - therapist shifts of discussion to a need topic or reintroduction of need topic expressed earlier in the interview or in a previous interview.

Interpretation - pointing out of patterns or relationships in the client's feelings, attitudes and behavior; explaining the antecedents of feelings, attitudes and behavior; pointing out of the similarity of the client's reactions in diverse situations or at separate times.

Factual Information

Generalization - therapist points out to the client that his feelings, attitudes and behavior are common and natural.

2. Avoidance categories

Includes statements which seem designed to inhibit, discourage, or divert further expressions of feelings, attitudes and actions; includes the following kinds of responses:

Disapproval - critical, sarcastic or antagonistic statements by the therapist to the client, expression of rejection of the client in some way

C: Why don't you make statements? Make a statement; don't ask another question.
T: I'm not making any statements.

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

Topical Transition - changing of the subject by the therapist

C: My father was a nice guy to other people, but he never seemed interested in me.
T: And what about your mother?

Ignoring - response to part of a client statement but ignoring the expressed affect

C: You've been through this with other people so help me out; go ahead and help me out.
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 think is important about that

Mislabeling - incorrect naming of the client's feelings by the therapist.

3. Other

a. Silence

No response by the therapist for 6 or more seconds after the client stops talking.

b. Retraction

When the therapist takes back his interpretation after the client's negative or positive response to it.

c. Misc.

Statements by the therapist which do not fall into any of the other categories.

d. Inaudible

Statements by the therapist which are not heard clearly enough to be categorized.

e. Irrelevant

see client category

APPENDIX B

MATERIALS FOR THE RATING OF THE THERAPISTS' PERSONALITY

APPENDIX B

MATERIALS FOR THE RATING OF THE THERAPISTS' PERSONALITY

Task One

I am asking you to rate each of seventeen people on nine 5-point scales. All of these people are now or have recently been internes at the Counseling Center. The persons to be rated are:

(LISTING OF NAMES OF SEVENTEEN THERAPISTS)

Please use this group of people as your reference group. Do not hesitate to give someone a rating of 1 or 5 because it is possible to think of someone outside the group who is more extreme on a given variable in comparison to the others, he is to be rated as extreme.

The rating sheet for each person includes space in which to indicate whether rating a person was especially difficult due to lack of knowledge of that person or for other reasons. Please rate each person on each trait regardless of the difficulty involved for an individual case.

Thank you for your cooperation.

RATING SCALES

Scale I: Direct Hostility

This scale is concerned with the degree to which the subject expresses hostility openly and directly.

1. Practically never openly hostile, critical, argumentative, derogatory.

2. Will occasionally express open hostility, argue, criticize, derogate.

3. Moderately hostile, critical, argumentative, derogatory.

4. Frequently openly hostile, critical, argumentative, derogatory.

5. Very frequently openly hostile, critical, argumentative, derogatory.

Scale II: Help-Seeking

This scale measures the extent to which the subject seeks and asks for help, advice, suggestions, direction.

1. Practically never asks for help, advice, suggestions, or direction.

2. Occasionally asks for help, advice, suggestions, direction.

3. Moderately often asks for help, advice, suggestions, direction.

4. Frequently asks for help, advice, suggestions, direction.

5. Constantly asks for help, advice, suggestions, direction.

Scale III: Indirect Hostility

This scale deals with the extent to which the subject expresses hostility indirectly in such forms as passive resistance, ignoring of explicit assignments or responsibilities, indirect criticism.

1. Practically never passively resistant, ignores explicit responsibilities, or indirectly critical and oppositional.

2. Occasionally passively resistant, ignores explicit responsibilities, indirectly critical and oppositional.

3. Moderately passively resistant, ignores explicit responsibilities, indirectly critical and oppositional.

4. Frequently passively resistant, ignores explicit responsibilities, indirectly critical and oppositional.

5. Very frequently passively resistant, ignores explicit responsibilities, indirectly critical and oppositional.

Scale IV: Cognitive-Affective Level

This scale is concerned with the degree to which the subject habitually responds to other people and talks about himself in an affective manner.

1. Practically never expresses sympathy or understanding of the feelings of others. Very frequently responds to the content of what is said rather than the feelings of the person speaking. Practically never talks about his own feelings.

2. Occasionally expresses sympathy or understanding of the feelings of others. Frequently responds to the content spoken rather than the feelings of the person speaking. Occasionally talks about his own feelings.

3. Expresses sympathy or understanding of the feelings of others. Only occasionally responds to the content spoken rather than the feelings of the person speaking. Often, his talk about himself concerns his feelings.

4. Frequently expresses sympathy or understanding of the feelings of others. Often responds to the feelings of the person speaking to him rather than to the content of what is said. Frequently, his talk about himself concerns his feelings.

5. Very frequently expresses sympathy or understanding of the feelings of others. Usually responds to the feelings of the person speaking to him rather than to the content of what is said. Very frequently, his talk about himself concerns his feelings.

Scale V: Hostility Inhibition

This scale deals with the readiness with which the subject gets irritated, annoyed, angered when frustrated, provoked or thwarted, e.g., when delayed, inconvenienced, criticized, opposed, etc.

1. Very difficult to arouse to anger or irritate. Practically never expresses irritation, annoyance or anger when strongly frustrated, provoked, or thwarted.

2. Difficult to arouse to anger or irritate. Expresses irritation, annoyance, anger only when strongly frustrated, provoked, or thwarted.

3. Expresses irritation, annoyance, anger when moderately frustrated, provoked, or thwarted.

4. Easily irritated and angered. Expresses irritation, annoyance, anger even when mildly frustrated, provoked, or thwarted.

5. Very easily irritated and angered. Expresses irritation, annoyance, anger at the slightest frustration.

Scale VI: Approval-Seeking

This scale is concerned with the extent to which the subject seeks approval, acceptance, and the expression of favorable opinion and liking of him.

1. Practically never seeks approval, acceptance. Makes no effort to please others. Unconcerned with what others think of him.

2. Occasionally seeks approval and acceptance. Makes occasional efforts to please others. For the most part unconcerned what others think of him.

3. Moderately eager for approval and acceptance. Tries to please others. Generally wants to be liked.

4. Frequently seeks approval and acceptance. Tries hard to pleas others, strongly desires to be liked.

5. Very frequently seeks approval and acceptance. Tries very hard to please others, very strongly desires to be liked.

Scale VII: Dependency Inhibition

This scale deals with the subject's readiness to ask for help, assistance, advice, suggestions on how things should be done, what decisions should be made, etc.

1. Finds it very difficult to ask for help and assistance. Practically never seeks help or assistance even when faced with obvious difficulties with a problem that he is unable to handle on his own. Resists help when offered.

2. Finds it difficult to ask for help and assistance. Does not ask for help except when in obvious difficulties. Will accept help only if he has to, wants to carry on by himself as soon as possible.

3. Seeks help and assistance when the problems and decisions are difficult for him. Usually tries to do it on his own first. Accepts offered help without resistance, readily carries on by himself when he is able to do so.

4. Seeks and accepts help readily. Seeks help and assistance as soon as he encounters a difficulty even when he could handle it on his own.

5. Seeks and accepts help readily. Seeks help and assistance when he encounters the slightest difficulty even when he is clearly able to do it on his own. Will often let others do things for him.

Scale VIII: Ease with Sexual Topics

This scale is concerned with the ease with which the subject discusses sexual matters.

1. Very open and matter-of-fact attitude. Talks about sexual matters very readily without any uneasiness.

2. Open and matter-of-fact attitude. Discusses sexual matters readily with only occasional uneasiness or hesitancy.

3. Moderately uneasy and hesitant in talking about sexual matters.

4. Finds it very difficult to talk about sexual matters.

5. Finds it extremely difficult to talk about sexual matters.

Scale IX: Demonstration of Sexual Interests

This scale is concerned with the extent to which the subject expresses personal sexual interests.

1. Very often shows sexual interests. Admits to having sexual needs. Is an active participant when sexual joking is going on in a group.

2. Often shows sexual interests. Somewhat reticent about admitting sexual needs. Participates in group sexual joking.

3. Only occasionally shows sexual interests. Occasionally participates in sexual joking sessions.

4. Inhibited sexually. Practically never shows any sexual interests.

5. Very inhibited sexually. Never shows any sexual interests.

Task Two

You have previously rated 17 internes on each of 9 personality scales. Now I would like you to indicate something about how difficult this task was, how well you feel you know each of the persons you rated and the kinds of situations through which you acquired your knowledge of them.

1. You obviously have different degrees of familiarity with the different persons you rated. Below their names are listed. Please rank the people in terms of your familiarity with them, a rank of 1 being given to the person of the group with whose personality and behavior you feel you are most familiar and a rank of 17 being given to the person whom you feel you know least well.

(LIST OF SEVENTEEN PEOPLE)

Where does the gap occur? That is, from which rank number down do you consider your degree of familiarity with the person really inadequate for the task of rating which you did?

2. How did you come to know each of these people? Check all the situations which you feel have contributed to your knowledge of each of these persons. Add others which you think were important also.

Subjects	therapy with you	individual supervision	conferences or groups	social contact on job	social contact apart from job
A					
B					
C					
D					
E					
F					
G					
H					

I

J

K

L

M

N

O

P

Q

ADDITIONAL: List the persons' names and the situations other than those listed above if they apply.

3. Some of the scales must have been more difficult to use than others. Please rank the scales with regard to the difficulty that was involved in rating. Rank 1 should be used for the scale that was the easiest for you to use and rank 9 for the one that was the most difficult.

Direct Hostility

Help - Seeking

Indirect Hostility

Cognitive - Affective Level

Hostility Inhibition

Approval - Seeking

Dependency Inhibition

Ease with Sexual Topics

Demonstration of Sexual Interests

4. Anything else you wish to say about the rating task?

Task Three -- Second Rating by the Judges

On the personality ratings that you previously did for me, sufficient agreement among judges was reached on all but three scales. These were: cognitive-affective level, help seeking and dependency inhibition. Upon further study, it was felt that agreement on the cognitive-affective dimension could be improved if this single scale were broken down into three separate scales, each measuring a different aspect of what it is I am trying to get at. In addition, it was felt that further instructions about what is involved in the help seeking and dependency inhibition scales might be helpful. This is included below and you are being asked to re-rate the people you rated on these dimensions, after studying the distinctions involved in the scales.

The Cognitive-Affective Level scale has been subdivided into a Cognitive-Affective Level scale, a scale measuring Inhibition of Feel Expression and a scale measuring Empathic Behavior. Each of these is a five - point scale as the others have been.

Cognitive-Affective Level

This scale is concerned with the degree to which the subject habitually responds to other people in an affective manner.

1. Very frequently responds to the content of what is said rather than the feelings of the person speaking.

2. Frequently responds to the content spoken rather than the feelings of the person speaking.

3. Only occasionally responds to the content spoken rather than the feelings of the person speaking.

4. Often responds to the feelings of the person speaking to him rather than to the content of what is said.

5. Usually responds to the feelings of the person speaking to him rather than to the content of what is said.

Inhibition of Feeling Expression

This scale is concerned with the degree to which the subject, when he is talking about himself, does so in an affective manner.

1. Practically never talks about his own feelings.

2. Occasionally talks about his feelings.

3. Often, his talk about himself concerns his feelings.

4. Frequently, his talk about himself concerns his feelings.

5. Very frequently, his talk about himself concerns his feelings.

Empathic Expression

This scale is concerned with the manner in which a subject habitually responds to other people.

1. Practically never expresses empathy or understanding of the feelings of others.

2. Occasionally expresses empathy or understanding of the feelings of others.

3. Expresses empathy or understanding of the feelings of others moderately often.

4. Frequently expresses empathy or understanding of the feelings of others.

5. Very frequently expresses empathy or understanding of the feelings of others.

The two other scales which seemed problematical were Help Seeking and Dependency Inhibition. As they are described, the two are readily confusable. Perhaps the most valid distinction between the two is in terms of the degree of inference which is to be involved in making the ratings of these scales. Help Seeking deals with overt observable behavior. Rating Dependency Inhibition involves some inferences from behavior on the part of the person doing the rating. These inferences have to do with the person's ease in asking for help, his resistance to offered help and the relation to help seeking and help accepting behavior of his perception of the difficulties involved in given tasks. If these comments do not help to clarify the distinctions between the two scales, perhaps we can talk about some of the difficulties involved in making these ratings <u>after</u> you have completed the re-rating task.

<u>Help-Seeking</u>

This scale measures the extent to which the subject <u>overtly</u> seeks and asks for help, advice, suggestions, direction.

1. Practically never asks for help, advice, suggestions, or direction.

2. Occasionally asks for help, advice, suggestions, direction.

3. Moderately often asks for help, advice, suggestions, direction.

4. Frequently asks for help, advice, suggestions, direction.

5. Constantly asks for help, advice, suggestions, direction.

<u>Dependency Inhibition</u>

This scale deals with the subject's readiness to ask for and to accept help, assistance, advice, suggestions on how things should be done, what decisions should be made, etc.

1. Finds it very difficult to ask for help and assistance. Practically never seeks help or assistance even when

faced with obvious difficulties with a problem that he is unable to handle on his own. Resists help when offered.

2. Finds it difficult to ask for help and assistance. Does not ask for help except when in obvious difficulties. Will accept help only if he has to, wants to carry on by himself as soon as possible.

3. Seeks help and assistance when the problems and decisions are difficult for him. Usually tries to do it on his own first. Accepts offered help without resistance, readily carries on by himself when he is able to do so.

4. Seeks and accepts help readily. Seeks help and assistance as soon as he encounters a difficulty even when he could handle it on his own.

5. Seeks and accepts help readily. Seeks help and assistance when he encounters the slightest difficulty even when he is clearly able to do it on his own. Will often let others do things for him.

NOTE

As before, please use the group of people that you are rating as your reference group. Do not hesitate to give someone a rating of 1 or 5 because it is possible to think of someone outside the group who is more extreme with regard to the characteristic in question. If the person is extreme on a given variable in comparison to the others, he is to be rated as extreme.