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Differences between more and less effective psychotherapists: A study of select therapist variables

Lafferty, Patricia, Ph.D.

The University of Arizona, 1987

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DIFFERENCES BETWEEN MORE AND LESS EFFECTIVE PSYCHOTHERAPISTS: A STUDY OF SELECT THERAPIST VARIABLES

by

Patricia Lafferty

A Dissertation Submitted to the Faculty of the

DEPARTMENT OF PSYCHOLOGY

In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF PHILOSOPHY

In the Graduate College

THE UNIVERSITY OF ARIZONA

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As members of the Final Examination Committee, we certify that we have read the dissertation prepared by Patricia Lafferty

entitled Differences Between More and Less Effective Psychotherapists: A Study of Select Therapist Variables

and recommend that it be accepted as fulfilling the dissertation requirement for the Degree of Doctor of Philosophy.

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SIGNED: Patricia Lafferty

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ABSTRACT

This study examined differences between more and less effective trainee psychotherapists. Trainee therapists were assigned to one of two groups depending on whether their patients' mean change in symptomatology indicated more or less improvement over the course of therapy. Differences between these two therapist groups were examined on a select number of therapist variables that previous research has found to relate to therapy outcome. These variables included: therapist emotional adjustment, relationship skills, ability to elicit patient involvement, credibility, directiveness, and theoretical orientation variables. The variables which were found to be most effective in differentiating between the two groups were specific to the therapy process. The most discriminating variable was the therapist relationship skill of empathic understanding. That is, less effective therapists were revealed to manifest lower levels of empathic understanding, as measured by their patients' perceptions of feeling understood. Next, less effective therapists were distinguished by their own perceptions of their patients as more involved in the therapy process and of themselves as providing more direction and support to patients.

A preliminary examination of differences in the value systems of more and less effective psychotherapists was conducted with the use of the Rokeach Value Survey. This revealed that the less effective

therapists valued their own prosperity and stimulation significantly more than more effective therapists did, and valued their intellectual development significantly less than more effective therapists did. These findings of value differences between more and less effective therapists merit further investigation.

Overall, the present findings with regard to the differences in relationship skills manifest by more and less effective psychotherapists are consistent with previous findings. The findings which suggest that less effective therapists may also manifest: 1), a more general discomfort with affect 2), idiosyncratic perceptions of the therapy process, and 3), a discriminant pattern of values, require further investigation.

CHAPTER 1

BACKGROUND AND PURPOSE

The present study examined differences between more and less effective trainee therapists. Therapist effectiveness was measured by comparing the level of symptomatic distress experienced by patients before and after treatment. Therapists whose patients experienced relatively more distress after treatment were assigned to the less effective group; therapists whose patients experienced relatively less distress after treatment were assigned to the more effective group. This approach to measuring effectiveness is consistent with the recommendations of the NIMH sponsored study evaluating assessment methods in outcome studies (Waskow and Parloff, 1975). A select number of therapist characteristics that have previously been found to enhance therapy gain were examined to elucidate their differential contributions to therapist effectiveness. These included therapist emotional adjustment, relationship attitudes, ability to elicit patient involvement, credibility, directiveness/support, theoretical orientation, and personal values. Particular attention was paid to whether a constellation of characteristics might be seen as characterizing the less effective psychotherapist, given that less is known about such therapists.

Previous Research On Therapist-Induced Deterioration

In general, deterioration has been defined as a worsening of the patient's symptomatic picture which involves the exacerbation of existing symptoms and/or the development of new symptoms (Bergin and Lambert, 1978). Deterioration is assessed by comparing the patient's before and after treatment status.

Bergin and Lambert (1978) state that over 40 studies provide support for the premise that psychotherapy can induce deterioration in some of its recipients. They note, for example, that in controlled outcome studies it has frequently been found that patients who are assigned to treatment groups tend to become either less or more disturbed than they were prior to treatment while untreated control subjects tend to remain about the same when assessed before and after treatment. Further, deterioration has been found to occur in a wide variety of patient populations, with therapists who differ sharply in training and experience, and with a wide variety of treatment techniques (Bergin & Lambert , 1978). Few studies, however, have contributed to an understanding of the mechanisms involved in patient deterioration. The exceptions include the studies of Hadley and Strupp (1976), Ricks (1974), Sloane et al. (1975), Strupp, Hadley, and Gomes-Schwartz (1977), Truax and Mitchell (1971), and Yalom and Lieberman (1971).

From their survey of 70 eminent clinicians and researchers, Hadley and Strupp (1976), and Strupp, Hadley, and Gomes-Schwartz (1977) derived 15 separate factors that lead to deterioration. Those that were

therapist-induced included overly intense therapy, technical rigidity, misplaced focus, and dependency fostering techniques.

In a study utilizing long term outcome data, Ricks (1974) found striking differences in the therapeutic styles and outcomes of two therapists who worked with adolescent boys in a major child guidance clinic. Although the caseloads of both these therapists were equal in degree of disturbance and other characteristics at the beginning of therapy, examination of the adult status of therapist B's patients revealed that 84 percent had become schizophrenic while only 27 percent of therapist A's patients had this outcome. In analyzing differences in these therapists' styles, it was found that therapist A devoted more time to those who were most disturbed while the less successful therapist B did the opposite. In addition, therapist A made more use of resources outside of the immediate therapy situation, was firm and direct with parents, supported movement toward autonomy, and facilitated problem solving in everyday life, all in the context of a strong therapeutic relationship. In contrast, Ricks (1974) describes therapist B as "moving precipitously into presumably deep material" without also helping his patients to develop ways of coping with the issues and feelings this material raised. Further, analyses of these therapists' case notes suggest that therapist B seemed to become depressed when confronted with difficult patients and, in one case, clearly reinforced a patient's sense of self-rejection and futility.

VandenBos and Karon (1971) also found a relationship between therapists' emotional adjustment and their effectiveness in a study that

examined therapist "pathogenesis" using the Thematic Apperception Test. Pathogenic therapists were defined as those who consciously or unconsciously used their patients to satisfy their own needs. These researchers found that after six months of treatment, the patients of pathogenic therapists were consistently functioning at lower levels, across diverse indices of functioning, than were the patients of more benign therapists.

In an oft-cited and revealing study of the effects of encounter groups, Yalom and Lieberman (1971) found that the style of the group leader was the major cause of patient deterioration. The most damaging style was characterized by an intrusive, aggressive approach that involved considerable challenging of the group members. These leaders were labeled "Aggressive Stimulators"; they were impatient and authoritarian in approach and they insisted on immediate self-disclosure, emotional expression, and attitude change. Yalom and Lieberman's study included 5 leaders of this type, all of whom produced deterioration except one who stated that he realized there were fragile persons in his group and "pulled his punches." Further, group members who were identified as gaining the most from the group emphasized the importance of being accepted, liked, and cared for by the group leader and by group members.

The client-centered school of psychotherapy has produced the most literature on deterioration to date (Lambert, Bergin, & Collins, 1977). In particular, the therapist-offered conditions of accurate empathy, positive regard, nonpossessive warmth, and genuineness, as

experienced by the patient, have been found to correlate with (and perhaps produce) positive outcomes (Lambert & Bergin, 1983). A corollary finding has been that low levels of these relationship variables have been found to be associated with patient deterioration (Lambert & Bergin, 1983). In a review based upon several controlled outcome studies employing both individual and group treatment, and a diversity of patient populations, Truax and Mitchell (1971) conclude that "the patients seen by therapists low in accurate empathy, and non-possessive warmth, and genuineness account for the vast majority of deteriorated cases, while therapists high in these conditions account for the majority of the benefitted and "no change patients" (p.312).

Purpose of the Present Study

The present study was conducted to contribute to the present available knowledge about therapist effectiveness. Although a fair amount is known about those therapist characteristics that are associated with positive psychotherapy outcome (e.g. Beutler et al., 1986), the factors involved in less favorable outcome have not received substantial study. The present study cannot claim to be an investigation of deterioration-inducing therapists because the symptomatology of the patients in the less effective group did not worsen in all cases. Rather, the post-treatment status of the less effective group was merely indicative of less improvement than the post-treatment status of the patients of the more effective therapists. Thus, the present study is an investigation of differential effectiveness between therapists. The specific variables to be

investigated include those that have been found to be important in research on deterioration as well as some of the therapist variables that research has found to facilitate improvement in psychotherapy. These select variables were examined to determine their relative contribution to distinguishing between more and less effective trainee therapists.

Previous research has found that the most consistent and relatively strong effects on outcome are exerted by variables involving inferred characteristics of the therapist that are specific to the treatment process, such as therapist relationship attitudes and social influence attitudes (Beutler et al., 1986). The present study expected to find that these variables most clearly differentiated between more and less effective therapists. These variables may be contrasted with variables that must also be inferred but which exist independently of the therapy process, such as therapist emotional adjustment and values. These extratherapy characteristics were examined but were assumed to exert an unplanned and incidental effect on therapy outcome and, thus, were expected to be less strongly related to differential effectiveness. Further, demographic variables such as therapist age, sex, and ethnicity - variables that also exist apart from the therapy process but that can be externally observed - have been found to exert little direct impact on therapy outcome (Parloff et al., 1978) and, thus, received minimal consideration in the present study.

Therapist Variables

Emotional Adjustment

The influence that therapist emotional disturbance may have on patient deterioration is suggested by both the Ricks (1974) and VandenBos and Karon (1971) studies. Moreover, most major reviews on therapist variables (e.g. Beutler, Crago & Arizmendi, 1986; Lambert & Bergin, 1983; Parloff et al., 1978) suggest that therapists' emotional stability is positively related to psychotherapy process and outcome. These reviews cite the studies of Anchor (1977), Bergin (1966), Bergin and Jasper (1969), Bergin and Soloman (1970), Bugen (1979), Cutler (1958), Donner and Schonfield (1975), Garfield and Bergin (1971), Moras and Strupp (1982), Ricks (1974), Singer and Luborsky (1977), VandenBos and Karon (1971), and Wogan (1970). These studies all suggest that the therapist's level of emotional stability can be positively related to various process and outcome criteria. In their review of this area, Lambert and Bergin (1983) conclude, however, that the adjustment of the therapist continues to warrant further investigation. The present study expected to find that this variable was able to significantly discriminate between more and less effective therapists.

Relationship Attitudes

The therapist variables that have been most extensively studied with regard to patient deterioration have been those identified by the client-centered school as "necessary and sufficient" conditions for patient change. These include accurate empathy, nonpossessive warmth, congruence, and positive regard. The current consensus in the

literature relating these conditions to deterioration and improvement is that low levels of these variables have been associated with deterioration while higher levels correlate with (and perhaps produce) positive outcomes (Lambert & Bergin, 1983). However, this conclusion with regard to deterioration is based upon more limited data than this conclusion with regard to improvement (Lambert et al., 1977). The present study employed these relationship variables in an effort to replicate previous findings and to directly examine the relative contribution of these variables to differential effectivenes when studied simultaneously with other therapist variables.

It is important to note that, until recently, initial positive findings relating the presence of facilitative relationship conditions to treatment gains (Truax & Carkhuff, 1967) had given way to inconsistent findings (Beutler, Johnson, Neville & Workman, 1973; Chinsky & Rappaport, 1970; Garfield & Bergin, 1971; Gurman, 1973). More recently, however, reviews of the available literature (e.g. Gurman, 1977; Lambert, DeJulio & Stein, 1978) suggest that the initially proposed relationship does indeed appear to be true when patients' perceptions of therapists form the basis for determining the presence of these conditions rather than assessing them with the judgements of independent observers. This finding has led to an increased emphasis on the importance of the patient's contribution to a productive therapeutic relationship; the presence of Roger's (1959) necessary and sufficient conditions has come to be regarded as function of the interaction of the therapist and patient rather than as being created solely by the

therapist. The methodological impact of this finding has been that therapists' "relationship skills" are seen as best measured by patient perceptions. Thus, the present study used patients' assessments of therapists' empathy, regard, acceptance and congruence. Further, because of the current status of these variables in the outcome literature, the present study expected that they would be relatively effective in differentiating between more and less effective therapists in contrast to the other variables examined in the present study.

Patient Involvement

The idea that the quality of the therapeutic relationship is a function of both the patient and the therapist has resulted in increased interest in the nature of the patient's contribution to a productive therapeutic alliance. Patient involvement in psychotherapy has been found to be a particularly powerful variable in relation to subsequent improvement (Beutler et al., 1986). Baer et al. (1980) define patient involvement as the extent to which the patient is motivated for treatment and able to enjoy it, and the degree to which the patient participates actively by demonstrating self-awareness, self-disclosure, insight or behavior change; these authors and Beutler et al. (1980) found this dimension of the psychotherapy process to be strongly related to outcome as measured by therapists ratings of improvement. Gomes-Schwartz (1978) also found that patient involvement in psychotherapy was the most powerful among a number of patient and therapist variables in relation to subsequent improvement. This

conclusion has received further support from Marziali, Marmor and Krupnick (1981).

The present study determined the mean level of involvement of the patients of each particular therapist. Given this approach, patient involvement may be regarded as a therapist-influenced variable. This approach to examining patient involvement was used to determine whether a significant difference exists between more and less effective therapists with regard to their abilities to engender involvement in the therapeutic process among their patients.

Credibility

Discriminative definition of the concept of credibility has eluded psychotherapy researchers. Credibility has been defined as various combinations of perceived expertise, trustworthiness, objectivity, attractiveness, and persuasiveness (Beutler & McNabb, 1981; Corrigan, 1978; Strong, 1968; Truax, Fine, Moravec, & Millis, 1968). Beutler (1983) defines credibility as "...the therapist being perceived as a knowledgeable, educated, and helpful individual who has both the skill and training to bring to bear on the patient's dilemma" (p. 25).

Despite a lack of consensus on the precise definition of credibility, both social influence research and psychotherapy research have generally suggested that those who are perceived as experts and who engender trust produce greater influence over attitude and behavior change that do nonexperts (Aronson, Turner & Carlsmith, 1963; Bergin, 1962). A number of analogue studies have shown therapist expertness to be positively correlated with the patient's choice of therapist

(Corrigan, 1978), levels of rated attraction and trustworthiness (Greenberg, 1969; McKee & Smouse, 1983), information recall (Guttman & Haase, 1972), attitudinal change (Binderman, Fretz, Scott & Abrams, 1972; Bergin, 1962) and to both self reported and actual behavior change (Dell, 1973; Hoffman & Spencer, 1977). In one of a few naturalistic long term treatment studies, Beutler, et al. (1975) found that patients post hoc perceptions of therapist credibility were significantly and positively related to patient improvement. Childress and Gillis (1977), Goldstein (1971), Heppner & Heesaker (1982; 1983) have also employed naturalistic research designs and have found that perceptions of therapists' credibility and expertness facilitate psychotherapeutic improvement. In a major review of the literature on therapist variables, Beutler et al. (1986) conclude that perceived credibility exerts a strong and consistent influence on outcome that is rivaled by few other therapist variables. Thus, the present study examined the relationship between this significant variable and relative effectiveness. This study expected that perceived credibility would strongly differentiate between more and less effective therapists.

Therapist Directiveness/Support

This therapist style variable primarily distinguishes between therapists who take a leading, structuring, initiating role in therapy and those who respond with open-ended invitations to talk (Lambert & Bergin, 1983). A number of studies suggest that relatively effective therapists provide more direction for their patients than do less effective ones (Andrews, 1976; Beutler et al., 1980; Bergin, 1971;

Foreman & Marmar, 1984; Gomes-Schwartz, 1978; Grigg & Goodstein, 1957; Hill et al., 1983). However, other studies have found that low levels of directiveness are beneficial to treatment (Lorr, 1965; Mintz et al., 1971) and still others have obtained nonsignificant or zero-level effects (Ashby et al., 1957; Cooley & Lajoy, 1980; Goin et al., 1965; Luborsky, et al., 1980). Thus, the current status of the research on directiveness as a unidirectional variable reveals inconsistent findings. In a major review of the literature on therapist variables, Lambert and Bergin (1983) suggest that additional studies are needed to supplement the data already collected in this area.

The present study used a measure of directiveness that primarily contains items whose content refers to the therapist's taking a active, structuring role in the therapy process. However, this measure also contains items whose content involves the therapist's providing concern, support, and "sympathy" for the patient's difficulties. Thus, the present study did not employ a conceptually "pure" measure of directiveness which must be taken into account when interpreting the findings. This measure was used because it has previously been found to discriminate between trainee therapists whose relative effectiveness was assessed by their supervisors (Beutler, Dunbar & Baer, 1980).

The present study expected that this variable would significantly discriminate between more and less effective therapists. Further, it was expected that more effective therapists would be found to offer their patients more emotional support and would provide more direction by establishing specific treatment goals, recommending

activities to reinforce the gains made in therapy, and offering more clarification and information to the patient.

Theoretical Orientation

The theoretical orientations of therapists have quite consistently been shown to relate to differences in the type of activity employed by different therapists (Brunink & Schroeder, 1979; Cross & Sheehan, 1982; Larson, 1980; Lohmann & Mittag, 1979; Luborsky et al., 1982; Meara et al., 1981; Sloane et al., 1975). However, there have been relatively few differences in treatment outcome found to result from different theoretical orientations (Luborsky, Singer & Luborsky, 1975). For example, Smith, Glass & Miller (1980) conducted an extensive meta analysis to examine whether there are significant differences in outcome as a result of different therapeutic approaches. They found that the amount of the variance accounted for by different treatment methods was small. However, cognitive and behavior therapies were found to produce the two highest effect sizes and to impact a broader range of problems than the four other classes studied. The meta analysis of Shapiro and Shapiro (1982) likewise found that cognitive and behavioral treatments produced the largest effects, although treatment methods were found to account for only 10% of the substantial variance that differentiated treated from untreated groups. Miller and Berman (1983), thus, conducted a meta analysis of 48 studies to examine differences in outcome between cognitive and behavioral interventions. They found no significant differences and concluded that both treatments obtain similar effects. This finding has been supported by the work of

Gallagher and Thompson (1982), Taylor and Marshall (1977), and Wilson et al., (1983).

Because of this dearth of findings differentiating the effects of one psychotherapy from another, increasing attention has subsequently been paid to the possibility that even though the average effects of different psychotherapies may be the same, patients with different characteristics may respond differently to different interventions. In pursuit of this possibility, Beutler (1979c) reviewed 52 comparative psychotherapy studies in which differences were found between different psychotherapies and extrapolated three patient dimensions which appeared to determine the effectiveness of different approaches. These dimensions included symptom complexity, style of defense, and degree of sensitivity to perceived threats to autonomy. This effort suggests that a consideration of highly specific patient dimensions may be quite helpful in attempting to match patients to the most useful procedure. (Patient diagnosis, on the other hand, appears to be too broad a dimension to allow for effective matching.)

The present study examined the contribution that theoretical orientation variables made to effectiveness. It was anticipated that these variables would not significantly differentiate between more and less effective therapists dealing with nondistinguished patient groups. The intent of the present study was to examine the relative contributions of outcome made by specific therapist variables, rather than to test hypotheses about therapist-patient matching. Thus, the relationships between therapists' theoretical orientations and patient

variables was not examined. However, the potential sources of variance were not ignored because of the importance theoretical orientation is accorded by current methods of training psychotherapists and by traditional explanations of patient change.

Values

Considerable importance is attached to the role of values in psychotherapy although there has been little empirical research in this area (Barrett & Wright, 1984). This is most likely due to methodological problems in this area including the lack of a consensual definition of the concepts of belief, attitude and value, difficulty determining what values are likely to be important in psychotherapy, and difficulties in assessing cause and effect relationships (Beutler et al., 1986).

The importance of studying therapist values is underscored by the proposal that psychotherapy is a process of persuasion in which the effective therapist will influence the beliefs of his or her patient (Beutler, 1971a, 1971b, 1979a, 1979b; Frank, 1973; Goldstein et al., 1966; Goldstein & Simonson, 1971; Strong, 1968). Reviews of relevant empirical research (Beutler, 1981; Kessel & McBrearty, 1967) do suggest that, in substantial numbers of instances, patients do adopt therapists values. Beutler (1981) documented a consistent and strong relationship between the degree to which the patient acquires the therapist's attitudes (convergence) and the amount of therapeutic improvement attained. In this review, both convergence and improvement were assessed on a wide variety of dimensions. Thus, the effective therapist

may be able to motivate his or her patient to assimilate a new set of values that are more in line with those of the therapist (Beutler, 1983).

Tjeltveit (1986) discusses the serious ethical problems raised by the finding that patients adopt (or are converted to) their psychotherapist's values. He distinguishes between mental health values and moral, religious, and political values. He suggests that when a patient adopts the therapist's mental health values, no ethical problems arise because this is consistent with both the therapist's societally recognized competence in this area and the patient's desire for improved mental health. He suggests that when therapists influence their patients moral, religious or political values, this is problematic because they are: (1), most likely operating beyond the limits of their competence, (2), may be adversely effecting the patient's right to fully choose his or her own values (3), may be violating an implicit or explicit therapeutic contract, and/or (4), may be operating without the informed consent of the patient.

Tjeltveit proposes several solutions for addressing the ethical problems raised by dealing with values in psychotherapy. Among these, he suggests that theapists receive formal training in ethics and value theory, become more aware of their own personal values, and become more aware of their assumptions regarding the relationship of mental health and moral, religious, and political values.

In light of the proposed importance of the role of values in psychotherapy, the present study conducted an exploratory examination of

the value systems of more and less effective trainee therapists. This was done to see if there were significant differences between these two kinds of therapists with regard to values and thus, whether some value systems might be said to be more conducive to improvement in psychotherapy than others.

CHAPTER 2

METHOD

Therapists

Thirty trainee therapists were divided into two groups on the basis of their patients' mean change in symptomatology over the course of treatment. One group included fifteen therapists' whose patients' symptoms tended to improve over the course of treatment and the other group included fifteen therapists' whose patients' symptoms failed to change or became more severe. The therapists assigned to the former group were collectively labeled "more effective" while the therapists in the later group were labeled "less effective."

Each therapist was assigned to a group using a mean residual symptom change score that reflects the mean change in symptomatology of two patients whom the therapist has treated. Symptom change scores were obtained by calculating the difference between each patient's pre-treatment and post-treatment scores on the Global Severity Index of the SCL-90-R. The SCL-90-R is a 90-item self-report symptom inventory with established reliability and validity (Derogatis et al., 1976). The SCL-90-R has been recommended for use in assessing psychotherapy outcome by the NIMH-sponsored study of assessment in outcome studies (Waskow & Parloff, 1975). The Global Severity Index is the best single indicator of the level of a patient's distress which can be obtained from the

SCL-90-R (Derogatis et al., 1976). The GSI combines information on the numbers of symptoms a patient reports, with the reported intensity of those symptoms, to generate a single measure of the amount of distress a patient is experiencing. This score can be compared to the GSI scores of different normative groups to determine how disturbed an individual is relative to a particular normative group.

Residual change scores rather than uncorrected change scores were used because they are thought to provide more reliable and stable measures of outcome (Beutler & Crago, 1983). These are post- minus pre-treatment difference scores which have been corrected for the correlation between initial and end point ratings. This was done to compensate for the artifactual change that may be reflected in post-minus pre-treatment difference scores because of the influence of regression effects. Mean residual change scores were calculated for each therapist by taking an average of the residual change scores of two patients whom the therapist has treated. These scores were used to assign the therapist to the more effective or to the less effective group. The fifteen therapists whose patients' mean residual change scores were negative were assigned to the less effective group; the fifteen therapists whose patients' mean residual change scores were positive were assigned to the more effective group.

For therapists who treated more than two patients, change score data on only two patients were used, this as obtained by randomly excluding data from consideration until data on only two patients per

therapist remained. This was done so that each therapist could be assigned to a group on the basis of the same number of patients.

The thirty trainee therapist used in the present study were obtained from a larger sample of forty-five trainees, each of whom had treated patients in individual psychotherapy in a psychiatry department outpatient clinic. The present therapists were selected because they each: (1) had two or more patients who completed pre- and post-treatment SCL-90-Rs and (2) treated patients who earned negative or positive mean residual change scores. Eleven therapists were excluded from consideration because they had seen only one patient in treatment who completed pre- and post-treatment testing. Three therapists were excluded because their patients' mean residual change scores were essentially zero, indicating neither more nor less improvement.

19 men and 11 women who ranged in age from 23 to 38 years (M = 29.73, S.D. = 3.92) were the trainee therapists in this study. All but 4 were Caucasian. All of them were mental health trainees and included 11 psychiatric residents, 12 clinical psychology interns and externs, 5 clinical social work trainees, and 2 psychiatric nursing trainees. The majority of patients were thus seen by either the psychiatric residents or by the psychology trainees. Expressed, preferred theoretical orientations included psychodynamic (59.3%), eclectic (29.6%), client-centered (7.4%), and behavioral (3.7%).

Patients

Sixty outpatients who sought treatment over a 24 month period through a university psychiatric clinic are involved in this study. All

patients who obtained treatment in the clinic were asked to complete pre- and post-treatment measures, except those with organic brain syndromes, those with schizophrenic disorders, those for whom the recommended treatment was not individual psychotherapy, and those who refused to sign the informed consent form. The sixty patients in the present study were selected from a larger sample of 106 patients who had completed pre- and post-treatment testing, so that each therapist could be assigned to a group on the basis of the mean symptom change of two randomly selected patients from their case loads.

It is also important to note that patients were originally assigned to therapists for treatment in a manner approaching randomness. After an initial screening by a senior psychiatric resident to determine their appropriateness for individual therapy, they were assigned to therapists on a rotational schedule with allowances given for scheduling and case loads. To ensure the lack of a systematic bias in one assignment of patients to the present groups of therapists, a series of validational analyses were conducted by the present researcher. These are discussed in the results section of this paper.

The sixty patients included in this study consisted of 11 males and 49 females who ranged in age from 19 to 68 ($\underline{M}$ = 30.88, S.D. = 10.87). All but 3 were Caucasian, 2 were Mexican-American and 1 was an American Indian. The present patients primarily received diagnoses of anxiety and affective disorders; patients also received diagnoses of adjustment disorders and conditions not attributable to a mental disorder that are a focus of treatment (e.g., marital problems).

Pre-treatment Standardized (T score) Global Severity Index (GSI) scores from the SCL-90R (Derogatis et al., 1976), for the present sample, ranged from 25.00 to 69.00 with a mean of 49.08 (S.D. = 8.99) when plotted on outpatient norms. This reveals that the current sample's pre-treatment symptom severity was similar both to the present clinic's typical patient population and to typical outpatient populations more generally.

The average number of sessions for patients in this study was 17.48 (S.D. = 12.45), with a range of 3 to 60. 33 patients (i.e., 55% of the total sample) terminated therapy with their therapist in a planned fashion. 18 patients (i.e., 30%) ended therapy prior to any planned termination date (i.e., they "dropped out" of treatment). 9 patients (i.e., 15%) were transfered to another therapist when the trainee therapist completed their training responsibilities.

Measures

Emotional Adjustment

Therapist adjustment was measured by the neuroticism scale of Form A of the Eysenck Personality Inventory (EPI) (Eysenck & Eysenck, 1968). The EPI is a 57-item self-report questionnaire designed to assess personality along the dimensions of extraversion-introversion and neuroticism-stability. Each of these traits is measured by 24 questions, selected on the basis of item and factor analyses, to which the respondent answer's "Yes" or "No". Neuroticism is defined by the Eysencks as "... general emotional overresponsiveness and liability to neurotic breakdown under stress" (1968, p. 5). Eysenck and Eysenck

(1968) report test-retest reliability coefficients of .84 and .88 on the neuroticism scale for two groups of normals who retook Form A of the test at one year and at nine months, respectively. These authors also present considerable evidence for the factorial, construct and concurrent validity of neuroticism scale, as well as documenting the validity of this scale by using the method of nominated groups.

Relationship Attitudes

The Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962) was used to measure therapists' relationship attitudes. This is a questionnaire which assesses patients' perceptions of therapists along four dimensions originally described by Rogers (1957): (1) empathic understanding, (2) positive regard, (3) unconditional acceptance, (4) congruence. The Relationship Inventory consists of 85 statements that are rated by patients using a six-point scale, the end points representing strong agreement and strong disagreement. This instrument is scored by simply calculating an algebraic sum of patients' responses to the items which comprise each dimension. Snelbecker's (1967) revision for participant observers (Form OS-M-C) of the original scale was used in the present study. Snelbecker (1967) obtained split-half reliability coefficients in the +.80s for Form OS-M-C. See Appendix 1 for a copy of this questionnaire. The items that compose each scale are presented in Appendix 2.

Patient Involvement

Patient involvement was measured using the therapeutic participation factor of the Psychotherapy Process Inventory (Baer

et al., 1980), an instrument reprospectively completed by the therapists for each individual patient. The therapeutic participation factor is derived from this 74-item therapy process inventory which has demonstrated factorial validity, internal consistency, and interrater reliability. The therapeutic participation factor consists of sixteen items that address the patient's achievements in the therapy and his or her motivation in the therapy. The three items which load the highest on this factor are:

1. The patient tried to change his/her behavior.
2. The patient was able to apply the therapeutic experiences in every day life.
3. The patient expressed satisfaction with his/her progress.

Thus, this factor is thought to reflect the extent to which the patient participates productively in the therapeutic process by demonstrating self-disclosure, self-awareness, insight or behavioral change, and the extent to which the patient is seen as motivated for treatment and satisfied with treatment.

This factor has been found to differentiate between trainee therapists rated as high or low in effectiveness by their supervisors (Beutler, Dunbar & Baer, 1980).

Each item of this factor was rated by the therapist on a 5-point scale with regard to the patient's participation, on the average, over the entire length of the therapy.

The score for this factor is the mean of the therapist's ratings of all of the items. Higher scores reflect greater amounts of perceived patient participation. The normative mean score on this factor is 3.00 with a standard deviation of .60 (Baer et al., 1980). This factor was

found to have a .92 alpha reliability coefficient by Baer et al., indicating that it provides a sufficiently reliable measurement.

The Psychotherapy Process Inventory is reproduced in Appendix 3 and the items which comprise the various factors yielded by this instrument are reported in Table 2, along with the expected mean scores on these factors and their standard deviations.

Directiveness/Support

Therapist directiveness and support was measured using the directive support factor of the Psychotherapy Process Inventory (Baer et al., 1980). This factor is derived from a 74-item therapy process inventory with demonstrated factorial validity, internal consistency, and interrater reliability. This factor consists of eight items concerning the level of the therapist's activity and the amount of concern and support provided to a specific patient over the course of treatment. The three items which load the highest on this factor are:

1) The therapy involved giving the patient directions.
2) The therapy involved giving the patient homework.
3) Explicit therapeutic goals were established with the patient.

Each item of this factor was rated by the therapist on a 5-point scale with regard to his or her activity level, on the average, over the entire length of the therapy. The factor score is the mean of the therapist's ratings of all the items. Higher scores on this factor reflect higher levels of activity and support. The normative mean score on this factor is 2.63 with a standard deviation of .70 (Baer et al., 1980).

This factor was found to have a .83 alpha reliability coefficient by Baer et al., indicating that it is a sufficiently reliable measurement device. See Appendix 4 for a list of the items which compose this factor.

Credibility

The Therapist Credibility Scale (Beutler & McNabb, 1981) was used to assess patients' perceptions of therapists' credibility and attractiveness. This scale consists of twelve pairs of adjectives on which the patient rates his or her therapist on a scale ranging from one to seven. One is the lowest negative rating and seven is the highest positive rating. The therapist's overall score is obtained by summing the ratings given him or her in each of the twelve variables. Scores can range from 12 to 84, with 48 representing a neutral or middle rating. The validity of this scale is based on the work of Beutler, Jobe and Elkins (1974), in which the scores of this scale were found to have both construct validity and to have a reasonably close correspondence to treatment gain. A copy of this scale can be found in Appendix 5.

Theoretical Orientation

The Therapist Orientation Questionnaire (TOQ) originally developed by Sundland and Barker (1962) and revised by Sundland (1977) was used to measure theoretical orientation. This questionnaire consists of 76 statements concerning therapist's beliefs about what is desirable in therapy. These statements were rated by therapists on a

5-point scale which ranges from strong agreement to strong disagreement. This instrument was then scored to yield eleven first order factors and three second order factors or clusters (Sundland, 1977). The ratings on each of the items that constitute a specific factor were summed and then converted into a standard score. A standard score was obtained for each factor. The unstandardized factor scores were summed to generate three cluster scores. The cluster scores were then also transformed into standard scores.

The factors and clusters obtained may be briefly described as follows. Factor 1 involves the therapist's beliefs about the usefulness of expressive techniques. Factor 2 indicates the therapist's belief in basic analytic tenets. Factor 3 reflects the therapist's belief in the importance of having a treatment plan and helping the patient adjust to society. Factor 4 concerns the therapist's level of activity in therapy. Factor 5 involves the therapist's stress on the importance of the patient's being more aware of his feelings in therapy. Factor 6 involves the therapist's valueing of being emotionally involved and caring for his or her patients. Factor 7 concerns the therapist's belief regarding the existence of an innate drive toward health in people. Factor 8 measures the therapist's reported lack of counter transference feelings. Factor 9 involves the therapist's belief about whether therapy is more an art than a science, and about the importance of the personality of the therapist. Factor 10 concerns the therapist's belief about whether the learning process in therapy is a verbal and conceptual one. Factor 11 reflects the therapist's acceptance of physical contact with patients and marathons.

Three secord order factors or clusters were obtained by Sundland (1977). Cluster 1 is composed of Factors 1,5,7,6,9,11, and 2 and seems to indicate an experiential approach. Cluster 2 is composed of factors 11,2,4,6 and 1 and reflects a formal, passive, psychoanalytic approach. Cluster 3 consists of Factors 9,10,8,6,11,1 and 3 and seems to involve beliefs that are characteristic of behavioral and cognitive therapists. Scores on these clusters are not mutually exclusive, however. It is possible to score high on all three clusters. These factors and clusters do appear to have construct validity as indicated by Sundland's (1977) findings that the factor/cluster scores of different professional groups are significantly different in a manner which is consistent with expectation. For example, he found that psychiatrists in his sample were characterized as more "psychoanalytic" by the TOQ.

Both the individual factor scores and the cluster scores were used in the present study to examine their ability to discriminate between the two therapist groups. However, only the cluster scores were used in the main discriminant function analysis. Differences between the groups on the factor scores were examined with supplementary one-way analyses of variance. See Appendix 6 for a description of the factors which make up each cluster and Appendix 7 for a brief description of the factors. A copy of this instrument in its entirety is contained in Appendix 8.

Values

The Rokeach Value Survey (RVS) (Rokeach, 1973) was used to assess therapist values. Rokeach defines a value as an enduring belief

that a specific end-state of existence (terminal value) or mode of conduct (instrumental value) is preferable to its opposite. He defines a value system as an array of values along a continuum of relative importance. His instrument is based on his theoretical work and is designed to assess the two independent value systems he has identified by obtaining a rank ordering of single values within each system. The instrument consists of two value scales composed of eighteen items each which are listed alphabetically and accompanied by a brief description. The respondent is instructed to rank order each set of 18 values in order of their importance in his or her life. The rank orders thus obtained constitute the scores generated by this test. The rankings obtained are frequently used to compare the value systems of different groups.

Test-retest reliabilities have been obtained for value rankings by various groups which range from .63 to .80 for terminal values and from .53 to .72 for instrumental values. These groups were retested anywhere from 3 weeks to 14-16 months later (Rokeach, 1973).

Rokeach's (1973) book, The Nature of Human Values, offers an extensive amount of data bearing on the construct validity of the RVS relative to Rokeach's theories of values in relationship to the quality of life in America, political and social behavior, and cognitive change. Many research studies are reported and, among other variables, value ranks are related to sex, income, education, race, age, religion, 1968 presidential candidates, political and social attitudes and behavior, and membership in groups ranging from American Catholic priests to artists in Calcutta.

Despite criticism of the ipsative nature of the data and the wording of the items, the RVS appears to be a useful research instrument in this early stage of value theory development because of its reliability, construct validity, and the extensive norms which Rokeach has collected (Cohen, 1978; Kitwood, 1978). See Appendix 9 for a copy of this instrument.

Procedures

Patient evaluation took place before treatment began and when treatment ended. Patients completed pre- and post-treatment SCL-90-Rs, and also completed the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962) and the Therapist Credibility Rating Scale (Beutler & McNabb, 1981) at the end of treatment. Therapists took the Eysenck Personality Inventory (Eysenck & Eysenck, 1968), the Rokeach Value Survey (Rokeach, 1973), and the Therapist Orientation Questionnaire (Sundland, 1977) at the beginning of the academic year prior to the assignment of outpatient caseloads; they completed the Psychotherapy Process Inventory (Baer et al., 1980) for each assigned patient at the end of treatment. These instruments were given to therapists and patients by a research assistant who monitored the trainee's case loads to determine when pre- and post-treatment data needed to be obtained. When patients terminated treatment in an unplanned fashion, this research assistant still contacted them to supply the instruments and request that they be completed.

CHAPTER 3

RESULTS

Preliminary Analyses

Before initiating the primary analyses, a number of validational analyses were conducted. As mentioned in the methods section, the severity of the pre-treatment symptomatology of the present sample was compared to the severity of the presenting symptomatology on the normative samples provided by Derogatis et al. (1977). This was done in order to determine the representativeness of the present patient sample. This was accomplished by converting patients' raw GSI (Global Severity Index) scores from the SCL-90-R into standardized T-scores using the outpatient norms provided by Derogatis et al. (1976). The T-scores obtained range from 25.00 to 69.00 with a mean of 49.08 (S.D. = 8.99). This indicates that the overall level of symptomatic distress experienced by the present sample prior to treatment could be said to be within normative limits for individuals seeking outpatient treatment.

Chi-square analyses were then conducted to determine whether there were any significant differences between the two therapist groups with regard to patient gender, ethnicity, or type of termination evidenced by patient. With regard to termination, three different outcomes were possible: (1) the patient could have terminated therapy in a planned fashion after discussion with the therapist, (2) transfered

to a new therapist at the end of the training rotation, or, (3) terminated therapy prematurely. Premature termination was defined as a failure to attend two consecutively scheduled appointments, fewer than twelve sessions, or a refusal to continue in spite of the therapist's advice to the contrary. As indicated in Table 1, no significant differences were found with regard to these patient variables of type of termination, ethnicity, or gender.

One-way analyses of variance were conducted to examine whether any significant differences existed between the two therapist groups with regard to patient age, total number of sessions attended, or severity of pre-treatment symptomatology (pre-treatment GSI). As indicated in Table 2, no significant differences were found on these variables either.

Both the chi-square and the one-way analyses of these external, observable patient characteristics were done to examine the comparability of the patients seen by each therapist group. This was done to examine whether outcome differences between the groups could be more readily attributed to therapist characteristics. The lack of significant differences found on these patient variables, and their similarity upon direct inspection, lends support to interpreting outcome differences between the groups with regard to differences between the therapists.

Finally, as Appendix 10 shows, examination of the highest and lowest scores obtained on each variable by both groups suggests that the

Table 1

Preliminary Chi-Square Analyses of Patient Variables of Gender, Ethnicity, and Type of Termination in order to Examine Pre-Treatment Differences between the Groups

Variable:	More Effective Therapists	Less Effective	Row Total
Gender:			
Male	5 (16.7%)	6 (20%)	11 (18.3%)
Female	25 (83.3%)	24 (80%)	49 (81.7%)
Column Total	30 (50%)	30 (50%)	60 (100%)
	Chi-Square = .000, df = 1, Significance = 1.00		
Ethnicity:			
White	28 (49.1%)	29 (50.9%)	57 (95%)
Mexican-American	1 (3.3%)	1 (3.3%)	2 (3.3%)
American-Indian	1 (3.3%)	0 (0%)	1 (1.7%)
Column Total	30 (50%)	30 (50%)	60 (100%)
	Chi-Square = 1.01, df = 2, Significance = .60		
Type of Termination:			
Planned	17 (56.7%)	16 (53.3%)	33 (55%)
Dropped-Out	8 (26.7%)	10 (33.3%)	18 (30%)
Transfered	5 (16.7%)	4 (13.3%)	9 (15%)
Column Total	30 (50%)	30 (50%)	60 (100%)
	Chi-Square = .363, df = 2, Significance = .833		

Table 2

Preliminary One-Way Analyses of Variance on Patient Variables of Age, Total Number of Sessions Attended, and Pre-Treatment Symptomatology in order to Examine Pre-Treatment Differences between the Groups

Variable	More Effective Therapists Mean (SD)	Less Effective Therapists Mean (SD)	F	df	P
Age	33.00 (13.26)	28.76 (7.45)	2.32		.13
No. of Sessions	17.36 (13.43)	17.60 (11.55)	.005		.94
SCL-90-GSI (Pre)	54.53 (7.81)	53.63 (7.78)	.489		.53

lack of significant differences between the two groups on specific variables is not a function of a restricted range of scores.

Main Therapist Variables

The main analysis involved a step-wise discriminant function analysis which included the eleven therapist variables of: patient involvement, therapist directiveness/support, therapist emotinal adjustment, therapist credibility, the four therapist relationship skills variables of empathic understanding, positive regard, unconditional acceptance, and congruence, and the three therapist theoretical orientation variables measuring experiential, psychoanalytic, and cognitive- behavioral beliefs about therapy. The step-wise variable selection role used was to minimize Wilk's Lambda; a variable entered the equation when it provided a significant increase in explanatory efficiency at the .05 level; a variable was removed from the equation if its inclusion resulted in a decrease in explanatory efficiency to the .1 level.

The therapist variables which were expected to most strongly differentiate between the two groups were those involving in-therapy behavior directly. This was exactly what was found. The relationship skill variable of therapist empathy and the therapy process variables of patient involvement and therapist directiveness when combined, were most effective in discriminating between the more effective and less effective groups. As indicated in Table 3, the empathy variable entered the discriminant function equation first with an F-ratio that was significant at the .0258 level; next, the patient involvement variable

Table 3

Step-Wise Discriminant Function Analysis of Main Therapist Variables

Step	Variable Entered	Direction of Effect	Wilks' Lambda	Equivalent	df	P
1	Empathy	+	.764	5.849	(1,19)	.0258
2	Directive Support	-	.586	6.357	(2,18)	.0082
3	Patient Involvement	-	.450	6.904	(3,17)	.0030

Variables Not in the Analysis After Step 3

Therapist Emotional Adjustment	
Therapist Credibility	
Regard	
Unconditional Acceptance	
Congruence	
Experiential Orientation	(Cluster 1)
Psychoanalytic Orientation	(Cluster 2)
Cognitive-Behavioral Orientation	(Cluster 3)

entered the equation increasing the significance of the F-ratio to .0082; finally, the therapist directiveness/support variable was added and increased the significance of the F-ratio to .0030. The remaining eight variables did not enter the equation as to do so would not have increased the equation's discriminant ability.

Table 4 presents the number of cases that could be predicted as belonging to either the more effective or less effective group based on a score obtained from the combination of these three variables. As indicated in Table 4, 78.57% of the therapists could be assigned to the correct group based on the discriminant score obtained.

26.7% of the more effective therapists were misassigned to the less effective group and 15.4% of the less effective therapists were misassigned to the more effective group on the basis of the discriminant score obtained. Therefore, the specificity of the discrimination obtained with this equation was within an acceptable range although 21.43% of all cases were misassigned. Thus, the three therapist variables of therapist empathy, patient involvement, and therapist directiveness/support were significant ones in terms of differentiating between the more and less effective psychotherapists.

The direction of these three therapist variables in discriminating between the two groups is important to note. It was not surprising that the patients of less effective therapists felt less understood by their therapists than did the patients of more effective therapists. This finding supports previous research (Lambert & Bergin, 1983). Interestingly, however, the less effective group evidenced

Table 4

Comparison of Predicted vs. Actual Group Membership on the Basis of a Discriminant Function Analysis of Empathic Understanding, Patient Involvement, and Therapist Directiveness

ACTUAL GROUP	No. of Cases	PREDICTED GROUP: Less Effective Therapists	PREDICTED GROUP: More Effective Therapists
Less Effective Therapists	13	11	2
		84.6%	15.4%
More Effective Therapists	15	4	11
		26.7%	73.3%

PERCENT OF GROUPED CASES CORRECTLY CLASSIFIED: 78.57%

somewhat higher levels of patient involvement and therapist directiveness. That is, the less effective therapists perceived their patients as somewhat more involved in the therapy process than did more effective therapists, and reported being more directive and supportive than did the effective group. These findings were contrary to the expectations of this investigator; the interpretations that should be given to them are somewhat speculative and will be considered in the discussion section of this report.

Finally, it is important to note that although the patient involvement and the therapist directiveness variables did enter the present discriminant function analysis and, in this analysis, did significantly contribute to the differentiation between the two groups, neither variable was found to significantly distinguish between the two groups when considered separately in one-way analyses of variance. This pattern indicates that these variables manifest their effect only when the effects of therapist empathy is factored out or held constant.

After the discriminant function analysis was conducted, one-way analyses of variance were performed on each of the variables under investigation in this study as indicated by Appendix 11. This was done to examine any potential significant differences between the groups on particular variables which were not revealed by the discriminant function analysis. Because of the statistical artifacts that can be produced by supplementary data analyses, the results obtained can merely be considered to be suggestive.

Supplementary analyses did suggest that significantly lower scores were obtained by the less effective group on three out of the four relationship skills variables. That is, less effective therapists were perceived by their patients to be significantly less empathic (i.e., understanding), ($p=.001$), significantly less unconditionally accepting (i.e., accepting of the patient regardless of the patient's behavior), ($p=.015$), and significantly less congruent (i.e., real and genuine), ($p=.026$), then the more effective therapists were perceived to be by their patients. The remaining relationship skill variable, that of regard (i.e., therapist is perceived to care for and like the patient), did not appear to significantly differ between the two groups ($p=.091$). These findings do suggest that the therapist's ability to be perceived by his or her patients as relating in the above described ways does significantly distinguish between more and less effective therapists. The high degree of intercorrelation among these variables (ranging from $r=.77$ to $r=.40$) most likely explains the fact that only one of them entered the discriminant function analysis - an analysis which revealed that the patient's perception of having been empathically understood was the most important relationship skill distinguishing more helpful from less helpful therapists.

Of the remaining variables examined in one-way analyses of variance, only one, involving a theoretical orientation variable, appeared to significantly differentiate between the groups. Out of eleven factors and three higher order clusters generated by the Theoretical Orientation Inventory (TOQ), only factor ten appeared to

significantly differed between the two groups (p=.046). That is, the less effective group appeared significantly more likely to regard effective therapy as an experience in which the patient learns mostly through a verbal and conceptual interchange between himself and the therapist. The more effective group appeared less likely to regard therapy as primarily a verbal and conceptual process. Thus, it may be that more effective therapists are more aware of and concerned with aspects of the therapy process that are other than verbal and conceptual, such as unverbalized and affective aspects of the therapeutic relationship.

It is worth noting that another difference between the two groups on one of the factors of the TOQ appeared to approach significance (p=.057). This difference was on factor eleven which involves endorsing more or less formal attitudes toward therapy, as indicated by attitudes toward physical contact between therapist and patient, towards marathon group therapy and towards sensitivity training. The less effective therapists may be more likely to adopt a formal approach to psychotherapy than more effective psychotherapists; that is, they may be more likely to be against physical contact between therapist and patient (i.e., embracing), and to take a less favorable view of marathon groups and sensitivity training than more effective therapists.

Potential differences on the cluster scores of the TOQ were of particular interest to the present investigator. There are three cluster scores generated by the TOQ. These are second-order factors

each composed of a number of the twelve factors which significantly intercorrelate and conceptually relate to either a psychoanalytic, an experiential, or a cognitive-behavioral approach toward therapy. Thus, cluster scores reflect the therapist's endorsement of beliefs about therapy that may be categorized as relating to these three global theoretical orientations. No significant differences were revealed, indicating that the present groups did no significantly differ in their professed global beliefs about therapy.

Finally, neither of the two remaining therapist variables included in the present study - neither the extratherapy trait variable of therapist emotional adjustment nor the social influence attribute of therapist credibility - significantly differed between the two groups when examined by one-way analyses of variance. Predictably, however, the therapist credibility variable did appear to approach significance ($p=.050$), with the less effective group being perceived by patients as less credible.

Therapist Values Variables

Discriminant function analyses and one-way analyses of variance were conducted to examine what, if any, value differences might exist between more and less effective psychotherapists. The values data was examined separetely from the other variables in the present study because of its ipsative nature. The step-wise discriminant analysis which was done included both the terminal and instrumental values as predictor variables and the differently designated therapist groups as the dependent variable. (It may be helpful to remember that terminal

values relate to preferred end states of existence and instrumental values pertain to modes of conduct). As indicated by Table 5, this first analysis found that out of thirty-six possible values, the rankings of three values significantly differentiated between the two therapist groups: 1) the terminal value of "a comfortable life", 2) the instrumental value of "intellectual", and 3) the terminal value of "an exciting life". Using a score derived from the combination of these three variables, 83.33% of the therapists could be correctly predicted to belong to one of the two therapist groups. Less effective therapists placed significantly more importance on having a "comfortable" (i.e., a prosperous), and "exciting" (i.e., a stimulating and active) life, and significantly less importance on being "intellectual" (i.e., intelligent and reflective), than did more effective therapists. (See Table 6).

How the value differences reported above might contribute to a therapist's relative effectiveness is open to speculation and will be discussed in the discussion section of this paper.

Table 5

Step-Wise Discriminant Function Analysis of Therapists' Terminal and Instrumental Values

Step	Value Entered	Wilks' Lambda	Equivalent F	DF	P
1	A Comfortable Life	.711	11.33	(1,28)	.002
2	Intellectual	.611	8.56	(2,27)	.001
3	An Exciting Life	.514	8.19	(3,26)	.000

Variables Not in the Analysis After Step 3

Terminal Values:

A Sense of Accomplishment
A World at Peace
A World of Beauty
Equality
Family Security
Freedom
Happiness
Inner Harmony
Mature Love
National Security
Pleasure
Salvation
Self-Respect
Social Recognition
True Friendship
Wisdom

Instrumental Values:

Ambitions
Broadminded
Capable
Cheerful
Clean
Courageous
Forgiving
Helpful
Honest
Imaginative
Independent
Logical
Loving
Obedient
Polite
Responsible
Self-Controlled

Table 6

Comparison of Predicted vs. Actual Group Membership on the Basis of a Discriminant Function Analysis of Rokeach Values: "A Comfortable Life", "Intellectual", "An Exciting Life"

ACTUAL GROUP	No. of Cases	PREDICTED GROUP: Less Effective Therapists	PREDICTED GROUP: More Effective Therapists
Less Effective Therapists	15	11	4
		73.3%	26.7%
More Effective Therapists	15	1	14
		6.7%	93.3%

PERCENT OF GROUPED CASES CORRECTLY CLASSIFIED: 83.33%

CHAPTER 4

DISCUSSION

The primary findings in this study reveal that those therapist variables that are the best predictors of effectiveness relate to relatively discrete in-therapy experiences of the participants in contrast both to variables involving extratherapy traits of the therapist (such as the therapist's emotional adjustment) and variables involving global in-therapy experiences (such as the therapist's credibility or theoretical orientation). This conclusion is consistent with Beutler, Crago and Arizmendi's (1986) review of the literature on therapist variables and their conclusion that "the more specific the variable is to the treatment relationship and the more closely it reflects internal therapist experiences and attitudes, the more consistent the influence exerted by the variable" (p. 297).

Further, the present study strongly supports the significance of the particular therapist relationship skill variable of empathy in effective psychotherapy. Previous research has indicated that this variable correlates with (and perhaps produces) positive outcomes; a corrolary finding has been that low levels of this variable seem to be associated with patients' worsened symptomatology over the course of treatment (Lambert & Bergin, 1983). The present study provides additional support for these findings.

The mechanisms through which patient improvement and deterioration may relate to the experience of being understood have been well articulated by significant theories of psychotherapeutic change. For example, Kohut (1971, 1977, 1982) posits that a human environment that is perceptive of and responsive to the developing child's psychological needs and wishes is a sine qua non of healthy development. He suggests that psychopathology results from a failure of environmental response to the needs of the child's developing self. In therapy, through the process of establishing a relationship with the therapist in which the patient experiences being deeply understood and responded to, previously thwarted developmental processes are seen as being set in motion. Thus, there is an assumption of a basic tendency toward growth and development in every individual that requires the optimal responsiveness of a significant other in order to be realized. The experience of being understood in the context of an emotionally significant relationship is considered to be a crucial aspect of the curative process in this theoretical framework.

Likewise, Rogers (1959) regards the primary work of the therapist as providing the patient with accurate empathic understanding, an understanding of the patient's phenomenal world. In order to provide this, the client-centered (Rogerian) therapist attempts to immerse himself in this world, listening not just to the patient's words but also to the personal meanings that the patient has not yet conceptualized into awareness. When the therapist communicates an understanding of these meanings to the patient, he or she helps the

patient broaden his understanding of himself. This increased understanding, and the accepting attitude of the therapist toward the patient's emerging inner experience, often allows the patient to integrate previously disavowed aspects of his experience. With increased awareness of and openness to his own experiencing, the patient is better able to develop to his full potential. As in Kohut's theory, a basic tendency toward growth and development is assumed; here too, the thwarted development of the individual is seen as being re-vitalized when the patient is helped toward increased self-understanding and self-acceptance through a significant relationship with the therapist.

Thus, the patient's experience of having been understood by the therapist is accorded a significant role in the curative process by at least two major theories of psychotherapy. The patient's experience of having been understood by the therapist has been actively researched by investigators concerned with client-centered theory for some time now. The questionnaire used in the present study to measure the empathy variable was developed to measure the therapist's "relationship skills" as conceptualized by client centered theory. The more recent theoretical contributions of Heinz Kohut (i.e., self psychology theory) bear mentioning because they were developed from a psychoanalytic perspective and provide a well-elaborated framework for understanding personality development and psychopathology not offered by client-centered theory. In the opinion of the present author, client-centered theory is quite useful in helping the therapist conceptualize important aspects of the psychotherapy process and the

therapeutic relationship. However, this theory does not provide the therapist with a framework to facilitate a deeper understanding of the meanings contained in the patient's remarks, the patient's affective experience, and behavior. Conversely, self psychology theory offers a great deal to the therapist in terms of an increased understanding of significant aspects of the patient's experience. This may then aid the therapist in listening to and understanding the patient's communications and communicating this understanding to the patient. This includes an understanding of the patient's relationship to the therapist not addressed by client-centered theory. Moreover, Kohut's emphasis on the curative aspects of being understood and on other curative aspects of the therapeutic relationship have enriched the perspective provided by psychoanalytic theory which has historically emphasized the role of explanation/interpretation in the curative process.

Given the contributions to effective treatment afforded by additional perspectives, it is important to note that the present study found empathy to be a significant variable in non-client centered therapies. The present sample of trainee therapist's primarily identified themselves as having psychodynamic or eclectic approaches to psychotherapy, however, empathy nonetheless remained an important variable in more effective treatment. In a 1977 study, Mitchell, Bozarth and Krauft had suggested that the influence on outcome exerted by client-centered relationship skills may be restricted to client-centered therapies. The present study suggests, as does Sweet (1984), that this is not so.

Additional findings of the present study involved the patient involvement variable. Patient involvement in the therapy process was revealed by discriminant function analysis to significantly add to discriminant efficiency when included as a predictor variable in the discriminant equation. This was not an unexpected finding. Patient involvment in the therapy process has been variously defined and measured in previous studies but it has emerged as the best predictor of outcome in studies by Gomes-Schwartz (1978); Kolb et.al. (in press); Marziali, Marmar and Krupnick (1981), and Morgan et.al. (1981).

The direction of the relationship found by the present study, however, is not consistent with the results of previous studies. Previous studies have found that higher levels of patient involvement relate to higher levels of improvement. In the present study, this is not the case; the group of therapists whose patients evidenced less improvement reported a slightly higher level of the patient involvement variable. Examination of the range of scores obtained does not suggest that this finding was due to the presence of a "ceiling effect" due to constricted range. This discrepant finding may be related to conceptual and methodological differences between the present study and previous studies.

The patient involvement variable was initially introduced into psychotherapy research in an attempt to examine the patient's contribution to the development of a productive therapeutic relationship. Specifically, there was an interest in the patient's

willingness and/or capacity to get involved in the therapy process and actively examine his or her feelings and experiences.

The present study defined patient involvement as the extent to which the patient participates productively in the therapy process by demonstrating self-discolsure, self awareness, insight of behavioral change, and the extent to which the patient is seen as motivated for treatment and satisfied with treatment. In previous studies, patient involvement has been defined in ways that involve significant overlap with the concepts of feeling understood by the therapist and accepted by the therapist; in other words, the patient's expression of feeling understood and accepted by the therapist was one of the behaviors rated by independent clinical obsrevers as a dimension of patient involvement (Marziali et.al., 1981; Morgan et.al., 1981). Although there was a statistically significant relationship between the patient involvement variable and the empathy (patient feeling understood by the therapist) variable ($r=.434$; $p=.021$; $N=28$), in the present study, examination of the content of the items used to measure variables suggests that there was more of a conceptual difference between these two variables in the present study than in previous studies. It does seem likely that patients will differ in their predisposition toward feeling understood and that this predisposition may be an important component of the patient's contribution toward developing a productive therapeutic alliance. However, given the relatively extensive research data on the empathy (i.e., the patient's feeling understood) variable, it seems

worthwhile to utilize the patient involvement variable to look at other aspects of the patient's participation in the therapy process.

Further, the present study and the Kolb et al. (in press) study measured the patient involvement variable by using therapist ratings of the average amount of involvement present over the entire course of the patient's therapy. Other studies have used independent clinical observers to rate patient involvement during brief segments of selected therapy sessions. Thus, the present macroanalytic approach to the study of this variable, as compared to the microanalytic approach of previous studies, may relate in some way to the discrepant findings of the present study. Even more significant may be the use of therapist ratings. Although Kolb et al. (in press) found that therapists' ratings of more patient involvement were significantly and positively related to better outcomes, the present study differs from Kolb's study in its focus on differential effectiveness between psychotherapists. It may be that the observations of the therapy process made by less effective therapists differ from the observations of the therapy process made by more effective psychotherapists and also differ from the perceptions of independent clinical observers. In the present study, the more effective therapists perceived slightly less patient involvement in the therapy process than did the less effective therapists. It may be that less effective therapists perceive their patients as more involved and as making more progress in treatment than do more effective therapists. As a consequence of this, they may fail to see the need to stimulate

further involvement in the therapy process which is more accurately perceived and responded to by their more effective counterparts.

Beutler, Dunbar and Baer (1980), using the same measure of patient involvement as the present study, obtained different findings. They found that less effective therapists tended to perceive less patient involvement in the treatment process than did more effective therapists. Their study involved five trainee therapists who were rank-ordered on the basis of their therapeutic effectiveness by their supervisors. As in the present study, these therapists completed the Psychotherapy Process Inventory (Baer, Hamilton & Dunbar, 1977) to assess their perceptions of the therapeutic process. The two therapists who were ranked most effective by supervisors perceived significantly more engagement and progress in their patients than two of the three less effective therapists. However, one of the least effective therapists did not fit this pattern and reported a higher level of patient involvement than would be expected given the correspondence between lower ranked effectiveness and perception of less patient involvement manifest by the other trainees. Beutler et al. (1980) speculate that this finding may suggest that idiosyncratic perceptions of patient involvement in the therapy process may occur among less effective psychotherapists.

Therapist directiveness and support was also revealed by discriminant function analysis to add to discriminant efficiency when included as a predictor variable in the discriminant equation. This variable was also measured by therapist self-report. The less effective

group of therapists reported providing slightly more direction and support for their patients than did more effective therapists.

The interpretation of this finding is less than clear. This finding also runs contrary to the findings of Beutler et al. (1980) who found that the more effective therapists in their study reported providing significantly more direction and support to their patients than did the less effective therapists.

As discussed about, this finding may reflect a tendency for the perception of less effective therapists to be rather idiosyncratic. It may be that less effective therapists are benevolent observers of their own contributions to the process of therapy in much the same way that they may benevolently perceive the involvement of their patients in the therapy process. However, it may be that more and less effective therapists label patient "involvement" and therapist provided "directiveness" and "support" with reference to different behaviors. That is, the behaviors that a more effective therapist perceives as providing support and structure, or as evidence of the patient's participation in therapy, may be different than the behaviors that a less effective therapist views as indicative of these therapy process dimensions. Taking into consideration the pattern revealed by the discriminant function analysis, namely that the empathy variable most differentiated between the two therapist groups followed by the patient involvement and therapist directiveness/support variables, it seems quite likely that the kinds of involvement and directiveness/support

perceived and provided by more and less empathic therapists wil significantly differ.

Alternatively, the higher level of directiveness/support reported by the less effective therapists in the present study may reflect an accurate perception of the directiveness dimension in the work of less effective therapists. There is some evidence to suggest that more directive therapists produce poorer outcomes (Hoyt, 1980; Lieberman, Yalom & Miles, 1973; Patterson & Forgatch, in press). Overall, however, no consistent pattern has been revealed with regard to the influence exerted on outcome by therapist directiveness, when directiveness is examined as a undirectional variable (Beutler et.al., 1986). Some studies have found that low levels of directiveness are beneficial to treatment (Lorr, 1965; Mintz et.al., 1971). Other studies (Andrews, 1976; Beutler et.al., 1980; Bergin, 1971; Foreman & Marmar, 1984; Gomes-Schwartz, 1978; Grigg & Goldstein, 1957; Hill et.al., 1983) have found that more directive therapists obtain better outcomes. Other studies have obtained nonsignificant or zero-order effects (Ashby et.al., 1957; Cooley & Lajoy, 1980; Goin et.al., 1965; Luborsky et.al., 1980).

Finally, in attempting to integrate the findings of the present study with the findings of other studies, with regard of the directiveness variable, consideration must be given to the fact that the present study did not employ a conceptually "pure" measure of directiveness. The factorial dimension used to measure directiveness/support in the present study primarily contains items

whose content refers to the therapist taking a leading, structuring role in the therapy process. However, this dimension also contains items whose content refers to the therapist providing concern, support, and "sympathy" for the patient's difficulties. Thus, conclusions about directiveness in and of itself are not warranted by the present data. As always, the conceptual and methodological differences between studies attempting to investigate the same general variable merit consideration when attempting to integrate research findings. Given the diverse findings about directiveness as a undirectional variable, however, even a significant finding with a conceptually pure measure of the directiveness variable would be difficult to unequivocally interpret.

The trends suggested by the supplementary one-way analyses of variance also merit discussion. With regard to the theoretical orientation variables, the one significant difference involved the less effective group more strongly endorsing the belief that effective therapy primarily involves a verbal and conceptual learning process for the patient. The data also suggested a trend toward this group endorsing more formal attitudes toward physical and social contact between patient and therapist, toward sensitivity training, and marathon groups. Finally, the data also suggested a trend toward the less effective group endorsing the cluster of attitudes towards psychotherapy that Sundland (1977, 1962) has designated as "psychoanalytic". These attitudes include: 1) a disapproval of physical and social contact between patient and therapist, marathons and sensitivity training; 2) an emphasis on the patient's coming to understand how his early childhood

relationships continue to influence his present functioning; 3) a non-interruptive and passive approach toward therapy; 4) an emotionally detached and impersonal approach toward relating to patients; and 5) a lack of belief in the usefulness of Gestalt techniques including, for example, a psychodramatic approach toward working with dreams, an emphasis on increased awareness of bodily movements and postures and the use of guided imagery.

The trends suggested by the present data with regard to theoretical orientation seem to be consistent with a previous finding by Beutler and Mitchell (1981). In contrast to the present study which assessed therapists attitudes toward therapy, Beutler and Mitchell determined the theoretical orientation of their therapists by observing their differential use of specific treatment procedures. These authors found that therapists using "analytic" treatment procedures were less effective than therapists who emphasized discussion of the patient's current feelings, were more personal and self disclosing, and were more active, and de-emphasized discussion of the patient's childhood and unconscious experiences.

A cautionary note, however, appears to be warranted with respect to the use of Sundland's (1977,1962) dimensions for designating practitioners as "psychoanalytic", dimensions which were employed by both the present author and by Beutler and Mitchell. Most important to the present author appears to be the emphasis on an impersonal and passive approach towards interacting with patients that is a signifiant part of Sundland's (1972) definition of a "psychoanalytic" approach

towards psychotherapy. The practice of psychoanalysis and psychoanalytic psychotherapy, however, has undergone significant change in the past decade. The treatment of patients with severe personality disorders and the contributions of object relations and self theorists, have prompted theoretical and technical developments (Atwood & Stolorow, 1984; Goldberg, 1985; Kohut 1971, 1977, 1982; Stepansky & Goldberg, 1984). Beginning with his contributions to the treatment of patients with narcissistic personality disorders, Kohut (1977) recognized the importance of the patient's establishing closeness to an empathically responsive other (the analyst) in the process of cure. Thus, he has cautioned against equating the principle of analytic neutrality -- that is, the principle that the structure of the patient's personality will emerge optionally in a neutral analytic atmosphere -- with minimal responsiveness to the patient. Kohut states:

> Lack of emotional responsiveness, silence, the pretense of being an inhuman computer-like machine which gathers data and emits interpretations, do no mor supply the psychological mileui for the most undistorted delineation of the normal and abnormal features of the person's psychological make-up than do an oxygen-free atmosphere and a temperature close to the zero-point supply the physical mileui for the most accurate measurement of his physiological responses. Appropriate neutrality in the analytic situations is provided by average conditions. The analysts behavior vis-a-vis his patient should be the expected average one - the behavior of a psychologically perceptive person vis-a-vis someone who is suffering and has entrusted himself to him gor help . . . analysts must behave humanly, warmly, and with appropriate empathic responsiveness . . . (1977, p. 253-254).

Statements such as these have had an impact on the modern practice of psychoanalysis and psychoanalytic psychotherapy making it imperative not to confuse out-dated notions about relating to patients

with the more substantive theoretical contributions psychoanalysis has made with regard to understanding personality development, psychopathology, and treatment. Sundland's Theoretical Orientation Inventory was developed largely before the impact of more recent developments were reflected in the analyst's mode of relating to the patient. In addition, this instrument relies rather heavily on the analyst's mode of relating to the patient to define a psychanalytic approach rather than, for example, on the use of the empathic introspective method and interpretation. The present author agrees with Beutler and Mitchell's (1981) observation that the measurement of theoretical orientation is best done with the use of more specific procedural dimensions rather than the measurement of more global beliefs about psychotherapy. Perhaps ideally, this measurement would include the independent observation of the therapist's application of specific treatment procedures.

With regard to the present data, the differences and trends revealed by the one-way analyses of variance on theoretical orientation variables and relationship skills variables may be interpreted as indicating that more muted affective responsiveness and more formal self presentations characterized the less effective therapists. This characterization of less effective therapists is suggested by the less effective therapists' emphasis on the verbal and conceptual aspects of therapy, and preference for more formal, passive, and impersonal, approaches to interacting with patients, and by patients' perceptions of the less effective group as significantly less accepting, significantly

less real and genuine, and tending towards being less caring. Thus, this characterization is suggested by the disparate therapist characteristics of therapists' beliefs about therapy and therapists relationship skills. The abstraction of a general tendency toward displaying a more muted emotional responsiveness may be useful in providing some link between these different dimensions of the less effective therapist, that is, between his or her relationship skills and his or her beliefs about therapy. Collectively, these findings lend support and, perhaps, extend previous findings (e.g., Lambert & Bergin, 1983) relating lower levels of therapist relationship skills to patient deterioration. The extension suggested by the interpretation of the present data is the proposal that a more general tendency expressed in therapist's beliefs, as well as in specific relationship skills, may be characteristic of less effective therapists. This general tendency appears to involve a muted emotional responsiveness and, perhaps, is suggestive of a some discomfort with affectivity. This discomfort could be posited to interfere with therapeutic effectiveness in a variety of ways. For example, the therapist may be less skillful in dealing with more affect laden material or tend to de-emphasize discussion of current feelings. The latter is a tendency which Beutler and Mitchell (1981) found to be associated with diminished effectiveness. This characterization is quite speculative but may suggest an additional perspective for future research.

Finally, with regard of the value differences between the two groups of therapists revealed by discriminant function analysis, several

generalizations seem to merit discussion. It does appear that the less effective therapists in the present study placed somewhat greater emphasis on their own prosperity and stimulation as valued end-states of existence than did the more effective group. This may in some way reflect some tendency toward greater self-involvement on the part of these therapists which may then interfere with their abilities to provide therapeutic conditions, such as empathic understanding, that are most helpful to patients. With regard to the instrumental value difference that was revealed, it may be that the lesser value placed on being "intellectual" may impact the therapist's effectiveness by virtue of his or her taking a less reflective, inquisitive approach toward practicing psychotherapy itself. This attitude may then limit the acquisition and/or refinement of ideas and skills.

Thus, speculations as to how the value differences revealed by the present study may impact the process and outcome of psychotherapy are not difficult to generate. However, the validity of the above speculations is questionable given the limited available knowledge in this area. The intent of the present study was to conduct an exploratory examination of whether significant value differences between these groups were to be found; this being the case, it appears that further research replicating these differences and examining the relationships between value differences and process dimensions in psychotherapy may be worthwhile, given the significance that has been accorded the role of psychotherapist's values in the therapy process by

some theorists (Beutler, 1971a, 1971b, 1979a, 1979b; Frank, 1973; Goldstein et.al., 1966; Goldstein & Simonson, 1971; Strong, 1968).

Overall, with regard to generalizability of the present findings, several factors need to be considered. First, the therapists used in the present study were primarily psychology interns and psychiatric residents. Although, therapist experience has not shown itself to be a consistently significant variable in facilitating treatment outcome (Auerbach & Johnson, 1977), it should be considered that more experienced therapists of differing effectiveness might have differed from each other in different ways or to different degrees. However, the pattern of differences revealed does seem to be consistent with the present available knowledge about therapist effectiveness. Further, the present findings are most applicable to therapists engaged in short-term therapy with mildly to moderately disturbed outpatient psychiatric patients as this was the modality and the population engaged in the present study.

Thus, in summary, given mild to moderately disturbed patients in short-term therapy, the picture of the less effective therapist which emerges from the present study is a therapist who, first and foremost, does not help his patients to feel understood. Thus, this therapist is likely neither to help the patient to better understand him or herself (i.e., to gain insight), nor to be able to experience a finely-tuned empathic responsiveness which in and of itself may be curative. Further, this therapist is likely to convey less acceptance, less genuineness, perhaps less caring to his or her patients than his or her

more effective counterpart. This therapist is also more likely to conceive of effective therapy as involving primarily a verbal and conceptual exchange between the therapist and the patient. Perhaps taken together, these findings indicate a more general tendency toward muted affective responsiveness on the part of the less effective therapist. Finally, this therapist will tend to be perceived as less credible by his or her patients. Thus far, this picture is quite consistent with previous findings with regard to therapist characteristics and outcome in general, revealed in the present study as being generalizable to therapists whose patients symptomatically worsen over the course of treatment.

In addition, the less effective therapist may be an inaccurate observer of the therapy process as well. It appears that he may fail to perceive the need to stimulate the patient's involvement in the therapy process and may benevolently perceive the direction and support he is providing the patient. These tentative conclusions may be usefully examined in future research.

Finally, the less effective therapist does seem to evidence a discriminant pattern of values that also seem to merit further investigation. He may place more emphasis on his own prosperity and stimulation and less emphasis on his own intellectual development than does the more effective therapist. These preliminary findings require replication.

APPENDIX 1

(BARRETT-LENNARD) RELATIONSHIP INVENTORY

FORM OS-64**

Below are listed a variety of ways that one person may feel or behave in relation to another person.

Please consider each numbered statement with reference to your present relationship with (your therapist), mentally adding his or her name in the space provided. For example, if the therapist's name was John, you would read statement #1 as "John respects me as a person."

Mark each statement in the answer column on the right, according to how strongly you feel that it is true, or not true, in this relationship. Please be sure to mark every one. Write in +3, +2, +1, or -1, -2, -3, to stand for the following answers:

+3: Yes, I strongly feel that it is true.
+2: Yes, I feel it is true
+1: Yes I feel that it is probably true, or more true than untrue
-1: No, I feel that it is probably untrue, or more untrue than true.
-2: No, I feel it is not true
-3: No, I strongly feel that it is not true.

1. _____respects me as a person _____

2. _____wants to understand how I see things _____

3. _____'s interest in me depends on the things I say or do _____

4. _____is comfortable and at ease in our relationship _____

5. _____feels a true liking for me _____

**Combines Forms OS-M-64 and OS-F-64

APPENDIX 1, continued

6. _____may understand my words but he/she does not see the way I feel _____

7. Whether I am feeling happy or unhappy with myself makes no real difference to the way _____feels about me _____

8. I feel that _____puts on a role or front with me _____

9. _____is impatient with me _____

10. _____nearly always knows exactly what I mean _____

11. Depending on my behavior, _____has a better opinion of me sometimes than he/she has at other times _____

12. I feel that _____is real and genuine with me _____

13. I feel appreciated by _____ _____

14. _____looks at what I do from his/her own point of view _____

15. _____'s feeling toward me doesn't depend on how I feel toward him/her _____

16. It makes _____uneasy when I ask or talk about certain things _____

17. _____is indifferent to me _____

18. _____usually senses or realizes what I am feeling _____

19. _____wants me to be a particular kind of person _____

20. I feel that what _____says usually expresses exactly what he/she is feeling and thinking at that moment _____

21. _____finds me rather dull and uninteresting _____

22. _____'s own attitudes toward some of the things I do or say prevent him/her from understanding me. _____

23. I can (or could) be openly critical or appreciative of _____ without really making him/her feel any differently about me _____

24. _____wants me to think that he/she likes me or understands me more than he/she really does _____

25. _____cares for me _____

APPENDIX 1 continued

26. Sometimes _____thinks that I feel a certain way, because that's the way he/she feels _____

27. _____likes certain things about me, and there are other things he/she does not like _____

28. _____does not avoid anything that is important for our relationship _____

29. I feel that _____disapproves of me _____

30. _____realizes what I mean even when I have difficulty in saying it _____

31. _____'s attitude toward me stays the same: he/she is not pleased with me sometimes and critical or disappointed at other times _____

32. Sometimes _____is not at all comfortable but we go on, outwardly ignoring it _____

33. _____just tolerates me _____

34. _____usually understands the whole of what I mean _____

35. If I show that I am angry with _____he/she becomes hurt or angry with me, too _____

36. _____expresses his/her true impressions and feelings with me _____

37. _____is friendly and warm with me _____

38. _____just takes no notice of some things that I think or feel _____

39. How much _____likes or dislikes me is not altered by anything that I tell him/her about myself _____

40. At times I sense that _____is not aware of what he/she is really feeling with me _____

41. I feel that _____really values me _____

42. _____appreciates exactly how the things I experience feel to me _____

43. _____approves of some things I do, and plainly disapproves of others _____

APPENDIX 1 continued

44. _____is willing to express whatever is actually in his/her mind with me, including personal feelings about either of us _____

45. _____doesn't like me for myself _____

46. At times _____thinks that I feel a lot more strongly about a particular thing than I really do _____

47. Whether I happen to be in good spirits or feeling upset does not make _____feel any more or less appreciative of me _____

48. _____is openly himself/herself in our relationship _____

49. I seem to irritate and bother _____ _____

50. _____does not realize how sensitive I am about some of the things we discuss _____

51. Whether the ideas and feelings I express are "good" or "bad" seems to make no difference to _____'s feeling toward me _____

52. There are times when I feel that _____'s outward response to me is quite different from the way he/she feels underneath _____

53. _____feels contempt for me _____

54. _____understands me _____

55. Sometimes I am more worthwhile in _____'s eyes than I am at other times _____

56. _____doesn't hide anything from himself/herself that he/she feels with me _____

57. _____is truly interested in me _____

58. _____'s response to me is usually so fixed and automatic that I don't really get through to him/her _____

59. I don't think that anything I say or do really changes the way _____feels towards me _____

60. What _____says to me often gives a wrong impression of his/her total thought or feeling at the time _____

61. _____feels deep affection for me _____

APPENDIX 1 continued

62. When I am hurt or upset _____can recognize my feelings exactly, without becoming upset too _____

63. What other people think of me does (or would, if he/she knew) affect the way _____feels toward me _____

64. I believe that _____has feelings he/she does not tell me about that are causing difficulty in our relationship _____

APPENDIX 2

SCALE CONTENT OF THE BARRETT-LENNARD RELATIONSHIP INVENTORY

Level of Regard		Empathy		Unconditionality		Congruence	
Positive Items	Negative Items	Positive Items	Negative Items	Positive Items	Negative Items	Positive Items	Negative Items
1	9	2	6	7	3	4	8
5	17	10	14	15	11	12	16
13	21	18	22	23	19	20	24
25	29	30	26	31	27	28	32
37	33	34	38	39	35	36	40
41	45	42	46	47	43	44	52
57	49	54	50	51	55	48	60
61	53	62	58	59	63	56	64

Note: A score for each scale is derived by adding the algebraic sum of positive item responses to-1 times the algebraic sum of the negative item responses.

APPENDIX 3

PSYCHOTHERAPY PROCESS INVENTORY

This instrument is designed to rate various aspects of the therapeutic process with a given patient. Please rate only patients who:

1. are 18 or more years old
2. are currently being treated only with individual psychotherapy (with or without concurrent drug therapy)
3. have been seen for at least eight sessions.

The following items deal with aspects of the psychotherapeutic interaction; each item carries a labeled five-point rating scale. Scale labels vary among the items, and in a few cases, items are repeated in order to be rated on differently labeled scales (e.g., one for frequency and another for intensity). To rate an item, circle the appropriate point on its scale; please circle only one scale point per item. Each rating should be an "average" over the entire therapeutic contact from the initiation of therapy to the date of rating. We realize that such ratings may change over the course of therapy , but for present purposes we are interested in an overall impression. When you have completed the ratings, we would appreciate any comments or questions regarding the inventory; please write any such remarks on the back of the list sheet.

1. The patient's involvement in therapy was characterized by resistance.

no evidence	weak evidence	moderate evidence	strong evidence	extremely strong evidence

APPENDIX 3 continued

2. The therapist liked the patient.
not at all slightly moderately considerably very much

3. In the psychoanalytic sense, a negative transference developed.
no evidence weak evidence moderate evidence strong evidence extremely strong evidence

4. The patient expressed or exhibited angry feelings.
never seldom occasionally frequently extremely frequently

5. The patient expressed or exhibited angry feelings.
absent mildly moderately intensely extremely intensely

6. The patient expressed guilty feelings.
never seldom occasionally frequently extremely frequently

7. The patient expressed guilty feelings.
absent mildly moderately intensely extremely intensely

8. The patient tended to feel insecure and readily felt rejected.
not at all slightly moderately considerably very much

9. There was emotional distance between the patient and therapist.
not at all slightly moderately considerably very much

10. The therapy involved giving the patient directions.
never seldom occasionally frequently extremely frequently

11. The patient was able to apply the therapeutic experience in everyday life.
no evidence weak evidence moderate evidence strong evidence extremely strong evidence

12. The patient was concerned about moral issues.
not at all slightly moderately considerably very much

13. The therapy included giving the patient "homework."
never seldom occasionally frequently extremely frequently

14. The therapy was focused upon fantasies and dreams.
not at all slightly moderately considerably very much

APPENDIX 3 continued

15. The patient expressed or exhibited self-satisfaction.
not at all slightly moderately considerably very much

16. The patient achieved personal insight.
no evidence weak evidence moderate evidence strong evidence extremely strong evidence

17. The patient was enthusiastic and worked hard.
not at all slightly moderately considerably very much

18. The patient expressed or exhibited sadness.
never seldom occasionally frequently extremely frequently

19. The patient expressed or exhibited sadness.
absent mildly moderately intensely extremely intensely

20. The patient was competitive with the therapist.
not at all slightly moderately considerably very much

21. The patient revealed personal intimate information.
never seldom occasionally frequently extremely frequently

22. The therapist felt warmth towards the patient.
absent mildly moderately intensely extremely intensely

23. The therapist openly sympathized with the patient's difficulties.
never seldom occasionally frequently extremely frequently

24. The patient questioned the motives of the therapist.
never seldom occasionally frequently extremely frequently

25. The patient experienced a sense of self-awareness.
not at all slightly moderately considerably very much

26. The therapy was focused upon the relationship between the patient and the therapist.
not at all slightly moderately considerably very much

27. The patient emphasized having important people in his life change.
never seldom occasionally frequently extremely frequently

APPENDIX 3 continued

28. There was a power struggle between patient and therapist.
no evidence | weak evidence | moderate evidence | strong evidence | extremely strong evidence

29. The therapist could empathize with the patient.
not at all | slightly | moderately | considerably | very much

30. The patient disliked the therapist.
not at all | slightly | moderately | considerbaly | very much

31. The patient tended to approach problems from an intellectual point of view.
never | seldom | occasionally | frequently | extremely frequently

32. The patient expressed or exhibited anxiety or fear.
never | seldom | occasionally | frequently | extremely frequently

33. The patient expressed or exhibited anxiety or fear.
absent | mildly | moderately | intensely | extremely intensely

34. The patient was aware of his/her feelings.
not at all | slightly | moderately | considerably | very much

35. Therapy tended to be focused.
not at all | slightly | moderately | considerably | very much

36. The therapist's negative personal feelings got involved in the therapy.
not at all | slightly | moderately | considerably | very much

37. The patient was optimistic about the effects of therapy.
not at all | slightly | moderately | considerably | very much

38. The patient brought up somatic complaints.
never | seldom | occasionally | frequently | extremely frequently

39. The therapist clarified the patient's statements.
never | seldom | occasionally | frequently | extremely frequently

40. The therapy was focused upon "the here and now."
not at all | slightly | moderately | considerably | very much

APPENDIX 3 continued

41. The patient's nonverbal communication played a role in the therapy.
not at all slightly moderately considerably very much

42. The patient accepted his/her feelings.
not at all slightly moderately considerably very much

43. The patient was domineering and tried to control the therapeutic relationship.
not at all slightly moderately considerably very much

44. The therapist made interpretations to the patient.
never seldom occasionally frequently extremely frequently

45. The therapist disliked the patient.
not at all slightly moderately considerably very much

46. The patient tended to make excuses for him/herself.
never seldom occasionally frequently extremely frequently

47. The patient expressed or exhibited sexual feelings.
never seldom occasionally frequently extremely frequently

48. The patient expressed or exhibited sexual feelings.
absent mildly moderately intensely extremely intensely

49. The patient needed the therapist's interest, concern, and support.
not at all slightly moderately considerably very much

50. The therapist tended to become bored, and his/her attention wandered.
never seldom occasionally frequently extremely frequently

51. The therapist's positive personal feelings got involved in therapy.
not at all slightly moderately considerably very much

52. The patient was pessimistic about the effects of therapy.
not at all slightly moderately considerably very much

53. The patient tended to become confused.
never seldom occasionally frequently extremely frequently

APPENDIX 3 continued

54. The patient asked the therapist personal questions.
never seldom occasionally frequently extremely frequently

55. The therapy was focused upon personal experience in the past.
not at all slightly moderately considerably very much

56. The patient demonstrated a sense of humor.
never seldom occasionally frequently extremely frequently

57. The patient took a dependent position in the therapeutic relationship.
not at all slightly moderately considerably very much

58. The patient liked the therapist.
not at all slightly moderately considerably very much

59. In the psychoanalytic sense, a positive transference developed.
no evidence weak evidence moderate evidence strong evidence extremely strong evidence

60. The patient tended to be self-derogatory.
never seldom occasionally frequently extremely frequently

61. The patient expressed or exhibited enjoyment.
never seldom occasionally frequently extremely frequently

62. The patient expressed or exhibited enjoyment.
absent mildly moderately intensely extremely intensely

63. The therapist provided concern and support to the patient.
not at all slightly moderately considerably very much

64. There were problems of communication between patient and therapist.
never seldom occasionally frequently extremely frequently

65. The patient was committed to making personal changes.
not at all slightly moderately considerably very much

66. The patient expressed satisfaction with his/her progress.
never seldom occasionally frequently extremely frequently

APPENDIX 3 continued

67. The patient tried to change his/her behavior.
not at all slightly moderately considerably very much

68. Explicit therapeutic goals were established with the patient.
not at all slightly moderately considerably very much

69. The therapy was focused upon behaviors and activities.
not at all slightly moderately considerably very much

70. The patient demonstrated an awareness of his/her body.
not at all slightly moderately considerably very much

71. The therapist provided the patient with information.
never seldom occasionally frequently extremely frequently

72. The patient sought advice from the therapist.
never seldom occasionally frequently extremely frequently

73. The patient's reality testing was impaired.
never seldom occasionally frequently extremely frequently

74. The therapist reflected the patient's statements.
never seldom occasionally frequently extremely frequently

APPENDIX 4

ITEM COMPOSITION OF THE PSYCHOTHERAPY PROCESS INVENTORY [a]

Scales	Therapeutic Progress	Competition/ Resistance	Directive Support	Dysphoric Concerns
Reliability coefficient	.92	.87	.83	.79
Items	2	1	10	-6[b]
	11	3	13	-7
	15	9	23	-8
	16	20	39	-18
	17	24	63	-19
	21	28	68	-33
	25	30	71	-60
	34	31	72	-69
	37	43		
	42	45		
	47	52		
	56			
	61			
	62			
	65			
	66			
Mean Scores[c]	3.00(0.60)	2.63(0.70)	2.61(0.60)	3.15(0.59)

[a] Only items whose factor loading was equal to or greater than .50 are reported.
[b] Negative sign indicates reverse scored items.
[c] S.D.s are in parentheses.

APPENDIX 5

THERAPIST CREDIBILITY SCALE

The purpose of this questionnaire is to find out your feelings about your therapist or counselor. In taking this test, please make your judgments on the basis of your current impressions, realizing that your responses will be confidential.

Here is how you are to use these scales:

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

	Very Much	Quite	Only Slightly	Neutral	Only Slightly	Quite	Very Much	
Fair	x							Unfair
				OR				
Fair							x	Unfair

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

Strong		x						Weak
Strong						x		Weak

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

Safe ____ ____ _____ x____ _____ ____ ____ Dangerous

	Very Much (7)	Quite (6)	Only Slightly (5)	Neutral (4)	Only Slightly (3)	Quite (2)	Very Much (1)	
Likeable	____	____	_____	_____	_____	____	____	Unlikable
Confident	____	____	_____	_____	_____	____	____	Uncertain
Intelligent	____	____	_____	_____	_____	____	____	Unintelligent
Believable	____	____	_____	_____	_____	____	____	Unbelievable
Trustworthy	____	____	_____	_____	_____	____	____	Untrustworthy
Knowledgeable	____	____	_____	_____	_____	____	____	Ignorant
Responsible	____	____	_____	_____	_____	____	____	Irresponsible
Competent	____	____	_____	_____	_____	____	____	Incompetent
Successful	____	____	_____	_____	_____	____	____	Unsuccessful

	Very Much (7)	Quite (6)	Only Slightly (5)	Neutral (4)	Only Slightly (3)	Quite (2)	Very Much (1)	
Reputable	____	____	_____	_____	_____	____	____	Disreputable
True	____	____	_____	_____	_____	____	____	False
Honest	____	____	_____	_____	_____	____	____	Dishonest

SCORING

This scale is scored by assigning a value of 1 to 7 to each rating, with 1 the lowest negative rating and 7 the highest positive rating. The therapist's overall score is obtained by summing the ratings given him or her in each of the twelve variables. Scores can range from 12 to 84, with 48 representing a neutral or middle rating.

APPENDIX 6

CLUSTERS OF THE THERAPIST ORIENTATION QUESTIONNAIRE

Cluster 1

Loading*	Factor No.	Item Content
(.55)	1	Awareness of body, guided daydreams, Gestalt Therapy, released emotions.
(.51)	5	Awareness of feelings.
(-.49)	7	Innate drive toward health.
(.41)	6	Personally involved, caring and concern.
(.39)	9	Therapist's personality crucial, therapy more an art than a science.
(-.37)	11	Approves of physical contact with clients, marathons, sensitivity training.
(.16)	2	Know childhood, conceptualize case, psychoanalytic.

This cluster seems to measure some of the beliefs of therapists with an experiential orientation.

Cluster 2

(.64)	11	Disapproves of physical contact with client, marathons, sensitivity training.
(.58)	2	Know childhood, conceptualize case, psychoanalytic.
(-.44)	4	Non-interruptive, passive, non-confrontative.
(-.24)	6	Impersonal, emotionally uninvolved.
(-.22)	1	Unbeliever in body awareness, guided daydreams, Gestalt Therapy, emotional release.

This cluster seems to measure some of the beliefs of therapists with a psychoanalytic orientation.

APPENDIX 6 continued

Cluster 3

Loading*	Factor No.	Item Content
(-.52)	9	Professional training important, psychotherapy NOT more of an art than a science.
(.41)	10	Learning through verbal and conceptual interchange.
(.40)	8	Have a lack of countertransference feelings.
(-.36)	6	Impersonal, emotionally uninvolved.
(.26)	11	Disapproves of physical contact, marathons and sensitivity training.
(-.25)	1	Unbeliever in body awareness, guided daydreams, Gestalt Therapy, emotional release.
(.24)	3	A social adjustment is important.

This cluster seems to measure some of the beliefs of therapists with a cognitive behavioral orientation.

* From Sundland (1972).

APPENDIX 7

BRIEF DESCRIPTIONS OF THE FACTORS THAT COMPRISE THE THERAPIST ORIENTATION QUESTIONNAIRE

Factor	Label (high score)
1	Use of expressive techniques In working with dreams, effective therapists have their patients role-play the characters and other elements of their dreams. (710)*
2	Psychoanalytically - oriented. For a patient to improve his current way of life, he must come to understand his early childhood relationships. (701)
3	Social adjustment Having a patient move in the direction of the goals of society is <u>not</u> an important therapeutic aim. (793)
4	Interruptive / active I interrupt a patient while he is talking. (704)
5	Importance of feeling awareness The patient's coming to accept and experience his feelings is <u>not</u> the primary gain he derives from therapy. (780)
6	Involvement and caring. A good therapist acts personally and emotionally involved and concerned with his patient. (691)

APPENDIX 7 continued

Factor	Label (high score)
7	No innate drive toward health. People do not have any inherent "drive towards health". (884)
8	Lack of countertransference. At times, I feel contempt for a patient. (648)
9	Personality and artistry. Patients get better more because their therapists are the kinds of persons they are, than because of their therapist's professional training. (750)
10	Verbal / Conceptual process. In effective therapy, the patient learns mostly through the verbal and conceptual interchange between himself and the therapist. (786)
11	Acceptance of physical contact / marathons etc. It is sometimes all right for a patient and therapist to embrace. (725)

* value of the factor loading

APPENDIX 8

THERAPIST ORIENTATION QUESTIONNAIRE, Form 1972

Indicate your AGREEMENT OR DISAGREEMENT with the following statements.

CIRCLE one of the following:

5	Strongly agree	5
4	Agree	4
3	Undecided	3
2	Disagree	2
1	Strongly disagree	1

NAME _____

1.	The therapist's personality is more important to the outcome of therapy than his professional training.	5	4	3	2	1
2.	A good therapist will help his patients become aware of their bodily movements and postures, and help them explore their possible meanings.	5	4	3	2	1
3.	It is sometimes all right to visit a patient socially in his home.	5	4	3	2	1
4.	Understanding why one does things is <u>not</u> the major factor in correcting one's behavior.	5	4	3	2	1
6.	A therapist should never interrupt a patient while he is talking.	5	4	3	2	1
7.	It is <u>unnecessary</u> for a patient to learn how early childhood experiences have left their mark on him.	5	4	3	2	1
8.	A mature, mentally healthy person will necessarily move in the direction of society's goals.	5	4	3	2	1
9.	A good therapist expresses to his patients a sense of personal involvement and concern.	5	4	3	2	1
10.	Good psychotherapists encourage their patients to use meditative techniques.	5	4	3	2	1
11.	Primary emphasis should be placed on the patient's manifest behavior.	5	4	3	2	1

APPENDIX 8 continued

Indicate your AGREEMENT or DISAGREEMENT with the following statements.

CIRCLE one of the following:

5	Strongly agree	5
4	Agree	4
3	Undecided	3
2	Disagree	2
1	Strongly disagree	1

12.	It is very beneficial to use the "guided-daydream" technique.	5	4	3	2	1
14.	People can be understood without recourse to the concept "unconscious determinants of behavior".	5	4	3	2	1
15.	A patient can be very critical of me or very appreciative of me without any resulting change in my feeling toward him.	5	4	3	2	1
16.	The patient's coming to experience his feelings more fully is not the most important therapeutic result.	5	4	3	2	1
17.	It is important that a therapist show caring and concern for his patients.	5	4	3	2	1
19.	Desensitization and re-conditioning are effective psychotherapeutic techniques.	5	4	3	2	1
20.	I would not interrupt a patient during a therapy session as I might if we were having merely a social conversation.	5	4	3	2	1
21.	It is very important for a therapist to conceptualize, think through, how a patient is relating to him.	5	4	3	2	1
23.	Rather than talk about another person, good therapists have their patients talk to an empty chair as if the person was sitting there.	5	4	3	2	1
26.	It is a useful therapeutic technique for patients to shout, or beat pillows to express blocked feelings.	5	4	3	2	1
27.	It is preferable for the therapist to feel impersonal in the therapy relationship.	5	4	3	2	1

APPENDIX 8 continued

Indicate your AGREEMENT or DISAGREEMENT with the following statements.

CIRCLE one of the following:

5	Strongly agree	5
4	Agree	4
3	Undecided	3
2	Disagree	2
1	Strongly disagree	1

28.	It is never all right for a therapist to have physical contact with patients (except perhaps for occasional handshakes).	5	4	3	2	1
30.	With most patients I do analytic dream interpretation.	5	4	3	2	1
34.	Even a good therapist may find it difficult to cope with a patient's hostility.	5	4	3	2	1
35.	A successful adjustment to the social environment is not an important goal of therapy.	5	4	3	2	1
36.	The therapist should not act as though he were personally or emotionally involved with the patient.	5	4	3	2	1
37.	I instruct most patients to free associate.	5	4	3	2	1
39.	Hopefully the current fad of sensitivity training will soon disappear.	5	4	3	2	1
41.	I am a fairly active, talkative therapist, compared to most therapists.	5	4	3	2	1
42.	Inherent in human beings is a natural propensity toward health, physical, mental, and emotional.	5	4	3	2	1
43.	Whatever the intensity or nature of the patient's emotional expression, the therapist is most effective when he feels detached, objective, and impersonal.	5	4	3	2	1
45.	For effective therapy, it is only necessary to concentrate on the here-and-now experiencing of the patient.	5	4	3	2	1
46.	The most important results of therapy are the new feelings and emotions that the patient comes to experience.	5	4	3	2	1

APPENDIX 8 continued

Indicate your AGREEMENT or DISAGREEMENT with the following statements.	CIRCLE one of the following:					
	5	Strongly agree				5
	4	Agree				4
	3	Undecided				3
	2	Disagree				2
	1	Strongly disagree				1
47. In effective therapy, the patient learns mostly through the verbal and conceptual interchange between himself and the therapist.	5	4	3	2	1	
50. It is never all right to accept a friend or relative for psychotherapy.	5	4	3	2	1	
51. The most beneficial outcome of therapy is the patient's becoming more open to his feelings.	5	4	3	2	1	
52. The patient should be directly confronted with evidence of his irrational thoughts and behavior.	5	4	3	2	1	
53. It is possible to make sense of a patient's behavior without assuming motives of which he is unaware.	5	4	3	2	1	
57. I interrupt a patient while he is talking.	5	4	3	2	1	
59. Patients get better more because their therapists are the kinds of persons they are, than because of their therapist's professional training.	5	4	3	2	1	
60. Release of pent-up bodily energies is important as part of psychotherapy.	5	4	3	2	1	
61. For a patient to improve his current way of life, he must come to understand his early childhood relationships.	5	4	3	2	1	
62. People do <u>not</u> have any inherent "drive toward health".	5	4	3	2	1	
63. My own attitudes toward some of the things my patients say or do stop me from really understanding them.	5	4	3	2	1	
64. An affective change in the patient is <u>not</u> the major gain from therapy.	5	4	3	2	1	

APPENDIX 8 continued

Indicate your AGREEMENT or DISAGREEMENT with the following statements.	CIRCLE one of the following:					
	5	Strongly agree				5
	4	Agree				4
	3	Undecided				3
	2	Disagree				2
	1	Strongly disagree				1
66. The crucial learning process in therapy is a verbal and conceptual process.	5	4	3	2	1	
67. It is sometimes all right to take a walk with a patient during the therapy hour.	5	4	3	2	1	
68. It is important to analyze the transference reactions of the patient.	5	4	3	2	1	
69. A treatment plan is not important for successful therapy.	5	4	3	2	1	
70. Marathon psychotherapy groups are useful in helping a patient progress in treatment.	5	4	3	2	1	
71. I am a fairly passive, silent therapist, compared to most therapists.	5	4	3	2	1	
72. The patient's coming to accept and experience his feelings is not the primary gain he derives from therapy.	5	4	3	2	1	
73. It is important for a patient to be helped to make a social adjustment.	5	4	3	2	1	
74. In working with dreams, effective therapists have their patients role-play the characters and other elements of their dreams.	5	4	3	2	1	
76. It is important for the therapist to feel a deep personal and emotional involvement with his patients.	5	4	3	2	1	
77. Encounter groups are a useful addition to the approaches to mental health.	5	4	3	2	1	
78. The more effective therapists do things during the therapy hour for which they have no reasoned basis, merely a feeling that it is right.	5	4	3	2	1	

APPENDIX 8 continued

Indicate your AGREEMENT or DISAGREEMENT with the following statements.

CIRCLE one of the following:

5	Strongly agree	5
4	Agree	4
3	Undecided	3
2	Disagree	2
1	Strongly disagree	1

80.	For a patient to improve his current way of life, he does not necessarily have to come to understand his early childhood relationships.	5	4	3	2	1
82.	At times, I feel contempt for a patient.	5	4	3	2	1
83.	Body movements and postures tell us a lot about the patient's psychopathology.	5	4	3	2	1
84.	It is irrelevant whether a therapist "cares" for the people who come to him for help.	5	4	3	2	1
85.	It is quite acceptable to interrupt a patient while he is talking.	5	4	3	2	1
86.	In effective therapy, the patient learns mostly through the affective and unverbalized relationship between himself and the therapist.	5	4	3	2	1
87.	Psychotherapy is much more an art than a science.	5	4	3	2	1
89.	There is not an innate tendency in human beings toward emotional health.	5	4	3	2	1
90.	It is never all right to offer the patient a ride, or ask him for one.	5	4	3	2	1
93.	To make sense of a patient's behavior, one must assume motives of which he is unaware.	5	4	3	2	1
94.	Having the patient move in the direction of the goals of society is not an important therapeutic aim.	5	4	3	2	1
95.	A good therapist acts personally and emotionally involved and concerned with his patient.	5	4	3	2	1
96.	I am very secure and comfortable in my relationships with my patients.	5	4	3	2	1

APPENDIX 8 continued

Indicate your AGREEMENT or DISAGREEMENT with the following statements.	CIRCLE one of the following:				
	5	4	3	2	1
	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
97. In all human beings there is a sort of "life force", a striving for perfection.	5	4	3	2	1
98. A therapist should realize that his efforts may prove harmful to patients.	5	4	3	2	1
100. I prefer to conduct intensive rather than goal-limited therapy.	5	4	3	2	1
101. It is sometimes all right for a patient and a therapist to embrace.	5	4	3	2	1
103. Good therapists do a lot of talking during the therapeutic hour.	5	4	3	2	1
104. The most important results of therapy are the new idea and new ways of thinking about himself that the patient achieves.	5	4	3	2	1

* Note - Some of the items were dropped from the questionnaire but the original numbering of items was retained to facilitate scoring.

APPENDIX 9

ROKEACH VALUE SURVEY

INSTRUCTIONS

On the next page are 18 values listed in alphabetical order. Your task is to arrange them in order of their importance to YOU, as guiding principles in YOUR life. Study the list carefully and pick out the one value which is the most important for you. Write it on the answer sheet provided. Then pick out the value which is second most important for you and write it on the answer sheet. Do the same for each of the remaining values.

Work slowly and think carefully. If you change your mind, feel free to change your answers. The end result should truly show how you really feel.

APPENDIX 9 continued

1	A COMFORTABLE LIFE (a prosperous life)
2	AN EXCITING LIFE (a stimulating, active life)
3	A SENSE OF ACCOMPLISHMENT (lasting contribution)
4	A WORLD AT PEACE (free of war and conflict)
5	A WORLD OF BEAUTY (beauty of nature and the arts)
6	EQUALITY (brotherhood, equal opportunity for all)
7	FAMILY SECURITY (taking care of loved ones)
8	FREEDOM (independence, free choice)
9	HAPPINESS (contentedness)
10	INNER HARMONY (freedom from inner conflict)
11	MATURE LOVE (sexual and spiritual intimacy)
12	NATIONAL SECURITY (protection from attack)
13	PLEASURE (an enjoyable, leisurely life)
14	SALVATION (saved, eternal life)
15	SELF-RESPECT (self-esteem)
16	SOCIAL RECOGNITION (respect, admiration)
17	TRUE FRIENDSHIP (close companionship)
18	WISDOM (a mature understanding of life)

WHEN YOU HAVE FINISHED, GO TO THE NEXT PAGE

APPENDIX 9 continued

1	AMBITIOUS (hard-working, aspiring)
2	BROADMINDED (open-minded)
3	CAPABLE (competent, effective)
4	CHEERFUL (lighthearted, joyful)
5	CLEAN (neat, tidy)
6	COURAGEOUS (standing up for your beliefs)
7	FORGIVING (willing to pardon others)
8	HELPFUL (working for the welfare of others)
9	HONEST (sincere, truthful)
10	IMAGINATIVE (daring, creative)
11	INDEPENDENT (self-reliant, self-sufficient)
12	INTELLECTUAL (intelligent, reflective)
13	LOGICAL (consistent, rational)
14	LOVING (affectionate, tender)
15	OBEDIENT (dutiful, respectful)
16	POLITE (courteous, well-mannered)
17	RESPONSIBLE (dependable, reliable)
18	SELF-CONTROLLED (restrained, self-disciplined)

APPENDIX 10

RANGE OF SCORES OBTAINED

	More Effective Therapists		Less Effective Therapists	
Variables:	Highest Score	Lowest Score	Highest Score	Lowest Score
Emotional Adjustment	13	4	14	1
Regard	42	16	40	4
Empathy	40	13	31	9
Unconditionalist	48	8	33	12
Congruence	48	4	39	13
Credibility	84	63	80	43
Patient Involvement	62	39	63	42
Directive/Support	65	42	71	40
Experiential Orientation	5832	4084	6179	4294
Psychoanalytic Orientation	5820	4704	6462	4881
Cognitive-Behavioral Orientation	5782	4214	5673	4239
(TOQ Factors)				
Factor 1	5815	3891	6640	4063
Factor 2	6171	3960	6907	3223
Factor 3	5978	4797	6863	4207
Factor 4	5744	3812	6072	3666
Factor 5	6134	4340	6518	4511
Factor 6	6788	4272	7117	3980
Factor 7	6172	3677	6952	3365
Factor 8	5643	3628	5953	3163
Factor 9	6564	3725	6158	3996
Factor 10	5809	3631	6681	4502
Factor 11	6060	4714	6813	4795

APPENDIX 10 (continued)

Range of Scores Obtained

	More Effective Therapists		Less Effective Therapists	
Variables:	Highest Score	Lowest Score	Highest Score	Lowest Score
(Terminal Values)				
A Comfortable Life	18	9	16	5
An Exciting Life	15	4	14	3
A Sense of Accomplishment	14	3	12	3
A World at Peace	16	6	17	2
A World of Beauty	17	6	16	7
Equality	17	5	17	4
Family Security	16	2	15	3
Freedom	11	4	14	4
Happiness	15	1	13	1
Inner Harmony	17	1	11	1
Mature Love	7	1	11	2
National Security	18	11	18	6
Pleasure	17	5	17	5
Salvation	18	2	18	11
Self Respect	12	1	11	1
Social Recognition	17	9	16	4
True Friendship	10	2	13	4
Wisdom	13	2	14	2
(Instrumental Values)				
Ambitions	18	10	16	1
Broadminded	10	2	12	1
Capable	11	2	9	2

APPENDIX 10 (continued)

Range of Scores Obtained

	More Effective Therapists		Less Effective Therapists	
Variables:	Highest Score	Lowest Score	Highest Score	Lowest Score
(Instrumental Values)				
Cheerful	18	6	15	2
Clean	18	9	18	7
Courageous	13	3	15	2
Forgiving	13	3	15	4
Helpful	15	2	14	2
Honest	12	1	15	1
Imaginative	14	2	15	1
Intellectual	12	3	15	4
Logical	15	5	17	2
Loving	13	1	9	1
Obedient	18	13	18	12
Polite	18	11	18	12
Responsible	12	2	14	3
Self-Controlled	18	9	18	10

APPENDIX 11

ONE-WAY ANALYSIS OF VARIANCE RESULTS FOR ALL DEPENDENT VARIABLES

Variable	More Effective Therapists Mean (SD)	Less Effective Therapists Mean (SD)	F	DF	P
Relationship Skills Variables:					
Regard	30.76(7.50)	24.93(10.51)	3.05	(1,28)	.09(AS)
N	15	15			
Empathy	27.06(9.86)	11.70(13.26	12.96	(1,28)	.001**
N	15	15			
Unconditionality	25.73(13.80)	13.56(11.85)	6.70	(1,28)	.01*
N	15	15			
Congruence	30.26(15.34)	16.76(16.12)	5.51	(1,28)	.02*
Therapy Process Variables:					
Patient Involvement	50.34(6.46)	51.84(6.76)	.357	(1,26)	.55
N	15	13			
Direction Support	57.33(7.10)	59.46(7.96)	.561	(1,26)	.46
N	15	13			
Social Influence Variables:					
Credibility	75.63(5.40	69.73(9.76)	4.19	(1,28)	.05(AS)
N	15	15			
Personality Variable:					
Emotional Adjustment	7.73(2.57)	6.60(4.01)	.847	(1,28)	.36
N	15	15			

APPENDIX 11 (continued)

One-Way Analysis of Variance Results for All Dependent Variables

Variable	More Effective Therapists Mean (SD)	Less Effective Therapists Mean (SD)	F	DF	P
Theoretical Orientation Variables:					
Experiential Cluster	5136(448)	5202.31(580.21)	.088	(1,20)	.76
N	11	11			
Psychoanalytic Cluster	5302(346)	5613.92(475)	3.08	(1,20)	.09(AS)
N	11	11			
Cognitive-Behavioral Cluster	5043(445)	5137(543)	.197	(1,20)	.66
N	11				
Factor 1 (Expressive Techniques)	5012(566)	4837(741)	.386	(1,20)	.54
N	11	11			
Factor 2 (Analytic Tenets)	5161(606)	5326(878)	.263	(1,20)	.61
N	11	11			
Factor 3 (Treatment Plan + Adjustment to Society)	5385(449)	5539(810)	.305	(1,20)	.58
N	11	11			
Factor 4 (Active)	4728(675)	4849(832)	.140	(1,20)	.71
N	11	11			

APPENDIX 11 (continued)

One-Way Analysis of Variance Results for All Dependent Variables

Variable	More Effective Therapists Mean (SD)	Less Effective Therapists Mean (SD)	F	DF	P
Theoretical Orientation Variables (continued):					
Factor 5 (Awareness of Feelings)	5301(662)	5532(663)	.668	(1,20)	.42
N	11	11			
Factor 6 (Caring)	5263(802)	5462(888)	.304	(1,20)	.58
N	11	11			
Factor 7 (Innate Drive toward Health)	4846(660)	4749(896)	.083	(1.20)	.77
N	11	11			
Factor 8 (Lack of Counter transference Feelings)	4656(601)	4539(792)	.153	(1,20)	.69
N	11	11			
Factor 9 (Therapy More Art than Science)	4876(836)	5007(707)	.157	(1,20)	.69
N	11	11			
Factor 10 (Acceptance of Physical Contact + Marathons)	5313(389)	5751(606)	4.06	(1,20)	.05(AS)
N	11	11			

APPENDIX 11 (continued)

One-Way Analysis of Variance Results for All Dependent Variables

Variable	More Effective Therapists Mean (SD)	Less Effective Therapists Mean (SD)	F	DF	P
Terminal Values Variables:					
A Comfortable Life	13.36(2.48)	9.53(3.64)	11.33	(1,28)	.002*
N	15	15			
An Exciting Life	11.34(3.39)	8.18(3.69)	5.94	(1,28)	.02*
N	15	15			
A Sense of Accomplishment	7.89(3.31)	8.66(2.70)	.49	(1,28)	.48
N	15	15			
A World of Peace	10.46(2.96)	12.38(5.33)	1.48	(1,28)	.23
N	15	15			
A World of Beauty	11.58(3.05)	11.86(2.47)	.078	(1,28)	.78
N	15	15			
Equality	10.27(3.49)	12.67(3.65)	3.37	(1,28)	.07(AS)
N	15	15			
Family Security	7.50(4.19)	8.82(4.00)	.780	(1,28)	.38
N	15	15			
Freedom	6.46(1.93)	7.11(3.12)	.469	(1,28)	.49
N	15	15			
Happiness	7.68(4.07)	5.66(3.69)	2.02	(1,28)	.16
N	15	15			

APPENDIX 11 (continued)

One-Way Analysis of Variance Results for All Dependent Variables

Variable	More Effective Therapists Mean (SD)	Less Effective Therapists Mean (SD)	F	DF	P
Terminal Values Variable (continued):					
Inner Harmony	5.48(5.14)	5.27(3.25)	.018	(1,28)	.89
N	15				
Mature Love	4.40(1.90)	5.02(3.50)	.365	(1,28)	.55
N	15				
National Security	14.90(2.45)	15.97(2.97)	1.17	(1,28)	.28
N	15	15			
Pleasure	13.26(3.33)	9.16(3.73)	10.02	(1,28)	.003*
N	15	15			
Salvation	15.48(4.57)	16.93(2.04)	1.25	(1,28)	.27
N	15	15			
Self-Respect	5.58(3.07)	6.00(2.62)	.159	(1,28)	.69
N	15	15			
Social Recognition	13.03(2.48)	12.90(3.34)	.017	(1,28)	.89
N	15	15			
True Friendship	6.20(2.33)	7.08(3.80)	.588	(1,28)	.44
N	15	15			
Wisdom	6.05(2.85)	7.71(3.02)	2.37	(1,28)	.13
N	15	15			

APPENDIX 11 (continued)

One-Way Analysis of Variance Results for All Dependent Variables

Variable	More Effective Therapists Mean (SD)	Less Effective Therapists Mean (SD)	F	DF	P
Instrumental Values Variables:					
Ambitious	12.99(2.72)	10.36(4.56)	3.67	(1,28)	.06(AS)
N	15	15			
Broadminded	4.74(3.02)	6.44(2.93)	2.44	(1,28)	.12
N	15	15			
Capable	5.64(3.10)	5.28(1.86)	.145	(1,28)	.70
N	15	15			
Cheerful	11.75(3.96)	8.25(4.20)	5.48	(1,28)	.02*
N	15	15			
Clean	15.78(2.40)	14.88(2.74)	.914	(1,28)	.34
N	15	15			
Courageous	8.11(3.08)	9.68(3.56)	1.67	(1,28)	.20
N	15	15			
Forgiving	8.76(3.23)	11.18(3.07)	4.44	(1,28)	.04*
N	15	15			
Helpful	8.36(3.60)	8.45(3.73)	.005	(1,28)	.94
N	15	15			
Honest	5.70(2.99)	5.77(3.72)	.003	(1,28)	.95
N	15	15			

APPENDIX 11 (continued)

One-Way Analysis of Variance Results for All Dependent Variables

Variable	More Effective Therapists Mean (SD)	Less Effective Therapists Mean (SD)	F	DF	P
Instrumental Values Variables (continued):					
Imaginative	7.99(3.35)	7.12(4.25)	.389	(1,28)	.53
N	15	15			
Independent	7.03(4.14)	6.45(2.28)	.228	(1,28)	.63
N	15	15			
Intellectual	6.98(2.54)	9.23(3.63)	3.83	(1,28)	.06(AS)
N	15	15			
Logical	10.75(2.69)	11.48(3.72)	.381	(1,28)	.54
N	15	15			
Loving	4.96(3.47)	4.23(2.90)	.393	(1,28)	.53
N	15	15			
Obedient	16.62(1.45)	16.35(1.65)	.229	(1,28)	.63
N	15	15			
Polite	15.13(2.22)	14.34(1.86)	1.11	(1,28)	.30
N	15	15			
Responsible	6.73(3.07)	7.28(3.44)	.217	(1,28)	.64
N	15	15			

APPENDIX 11 (continued)

One-Way Analysis of Variance Results for All Dependent Variables

Variable	More Effective Therapists Mean (SD)	Less Effective Therapists Mean (SD)	F	DF	P
Instrumental Values Variables (continued):					
Self-Controlled	13.12(2.55)	14.32(2.70)	1.54	(1,28)	.22
N	15				

** p < .001
* p < .05
AS = Approached Significance

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