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INITIAL ATTRACTION OF THE CLIENT TO PSYCHOTHERAPY, DIRECTIVENESS AND OUTCOME: AN EXPLORATORY STUDY

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ABSTRACT

INITIAL ATTRACTION OF THE CLIENT TO PSYCHOTHERAPY, DIRECTIVENESS AND OUTCOME: AN EXPLORATORY STUDY

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The purpose of this study was to examine the interactions of certain client and therapist variables, and their relationship to improvement in psychotherapy. More specifically, an attempt was made to study the interactions of the initial levels of client attraction and distress with therapist directiveness, and to relate these to improvement in psychotherapy.

Four hypotheses were presented which proposed that outcome is differentially affected by variations in the above mentioned variables. However, unexpected sampling difficulties, in terms of the availability of an adequate number of client protocols, necessitated the modification of the hypotheses. For this reason, this study should be considered exploratory rather than definitive in nature.

The subjects in this study were college students who had sought psychotherapy at the Michigan State University Counseling Center. They voluntarily agreed to participate in its research activities.

Attraction to psychotherapy was determined by use of Libo's (1966) Picture Impressions Test, a projective measure. Client distress was determined by two measures, Barron's Ego Strength Scale and a symptomatology index. The latter consisted of a combination of standard scores from Welsh's Anxiety Scale along with standard scores for the sum of each client's total MMPI scale scores of 70 or higher. Therapist directiveness was measured by Aronson's (1951) directiveness scale. Outcome was determined through pre-post therapy comparisons of distress scores.

Significant main effects for client distress were found. The initially distressed group showed a significant drop in anxiety after therapy, while the initially nondistressed clients demonstrated a significant increase. However, the possibility that even this finding occurred by chance can not be ignored in view of the number of statistical analyses performed. Methodological issues are discussed.

No significant interactions were uncovered, through an analysis of variance, for the variables of attraction, distress, and directiveness.

Overall, these findings underscore the complexity of research on the psychotherapeutic process. Nevertheless, the author is convinced that

meaningful information may be obtained by examining the effects of initial distress and attraction. Related research begun subsequent to the initiation of this study (Schaffer, 1974) corroborates this notion. Suggestions for further research directions are discussed.

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By

Lesley Dargin

A DISSERTATION

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DEDICATION

To my parents, Louis Wesley and Leomi Dargin

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CHAPTER I

INTRODUCTION

Increasing emphasis has been placed upon the relationship of client pre-therapy non-intrapsychic status to improvement in psychotherapy. Social psychological research has played a valuable supplementary role in attempts to delineate these pre-therapy variables. Extensions from this research have focused on interactional factors within the client-therapist dyad. Intriguing questions may, therefore, arise as one attempts to apply theories of dissonance reduction; communication effectiveness; susceptibility to influence; interpersonal attraction; and attitude change to a dyadic unit which has the attitudinal changes of only one of its members as its contractual goal. For example, it has been proposed that a dissimilarity of expectations betwwen therapist and client could affect the cohesiveness of the therapeutic system (Lennard and Bernstein, 1960). Goldstein (1962) has presented arguments for the position that client improvement in psychotherapy may partly be a function of the therapist's expectations could conceivably enhance therapeutic movement. Thus, Goldstein, Heller, and Sechrest (1966) have stated that greater therapist directiveness may be

necessary with certain clients over others. They argued that ambiguous forms of therapy with clients not highly motivated for treatment, may contribute to the therapeutic failure rate. This study is an attempt to examine the relationship of client attraction to therapy, directiveness, and improvement.

Review of the Literature

INTERPERSONAL ATTRACTION

Research focusing upon the variable of interpersonal attraction in therapy, typically proposes that there are potent interactional forces within a therapeutic dyad. Both in-therapy and analogue studies have been extended to study the impact of interpersonal attraction upon the influencing process. For example, Secord and Beckman (1964) state that there are two major classes of theories regarding the nature of interpersonal attraction. One revolves around analyses of the balance of losses and gains occurring within an interaction. The other examines the role of individual attributes in attractiveness. Newcombe (1950) has contributed a rather encompassing model to the first class. It has been described by Secord and Beckman (1964) as follows:

> Each variable--attraction, orientation, perception of the orientation of the other person--is in part a consequence of and in part a determinant of the other variable. Not only is the attraction of A toward B affected by the similarity between A's attitude toward X and his perception of B's attitude toward X, but his own attitude and B's attitude are influenced by the degree to which he is attracted to B. For example, assume that A, who is attracted to B, discovers a discrepancy between his attitude and B's attitude toward an object of common relevance, such as another person X. A likes X, i.e. has a variety of affective and cognitive components of a position or favorable nature with respect to X. He discovers, however, that B dislikes X and views many of X's attitudes unfavorably. Given the attraction of A toward B, this discrepancy between A's attitude and his perception of B's attitude would give rise to strain and to a postulated force toward change in the relations between these three systems components. p. 248.

Triandis (1960) expanded upon this model. Empirical support was found for the hypothesis that interpersonal attraction shows a direct and functional relationship to "cognitive similarity." Still, the exact meaning of the term, "cognitive similarity," was not specified. It was demonstrated that attempts to specify its meaning often result in definitions formed by circular interactions with the functions of liking, propinquity, and communication effectiveness. Nevertheless, "attribute similarity" and "communication similarity" are thought to be its major components (Triandis, 1960). Attribute similarity is concerned with the dimensions used by two individuals in describing a similar event. Communication similarity refers to the similarity in expressive styles between two persons while in the process of describing a major event (Triandis, 1960). Triandis concluded that

communication effectiveness within a dyad is primarily dependent upon the attitude and/or communication similarity between its members. Goldstein (1962) attempted to integrate the findings of both Triandis and Newcombe, and hypothesized that cognitive similarity is a function of both communication effectiveness and interpersonal attraction.

Others have suggested that personal attractiveness may be correlated with level of empathic competence (Maucorps, 1966). Encouraged by these findings, Poe and Mills (1972) hypothesized that there exists a positive relationship between the variables of interpersonal attraction and awareness of others. They administered the Edwards Personal Preference Schedule to 67 sorority women at the University of Iowa. Fifty of the women were active members, while 17 were in the pre-acceptance or pledging stage. The subjects were asked to rate their peers as being either "close," "distant," or "in-between." In addition, all subjects self-rated personal needs. The results of the study strongly supported the hypothesis that interpersonal attraction is significantly affected by and related to similarity of needs. Attractiveness of a peer was reported to be partly determined by perceived similarity of needs.

Summarily, the above studies postulate that greater affective and/or cognitive similarity in a dyad increases interpersonal attraction. Competent empathizers, by the very nature of their sensitivity--ability to assume the roles of others--may have an advantage in this area. They have access to the myriad attitudes and feelings of individuals

with whom they interact. This could possibly provoke them to search beyond initially superficial or negative impressions of persons, toward feelings of commonality. Gains may then be made in dyadic interpersonal attraction, unit cohesion, and influencing potential.

Attitude Change and Susceptibility to Influence

Social psychological research upon the processes of attitude change has extensive implications for the psychotherapeutic relationship (Frank, 1961). Still, the transfer and application of principles formulated in observation of an analogue is limited (Heller, 1972). The therapeutic dyad differs greatly from that of any other. It is with this judicious awareness by the researcher that theories of attitude change have relevance for psychotherapy.

Frank (1961) asserts that socially sanctioned forms of "healing" vary cross-culturally. He adds that influencing within psychotherapy is somewhat comparable to that characterizing religious conversions, brainwashing, and primitive healing:

> We shall consider as psychotherapy only those types of influence characterized by the following features:
>
> 1. A trained, socially sanctioned healer, whose healing powers are accepted by the sufferer and by his social group or an important segment of it.

2. A sufferer who seeks relief from the healer.

3. A circumscribed, more or less structured series of contacts between the healer and the sufferer, through which the healer, often with the aid of a group, tries to produce certain changes in the sufferer's emotional state, attitudes, and behavior. p. 2-3

However, individual susceptibility to influencing factors varies.

Susceptibility and Intolerance of Ambiguity

Hovland and Janis (1959) proposed that individual variables relating to persuasibility include field dependence, defensive-projection, and other-directiveness. Biological bases have been advanced by others (Strupp, 1973). Adding that if not biologically determined, this susceptibility probably develops early in life, Strupp (1973) traced it to the child's unavoidable dependency. He argued that the child learns to attend to "intrinsically gratifying" social cues as a means to gain approval. Some elements of this dependent orientation are retained as the child matures to adulthood. Strupp contends that this normal dependency renders individuals vulnerable to the influencing powers of "parental" authorities. Psychotherapists encourage and manipulate these dependent behaviors in their clients (Strupp, 1973 and Caracena, 1965). Others have stressed the

importance of a trait intolerance of ambiguity in disposing persons susceptible to influencing factors.

Intensive research efforts in the area of anxiety, dependency, and susceptibility to influence; and their relationship to an intolerance of ambiguity, appears to have begun after Frenkel-Brunswick's (1949) study. She defined "intolerance of ambiguity" as being "a preference for familiarity, symmetry, definiteness and regularity, . . . a tendency toward black-white solutions, over-simplified dichotomizing, premature, unqualified either/or sulutions . . . ." Earlier studies had suggested that "confusion" would further the persuasibility of any individual (Cantril, 1941). Cantril's conclusions were investigated by Crandall (1969). He found that individuals who were intolerant of ambiguity tended to describe themselves as being, "more docile, less competive, and less aggressive" on the Leary Interpersonal Adjective Checklist. Crandall's findings were in direct opposition to Eysenck's (1954) speculation that extraverts tend to be less tolerant of unstructured stimuli. Significantly, Cantril (1971) found that interpersonal attraction may be negatively related to the aforementioned capacity for tolerance. He administered a scale which had been constructed by Budner (1962), to 8 discussion groups composed of 5 members each. It was designed to measure individual ability to tolerate ambiguity. Scale scores were compared to self and other ratings made by each individual on the Leary Checklist. In general, it was shown that subjects who were tolerant of

ambiguity had the heaviest clusterings in the hostile-strong quadrant (Crandall, 1971). Those who were intolerant were primarily described as being "friendly and weak." A concurrent study (Crandall, 1971) had concluded that to a significant extent, persons intolerant of ambiguity were reported as being either neutrally regarded or disliked.

Others have attempted to examine the complicated role of situational factors which appear to increase the susceptibility of the individuals involved. Thus, Schacter (1959) emphasizes the role of ambiguity in increasing affiliative needs. He argued that affiliative gestures and responses are made in an effort to receive aid while attempting to impose structure. Schacter's hypothesis supports that of Sherif and Harvey (1952). Krasner (1961) states that individuals seek cues as to the appropriate actions to undertake in an influencing situation. He proposed that the notion of ambiguity is directly related to the construct of set. Ambiguity, he argued, is determined by an individual's expectancies about an influencing situation.

Ambiguity and the Therapist as Reinforcer

The issue of persuasibility and ambiguity is an important one in the psychotherapy literature (Dibner, 1958; Bordin, 1955; Goldstein, 1962; and Heller, 1968). It is possible that a number of people are threatened by

the ambiguous nature of many traditional psychotherapies (Goldstein, Heller, and Sechrest, 1966). Perhaps a more directive approach would be advantageous with these individuals. However, counter-arguments have been advanced which aver that ambiguity increases the reinforcing powers of the psychotherapist (Bordin, 1955 and Krasner, 1961). Experimental research in the area of verbal conditioning generally supports this latter position (Heller,(1968). In spite of this, the possibility does exist that less directive forms of therapy when structure is desired, lead to either client deterioration or termination.

Bordin (1955) emphatically stresses the reinforcing value of the therapist in an ambiguous mode of treatment:

> Ambiguity refers to the stimulus characteristics of the therapeutic situation, of which the therapist is the most significant part. As two people interact, each defines himself to the other as a stimulus object to a greater or lesser degree. As a therapist interacts with a patient, he defines himself and the situation both directly, i.e., by direct statement, and, most frequently, indirectly by the total import of his actions. p. 10.

He supported his position by adding that people tend to project their "internal need states" while in the presence of ambiguous stimuli. This argument has historical roots in the Freudian concept of the transference (Heller, 1968). Reference to the use of ambiguity as a "necessary though retarding precondition for new learning," was made by Kanfer and Marston (1961). They felt that because of the client's initial distrust of the therapist, he would come to feel more secure as he sensed an absence of therapist control. They stated that directive approaches should only be attempted after

an initial ambiguous period, and then only after the client has begun to show some behavioral changes. Client resistance to change, they continue, is best handled in an ambiguous context. Contrary to this position, Carkhuff and Berenson (1967) have noted that very defensive clients may best be approached in a directive manner. An increase in self-exploration under directive conditions of "conflict attention," as opposed to a nondirective style, was observed in a group of impatient veterans (Pierce and Drasgow, 1969). This relationship held irrespective of therapist level of competence.

Still, the issue concerning the merits of directiveness in psychotherapy is a very complicated one. Ashby et al (1957) compared client behaviors in both directive and reflective forms of therapy. Reflective styles were acknowledged as being principally Rogerian with a focus upon nondirective leads, nondirective structuring, and reflection of feelings. They noted that directive therapies have been greatly influenced by the work of Dollard and Miller and characterized them as being different in intent and style. Suggestion, persuasion, encouragement, directive structuring, and information-giving are typically directive techniques (Ashby et al, 1957). They found that aggressive clients tended to be more verbally defensive in the leading treatment conditions (Ashby et al, 1957). Indirectly, this finding supports the claims of Cantril (1941), Frank (1961) and others, that it is the less aggressive client who is open to directiveness in situations where rules of conduct and expectancies are not made explicit.

It has been suggested that the value of a directive approach is primarily determined by the unique nature of a client-therapist interaction. Mintz, Luborsky, and Auerbach (1970) attempted to isolate effective therapist and therapist-patient interactional variables. They noted that they themselves had conducted the first cross-sectional factor-analytic study involving a large number of process variables. Fifteen experienced psychotherapists (median of 9 years of experience) submitted tape-recordings of initial therapy sessions. The clients ranged in age from 15 to 55, with the heaviest clustering in the 20 and 30 year category. Seven were students, five housewives, 11 professionals, and 7 of unknown occupation. Two-thirds were of the middle class while the remaining individuals were from a lower socio-economic group. The study required that 60 therapy sessions be rated on 110 variables. Though 4 were later omitted, the remaining 110 were clustered under 27 separate categories. There were tree raters. An analysis of the data resulted in the recognition of four factors: I. Optimal Empathic Relationship; II. Directive Mode; III. Patient Health versus Distress; and IV. Interpretive Mode. Factors I, II, and IV were said to be representative of three predominant modes of therapy. Readers were cautioned not to assume that the three factors were mutually exclusive. Any of the factorial items could have appeared in any one of the 60 therapy sessions. Factor II (Directive Mode) accounted for 19% of the variance. This factor included the items: Therapist Directive, Therapist Activity, Therapist

Creativity, Therapist Approach, Therapist Hostile-Defensive, Therapist Intrusive, and Therapist Interpretive statements. This mode was thought to be determined by both therapist and client interactional patterns. The authors speculated that highly resistant and/or passive clients may have elicited leading responses from therapists. Therapist-client elicitation responses were noted in the other forms of treatment as well, but were of a different nature. Elicitation responses of reciprocal affect have also been noted by Leary (1957), Kell and Mueller (1967), and Pande and Gart (1968). Returning to the issue of directiveness, Mintz, Luborsky, and Suerbach (1970) found Rogerian variables (Factor I: Optimal Empathic Relationship) to be differentially related to outcome. That is, Rogerian process variables were positively related to successful outcome in non-directive modes of treatment. However, the presence of these variables in directive therapy was negatively related to successful outcome. It was speculated that the presence of therapist warmth in leading therapies deters progress through interference with attempts to maintain "professional detachment." A more plausible explanation was also advanced. Mintz et. al. (1970) observed that " . . . it is possible that directive therapies are more successful when the therapist typically goes beyond the patient's own level of understanding, that is, sees things differently from the patient."

Client Dependency and Verbal Conditioning

Rogers (1942) argued against the directive approach, positioning that it may foster client dependency. Though others have confirmed this speculation (Rottschafer and Renzaglia, 1962), the possibility exists that dependency heightens suggestibility (Strupp, 1973). Several researchers have studied the relationship of the former to verbal conditioning.

Caracena (1965) examined the differential process of elicitation of dependency responses, as opposed to the reinforcement of these verbal behaviors. The subjects involved were 60 undergraduates who had sought help at the Michigan State University Counseling Center. Seventy-two first and second tape-recorded therapy interviews were analyzed. Responses were judged to be eigher dependent: problem-description, help-seeking, approval-seeking, company-seeking, agreement, disapproval -concern, or initiative seeking; hostile; or other. Therapist approach statements were judged to be those which elicited expansion and exploration of client statements. Avoidance responses were those which discouraged the client's exploration of his previous statements. The author found that the continuation of dependency responses were significantly related to the therapist's approach statements. He interpreted this as suggesting that therapists exploit client dependency patterns quite early during the course of treatment. Though adding that psychotherapists develop the exploitation

of client dependent verbalizations elicited by approach statements into a technique as they gain experience, he did not find a significant relationship between expertise in this technique and experience.

The relationship between expectancy, directiveness, and dependency was studied by Rottschafer and Renzaglia (1962). Leading therapist styles were determined according to ratings received on a scale devised by Strupp (1957). The "clients" were student volunteers who, after the administration of the Mooney Problem Checklist, answered affirmatively to the question, "Would you like to have a counselor to talk things over with?" Each student was given an orientation sheet describing the counselor's role prior to the initial counselor contacts. Some clients were randomly told to expect leading therapists, while others expected reflective therapists. The counselors had no foreknowledge of the exact nature of the author's hypotheses or experimental design.

No significant interactions were found between pre-therapy induction of set and counselor style. However, pre-counseling orientation was thought to have some effect upon client "dependent-like talk." Clients experiencing leading forms of therapy expressed more of this verbal behavior. In a related matter, Heller (1968) found ambiguity, or a lack of directiveness, to be associated with an increase in client self-disclosure. Nevertheless, he added that it should not be inferred that an increase in self-disclosure is related to susceptibility to influence. Empirical support for such a conclusion has not been revealed (Heller, 1968).

Verbal conditioning may also account for increases in client self-references in nondirective therapies (Rogers, 1960). Truax (1965) reported evidence of unintentional "selective reinforcement" after an examination of in-therapy tapes made by Carl Rogers. Rogers (1960) demonstrated that negative client self-references can be increased by experimenter manipulation without the subject's awareness of the conditioning process. Contrary to earlier findings (Bordin, 1955), susceptibility to influencing processes, or conditionality, did not appear to be significantly related to anxiety level. It was also suggested that these conditioning effects were limited to the experimental situation and were not permanent (Rogers, 1960).

Methods of Intervention-Confrontation and Interpretation

Garduk and Haggard (1972) asserted that the therapist's style of intervention is directly related to the client's immediate response patterns. They argued that more immediate though fewer client verbalizations tend to follow an interpretation, as opposed to any other form of therapist intervention. They based this upon their finding that a greater willingness to discuss the transference and increases in client understanding were significantly correlated with therapist interpretive statements. Efforts were

also made by Frank and Sweetland (1962) to establish casual patterns between therapist verbal behaviors and client responses. They asked four psychologists to each interview every member of a group of ten clients. An analysis of data revealed that therapist use of Direct Questions tended to elicit more Statements about Problems than did interpretive techniques. Interpretation was significantly correlated with client processes of Insight and Understanding. Forcing Insight and Clarification of Feelings were also associated with an increase in client Insight and Understanding. Strupp (1973) offers that "here and now" interpretations, those reflective of the client's current life problems and situations, are frequently more effective than are those that focus upon the past.

Howe (1962) sought to clarify the relationship of therapist interpretation to subsequent client expressions of anxiety. His subjects were forty-eight psychiatrists and psychoanalysts. He constructed a fictitious case history of a twenty-seven year-old neurotic woman and asked the subjects to rate it. Ratings were made on Depth of Interpretation, plausibility of the interpretation to the client, and associated level of anxiety arousal in the client.. He found that the more specific interpretations were judged to be the least plausible to the client. Implications of these findings are that " . . . a plausible statement implies such a degree of generality as to make refutation or disproof of it as difficult as the statement is plausible" (Howe, 1962). His inferences appear to be unwarranted in view of the

limitations of his study. That is, he failed to obtain actual measures of client anxiety in response to true interpretations. Still, he stated that his results are in accord with those of Speisman (1959) which showed that moderate interpretations elicit low levels of client anxiety.

Of course, there are moments during the treatment process in which an interpretation would be inappropriate. Hobb (1962) cautions that a therapist interpretation in place of a direct expression of reaction can be unproductive. In such instances an interpretation could possibly negatively reinforce client approach behaviors. Other theorists have voiced similar concerns and have emphasized that the therapist may aid the treatment process by sharing his feelings (Fromm-Reichmann, 1950; Sullivan, 1949). Levy (1963) noted in an extensive study of the interpretive technique, that interpretation is one of the most powerful methods available to further therapeutic movement. He stressed that its use is necessary only at those moments when the client's behaviors introduce "incongruity or dissonance." An ill-timed interpretation can produce dissonance (Levy, 1963). Levy determined that there are other counterindications for the use of interpretations. For example, interpretations should not be made when the client is expeiencing very little dissonance. Its usefulness is particularly lessened with a very disturbed client if the therapist has not evaluated his capacity to tolerate additional strain. Furthermore, this technique may be counter-

productive if its introduction is designed to aid the therapist in coping with his own feelings of insecurity (Levy, 1963).

It is likely that many of the preceding statements can properly be applied to a discussion of confrontation techniques. Shulman argued that the primary value of confrontation exists in its potential to initiate forced cognitive dissonance upon the client. An Adlerian, he determined that such a disruption could cause the client to examine new roles for social interactions. Increased client insight and attitude change would follow (Shulman, 1971).

However, the value of the confrontation may partly be dependent upon the interval within the therapeutic hour, in which it is offered. Mitchell and Hall (1971) arrived at this conclusion after studying the first therapy sessions of fifty-six experienced and graduate student therapists. The timing and form of the confrontation used significantly differentiated between high versus low facilitative student therapists. This relationship only approached significance among experienced therapists. Overall, high facilitative therapists confronted their clients most frequently during the final third of the hour. The more facilitative graduate therapists offered more experiential confrontations during this period than did their low facilitative peers. Experiential confrontations were characterized as being, " . . . the therapist's specific response to any discrepancy between the patient's and the therapist's experiencing of the patient, or to any discrepancy between the patient's description of himself and the patient's inner experience of himself, or to

any discrepancy between the patient's and the therapist's experience of the therapist" (Mitchell and Hall, 1971).

Therapist Experience and Theoretical Orientation

Bergin and Garfield (1971), after an extensive review of the available literature, concluded that regardless of the therapist's training of theoretical orientation, his ability to be warm, genuine, and empathic was most crucial in determining his effectiveness. They found the evidence regarding therapist experience to be inconclusive.

Yet, Mullen (1969) found support for the hypothesis that inexperienced therapists may reach low levels of empathy to which experienced therapists never descend. Beery (1970), though finding that experienced therapists offer high levels of Roger's proposed "core" facilitative conditions (warmth, empathy, congruence, genuineness, and positive regard), also discovered that they are not unconditional in offering positive regard. They differed in their acceptance of friendly as opposed to hostile clients.

Other situations have been reported during which clients operated rather independently of the therapist's interventions. Holder, Carkhuff, and Berenson (1967) found that high functioning "clients" were able to operate at high levels of self-exploration regardless of the therapists' expressions of

high or low levels of core conditions. Six naive college students who had previously been found to operate at either very high or extremely low levels of the above mentioned variables, served as "clients." Each client was seen by an experienced therapist who offered Hi-Lo-Hi responses in twenty minute segments each. The therapists effected the "Lo" periods by withholding their best responses, though not offering negative responses either. The level of self-exploration of the low-functioning clients was determined by the level of therapist-offered conditions. Also, the high-functioning clients explored their feelings at a depth which was greater than that of the low-functioning clients.

Piaget, Carkhuff, and Berenson (1967) attempted to replicate and expand these findings by exposing four high-functioning and four low-functioning clients to one high functioning and one moderate-functioning therapist. They found that the therapists determined the level of therapist-offered conditions in the initial interview. These results confirmed those of Holder, Carkhuff, and Berenson (1967). An added finding was that both high- and low-functioning clients declined in level of self-exploration when seen by the moderate-functioning therapist. They also mentioned that the high-functioning clients performed at levels of self-exploration relatively independent of the therapist variables. Cannon and Pierce (1968), in studying six neuropsychiatric patients (schizophrenic reaction), found that low and moderate conditions of therapist-relationship variables actually caused a decline in self-exploration.

Beyond this, Fiedler (1950) has questioned the assumption that therapists of differing theoretical positions have meaningfully different intherapy behaviors. Several studies suggest that they do. Strupp (1958) advanced empirical evidence which shows that Rogerians work primarily toward client self-actualization. Analytic therapists were found to strive for client self-insight. These results were confirmed by Cartwright (1966) in examining the intherapy behaviors of client-centered and analytic therapists. Significant differences were noted in terms of therapist use of the techniques of clarification, interpretation, and reflection. Theoretical orientation appeared to be the determining factor. The analogue studies of Zimmer and Pepyne (1972) are in accord with these conclusions. Yet, Kiesler (1966) has presented data which strongly suggests that the assumption of a "uniformity" in either therapist style or client behavior is unwarranted. Sampling Kiesler, Mathieu, and Klien (1964) tape-recorded interviews with seven neurotics, seven hospitalized schizophrenics and seven normals in an effort to determine the affects of segment length on the variance of inter-rater reliabilities. An early interview (one of the first five) and a late interview (one of the last five) of each subject was selected for study. Two-, 4-, 8-, and 16-minute segments were judged according to Gendlin's Experiencing Scale. They found that the length of the segment recorded does not affect inter-rater reliabilities. Furthermore, the "Experiencing" ratings given did not significantly vary as a function of the length of the time

segment studies. However, it was pointed out that the absolute level of Experiencing ratings correlated positively with the length of the time segment sampled. So, at least with the Experiencing Scale, they felt that cross-time segment comparisons tend to be unreliable in the study of process variables. Yet, equal-time segments of any length (2-, 4-, 8-, 16-minutes) are comparable.

Still, the problem of time-segment location in studying process variables does exist. Conceivably, because of the factors of increases acquaintance and interactional ease over the course of a single therapeutic hour, or across the duration of the therapeutic encounter, a given variable may be more frequently expressed in one segment. Conversely, as more defensive material is dealt with, increased client anxiety may produce a variance in the expression of that variable.

Summarily, Karl and Abeles (1969) questioned the commonly held assumption that process variables are randomly distributed over the therapeutic hour. They found the expression of certain interactional variables, for example, hostility and avoidance, to be more frequent in certain 10-minute segments than in others. The authors conceded that random sampling techniques may appropriately be used when analyzing tapes for Rogerian factors. Nevertheless, they felt that an investigation of Freudian process variables could perhaps be better conducted par specific segment

location methods. In any case, they argued that a general formula for the representative location of process variables is not forthcoming.

CHAPTER II

HYPOTHESES

Hypothesis 1: Client low initial distress and low initial attraction to psychotherapy, combined, are associated with a successful outcome after directive therapy and an unsuccessful outcome after nondirective therapy.

Hypothesis 2: Client low initial distress and high initial attraction to psychotherapy, combined, are associated with a successful outcome after directive therapy and with an unsuccessful outcome after nondirective therapy.

Hypothesis 3: Client high initial distress and low initial attraction to psychotherapy, combined, are associated with a successful outcome after directive therapy and with an unsuccessful outcome after nondirective therapy.

Hypothesis 4: Client high initial distress and high initial attraction to psychotherapy, combined, are associated with a successful outcome after either directive or nondirective therapy.

CHAPTER III

METHOD

Source of Data

The cases used in the present student were selected from the research library of the Michigan State University Counseling Center. The clients seen at the Center are from the general student population of the University. The therapists at the Counseling Center include Ph.D. psychologists, counseling specialists, interns, and practicum students with varying degrees of experience. After an initial intake interview, clients are assigned to individual therapists on the basis of the therapist's desire to work with the presenting problem under question.

The clients asked to participate in the Center's research activities were requested to complete a battery of tests after the first and selected future interviews. Tape-recordings of the intereviews were also made.

Selection of Cases

Eighteen cases were used in the present study. Fifty-four tape-recorded sessions, representing the first, third, and final interviews of

each case, were studied for level of therapist directiveness. Completed pre- and post-therapy MMPI profiles, and responses to Libo's (1975) Picture Impressions Test, were included with each case.

Reliability and Validity of Instruments

Directiveness

Two advanced graduate students served as raters of directiveness, using Aronson's (1951) directiveness scale. They independently rated non-sample psychotherapy transcripts during the training period. A Pearson product-moment correlation of .78 was established for inter-rater reliability. This was based upon combined (directiveness and nondirectiveness scores added together by the use of a constant) directiveness scores. Aronson (1951) reported the average intercorrelations for directive techniques to equal .66 and those of nondirectiveness to level at .88.

Attraction

Another pair of advanced graduate students rated Libo's Picture Impression Test (PIT) protocols. They agreed on the classification of 24 out of 25 cases as being either attracted or not attracted to therapy. A Pearson product-moment correlation was calculated on the basis of the total number of + and - scores assigned by the individual raters to the stories.

Table 1 (Schaffer, 1974) shows the mean scores assigned and the inter-rater reliability calculated. Both Schaffer (1974) and the present author were able to make use of some of the same data regarding the PIT. Thus, his calculations are presented below and are applicable to this study.

TABLE 1. Inter-rater Reliability on the Picture Impressions Test

Rater	Mean	S.D.	Pearson
1	2.52	5.16	.95
2	3.04	4.82	

Libo (1957) found reliability coefficients for repeat scoring by independent scorers to reach .95 for the categories "attracted" or "not attracted." The comparable coefficients for "total" and "number of stories receiving a score" reached .92 and 1.00. Inter-rater reliability coefficients were established at .87, .87, and 1.00 on the respective categories of "attracted" or "not attracted;" "total score;" and "number of stories receiving a score." The above coefficients were determined for Libo's Picture Impressions Test.

Bergin (1971) has argued that the D, Pt, and Sc scales of the MMPI "provide consistent validity as change indices." He added that the Es, Si,

and K scales can also, frequently, evidence change and are correlated with the D, Pt, and Sc scales.

Still, there is no consistent agreement upon the validity of the MMPI as a change index. Subotnik (1972), in studying a group of college students, was able to offer support for the position that change on the MMPI (pre- and post-profiles) cannot be attributed to "spontaneous remission" phenomena. He concluded that the MMPI is in at least one respect, valid in measuring change. Furthermore, Lichtenstein and Bryan (1966) found high retest reliability for the MMPI when applied, after a two day period, to a group of patients and a group of volunteer workers. The product-moment correlations were .99 and .94 respectively, for the retest reliabilities. Others have suggested that patient initial level of distress confounds observed changes on the MMPI. Barron (1953) noted that patients with a higher level of reported distress showed less improvement on the MMPI. He added that this finding specifically applied to the Sc and Pa scales of the instrument. Research by Prager and Garfield (1972) lends support to this conclusion. However, the authors observed a, "small to modest inverse relationship between the measures of subjective disturbance and global ratings of outcome" and therefore, arrived at no definitive conclusions. Contradictory results were found by Truax, Tunnell, Fine, and Wargo (1966). Truax et al (1966) concluded that high initial client disturbance is associated with greater improvement on the MMPI scales of Depression, Hysteria,

Hypochondiasis, and Psychoasthenia. Thus, the relationship of initial client distress to MMPI profile elevation is unclear. Overall high test-retest reliability, nevertheless, has also been provided by Rosen (1953) and Abse, Dalhstrom, and Talley (1960) as cited in Welsh and Dalhstrom (1960). Bergin (1971) has offered that in spite of its limitations, the MMPI remains the most consistent and valid paper and pencil test available for the assessment of change.

Coding Procedures

Directiveness

Four two-minute segments were first transcribed from each sample tape. Two judges were then asked to each rate them all after having received initial training on several non-sample tapes. Therapist directiveness was independently coded by each according to a procedure outlined by Aronson (1951). Separate directive and nondirective scores were found by using the following (Aronson, 1951):

$$\text{Nondirective score} = \frac{\text{XRC+XCFa+XND}}{\text{Total Counselor Responses -XSA}} \times 100$$

$$\text{Directive score} = \frac{\text{XIT+XFT+XDQ+XEA+EIX+ECA+XPS+XDC}}{\text{Total Counselor Responses -XSA}} \times 100$$

Nondirective responses:

1. XRC Restatement of Content.
2. XCFa Clarification of Feelings, Accurate.
3. XSA Simple Acceptance.
4. XND Nondirective lead.

Directive responses:

1. XIT Interpretation.
2. XFT Forcing the Topic.
3. XDQ Direct Question.
4. XAE Approval and Encouragement.
5. XRS Reassurance.
6. XIX Giving Information.
7. XCA Proposing Client Activity.
8. XPS Persuasion.
9. XDC Disapproval and Criticism.

"Combined directiveness" scores were also calculated for each two-minute segment, after having added directive and nondirective scores through the use of a conversion factor (Aronson, 1951). The twelve segments per case were then averaged so that a single directiveness score was computed for each client. "Directiveness" or "nondirectiveness" was finally determined by a median split of the 18 (one per case) single directiveness scores (Appendix E).

Attraction

Initial attraction to psychotherapy, as a variable, was ascertained by an examination of client responses to the Libo Picture Impressions Test (Libo, 1957). Clients were asked to write a short story to accompany each of 4 pictures. The stories will give ratings of either +1 or -1. A score of -1 will

be assigned to those stories which contained themes interpretive of a desire for movement away from the therapist. +1 scores were given to those responses judged to be indicative of a desire for movement toward the therapist. Libo (1957) defined attraction in therapy as being, " . . . the resultant of forces acting on the patient to maintain his relationship with the therapist." Thus, an attraction score was determined by the application of Libo's criteria for attraction. The following table is from Libo (1957):

TABLE 2. Criteria Used in Making Judgements of Attraction

Total Score	No. of Stories Receiving a Score	Interpretation	Pred
+1 or higher	2, 3, or 4	Attracted	Returned
		Not	Not
0 or lower	Any	Attracted	Returned
		Not	Not
Any	0 or 1	Attracted	Returned

Distress

Distress scores were determined by two methods. Each involved the use of pre-therapy and post-therapy scores from the MMPI. A median split of Barron's Ego Strength T Scores (Es Scores), one per case, separated the clients into 9 distressed and 9 nondistressed. This procedure was followed for both the pre-therapy and post-therapy determinations of distress (Appendix D).

Other distress scores were arrived at by the combination of standard scores from Welsh's Anxiety Scale along with standard scores for the sum of each client's total MMPI scale scores of 70 or higher. This constituted a symptomatology index. As with Barron's Es scores, "distress" or "non-distress" was determined by a median split of the 18 scores (one per client). This was done for both pre- and post-therapy scores.

CHAPTER IV

RESULTS

Hypotheses 1-4 proposed that outcome is differentially affected by variations in client initial distress and attraction to therapy, and therapist directiveness. Because of this fact and the fact that there were no significant findings in support of the hypotheses, they will be considered together in this section. It is believed that this approach will make a meaningful analysis of the data all the less arduous.

Another very important consideration in using this approach is that a direct analysis of the hypotheses was not possible. This was so because of the complexity of the proposed interactions. A much larger sample size than that available for the present study would have been more appropriate in testing the hypotheses.

Still, an attempt will be made to see if some useful information related to the hypotheses may be derived at by a consideration of two-way interactions of the above mentioned variables. Suggestions for an improvement of the experimental design are made in the Discussion section.

Several two-way analyses of variance were made to study the interactions of client initial level of distress, initial attraction to therapy, and

therapist directiveness in relation to the outcome measures. The interactions presented below are from an examination of these variables when directiveness across all sample hours are considered. Analysis of variance (ANOVA) tables for differential outcome measures are discussed individually in sections A, B, C, and D which immediately follow. Individual consideration of these variables for the first, middle, and final hours of therapy are presented in Appendix C.

Criteria for Success: Client Pre-Post Therapy Change Scores on Barron's Ego Strength (Es) Scale

Table 3 shows that the interaction between directiveness and initial distress is not significant (F=2.23).

TABLE 3. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Average Therapist Directiveness Scores Across All Sample Hours. Success: Client Pre- Post-Therapy Change T Scores on Barron's Es.

Source	SS	DF	MS	F
Distress	2	1	2	.03
Directiveness	152.37	1	152.37	2.26
Interaction	152.19	1	152.19	2.23
Error	948.8	14	67.42	

In terms of the interaction of attraction and directiveness on the outcome measure, no significant findings are revealed in Table 4. This is contrary to the hypothesis.

TABLE 4. ANOVA of Client Attraction by Therapist Directiveness. Directiveness. Directiveness: Average Therapist Directiveness Scores Across All Sample Hours. Success: Client Pre- Post-Therapy Change T Scores on Barron's Es

Source	SS	DF	MS	F
Attraction	164.21	1	164.21	2.75
Directiveness	166.92	1	166.92	2.79
Interaction	43.48	1	43.48	.73
Error	837.35	14	59.8	

Criteria for Success: Client Pre- Post-Therapy Change Scores on the Symptomatology Index

As in Section A, there are no significant interactions between initial level of distress and therapist directiveness on the relevant outcome measure. Table 5 shows this interaction to have an F value of 1.17. This is not in support of the hypotheses. However, there is a significant main effect (F=13.12) for distress that should be noted.

TABLE 5. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Average Therapist Directiveness Scores Across All Sample Hours. Success: Client Pre- Post-Therapy Change Scores on the Symptomatology Index

Source	SS	DF	MS	F
Distress	3077.58	1	3077.58	11.9*
Directiveness	48.02	1	48.02	1.85
Interaction	303.12	1	303.12	1.17
Error	3999.3	14	258.67	

*p < .005

Thus, those who were most distressed when entering therapy showed the greatest decreases in anxiety. It was also noted that the prior elevated MMPI scores of those most distressed when entering therapy were shown to decrease.

Success: Client Post-Therapy T Scores on Barron's Ego Strength (Es) Scale

Table 6 reveals no significant interactions between initial level of distress and therapist directiveness (F=.10) in terms of post-therapy ego strength scores.

TABLE 6. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Average Therapist Directiveness Scores Across All Sample Hours of Therapy. Success: Client Post-Therapy T Scores on Barron's Es

Source	SS	DF	MS	F
Distress	115.75	1	115.75	1.22
Directiveness	19.63	1	19.63	.21
Interaction	9.35	1	9.35	.10
Error	1330.5	14	95.04	

In terms of the interaction of distress with attraction (Table 7), there is no statistical support for the notion that those who are both initially distressed and attracted to therapy have higher ego strength scores than do those who were not distressed or attracted.

TABLE 7. ANOVA of Client Distress by Client Attraction. Success: Client Post-Therapy T Scores on Barron's Es

Source	SS	DF	MS	F
Attraction	2.73	1	2.73	.04
Distress	107.95	1	107.95	1.42
Interaction	200.6	1	200.6	2.64
Error	1064.2	14	76.01	

In turn, Table 8 suggests that the interaction between initial attraction and therapist directiveness is not significant.

TABLE 8. ANOVA of Client Initial Attraction by Therapist Directiveness. Directiveness: Average Therapist Directiveness Scores Across All Sample Hours of Therapy. Success: Client Post-Therapy T Scores on Barron's Es

Source	SS	DF	MS	F
Attraction	238.74	1	238.74	.57
Directiveness	301.04	1	301.04	.72
Interaction	536	1	536	1.29
Error	5824.15	14	416	

In conclusion, none of the findings in Section C are in support of the hypotheses. It is possibly true that the change measures are more sensitive to meaningful interactions than are the post-therapy scores alone.

Success: Post-Therapy Scores on the Symptomatology Index

The data from Tables 9, 10, and 11 do not support the hypotheses. Table 9 does not reveal a significant interaction between distress and directiveness (Table 9, F=.99).

TABLE 9. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Average Therapist Directiveness Scores Across All Sample Hours of Therapy. Success: Client Post-Therapy Scores on the Symptomatology Index

Source	SS	DF	MS	F
Distress	28.35	1	28.35	.11
Directiveness	33.02	1	33.02	.12
Interaction	272.52	1	272.52	.99
Error	3885.75	14	277.56	

An examination of Table 10 suggests that the interaction between initial attraction to psychotherapy and initial level of distress does not significantly affect outcome.

TABLE 10. ANOVA of Client Distress by Client Attraction. Success: Client Post-Therapy Scores on the Symptomatology Index

Source	SS	DF	MS	F
Attraction	51.54	1	51.54	.2
Distress	15.01	1	15.01	.06
Interaction	453.43	1	453.43	1.73
Error	3674.8	14	262.49	

The interaction between attraction and directiveness was also found to be nonsignificant (Table 11, F=.89).

TABLE 11. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness Scores Across All Sample Hours. Success: Client Post-Therapy Scores on the Symptomatology Index

Source	SS	DF	MS	F
Attraction	49.17	1	49.17	.18
Directiveness	47.7	1	47.7	.17
Interaction	248.67	1	248.67	.89
Error	3888.75	14	277.77	

None of the above findings are in support of the hypotheses.

What follows are four summary tables of F's.

TABLE 12. Summary of F's of Client Post-Therapy T Scores for Barron's Ego Strength Scale

	Hour of Therapy				
	Pre	Average	First	Middle	Final
Attraction	.04	X	X	X	X
Distress	1.42	X	X	X	X
Interaction	2.64	X	X	X	X
Attraction	X	.57	.66	.04	.06
Directiveness	X	.72	.51	.11	.002
Interaction	X	1.29	1.01	1.99	.23
Distress	X	1.22	.51	1.44	1.62
Directiveness	X	.21	1.22	.06	.01
Interaction	X	.10	1.57	.02	.88

X = Not Applicable

No signiticant F's

TABLE 13. Summary Table of F's of Client Pre- Post-Therapy Change T Scores for Barron's Ego Strength Scale

	Hour of Therapy				
	Pre	Average	First	Middle	Final
Attraction	2.0	X	X	X	X
Distress	.25	X	X	X	X
Interaction	1.32	X	X	X	X
Attraction	X	2.75	2.06	1.71	2.10
Directiveness	X	2.79	.40	.66	2.58
Interaction	X	.73	3.54	.14	.36
Distress	X	.03	.03	.01	.04
Directiveness	X	2.26	.01	1.08	2.80
Interaction	X	2.23	.002	1.08	1.78

X = Not Applicable

No significant F's

TABLE 14. Summary Table of F's of Client Post-Therapy T Scores for Symptomatology Index

	Hour of Therapy				
	Pre	Average	First	Middle	Final
Attraction	.20	X	X	X	X
Distress	.06	X	X	X	X
Interaction	1.73	X	X	X	X
Attraction	X	.18	.11	.25	.16
Directiveness	X	.17	.29	.13	.08
Interaction	X	.89	1.17	.31	.99
Distress	X	.11	.05	.08	.18
Directiveness	X	.12	.51	.03	.05
Interaction	X	.99	.63	2.10	2.37

X = Not Applicable

No significant F's

TABLE 15. Summary Table of F's of Client Pre- Post-Therapy Change T Scores for Symptomatology Index

	Hour of Therapy				
	Pre	Average	First	Middle	Final
Attraction	2.00	X	X	X	X
Distress	13.12**	X	X	X	X
Interaction	.61	X	X	X	X
Attraction	X	.34	.20	.16	.68
Directiveness	X	.61	2.06	.02	.67
Interaction	X	.52	1.01	.43	2.55
Distress	X	11.90**	14.96**	12.06**	11.56**
Directiveness	X	.19	1.85	.34	.47
Interaction	X	1.17	1.04	2.41	.73

X = Not Applicable

** = $p < .005$

CHAPTER V

DISCUSSION

The overall findings support Kiesler's (1966) contention that a meaningful analysis of process and outcome variables in psychotherapy is an extremely complex task. While some main effects were uncovered, two-way interactions were not. Several methodological problems interfered with both the testing of the hypotheses and the generalizability of the limited findings.

Some of the methodological problems involved were an unbalanced design problem, a small sample size, and, on post-therapy testing, a possible statistical regression toward the mean. It is also possible that the few significant effects reported occurred by chance, given the large number of significance tests run. On the other hand, a strength in the present design is that there is a consistency between hourly rank order, and overall therapy statistical determinations of directiveness.

What follows is speculative. These speculations are based upon the limited results of this study plus the corroborative results reported in Schaffer's (1974) study.

Distress and Directiveness

Through an analysis of variance, there were no significant main effects revealed for the interaction of distress with directiveness. There was directional support for the notion that initially distressed clients show greater increases in ego strength after directive, as opposed to nondirective, therapy.

It is possible that the relatively high levels of distress of members of this group tended to elicit reciprocally high levels of therapist directiveness. It is not uncommon for psychotherapists to use more directive forms of therapy with very distressed, most notably schizophrenic, clients. Of course, the incidence of schizophrenia in a college population is very low and most complaints may have been related to feelings of alienation prevalent in the period during which this data was gathered (1968-9). Furthermore, the ethos among college students seems to be one of demanding answers. Perhaps this is simply a reaction to perceived therapist sensitivity. Or, it could be a function of wishing that the "experts" justify their expertise. All this would imply a desire for greater therapist verbal activity or directiveness.

Increased therapist directiveness with a very distressed client may facilitate client "engagement" in the therapeutic process. This may reduce the incidence of narcissistic withdrawal by the client and increase the occurrence of self-exploration. Such a process could conceivably account for the

relatively greater increases in ego strength of this high distress-high directiveness group.

Not surprisingly, similar findings did not hold for the initially nondistressed groups. The average increases in ego strength for nondistressed clients was not differentially affected by level of therapist directiveness. This latter finding is consistent with that of Piaget, Carkhuff, and Berenson (1967) who found that "high-functioning" clients engaged in self-exploration relatively independently of the level of therapist-offered conditions. It may have also been reflective of the time, probably existent today, that nondistressed clients even sought to establish relationships via psychotherapy. On a more benign level, many were away from home for the first time and were probably seeking guidance from an authority figure.

Attraction and Directiveness

Therapist directiveness seems to have less of an impact upon changes in ego strength with initially attracted clients than it does with the not-attracted group. For the latter, directiveness seemed to be positively associated with increases in ego strength. In contrast, the differential interactions of high and low therapist-directiveness with the attracted groups did not meaningfully affect the outcome measures.

It may be speculated that the initially not-attracted clients began psychotherapy with a degree of social distance approximating that of the more obviously distressed clients. If so, they could have elicited therapist directiveness with resultant effects similar to those proposed above for the high distress-high directiveness group.

Attraction and Distress

It should be recalled that there was a significant main effect for distress. Distressed clients showed significant drops in symptomatology while initially non-distressed clients demonstrated significant increases. The increases experienced by the initially nondistressed groups may not have been indicative of negative or deteriorative effects, but of improvement. Perhaps they experienced an increase in self-exploration and insight. A greater awareness of the richness of their emotional lives may have ensued with concomitant increases in anxiety because of its unfamiliarity and complexity.

Overall increases in ego strength for the initially attracted groups were smaller than were those of the non-attracted clients. Attracted clients also showed an overall increase on the symptomatology index. This is in contrast to the overall decreases in symptomatology of the initially not-attracted clients.

One possibility is that the findings of greater increases in ego strength for the non-attracted group were simply temporary variations. Perhaps, also, they had further to go in terms of achieving a fairly nondistressed level of ego functioning.

However, the findings also suggest that too much client attraction in short-term therapy can actually slow down the rate of improvement. The highly attracted client may have been afraid to risk possible rejection following self-disclosure. In other words, they may have been approval-seeking to the detriment of their ability to successfully engage in the therapeutic process.

A consideration of the interaction of distress with attraction suggests that the combination of low-initial distress and low-initial attraction probably is not affected by the therapist variable of directiveness. Nor does the combination of high-initial distress and high-initial attraction seems to be affected by the directiveness of the therapist.

It seems that it is only in the intermediate situations of low-initial distress and high-attraction or high-initial distress and low-attraction that confounding occurs. This finding is consistent with that of Schaffer (1974) who found that level of client "Experiencing" in therapy was low in high-high or low-low combinations of attraction and distress. "Experiencing" was found to be high in the intermediate conditions of attraction and distress identical to those just described.

This study suggests, in summary, that to the extent that directiveness structures it may have some immediate beneficial effects. This is particularly true as the initial distress level of the client increases.

These findings underscore the complexity of therapy even in this relatively homogeneous college population. Quite possibly, these patterns would have been hidden in the study of any more obviously heterogeneously population. One is reminded of Kiesler's (1966) warnings regarding assumptions of similarity in any population.

This study attempted to go beyond some commonly held assumptions regarding psychotherapy process by examining the impact of client pre-therapy variables. It was expected that interactions between attraction, distress, and directiveness would be reflected in post-therapy client ego strength and anxiety level. Increases in ego strength and decreases in anxiety should have, according to predictions, occurred in cases of high-therapist directiveness. Lack of appreciable gain in ego strength and increases in anxiety were predicted for most cases of low-directiveness. One exception in this latter expectation was for high distress-high attraction combinations.

These expectations were made with the knowledge that therapy in a student counseling service tends to be time-limited. This condition would seem to necessitate a departure from the more nondirective approaches frequently employed in private practice. Engagement and resolution must, it

was felt, be affected by a different process in short-term therapy with college students.

The interactions hypothesized in this study may have been uncovered with a larger sample size. It was the original intention of this study to examine the records of approximately 33 subjects. The Michigan State University Counseling Center's Tape Library, one of the best in this country, provided the protocols. However, limitations are almost inevitably imposed by the use of data banks and specialized tests. This problem does not, of course, outweigh their usefulness. Encountering some incomplete batteries, as was the case in this study, requires that modifications be made in either the experimental design or interpretations.

The design was also unbalanced due to the fact that, statistically, in only one cell of four was nondirectiveness hypothesized to enhance therapeutic movement. Yet, improvement was hypothesized for all cells of directiveness. The statistical probability of style of therapy as opposed to any of the client variables, being related to improvement by chance alone, may have been increased. Perhaps this problem could have been dealt with by simply correlating "directiveness" and "nondirectiveness" scores with the outcome measures. For these reasons, the present study should be considered to be exploratory rather than definitive in nature. Its results may, however, serve as an impetus for future research.

CHAPTER VI

SUMMARY

The purpose of this study was to examine the interactions of certain client and therapist variables, and their relationship to improvement in psychotherapy. More specifically, an attempt was made to study the interactions of the initial levels of client attraction and distress with therapist directiveness, and to relate these to improvement in psychotherapy.

Four hypotheses were presented which proposed that outcome is differentially affected by variations in the above mentioned variables. However, unexpected sampling difficulties, in terms of the availability of an adequate number of client protocols, necessitated the modification of the hypotheses. For this reason, this study should be considered to be exploratory rather than definitive in nature.

The subjects in this study were college students who had sought psychotherapy at the Michigan State University Counseling Center. They voluntarily agreed to participate in its research activities.

Attraction to therapy was determined by use of Libo's (1966) Picture Impressions Test, a projective measure. Client distress was determined by two measures, Barron's Ego Strength Scale and a symptomatology

index. The latter consisted of a combination of standard scores from Welsh's Anxiety Scale along with standard scores for the sum of each client's total MMPI scale scores of 70 or higher. Therapist directiveness was measured by Aronson's (1951) directiveness scale. Outcome was determined through pre- post-therapy comparisons of distress scores.

Significant main effects for distress were found. The initially distressed group showed a significant drop in anxiety after therapy, while the initially nondistressed clients demonstrated a significant increase. However, the possibility that even this finding occurred by chance cannot be ignored in view of the number of statistical analyses performed. Methodological issues are discussed.

No significant interactions were uncovered, through an analysis of variance, for the variables of attraction, distress, and directiveness.

Overall, these findings underscore the complexity of research on the psychotherapeutic process. Nevertheless, the author is convinced that meaningful information may be obtained examining the effects of initial distress and attraction. Related research begun subsequent to this initiation of this study (Schaffer, 1974) corroborates this notion. Suggestions for further research directions are discussed.

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APPENDICES

APPENDIX A

DEFINITIONS AND INSTRUCTIONS FOR COUNSELOR CODING CATEGORIES FOR DIRECTIVENESS

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DEFINITIONS AND INSTRUCTIONS FOR COUNSELOR CODING CATEGORIES FOR DIRECTIVENESS

XRC Restatement of Content

A simple repeating of what the client has said without any effort to organize, clarify, or interpret it, or any effort to show that the counselor is appreciating the feeling of the client's statement by understanding it. The wording need not be identical with that of the client.

Emphasis here is on statement of attitudes of others toward the client; statements of fact; statement of conditions of the environment. These statements usually reflect the intellectual rather than the affective aspects of the client's response.

XCFa Accurate Clarification of Feeling

A statement by the counselor which puts the client's feeling or affective tone in a clearer or more recognizable form; or any effort to show that the counselor is accurately recognizing the feeling of the client's statement by understanding it.

Emphasis here is on the client's attitudes and feelings toward the topic being discussed. The clarification, or reflection of the counselor must be reasonably accurate to be scored under this category.

XCFi Inaccurate Clarification of Feeling

A statement by the counselor which expresses attitudes and feelings of the client different from those he has expressed or implied. A mistake or an error has occurred in attempting to clarify the client's verbalized feelings or attitudes.

These statements are characterized by:

1. Reflecting a minor feeling and ignoring a major feeling when both are present in the client's statement.

2. Gross understatement of the client's feeling.

3. Real errors or mistakes as a result of musunderstanding the client.

XCFu Clarification of Unverbalized Feeling

A statement by the counselor which expresses unverbalized attitudes or feelings of the client. A recognition or clarification of a feeling or an attitude which the client has not verbalized but which is clearly implied in the client's previous statements and is in context with these previous statements.

The emphasis here is on recognition or clarifications which go beyond what the client has verbalized but which are implied in his previous statements. "Shrewd guesses" of the client's attitudes which are obtained from the counselor's knowledge of the total situation are coded in this category. Feeling must be clarified to use this category.

XIT Interpretation

Any counselor statement which indicates, even vaguely, a causal relationship in the client's behavior; points out a characterization, explains, or informs the client as to his patterns or personality; provided he has not specifically mentioned it in previous statements.

These statements frequently represent the counselor's attempt to impose his "diagnotic" concepts.

Scoring Notes:

1. Differentiating XRC from XIT: An XIT may be a non-feeling statement and confused with an XRC. However, the presence of a causal inference in the statement would place it in the XIT category.

Pointing out a characterization, explaining, or informing the client as to his patterns or personality goes beyond a restatement of content and would be an XIT. If the client had pointed out the characterization himself in the previous statement, the couselor response would be XRC.

2. Differentiating XCFu from XIT: An XCFu and an XIT might both have elements of unexpressed feeling (see definition of XCFu), but if, in addition, the statement contains elements of causal inference it is classified as XIT.

3. If no feeling has been clarified it cannot be considered an XCFu.

XCS Structuring

Statements which explain the counseling procedure; state the expected outcome of the treatment process in general (not in the client's specific case); the limitations of time; or the responsibilities of the counselor or client.

These statements emphasize the process of counseling itself.

XND Nondirective Leads

Counselor responses which are aimed at eliciting from the client a further statement of his problem.

These responses are planned in such a manner as to avoid limiting the nature of the discussion to a narrow topic.

EXAMPLES:

"What would you like to talk about today?"
"How have things been going?"
"How are you today?" (If asked in a general sense.)

XFT Forcing the Topic

Attempts by the counselor to redirect to the client the responsibility for selecting a topic for discussion; emphasis upon discussing a specific topic; or suggestions that the client discuss or develop a specific topic.

EXAMPLES:

"How do you feel about that?"
"Tell me how you felt then."
"Can you tell me more?"

XCA Proposing Client Activity

Any statement that implies that the client should take any kind of action. This does not imply a change of attitude.

EXAMPLES:

"You should work out in the gym sometimes."
"Why don't you read Shaffer's book on psychology."

XDQ Direct Questions

Questions asked by the counselor to obtain specific information from the client. Asking an outright question that requires the giving of a factual answer.

It does not include counselor statements phrased in the form of a question that really only clarify or restate the previous statement of the client.

EXAMPLES:

"How old are you now?"
"Did you read that book I suggested?"

XPS Persuasion

Any attempt to persuade the client to accept an alternate point of view; an implication that the client should change his attitude or frame of reference.

EXAMPLE:

"Don't you think it would be better that way, now?"

XSA Simple Acceptance

Simple agreement; statements that indicate understanding or assent, but do not imply approval or disapproval.

This category is used if the counselor statement is not an answer to a question.

EXAMPLES:

"Yes," "Mhmm," "I see."
"That's right." (If not in answer to a question.)

XRS Reassurance

Counselor statements which encourage the client; which are intended to reassure the client's self-esteem or self-assurance; or which imply sympathy.

Emphasis here is on items tending to alleviate anxiety by changing the client's evaluation of himself through a minimization of his problem.

XAE Approval and Encouragement

Counselor statements which evaluate the client or his ideals in terms of the counselor's own attitudes in such a manner as to provide emotional support.

This is emphatic acceptance, an obvious reward given by the counselor for an activity of the client.

EXAMPLES:

"That's fine."
"You bet."
"You've covered a lot of ground today; that's good."

XDC Disapproval and Criticism

Any expression of disapproval or criticism of the client by the counselor.

EXAMPLE:

"You need to get hold of yourself."

XFD Friendly Discussion

Any statement of friendly discussion with the client, unrelated to his problems, which are designed to maintain a positive rapport with the client.

XEC Ending of the Contact

Any statement involving the ending of the contact, or making future appointments.

XES Ending the Series of Interviews

Any statement involved in ending the series of interviews which result from the client's discussing the ending of the series.

XUNt Unclassifiable: Due to Transcription Difficulties

Any statement not classifiable because parts of it are missing, it was not clear on the recording, or for any transcription difficulties.

XIX Giving Information

Statements supplying factual data to the client.

XUN Unclassifiable

Any statements not classifiable into one of the other categories.

GENERAL INSTRUCTIONS FOR CODING COUNSELOR RESPONSES:

1. Carefully read the client statement so you will know if the counselor is accurately clarifying it, etc.

2. Read the counselor response. Decide which category it represents and place the number of the response on the work sheet and check the correct column for the category of the response.

3. Place an "a," "i," or "u" in the XCF column if the counselor has reflected feeling, depending on the type of reflection or clarification of feeling made.

4. If more than one type of category is represented in the counselor response indicate the end of each type of response and code as separate responses. Use subscripts of a, b, c, etc. under the number of the counselor statement. Put each coding on a separate line.

WORKSHEET FOR COUNSELOR CODING CATEGORIES

Case Number:_____ Interview Number:_____ Classifier:_____

RESPONSE NUMBER	COUNSELOR CATEGORIES														
	XRC	XCF	XSA	XIT	XCS	XFT	XDQ	XND	XAE	XRS	XIX	XCA	XPS	XDC	MINOR

APPENDIX B

ANALYSIS OF VARIANCE TABLES

APPENDIX B

ANALYSIS OF VARIANCE TABLES

TABLE B-1. Number of F Tests Per Main Effect or Interaction

	Client Distress	Client Attraction	Therapist Directiveness	Total
Client Distress	20*	4	16	40
Client Attraction	4	20*	16	40
Therapist Directiveness	16	16	32*	64
Total	40	40	64	108**

*Main Effects

**Duplicated Entries Ignored

TABLE B-2. Number of F Tests Reading Significance Per Main Effect or Interaction.

	Client Distress	Client Attraction	Therapist Directiveness	Total
Client Distress	5**	0	0	5
Client Attraction	0	0	0	0
Therapist Directiveness	0	0	0	0
Total	5	0	0	5

*$p < .05$ **$p < .005$

APPENDIX B

ANALYSIS OF VARIANCE TABLES

TABLE B-3. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness Across All Hours. Success: Client Pre-Post-Therapy Change T Scores on Barron's Es.

Source	SS	DF	MS	F
Distress	2	1	2	.03
Directiveness	152.37	1	152.37	2.26
Interaction	152.19	1	152.19	2.23
Within	943.8	14	67.42	

TABLE B-3a. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness in First Hour of Therapy. Success: Client Pre- post-Therapy Change T Scores on Barron's Es.

Source	SS	DF	MS	F
Distress	2.36	1	2.36	.03
Directiveness	1.25	1	1.25	.01
Interaction	.18	1	.18	.002
Within	1244.3	14	88.88	

TABLE B-3b. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness in Middle Hour of Therapy. Success: Client Pre- Post-Therapy Change T Scores on Barron's Es.

Source	SS	DF	MS	F
Distress	.98	1	.98	.01
Directiveness	81.3	1	81.3	1.08
Interaction	81.35	1	81.35	1.08
Within	1055.55	14	75.4	

TABLE B-3c. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness in Final Hour of Therapy. Success: Client Pre- Post-Therapy Change T Scores on Barron's Es.

Source	SS	DF	MS	F
Distress	2.36	1	2.36	.04
Directiveness	189.44	1	189.44	2.8
Interaction	119.17	1	119.17	1.78
Within	939.75	14	67.13	

TABLE B-4. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Average Therapist Directiveness Scores Across All Hours. Success: Client Pre- Post-Therapy Change T Scores on Barron's Es.

Source	SS	DF	MS	F
Attraction	164.21	1	164.21	2.75
Directiveness	166.92	1	166.92	2.79
Interaction	43.48	1	43.48	.73
Within	837.35	14	59.8	

TABLE B-4a. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness Scores in First Hour. Success: Client Pre- Post-Therapy Change T Scores on Barron's Es.

Source	SS	DF	MS	F
Attraction	131.28	1	131.28	2.06
Directiveness	25.14	1	25.14	.4
Interaction	224.99	1	224.99	3.54
Within	891.28	14	63.66	

TABLE B-4b. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness Scores in Middle Hour. Success: Client Pre- Post-Therapy Change T Scores on Barron's Es.

Source	SS	DF	MS	F
Attraction	118.51	1	118.51	1.71
Directiveness	45.3	1	45.3	.66
Interaction	9.85	1	9.85	.14
Within	969.55	14	69.25	

TABLE B-4c. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness Scores in Final Hour. Success: Client Pre- Post-Therapy Change T Scores on Barron's Es.

Source	SS	DF	MS	F
Attraction	164.21	1	164.21	2.1
Directiveness	201.23	1	201.23	2.58
Interaction	28.39	1	28.39	.36
Within	1093.75	14	78.13	

TABLE B-5. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness Across all Hours. Success: Client Pre-Post-Therapy Change Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Distress	3077.58	1	3077.58	11.9**
Directiveness	48.02	1	48.02	.19
Interaction	303.12	1	303.12	1.17
Within	3999.3	14	258.67	

**p <.005

TABLE B-5a. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness for First Hour. Success: Client Pre-Post-Therapy Change Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Distress	3341.95	1	3341.95	14.96**
Directiveness	413.85	1	413.85	1.85
Interaction	231.4	1	231.4	1.04
Within	3128.1	14	223.44	

**p < .005

TABLE B-5b. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness Scores for Middle Hour. Success: Pre-Post-Therapy Change Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Distress	3286.24	1	3286.24	12.06**
Directiveness	93.15	1	93.15	.34
Interaction	657.09	1	657.09	2.41
Within	3814.75	14	272.48	

**p < .005

TABLE B-5c. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness Scores for Final Hour. Success: Client Pre- Post-Therapy Change Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Distress	3310.49	1	3310.49	11.56**
Directiveness	133.37	1	133.37	.47
Interaction	208.84	1	208.84	.73
Within	40009.75	14	286.41	

**p < .005

TABLE B-6. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Average Therapist Directiveness Scores Across All Hours of Therapy. Success: Client Post-Therapy T Scores on Barron's Es.

Source	SS	DF	MS	F
Distress	115.75	1	115.75	1.22
Directiveness	19.63	1	19.63	.21
Interaction	9.35	1	9.35	.10
Within	1330.5	14	95.04	

TABLE B-6a. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness Scores in First Hour of Therapy. Success: Client Post-Therapy T Scores on Barron's Es.

Source	SS	DF	MS	F
Distress	49.97	1	49.97	.51
Directiveness	118.06	1	118.06	1.22
Interaction	152.24	1	152.24	1.57
Within	1358.2	14	97.02	

TABLE B-6b. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness Scores in Middle Hour of Therapy. Success: Client Post-Therapy T Scores on Barron's Es.

Source	SS	DF	MS	F
Distress	126.16	1	126.16	1.44
Directiveness	5.12	1	5.12	.06
Interaction	2.05	1	2.05	.02
Within	1227.95	14	87.71	

TABLE B-6c. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness Scores in Final Hour of Therapy. Success: Client Post-Therapy T Scores on Barron's Es.

Source	SS	DF	MS	F
Distress	134.6	1	134.6	1.62
Directiveness	1.13	1	1.13	.01
Interaction	72.98	1	72.98	.88
Within	1161.1	14	82.94	

TABLE B-7. ANOVA of Client Distress by Client Attraction. Success: Client Post-Therapy T Scores on Barron's Es.

Source	SS	DF	MS	F
Attraction	2.73	1	2.73	.04
Distress	107.95	1	107.95	1.42
Interaction	200.6	1	200.6	2.64
Within	1064.2	14	76.01	

TABLE B-8. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Average Therapist Directiveness Scores Across All Hours. Success: Client Post-Therapy T Scores on Barron's Es.

Source	SS	DF	MS	F
Attraction	238.74	1	238.74	.57
Directiveness	301.04	1	301.04	.72
Interaction	536	1	536	1.29
Within	5824.15	14	416	

TABLE B-8a. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness in First Hour. Success: Client Post-Therapy T Scores on Barron's Es.

Source	SS	DF	MS	F
Attraction	51.7	1	51.7	.66
Directiveness	39.83	1	39.83	.51
Interaction	79.06	1	79.06	1.01
Within	1099.45	14	78.53	

TABLE B-8b. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness in Middle Hour. Success: Client Post-Therapy T Scores on Barron's Es.

Source	SS	DF	MS	F
Attraction	3.62	1	3.62	.04
Directiveness	9.39	1	9.39	.11
Interaction	173.79	1	173.79	1.99
Within	1225.45	14	87.53	

TABLE B-8c. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness in Final Hour. Success: Client Post-Therapy T Scores on Barron's Es.

Source	SS	DF	MS	F
Attraction	5.6	1	5.6	.06
Directiveness	.134	1	.134	.002
Interaction	21.36	1	21.36	.23
Within	1332.55	14	95.18	

TABLE B-9. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness Scores Across All Hours. Success: Client Post-Therapy Scores on the Symtomatology Index.

Source	SS	DF	MS	F
Distress	28.35	1	28.35	.11
Directiveness	33.02	1	33.02	.12
Interaction	272.52	1	272.52	.99
Within	2885.75	14	277.56	

TABLE B-9a. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness Scores in First Hour. Success: Client Post-Therapy Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Distress	11.4	1	11.4	.05
Directiveness	139.56	1	139.56	.51
Interaction	173.87	1	173.87	.63
Within	3877.9	14	277	

TABLE B-9b. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness Scores in Middle Hour. Success: Client Post-Therapy Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Distress	19.18	1	19.18	.08
Directiveness	7.84	1	7.84	.03
Interaction	545.8	1	545.8	2.10
Within	3637.95	14	259.86	

TABLE B-9c. ANOVA of Client Distress by Therapist Directiveness. Directiveness: Therapist Directiveness Scores in Final Hour. Success: Client Post-Therapy Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Distress	19.63	1	19.63	.18
Directiveness	5.39	1	5.39	.05
Interaction	263.84	1	263.84	2.37
Within	1562	14	111.58	

TABLE B-10. ANOVA of Client Distress by Client Attraction. Success: Client Post-Therapy Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Attraction	51.54	1	51.54	.2
Distress	15.01	1	15.01	.06
Interaction	453.43	1	453.43	1.73
Within	3674.8	14	262.49	

TABLE B-11. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness Scores Across All Hours. Success: Client Post-Therapy Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Attraction	49.17	1	49.17	.18
Directiveness	47.7	1	47.7	.17
Interaction	248.67	1	248.67	.89
Within	2888.75	14	277.77	

TABLE B-11a. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness Scores in First Hour. Success: Client Post-Therapy Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Attraction	28.13	1	28.13	.11
Directiveness	76.21	1	76.21	.29
Interaction	310.32	1	310.32	1.17
Within	3733.49	14	266.68	

TABLE B-11b. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness scores in Middle Hour. Success: Client Post-Therapy Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Attraction	71.11	1	71.11	.25
Directiveness	37.14	1	37.14	.13
Interaction	87.57	1	87.57	.31
Within	4051.54	14	289.4	

TABLE B-11c. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness Scores in Final Hour. Success: Client Post-Therapy Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Attraction	49.22	1	49.22	.16
Directiveness	23.06	1	23.06	.08
Interaction	319.6	1	319.6	.99
Within	4509.5	14	322.11	

TABLE B-12. ANOVA of Client Attraction by Client Distress. Success: Client Pre- Post-Therapy Change T Scores on Barron's Es.

Source	SS	DF	MS	F
Attraction	133.11	1	133.11	2.00
Distress	16.58	1	16.58	.25
Interaction	87.98	1	87.98	1.32
Within	932.96	14	932.64	

TABLE B-13. ANOVA of Client Attraction by Client Distress. Success: Client Pre- Post-Therapy Change Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Attraction	521.07	1	521.07	2.00
Distress	3409.13	1	3409.13	13.12**
Interaction	157.58	1	157.58	.61
Within	3638.75	14	259.91	

**$p < .005$

TABLE B-14. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness Averaged Across All Hours. Success: Client Pre- Post-Therapy Change Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Attraction	166.92	1	166.92	.34
Directiveness	297.39	1	297.39	.61
Interaction	255.3	1	255.3	.52
Within	6887.35	14	491.95	

TABLE B-14a. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness Scores in First Hour. Success: Client Pre- Post-Therapy Change Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Attraction	74.98	1	74.98	.2
Directiveness	792.87	1	792.87	2.06
Interaction	389.17	1	389.17	1.01
Within	5387.69	14	384.84	

TABLE B-14b. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness Scores in Middle Hour. Success: Client Pre- Post-Therapy Change Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Attraction	80.58	1	80.58	.16
Directiveness	8.55	1	8.55	.02
Interaction	218.33	1	218.33	.43
Within	7194.22	14	513.87	

TABLE B-14c. ANOVA of Client Attraction by Therapist Directiveness. Directiveness: Therapist Directiveness in Final Hour. Success: Client Pre- Post-Therapy Change Scores on the Symptomatology Index.

Source	SS	DF	MS	F
Attraction	289.25	1	289.25	.68
Directiveness	282.4	1	282.4	.67
Interaction	1084.73	1	1084.73	2.55
Within	5952.15	14	425.15	

APPENDIX C

CLIENT SYMPTOMATOLOGY INDEX SCORES

APPENDIX C

CLIENT SYMPTOMATOLOGY INDEX SCORES

TABLE C-1. Pearson Product-Moment Correlations for Barron's Ego Strength Scale T Scores and the Symptomatology Index.

	Barron's Ego Strength Scores	
	Post-Therapy	Pre- Post-Therapy Change
Symptomatology Index	-.83	-.04

TABLE C-2. Determination of Level of Initial Client Distress Based Upon a Median -Split on Pre-Therapy Scores Obtained on the Symptomatology Index.

	Case Number	Symtomatology Score
Distressed	845	127
	815	122
	808	113
	812	107
	855	107
	835	106
	828	105
	801	103
	830	101
Not Distressed	834	100
	858	97
	823	97
	831	88
	829	84
	832	82
	848	82
	849	81
	859	76

TABLE C-3. Client Symptomatology Index: Combination of T Scores Calculated for Welsh's Anxiety Scale and MMPI T Scores of 70 or Higher.

Case Number	Pre-Therapy Sum of Ts	Post-Therapy Sum of Ts	Pre-Post Change
801	103	92	-11
808	113	89	-24
812	107	84	-23
815	122	113	-9
823	97	116	19
828	105	100	-5
829	84	96	12
830	101	110	9
831	88	148	60
832	82	89	7
834	100	92	8
835	106	101	-5
845	127	92	-35
848	82	86	4
849	81	98	17
855	107	93	-14
858	97	86	-11
859	76	83	7

TABLE C-4. Client Z and T Scores Calculated from the Sum of MMPI Standard Scores of 70 or More.

Case Number	Pre-Therapy		Post-Therapy	
	Z	T	Z	T
801	.07	57	-.2	48
808	.45	55	-.61	44
812	-.70	43	-.61	44
815	1.60	66	1.02	60
823	-.70	43	.2	52
828	.45	55	-.61	44
829	-1.08	39	.2	52
830	-.32	47	.2	52
831	2.75	23	3.47	85
832	-.70	43	-.61	44
834	.07	57	-.2	48
835	.07	57	-.2	48
845	1.21	62	-.61	44
848	-.70	43	-.61	44
949	-1.08	39	-.61	44
855	-.32	47	.61	56
858	-.32	47	-.61	44
859	-.70	43	-.61	44

TABLE C-5. Client Z and T Scores Calculated for Welsh's Anxiety Scale Based Upon Raw Scores on Welsh's Anxiety Scale (MMPI).

Case Number	Pre-Therapy		Post-Therapy	
	Z	T	Z	T
801	-.365	46	-.59	44
808	.827	58	-.506	45
812	1.438	64	-1.011	40
815	.589	56	2.275	73
823	.351	54	1.433	64
828	-.007	50	.59	56
829	-.484	45	-.59	44
830	.351	54	.843	58
831	1.543	65	1.264	63
832	-1.080	39	-.506	45
834	-.723	43	-.59	44
835	-.126	49	.337	53
845	1.543	65	-.169	48
848	-1.080	39	-.843	42
849	-.827	42	.421	54
855	.947	60	-1.264	37
858	-.007	50	-.843	42
859	-1.676	33	-1.096	39

TABLE C-6. Sum of Client MMPI Standard Scores of 70 or More.

Case Number	Pre-Therapy Sum	Post-Therapy Sum	Pre-Post Change Sum
801	3	1	-2
808	4	0	-4
812	1	1	0
815	7	4	-3
823	1	2	1
828	4	0	-4
829	0	2	2
830	2	2	0
831	10	10	0
832	1	0	-1
834	3	1	-2
835	3	1	-2
845	6	0	-6
848	1	0	-1
849	0	0	0
855	2	3	1
858	2	0	-2
859	1	0	-1

APPENDIX D

CLIENT BARRON'S EGO STRENGTH T SCORES

APPENDIX D

CLIENT BARRON'S EGO STRENGTH T SCORES

TABLE D-1. Client T Scores Obtained on Barron'es Ego Strength Scale: Pre-Therapy, Post-Therapy, and Pre- Post-Therapy Change Scores.

Case Number	Pre-Therapy T	Post-Therapy T	Change
801	59	65	6
808	43*	65	22
812	59	67	8
815	41*	48*	7
823	64	53*	-13
828	54*	61*	7
829	65	54*	-9
830	62	65	3
831	24*	32*	8
832	54*	54*	0
834	53*	64	11
835	59	65	6
845	45*	62*	17
848	65	70	5
849	56	59*	3
855	51*	58*	7
858	48*	67	19
859	61	62	1

* = Distressed

TABLE D-2. Client Pre- and Post-Therapy Raw Scores (Without K) Obtained on Welsh's Anxiety Scale.

Case Number	Welsh Anxiety Scores	
	Pre-Therapy	Post-Therapy
801	20	10
808	30	11
812	11	5
815	28	27
823	26	34
828	23	24
829	19	10
830	26	27
831	36	32
832	14	11
834	17	10
835	22	21
845	36	15
848	14	7
849	30	22
855	31	32
858	23	7
859	9	4

APPENDIX E

THERAPIST DIRECTIVENESS SCORES

APPENDIX E

THERAPIST DIRECTIVENESS SCORES

TABLE E-1. Average Therapist Directiveness Scores Across All Sample Hours of Therapy.

Case Number	Rater 1	Rater 2	Average Raters 1+2
801	62.38	61.84	62.11
808	74.50	54.75	64.63
812	99.18	98.17	98.67
815	44.80	23.33	34.07
823	47.58	60.40	53.99
828	113.67	86.41	100.04
829	67.78	73.06	70.42
830	59.19	46.83	53.01
831	87.42	79.92	83.68
832	68.04	57.53	62.78
834	54.83	68.92	61.88
835	58.30	59.02	58.66
845	56.70	53.67	55.18
848	43.14	59.47	51.30
849	50.07	42.08	46.08
855	61.94	60.25	61.10
858	35.92	43.08	39.50
859	62.50	65.44	63.97

TABLE E-2. Average Therapist Directiveness Scores for the First Hour of Therapy.

Case Number	Rater 1	Rater 2	Average Raters 1+2
801	41.53	46.18	43.86
808	87.50	23.00	55.25
812	108.25	93.75	101.10
815	50.00	20.00	35.00
823	53.75	43.70	48.73
828	163.50	113.98	138.74
829	58.33	99.53	78.93
830	99.75	75.00	87.38
831	108.25	58.25	83.25
832	75.13	66.66	70.90
834	64.50	82.00	73.25
835	57.45	63.65	60.55
845	56.25	75.00	65.63
848	51.78	78.35	65.07
849	58.25	75.00	66.63
855	64.28	70.53	67.40
858	43.75	31.25	35.50
859	57.63	75.00	66.32

TABLE E-3. Average Therapist Directiveness Scores for the Middle Hour of Therapy.

Case Number	Rater 1	Rater 2	Average Raters 1+2
801	89.37	74.00	81.69
808	78.50	77.50	78.00
812	100.00	107.50	103.75
815	44.15	21.00	32.58
823	47.50	62.50	55.00
828	87.50	62.75	75.13
829	83.65	82.15	82.90
830	38.23	23.50	30.86
831	75.00	81.25	78.13
832	59.58	48.42	54.00
834	50.00	83.25	66.63
835	31.66	33.63	32.65
845	50.45	51.00	50.73
848	33.25	51.32	42.29
849	37.50	12.75	25.13
855	64.30	50.00	57.15
858	37.50	60.75	49.13
859	59.93	50.68	55.30

TABLE E-4. Average Therapist Directiveness Scores for the Final Hour of Therapy.

Case Number	Rater 1	Rater 2	Average Raters 1+2
801	56.25	65.35	60.80
808	57.50	63.75	60.63
812	89.28	93.25	91.26
815	40.25	29.00	34.63
823	41.50	75.50	58.25
828	90.00	82.50	86.25
829	61.37	37.50	49.44
830	39.60	42.00	40.80
831	79.00	100.25	89.63
832	69.43	57.50	63.46
834	50.00	41.50	78.93
835	85.80	79.79	82.79
845	64.00	35.00	49.50
848	54.38	48.75	51.56
849	54.46	38.50	46.48
855	57.25	60.23	58.74
858	26.50	37.25	31.88
859	69.65	70.63	70.14

TABLE E-5. Median Spit on Therapist Directiveness (D Score).

	First Hr.		Middle Hr.		Final Hr.		Average Hr.	
	Case #	D Score	Case #	D Score	Case #	D Score	Case #	D Score
Nondirective	828	138.74	812	103.75	812	91.26	828	100.04
	812	101.10	829	82.90	831	89.63	812	98.67
	830	87.38	801	81.69	828	86.25	831	83.67
	831	83.25	831	78.13	835	82.79	829	70.42
	829	78.93	808	78.00	834	78.93	808	64.63
	834	73.25	828	75.13	859	70.14	859	63.97
	832	70.90	834	66.63	832	63.46	832	62.78
	855	67.40	855	57.15	801	60.80	801	62.11
	849	66.63	859	55.30	808	60.63	834	61.88
Directive	859	66.32	823	55.00	855	58.74	855	61.10
	845	65.63	832	54.00	823	58.25	835	58.66
	848	65.07	845	50.73	848	51.56	845	55.18
	835	60.55	858	49.13	845	49.50	823	53.99
	808	55.25	848	42.29	829	49.44	830	53.01
	823	48.73	835	32.65	849	46.48	848	51.30
	801	43.86	815	32.58	830	40.80	849	46.08
	858	37.50	830	30.86	815	34.63	858	39.50
	815	35.00	849	25.13	858	31.88	815	34.07

APPENDIX F

CLIENT SCORES ON LIBO'S PICTURE IMPRESSIONS TEST

APPENDIX F

CLIENT SCORES ON LIBO'S
PICTURE IMPRESSIONS TEST

TABLE F-1. Determination of Client Attraction to Psychotherapy Based Upon Pre-Therapy Scores Obtained on Libo's Picture Impressions Test.

Case Number	*Score	Attraction
801	+5(4)	Attracted
808	+10(3)	Attracted
812	+10(4)	Attracted
815	-2(1)	Not Attracted
823	+2(1)	Not Attracted
828	-1(3)	Not Attracted
829	+2(3)	Attracted
830	+2(2)	Attracted
831	+2(3)	Attracted
832	0(2)	Not Attracted
834	+1(1)	Not Attracted
835	+3(2)	Attracted
845	-2(3)	Not Attracted
848	+3(4)	Attracted
849	+1(2)	Attracted
855	+13(4)	Attracted
858	+9(3)	Not Attracted
859	-1(3)	Not Attracted

*Number outside of parentheses refers to total Attraction Score. Number inside refers to number of stories that received a score.