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Relationship Between a Therapist's Locus of Control, Therapeutic Orientation, and Directiveness of Therapeutic Communication

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RELATIONSHIP BETWEEN A THERAPIST'S LOCUS OF CONTROL, THERAPEUTIC ORIENTATION, AND DIRECTIVENESS OF THERAPEUTIC COMMUNICATION

Amy Suzanne Lammers, B. A.

An Abstract Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Art

1999

ABSTRACT

The importance of matching the client and the therapist on certain variables has been stressed by researchers as being an important part of the therapeutic process. While several studies have addressed the locus of control of the client and its relationship to therapeutic communications, few have focused on therapist variables as being just as important. This study examines the relationship between the locus of control of the therapist, the theoretical orientation of the therapist, and the directiveness of therapeutic communications. Subjects for this study were 82 Professional Counselors Licensed in the state of Missouri. In addition to demographic data sheets, subjects were asked to complete a measure of locus of control and a measure of directiveness. Chi-Squares and Pearson Correlations were performed to examine possible relationships. No significant relationship was found between any of the three variables examined. A significant result was found for gender and directiveness style of communication. A discussion of the limitations of this study and implications for future research are given.

RELATIONSHIP BETWEEN A THERAPIST'S LOCUS OF CONTROL, THERAPEUTIC ORIENTATION, AND DIRECTIVENESS OF THERAPEUTIC COMMUNICATION

Amy Suzanne Lammers, B. A.

A Culminating Project Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Art

1999

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CHAPTER I

INTRODUCTION

Researchers have stressed the importance of matching the client and the therapist on certain variables as being beneficial to the therapeutic process (Devine & Fernald, 1973: Foon, 1986a, 1986b). In order to view psychotherapy from an interpersonal perspective, one must understand the significance of one individual's influence over the other (Tracey & Miars, 1986; Marks, 1998). Researchers have debated over whether it is the client or the therapist who ultimately controls the outcome of therapy (Foon, 1986a, 1986b; Bischoff & Tracey, 1995). Though there has been little formal research on the subject of the personality of the therapist and its effect on the therapeutic process, much of the literature suggests that the personality of the therapist greatly shapes his or her theoretical orientation as well as how active a participant he or she chooses to be in the therapeutic relationship (Peterson & Nisenholz, 1995).

This level of participation is difficult to measure, however. One way researchers have attempted to measure therapeutic style is through measures of directiveness in therapeutic communication (Kilmann, Albert, & Sotile, 1975; Merta, Ponterotto, & Brown, 1992; Stinchfield & Burlingame, 1991). This has been troublesome because of the complexity of defining such a subjective concept. In one such attempt to define directiveness, Merta, Ponterotto, and Brown (1992) named four characteristics of a directive action:

concreteness, structuredness, directiveness, and supportiveness. The characteristic of directiveness is further defined through authoritative action, active collaboration, and the giving of advice by the therapist.

Another researcher who attempted to provide a concrete definition for directiveness is Seligman (1990). Seligman listed several directive techniques "...such as systematic desensitization, flooding, positive reinforcement...strategic techniques... and cognitive techniques" as directive and went further to describe directive therapist behaviors such as "an authoritative stance, clearly defines target concerns, and designs a specific program to change overt and covert symptoms" (p. 15). Seligman defined nondirective actions such as "catharsis and abreaction, ventilation, empathy and reflection of feeling, support, affection, praise, and unconditional positive regard" (p. 15).

Other researchers have attempted to develop means to measure directiveness. The Directiveness Rating System was created by Stinchfield and Burlingame (1991) in an attempt to give a precise definition of therapeutic directiveness as related to the therapist's theoretical orientation. This research classified directives as generated from both textbooks and through observations of popular therapeutic approaches such as cognitive-behavioral, rational-emotive, and strategic therapies. These therapies had been noted by previous research to take an overall directive stance, as opposed to the more client-centered approaches. Their research was based on existing

research which demonstrated that differences in theoretical orientation could be indicated by frequency of use of directives (Hill, Thames, & Rardin, 1979; Stiles, 1979). Stinchfield and Burlingame endeavored to create an instrument which divided therapist statements into forms of directives, such as commands or requests, instead of merely grouping all directives into one category, as had researchers in the past (Hill, 1978).

Researchers have long speculated about which parts of the therapist's personality contribute to his or her choice in theoretical orientation (Foon, 1986a). One personality variable to receive much attention is that of locus of control (Foon, 1986a, 1986b; Levenson, 1973; Rotter, 1975; Strupp, 1970). The concept of locus of control was developed by Rotter (1966) in response to research on the social learning theory. Rotter attempted to explain an individual's personality as internally motivated or externally motivated. A person who was internally motivated was said to receive reinforcement from within and believed failure or success to be attributable to his or her own actions. An externally motivated individual was defined as one who believed reinforcement was a determinant of fate or chance and, therefore, attributed success or failure to actions outside himself or herself (Rotter, 1966).

Rotter's theory of locus of control has been greatly researched since its inception, with researchers looking at it as related to a number of variables. One researcher who expanded on Rotter's theory was Levenson (1973). Based on research with political activists, Levenson argued that the

unidimensionality of Rotter's theory failed to take into account variance due to social, political, or religious pressures. She concluded that locus of control was a multidimensional construct and created a third dimension from external locus of control, powerful others, or the belief that other individuals with more power, not chance, are responsible for events (Levenson, 1973).

Many researchers have looked at the effects of locus of control on the therapeutic relationship. It has been stated that one of the primary functions of therapy is to modify the behavior of the client (Stinchfield & Burlingame, 1991) and to help the client gain a greater level of mastery and control over his or her actions with the primary goal to acquire autonomy and self control (Strupp, 1970). Specifically related to locus of control, it has been said that "the goal of therapy is often seen as the encouragement of an internal locus of control" (Levenson, 1973).

Statement of Purpose:

While there is much research on the relationship between the locus of control orientation of the client and therapeutic variables, little exists about that of the therapist. For example, little research exists about how a therapist's locus of control may impact the therapeutic orientation and their level of directiveness. The purpose of this study is to examine how certain therapist factors interact with that therapist's locus of control orientation and may similarly affect communications. One factor to be examined is the therapist's level of directiveness as exhibited by therapeutic communications. A second

factor, the therapist's self-reported theoretical orientation, is also investigated. It is expected that there will be a relationship between these three factors, specifically that a stronger or higher score on the internal locus of control dimension is correlated with similarly high scores on directiveness. Furthermore, it is expected that there is a relationship between theoretical orientation and levels of directiveness as well as the therapist's locus of control orientation.

The null hypotheses for this study are as follows:

1. There will be no significant relationship between the locus of control orientation of a therapist and that therapist's level of directiveness.
2. There will be no significant relationship between the theoretical orientation of a therapist and that therapist's level of directiveness.
3. There will be no significant relationship between the locus of control orientation of a therapist and that therapist's theoretical orientation.

CHAPTER II

LITERATURE REVIEW

In his widely respected theory, Carl Rogers (1957) maintains that the ideal therapeutic relationship is one in which the therapist is congruent in the therapeutic relationship and communicates unconditional positive regard and empathy to the client. In Rogers' theory, if the therapist consistently meets these specific conditions, personality change is inevitable. Rogers goes on to state that the specific techniques or theories subscribed to by the therapist make no difference as long as the therapist uses them as "channels for fulfilling one of the conditions" (Rogers, 1957). While Rogers' theory is highly renowned, researchers argue that the therapeutic relationship is much more complicated and that other more specific variables must contribute to therapeutic success. Because the foundation of therapy is seen as a relationship in which the actions of each participant have a reciprocal effect on the other (Foon, 1986a, 1986b; Strupp, 1970), it is sensible to attempt to identify what specific differential factors contribute to the success of the therapeutic relationship.

While it has been observed that certain therapists tend to be more successful with certain clients, researchers have had difficulties discerning whether the determinant is related to the therapist, the client, or a combination of the two (Van Der Veen, 1965; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971). Some research has centered on client factors (Luborsky et

al, 1971) such as nature of the symptoms or personality factors, while others, (Stiles, Shapiro, & Elliott, 1986, Tracey & Miars, 1986) have viewed therapist variables as a predictor of success.

Predictors of therapeutic success:

In an effort to understand the relationship between client characteristics and success in therapy, researchers have studied personality characteristics, attitudes, and values of the client such as self understanding (Tuma & Gustad, 1957) and level of functioning (Rice, 1973). Through a comprehensive review of 136 studies, Luborsky et al (1971) compiled a list of client factors which could possibly contribute to therapeutic change. Patient characteristics were classified as the following: (a) *Patient factors which influenced the outcome of psychotherapy* . These factors include the degree of initial disturbance, diagnosis, chronicity, motivation and expectations, attitudes toward treatment, level of intellectual functioning, patient "likability", suitability for psychotherapy, affect, authoritarianism, ethnocentrism, interest in human relations, somatic complaints, and insight; (b) *Demographic factors.* Included in this category are age, gender, social achievements, early childhood situation, student status, and existence of previous treatment; (c) *Physiological factors*; (d) *Patient factors as judged from treatment.* This classification includes a patient's attitudes toward problem solving and the ability of the patient to actively experience change (Luborsky et al, 1971).

Luborsky et al (1971) also indicated a great deal of research had been conducted concerning the identification of therapist variables which might have an impact on the therapeutic relationship. Classification of therapist characteristics was as follows: (a) *Therapist qualities.* This includes the therapist's training and experience, personal analysis, therapist expectations, interest patterns as measured by the Strong Vocational Interest Blank, and the therapist's attitude toward treatment; (b) *Therapist factors as judged by treatment.* Included are characteristics such as the amount of empathy shown, the communication of unconditional positive regard, genuineness, and warmth (Luborsky et al 1971). These findings are similar to those found by Spilken, Jacobs, Muller, and Knitzer (1969), in which researchers described ten therapist variables as being important to the success of the therapeutic relationship. These variables include objectivity, dependence, sincerity, sureness, directiveness, empathy, respect, interest, and warmth.

It has been suggested that researchers wishing to understand the therapeutic relationship should focus less on the understanding of specific variables per se, and more on the pairing of the therapist and client on specific factors (Bischoff & Tracey, 1995; Luborsky et al 1971). In one of the first studies to provide statistical evidence of the importance of matching the therapist and client on certain variables (Whitehorn & Betz, 1954, 1960), researchers looked at the therapeutic relationships of psychiatrists and schizophrenic clients. Using the Strong Vocational Interest Blank as a

measure of interests, it was found that dyads who had similar interest patterns had significantly higher improvement rates than those whose scores on the Strong scale differed.

Other measures have since been used to indicate similarity. It has been hypothesized that matching the therapist and client on MMPI scores, specifically P-T compatibility, would lead to a positive relationship. In fact, their results showed that, while client/therapist matching generally helped with communication, extreme similarity or dissimilarity would actually be seen as an impediment to the therapeutic process (Carson & Heine, 1962; Carson & Llewellyn; 1966).

Sheehan (1953) and Graham (1960) suggested matching therapist and client personality variables through the use of Rorschach tests. Both researchers found that there was a significant shift in personality structure, as measured by the Rorschach, during the course of therapy. In fact, it was found that in the course of therapy clients became more like their therapists on certain personality traits.

Various interest inventories have been examined as to their usefulness in matching. In a study by Welkowitz, Cohen, and Ortmeyer (1967), therapists and clients were given the Strong Vocational Interest Blank and the Ways to Live Scale. Researchers found that when therapists were asked to rate their clients, those rated "most improved" were those clients whose values and personality traits were similar to the values and personality traits of

the therapist. Additionally, therapists who had rated their own existing clients were more likely to indicate similarity than therapists who had been randomly paired with clients. The results of this study support the researchers' original assertions that the "matching" of the client and therapist on certain variables is conducive to therapeutic success.

Many different personality characteristics have been introduced in the literature as being important in determining a good "match" between client and therapist. One such characteristic is that of locus of control. Several studies have been conducted which examined the locus of control of the client. In a series of research studies, (Kilmann, 1974; Kilmann & Howell, 1974; Kilmann, Albert, & Sotile, 1975; Kilmann & Sotile, 1976) it was found that there was a relationship between a client's locus of control score and his or her preferred therapy type. Specifically, it was found that internals tend to react positively to an unstructured leader role, while externals preferred a structured leader.

Researchers have attempted to identify whether there was a link between an individual's locus of control orientation and success or failure in therapy (Nowicki & Duke, 1978) as well as the possibility of changing one's locus of control orientation through the therapeutic process (Neeman, 1995). Other studies have gone further to relate the therapist's locus of control with his or her therapeutic style and to suggest that matching the client and therapist according to this characteristic might produce positive results. Foon

(1986a, 1986b, 1988) maintains that the most likely determinant of therapeutic outcome is not demographic or social characteristics, but rather cognitive style characteristics which might be more intimately related to one's attitudes and behavior. Foon's research indicated that there was support for the utility of matching the therapist and client on the locus of control score (1986a, 1986b, 1988).

Locus of control:

The concept of internal versus external control of reinforcement, more commonly known as the locus of control construct (Rotter, 1966), was developed as an extension of the social learning theory (Rotter, 1954). This construct maintains that an individual's behavior in any given situation is a function of his or her expectancy of eventual reinforcement for that behavior. Rotter described a person's locus of control as being either external or internal. An externally oriented individual would be likely to believe that events are unrelated to one's own behaviors and beyond one's control and are instead attributable to luck, chance, or fate. An internally oriented individual would see these events as being within one's control, and therefore a consequence of one's behavior or characteristics (Rotter, 1966).

Rotter's Internal-External (I-E) scale (1966) was originally seen as a measure of a unidimensional quality. However, factor studies have indicated that the construct is in fact, multidimensional, with at least two factors accounting for variance. Mirels (1970) found that the I-E scale measured two

separate factors; a perceived mastery over one's life and perceptions related to political institutions and powerful others. The notion of yet a third factor related to locus of control was researched by Levenson (1973, 1974). Levenson believed that the external dimension could be separated into external control by chance and external control by powerful others. A new scale was developed that consisted of three subscales: internality, chance, and powerful others. Factor analysis of Levenson's scale was supportive of Levenson's hypotheses (Levenson, 1973, 1974). Further evidence for the multidimensionality of the I-E scale has been given in studies by Reid and Ware (1973), as well as Paulhaus & Christie (1981).

The introduction of this concept of locus of control led many researchers to begin to examine the relationship between an individual's control orientation and a number of personality variables. In a study by Hersch and Scheibe (1967), researchers correlated the I-E scale with the California Personality Inventory (CPI) and the Adjective Check List (ACL). It was found that there was a correlation between an internal locus of control and characteristics such as dominance, tolerance, assertiveness, independence, and sociability. In another study, a correlation was found between externals and behaviors such as anxiety and neuroticism (Feather, 1967). Externals have also been found to score higher on measures of hostility (Williams & Vantress, 1969) and mistrust (Miller & Minton, 1969).

In examining ethnic and social class differences, researchers have reported differences in locus of control as well. Research consistently suggests that, overall, Caucasians are more internally oriented than African-Americans (Battle & Rotter, 1963), Chinese (Hsieh, Shybut, & Lotsof, 1969), Hispanics, and Indian-Americans (Coleman, Campbell, Hobson, McPartland, Mood, Weinfeld, & York, 1966). However, while this research focuses on race in and of itself, other researchers have suggested that other variables may confound the results. An example of this can be seen in research on the locus of control orientations of persons participating in social action groups. While some researchers have found that African-Americans who were considered social activists scored higher on the internal control dimension than their non-activist African-American peers, others have found quite the opposite (Levenson, 1974).

The relationship between locus of control and the client's preference for therapy type has also been studied. In his original monograph, Rotter (1966) suggested that an unstructured therapist style could intensify the internal's need for personal control, while a structured therapist role could be beneficial for the external client. A study by Kilmann, Albert, and Sotile (1975) examined this hypothesis and found that internals in fact showed greater improvement in an unstructured setting, while externals needed more support and guidance to achieve the same results.

Studies such as these are evidence that a client's locus of control plays an integral part in the therapeutic process. It has been noted that it is beneficial for the therapist to understand the client's locus of control orientation at the beginning of the relationship and the way it may affect the therapeutic process (Foon, 1986a, 1986b; Neeman, 1995; Marks, 1998). It has even been suggested that the therapeutic process could be used to, in effect, change an individual's locus of control orientation (Neeman, 1995). This seems to be an underlying theme in much of the research on locus of control, in that "...the goal of therapy is often seen as the encouragement of an internal locus of control signifying mastery over the environment and competence (Levenson, 1973 p.397)".

The effect of the therapist's style on the relationship:

Since the therapeutic relationship is seen as a relationship in which each individual has an effect on the behavior of the other, one must also attempt to identify therapist characteristics that impact the therapeutic process. Many researchers have attempted to demonstrate how a difference in therapist style or therapeutic orientation might be related to therapeutic success. Historically, researchers held the belief that a behavior was a function of an external stimulus (Skinner, 1953) or an internal drive (Hull, 1943) and was formed mainly through a process of reinforcement. As cognitive theories emerged, researchers began to look at the manner in which an individual processes information and forms behaviors (Atkinson, 1964).

Researchers then began to look at the concept of autonomy of behavior and self-efficacy (Bandura, 1977). Over time, many new theories emerged that dealt with a multitude of individual, complex variables.

There are an abundance of factors that make one theory different from the next. Possibly the most obvious to any observer is the style of the therapist's communication, often demonstrated by the amount of directiveness the therapist shows in the relationship. For example, two theories, those of Carl Rogers and Albert Ellis, illustrate two opposite ends of the spectrum. According to Rogers' person-centered approach, therapeutic success is based on the client's trust of the therapist. The client is responsible for setting the course of therapy, choosing one's own goals, and ensuring those goals are met. The therapist is seen as the facilitator of this process and is expected to show "unconditional positive regard" for the client at all times (Raskin & Rogers, 1989). Conversely, Ellis' theory of rational emotive behavior therapy (REBT) proposes that the therapist be the motivator for change. It is not uncommon for a REBT therapist to "prescribe" a change in behavior or to overtly challenge a client's belief. An REBT therapist makes use of a variety of techniques to actually teach the client, rather than letting the client come to his or her own conclusions over time (Ellis, 1995).

It has been difficult for researchers to study directiveness of therapeutic communication, due in part to the difficulty of defining what a "directive" behavior really is. Some researchers have tried to identify

particular behaviors and classify those behaviors as being either "directive" or "nondirective" (Seligman, 1990) or by attempting to identify specific characteristics of a directive action (Merta, Ponterotto, & Brown, 1992). Hill (1978) also attempted to classify and measure counselor verbal behavior according to specific behaviors and skills. Hill was able to divide counselor responses into 17 categories. Hill later used this Verbal Response Rating System to compare verbal behavior of Rogers (Person-centered), Perls (Gestalt), and Ellis (REBT). The results of this comparison showed a difference in verbal behavior which seemed to correspond to the basic tenets of each therapist's theoretical base (Hill, Thames, & Rardin, 1979).

In response to the need for a more precise measure for directives, Stinchfield and Burlingame (1991) developed the Directives Rating System (DRS). The DRS classified actions according to the type of directive as well as the target. The type of directive could be an imperative, a request, or an advisory. The target involved whether this behavior was to occur in therapy, outside of therapy, or both. As in studies by Hill and others (1978, 1979, 1992), the researchers observed a relationship between DRS ratings and therapeutic orientation (Stinchfield & Burlingame, 1991).

One interesting study that examined the relationship between therapist behavior and client resistance looked at ten sessions which had been videotaped for training purposes (Bischoff & Tracey, 1995). The sessions viewed included a variety of therapists of differing theoretical orientations:

(a) Pearls, Rogers, and Ellis with "Gloria"; (b) Rogers, Shostrom, and Lazarus with "Kathy"; (c) Strupp, Meichenbaum, and Beck with "Richard"; and (d) Strupp with "Kelly". Raters used the Client Resistance Code (CRC) to categorize client behaviors and the Therapist Behavior Code (TBC) to classify therapist behaviors. Results suggested that there was a relationship between client behavior and therapist behavior. In fact, the results pointed to the fact that client behavior is not always random but can be predicted by the behavior of the therapist. In that these findings, especially those related to the directiveness of the therapist, mirrored others, researchers suggested that client behaviors of resistance could be partly attributable to directive therapeutic behaviors.

Howard, Nance, and Myers (1986) agreed that the directiveness of a therapist could greatly influence a client's behaviors, especially during different points in the counseling relationship. They pointed out that one major problem for clinicians was choosing one theoretical stance over another. It was proposed that in order to be an effective counselor, one must take a somewhat eclectic approach to counseling and be able to utilize a number of different techniques at the different developmental stages of the counseling process, a model they referred to as Adaptive Counseling and Therapy (ACT). The Therapist Style Inventory (TSI) was developed as a measure of a therapist's style in certain situations. The results could be interpreted simply, as a reflection of the therapist's general style preference,

or further, as a measure of style adaptability. The authors note the importance of understanding one's theoretical beliefs and the ability to adapt one's actions in order to better facilitate effective communication.

Given this evidence, it seems necessary to further evaluate the effect of the therapist variables and the effect they might have on the relationship with the client. While an abundance of research exists concerning the locus of control of clients and preference for therapy type as one possible explanation for failure to progress in therapy, little is known about that of the therapist. Given the reciprocal nature of the counseling relationship, one could assume the same for the therapist. This study examined the relationship between the locus of control orientation of a therapist as measured by Levenson's Multidimensional Locus of Control Scale (1973) and that therapist's style of communication, as measured by the TSI (Howard et al, 1986). Based on the assumption that a therapist chooses one's theoretical style or orientation according to his or her own personality characteristics or beliefs and communicates according to these beliefs, theoretical orientation are also carefully investigated.

CHAPTER III

METHOD

Participants:

The population for this study was all Licensed Professional Counselors (LPCs) of the state of Missouri. The number of currently-licensed LPCs at the time of the study was 2064. Demographical information about this population was unavailable with the exception of gender (M = 596; F = 1468). A list of Missouri LPCs was obtained from the state of Missouri Office of Professional Registration, and a total of 200 names were chosen randomly by computer from this list.

Of the 82 usable responses, 76 (92.7%) identified themselves as White, non-Hispanic; 4 (4.9%) as African-American; and 2 (2.4%) as Hispanic. Gender was represented by 30 (36.6%) male and 52 (63.4%) female participants. Sixty-six (80.5%) reported that they were currently practicing, with the remaining 16 (19.5%) not actively practicing. In terms of years in practice, 43 (52.4%) had been in practice over ten years, 32 (39.1%) five to ten years, 5 (6.1%) less than five years, and 2 (2.4%) did not indicate.

Instruments:

Two instruments were utilized for this study. Hanna Levenson's Multidimensional Locus of Control Scale (Levenson, 1973) was used as a measure of the therapist's locus of control. This scale is a twenty-four item scale in a Likert 6-point format. Responses are scored as follows: Strongly

disagree (-3), Disagree somewhat (-2), Slightly Disagree (-1), Slightly agree (+1), Agree somewhat (+2), and Strongly agree (+3). The instrument is broken down into three subscales (possible range on each subscale 0-48). The first subscale, I, deals with the aspect of internal control, or the extent to which the individual feels he or she controls his or her own life. The second subscale, P, measures the expectation that powerful others control events in the individual's life. The third subscale, C, indicates the amount to which the individual feels chance forces or fate control events in his or her life. In each scale, a high score indicates that it is mostly true, while a low score indicates it is mostly false. The scale is easy to administer and score. The questions are divided according to subscale and the responses are totaled up, giving three total scores for the scale. The scale is appropriate for the adult population.

Levenson's (1973) scale was developed in an attempt to demonstrate the multidimensionality of the locus of control construct. The first group of subjects to be tested consisted of 96 male and female adults living in a metropolitan area in the Southwest United States. Subjects were chosen randomly from three groups: a local anti-pollution group, those who had been notified of the group but had elected not to join, and those who had not been notified nor had joined the group. A second group of subjects consisted of 329 male undergraduate chemistry students at Texas A&M University.

Levenson (1973) conducted item analyses with pre-test groups to ensure that all items distinguished between low and high scorers within the three subscales. Internal consistency estimates as measured by Kuder-Richardson reliabilities were r+.64 (I), r=.77 (P), and r=.78 (C). These estimates were only moderately high, but were comparable to those obtained with similar measures. The retest reliabilities at one week were not statistically different. Factor analysis was performed through a Varimax rotation with results suggesting there was virtually no overlap on the three factors (subscales). Factor loading was high, with 22 of 24 items loading over ±.35 on only one factor, and three-quarters of the test items loading greater than ±.50.

The measure of therapist style used for this research was the TSI (Howard et al, 1986), which was developed to test the Adaptive Counseling and Therapy model. The TSI, formerly known as the Counselor Behavior Analysis (CBA) scale (Gabbard, Howard, & Dunfee, 1986), is a 48 item self-administered measure of therapist style and adaptability. The TSI-Long is also available in two short forms (TSI-A and TSI-B), each consisting of twelve vignettes. These vignettes depict client behavior at different points in therapy. Four counselor responses accompany each vignette, with each response representing one of four "styles" of communication. These styles are classified according to direction and support. Responses are scored according to preferred style and can then be further converted into a

adaptability score. For purposes of this research, only the preferred style was calculated.

In its initial trials, the TSI-Long from was administered to 44 practicing counselors aged 24 to 42 with counseling experience ranging from 1 year to 18 years. Internal consistency scores for the TSI were obtained by comparing form TSI-A and TSI-B to the long form(TSI-Long), resulting in .78 and .77 respectively. Test-retest reliability on 22 of the original subjects at three months was .46. Constancy of the four counselor styles was measured, yielding results of .55 (Q1), .76 (Q2), .70 (Q3), and .46 (Q4). Kappa coefficients ranged from .33 to .88, median value .60 (Gabbard, et al, 1986).

A second set of data was obtained to test counselor adaptability. Eleven counselors in training completed the TBI-Long and then attended a 2-hour workshop explaining the ACT theory. The same counselors were again given the TBI-Long and were asked to respond (a) as they would react and (b) how the ACT theory proposes one should react. Preintervention adaptability scores yielded a mean of 73.43 (SD = 4.45; range = 66-81). A significant difference was found between postintervention scores (M = 76.5; SD = 6.65; range = 66.87) under regular instructions and preintervention scores, $t(9)$ = 2.59, $p < .05$. Likewise, there was a significant difference between postintervention scores (M = 78.5; SD = 4.35; range = 73-85) when asked to give answers according to ACT theory, $t(9) = 5.83$. $p < .001$. These results

indicated that counselors could effectively identify responses which were consistent with the ACT theory (Gabbard et al, 1986).

Procedures:

Subjects (N=200) were mailed a packet containing a letter of introduction describing the study, a letter of informed consent, Levenson's Multidimensional Locus of Control Scale, the TBI-A or TBI-B, and a demographic sheet (See Appendices A-E). Self addressed envelopes (2) were also provided. Subjects were asked to return their completed scales and their signed consent documents in separate envelopes so that their confidentiality would not be compromised. A blank space was provided for interested subjects to include a "code number" of their own choosing to be used by this researcher to return the test results.

Data analysis:

All forms were hand-scored by the researcher and were entered into a computer. Statistical analysis was performed using the Statistical Package for Social Sciences (SPSS) 6.1 for Students (SPSS, 1994). Descriptive statistics were used to describe information gathered using the participants' personal data. For purposes of testing the null hypotheses, Pearson Product-Moment Coefficient of Correlation was used in addition to Chi-Square analyses with a set alpha of .05.

CHAPTER IV

RESULTS

Of the 200 packets mailed, 3 (1.5%) were returned as undeliverable. There were a total of 92 replies (46%) and 105 (52.5%) no response. Of the replies, 4 (2%) resulted in refusals to participate, and 6 (3%) were unusable due to incomplete or missing parts. Of the 92 replies, 82 (89%) were usable.

(i) In order to test whether there was a relationship between the locus of control and level of directiveness, the therapist's locus of control score on each of the three categories (I, P, or C) was first correlated with the score on each of the four style distinctions (Telling, Teaching, Supporting, and Delegating). Table 1 displays the Pearson Correlation associated with each set of scores.

Table 1
Correlation Coefficients of Locus of Control and Therapist Style Preference Scores

	Telling	Teaching	Supporting	Delegating
Internal	.059	.096	-.112	-.064
Powerful Others	-.007	-.041	-.081	-.036
Chance	.014	-.012	.072	-.093

In addition to the correlation of data based on each subscale score, a "dominant score" was computed for each subject for each of the two variables. To find the dominant locus of control, this researcher used the subscale (I, P, or C) on which the participant had the highest total score. The

dominant style for therapist was also taken from the highest-scoring of the four styles. In accordance with the requirements of the ACT model (Howard, et al, 1986), only scores which showed a clear preference, and not those with "tied" scores, were used. Of the 82 subjects, a total of 60 showed a clear preference for one style over another. The scores of these individuals on the two variables were crosstabulated, with results as shown in Table 2.

Table 2
Crosstabulations of Dominant Locus of Control and Style Orientations

	Telling	Teaching	Supporting	Delegating	Total
I	0	47	9	0	56
P	0	1	0	0	1
C	0	2	1	0	3
Total	0	50	10	0	60

Table 2 suggests that a majority (83%) indicated teaching as a clearly preferred style, followed by supporting (17%). Indeed, the data provided indicates a pattern of clear preference for few combinations with little or no participants in many of the other combinations if style and locus of control.

(ii) Chi-Square analyses were performed to examine the relationship between directiveness and theoretical orientation. It was found to be necessary to collapse some of these values in an attempt to increase cell size. The original orientations were combined into new sets based on similarity of the basic tenets of those orientations (i.e.: "behaviorally" based or "client-oriented" based). Classifications were determined by this researcher with the

help of a professor of counseling. Tables 3 and 4 represent the distribution of theoretical orientations for the original and collapsed set of data respectively.

Table 3
Frequencies of Theoretical Orientations: Original Distribution

	Frequency	Percent
Family Systems	16	19.5
Existential	1	1.2
Cognitive Behavioral	36	43.9
REBT	2	2.4
Psychoanalytic	2	2.4
Jungian	2	2.4
Adlerian	2	2.4
Cognitive	6	7.3
Brief/Strategic	3	3.7
Humanistic	5	6.1
Reality Therapy	7	8.5

Table 4
Description and Frequencies of Theoretical Orientation: Collapsed Data

	Freq.	%
Family Systems	16	19.5
Existential, Humanistic	6	7.3
Cognitive Behavioral, Cognitive, REBT	44	53.7
Psychoanalytic, Jungian, Adlerian	6	7.3
Brief/Strategic	3	3.7
Reality Therapy	7	8.5

It is evident that, even after collapsing the data, a great number of the participants are clustered within the same grouping, or "type" of theoretical orientation. This makes it difficult to make any clear assumptions based on the data offered.

The data representing the theoretical orientation of the therapist was crosstabulated with that therapist's clear preference for a particular style of communication. Again, only 60 of the original 82 subjects' scores were tabulated because of a lack of clear preference of the remaining 22 subjects. The results of the data analysis are demonstrated in Tables 5 and 6.

Table 5
Crosstabulation of Theoretical Orientation and Clear Style Preference

	Teaching	Supporting
Family Systems	8	3
Existential group	4	1
Cognitive Behavioral group	30	3
Psychoanalytic group	2	1
Brief/Strategic	1	2
Reality Therapy	5	0

Table 6
Chi-Square Analysis of Theoretical Orientation and Clear Style Preference

	Value	df[a]	Sig. (2-sided)
Pearson Chi-square	14.348[b]	10	.158
Likelihood Ratio	12.342	10	.263
N if Valid Cases	82		

[a]Degrees of Freedom
[b]Cells (77.8%) have expected count less than 5.

Again, it must be noted that, as demonstrated in Tables 5 and 6, there is a wide range of responses, with a great majority of the cells having fewer than the desired number of cases. In that the number in each of the cells is so

low and that only two of the four styles were chosen by participants as a preferred style, it is difficult to observe any significant patterns.

(iii) To test if any relationship exists between a therapist's theoretical orientation and locus of control preference, both variables were crosstabulated and a Chi-Square was performed on the data. This data is represented in Tables 7 and 8.

Table 7
Crosstabulation of Theoretical Orientation and Locus of Control Preference

	Internal	Powerful	Chance
Family Systems	16	0	0
Existential group	6	0	0
Cognitive Behavioral group	41	1	2
Psychoanalytic group	5	0	1
Brief/Strategic	3	0	0
Reality Therapy	7	0	0

Table 8
Chi-Square Analysis of Theoretical Orientation and Locus of Control Preference

	Value	df[a]	Sig. (2-sided)
Pearson Chi-square	5.089[b]	10	.885
Likelihood Ratio	5.334	10	.868
Linear-by-Linear association	.055	1	.814

[a]Degrees of Freedom
[b]Cells (72%) have expected count less than 5.

As before, it is evident that the range of scores is not evenly distributed, with cells having a very large or very small number of cases. It is clear that this sample consists of a disproportionately large number of therapists indicating a preference for a Cognitive Behaviorally based theoretical orientation. Also, in that so few participants scored a locus of control preference for the Powerful Others or Chance orientation, it is difficult to even make assumptions based on visual cues, if not through statistical analysis.

Additional statistical analyses:

Additional analysis was performed in an effort to determine if personal or demographical data gathered could be related to any of the aforementioned factors. To test if the therapist's self-reported level of directiveness was correlated with directiveness as measured by the TSI (Howard, et al, 1986). Results of a Pearson Correlation are shown in Table 9. Results indicate that there is a discrepancy between therapist self-perception of directiveness and the measure of directiveness on the TSI.

Table 9
Correlation of Directiveness as Measured Through Self-Report and the TSI

	Telling	Teaching	Supporting	Delegating
Self-Reported Score	.143	.107	-.143	-.102

Therapist factors were also analyzed with respect to gender, as gender was virtually the only demographic variable which was somewhat evenly

distributed and whose distribution (36.6% male, 63.4% female) was similar to that of the general population (29% male, 71% female). Tables 10 and 11 show the crosstabulation and Chi-Square analysis on gender and clear style preference.

Table 10
Crosstabulation of Gender and Clear Style Preference

	Teaching	Supporting
Male	17	1
Female	33	9

Table 11
Chi-Square Analysis of Clear Style Preference and Gender

	Value	df[a]	Sig. (2-sided)
Pearson Chi-Square	6.249[b]	2	.044
Likelihood Ratio	6.77	2	.034

[a]Degrees of Freedom
[b]1 Cell (16.7%) has expected count less than 5.

As evidenced in the Table 10 and further shown in Table 11, there is a significant difference in the proportion of male and female therapists in terms of clear style preference, with proportionately more females than expected indicating a clear preference for Supportive over Teaching, while proportionately more males indicated a very clear preference for Teaching. Only one male indicated a preference for Supportive style.

CHAPTER V

DISCUSSION

Limitations:

While this study found one significant relationship, that of gender and clear style preference, there was no statistical evidence found which would support rejection of any of the three null hypotheses. From visual inspection of the data gathered as well as the crosstabulations performed, it is immediately evident that, with few exceptions, participants' scores were clustered within very few therapist styles or locus of control orientations so that statistical analyses were difficult if not impossible to interpret.

Of the 82 participants, 78 scored highest on the internal control dimension of Levenson's (1974) measure of locus of control. One might question the validity of any results gathered from such a sample. Though the sample size chosen for this experiment (200) was not small (nearly 10% of the total population), one wonders if this is in fact an accurate description of the population as a whole.

Western culture has, in effect, "conditioned" individuals to hold the belief that "healthy" behaviors are those for which that individual holds him or herself accountable. It can be presumed that certain "types" of individuals seek out counseling as a profession because of their desire to help others. It could be an individual who believes others more powerful than him or herself ultimately control what happens; or it could be some person who believes that

happenings are just a matter of chance or fate; it could be an individual who believes that he or she has the ultimate power and control over his or her life and world. One might argue, based on these three personas, that the third description might most accurately describe an individual one might find in the counselor's seat. It has been said that one important purpose of counseling is to promote a greater sense of control over one's own actions (Levenson, 1973). It may be sensible to believe that, in order to successfully promote an internal locus of control, one must possess it and that counselors are socialized through training to espouse an internal locus of control.

Another variable which exhibited such a very limited range was style preference. Indeed, when style scores on each of the four styles were converted to clear preference scores, there were no participants found to indicate a true preference for Telling or Delegating, the two most directive styles of communication according to Howard et al (1986). However, when a visual inspection was made of the therapist's self-reported directiveness score, there were many who believed themselves to fall within the 4-5 range, or believing themselves to be somewhat to very directive in communication. There was no clear relationship between the two sets of scores. This causes one to wonder if one or both of the measures of directiveness is not accurate or if each is simply measuring a different construct of "directiveness".

An obvious limitation in reference to the self-report measure is that it is purely that: a self report measure. The idea of "directiveness" might vary

greatly from one therapist to the next and may be based on a wide variety of other factors. For example, one therapist might believe a behavior to be extremely directive, while another might view that very same behavior as being mid-range. Another possible explanation might be that the TSI (Howard et al, 1986) is not an accurate measure of directiveness. Indeed, the TSI is mainly used as a measure of counselor adaptability, where counselor's scores are first scored for directiveness and then scored for adaptability to situations. Although it has been used previously to measure directive behaviors, it has always been in pursuit of a different final goal, to measure adaptability within the counseling relationship.

Another limitation of this study could be the question of theoretical orientation. Subjects were asked to choose an orientation without being offered a description of beliefs or behaviors commonly held by other practitioners within that theoretical orientation. It may be argued that, while a majority of that person's beliefs fell within the tenets of a specific theory, these beliefs may change or be adapted to better fit different situations (a behaviorally-oriented individual might, based on the situation, throw in a little Rogerian therapy). One might ask the question: Is theoretical orientation a truly stable trait? While researchers in the past have stressed the importance of associating oneself with one particular theory, in later years this opinion has changed. It has been deemed more and more important for a capable therapist to understand many different theoretical standpoints and to use the

most appropriate theory for the situation (Howard et al, 1986; Marks, 1998).

Recommendations:

Though no significant relationships were found between the variables in this study, the question as to the relationship between therapist factors and treatment factors remains valid. Through previous research, evidence had been given to support theoretical orientation, therapeutic style, and locus of control as possible predictors of therapeutic outcome. Future research needs to be performed in an effort to understand how therapist traits and behaviors, just as client traits and behaviors, can ultimately affect the outcome of therapy. Directiveness of therapeutic communication is only one of many factors that could be examined. Future studies might attempt to better define this concept and might strive to better understand if traits such as directiveness as well as theoretical orientation are indeed truly stable, definable traits. Additionally, future researchers might attempt to include a more diverse range of therapists in terms of locus of control orientation and style preference. The concept of matching the therapist and client on certain important variables must also be further studied if counseling professionals are to continue to view the counseling relationship as a collaborative effort. Indeed, researchers such as Marks (1998) and Foon (1986a, 1986b, 1988) have stressed that it is of great importance for a therapist to understand the ways in which the personalities of the therapist and client interact within the counseling relationship. Through future studies, researchers may be better

able to understand the complicated nature of personality and the importance of creating the best match possible between individuals in order to achieve therapeutic success.

Appendix A

Appendix B

DEMOGRAPHIC INFORMATION

Check one:

Gender: _____M
_____F

Ethnicity: _____White non-Hispanic
_____African-American
_____Hispanic
_____Asian-American
_____Native American
_____Other

Are you currently practicing?

_____Yes Which State_____
_____No

Number of years in practice:

_____Less than 5 years
_____5 to 10 years
_____Over 10 years

Please select the following theoretical orientation that *best* describes you:

_____Family Systems
_____Existential
_____Cognitive Behavioral
_____Rational Emotive Behavior Therapy
_____Psychoanalytic
_____Jungian
_____Behavioral
_____Transpersonal
_____Adlerian
_____Cognitive
_____Gestalt
_____Brief/Strategic
_____Humanistic
_____Transactional Analysis
_____Reality Therapy

In terms of directiveness in therapy, indicate where you believe you fall:

Extremely non-directive *Extremely directive*

1 2 3 4 5

Appendix C

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Therapist Style Inventory by George S. Howard. c1986.

DESCRIPTION: This measure of therapist style, also called the *Counselor Behavior Analysis Scale,* is composed of brief vignettes describing counseling situations. Four possible choices of action are suggested. Each choice represents a therapy style. There are telling, teaching, supporting, and Delegation. The therapist selects one of the four choices. Based on the *Adaptive Counseling and Therapy (ACT)* model, this model emphasizes the use of whichever therapy style the situation requires. This inventory is suggested for use by therapists to help them make a link between the type of diagnosis and treatment selection the ACT model describes.

ADMINISTRATION: There are four choices of therapist behaviors for each situation described. The therapist selects the best style for each situation described. This instrument is self-administered. Two forms are included. There are 24 items that constitute a long form that is divided into two separate forms, A and B, each containing 12 vignettes.

SCORING AND INTERPRETATION: Point values are assigned to each response. Four points are assigned for the correct response to each situation. One who always selects the least preferred style would score 24 points on counselor adaptability. A scoring key, plus all inventory items, can be found in the first reference below.

TECHNICAL INFORMATION: Internal consistency coefficients are .78 and .77 and result from comparison of parts A and B respectively to the total score which is based on administering the full 24 items as a long form. A test/retest reliability coefficient was .46 over a three-month interval. Additional information on other types of reliability and a validity study can be found in the journal articles cited below.

MATERIALS: *Therapist Style Inventory, Form A; Therapist Style Inventory, Form B*

REFERENCES: Gabbard, Clinton E. and Others. "Reliability, Sensitivity to Measuring Change, and Construct Validity of a Measure of Counselor Adaptability." *Journal of Counseling Psychology*, v33, n4, p377-86, Oct 1986

Howard, George S. and Others. "Adaptive Counseling and Therapy: An Integrative, Eclectic Approach." *The Counseling Psychologist,* v14, n3, p363-42, Jul 1986

Form A **Code_____**

In answering the twelve questions below assume that you are the therapist involved in that situation described. Think about what action you would choose in that situation, and circle the response that most closely resembles the action you would take. Please circle only one response to each situation. Remember to answer as you think you would if you were the therapist, not as you think an ideal therapist should respond. Please answer the questions in order, without spending too much time on any situation. Finally, do not go back over your answers or make changes.

1) As an alcoholism counselor in an inpatient treatment program, you are scheduled to meet with Ann who has been given the assignment of identifying on a work sheet all the people who have been hurt by her alcoholism. The client arrives on time for the appointment and seems pleasant and willing to talk. After a few minutes of small talk you ask about the assignment. She begins to explain why she hasn't done the assignment. You would:
   (a) Say, "You have not done your assignment. We have nothing to talk about until you do."
   (b) Work with her to develop the list in the session.
   (c) Reflect your frustration and listen to her feelings.
   (d) Ignore the missing material and ask Ann what she wants to talk about today.

2) You are in the fourth session with a 15-year-old who has been sent to you for truancy problems. You have established a good relationship and have just begun to focus on the school behavior. During the session the client says, "I don't really want to go to school but I'll do it for you." Your response is:
   (a) If you go to school all week, I will authorize an extra privilege.
   (b) Good! It's important to continue your education; so I'm glad you'll go for me and for you.
   (c) I trust your judgment about whether you decide to go to school or not.
   (d) So you really don't want to go, but if you thought it would please me you would go.

3) You have seen Charlie, a middle-aged man, two times. He sought services voluntarily due to feelings of insecurity. He recently was diagnosed as diabetic and has lost some of his vision as a result of the disease. He also lost his job of 18 years due to the poor economy. He is happily married and has one son. You would:
   (a) Set up a program of physical therapy in conjunction with his doctor and refer him to a competent vocational rehabilitation counselor.
   (b) Discuss with the client his history of loss and begin to work out a plan with him on expanding his coping mechanisms.
   (c) Encourage the client to express his feelings and provide empathy and support.
   (d) Make no effort to focus on his loss, to avoid increasing his pain.

4) You are seeing the father of a client, at the client's request. The client, Clint, has a history of emotional problems, due in part at least to effects of brain damage from a motorcycle accident several years ago. Clint takes medication to control some of the effects. One of the effects of the injury is that the client occasionally has delusions that a sibling is stealing from him. The client wants the father to see you, so that you can convince the father that he is telling the truth about the delusions. The father is an articulate, patient man who has gone through similar situations with this son on many occasions. He understands the chronicity of his son's problems. He makes it clear that he is at the session "to keep peace" and that in the past this has worked. You would:

(a) Further discuss the pattern of incidents with the father in an attempt to help the father to express his feelings about the injury and to provide the father a plan to deal with the delusion and to avoid recurrent situations.

(b) Express to the father your understanding of his frustrating situation and encourage him to vent any pent-up emotions.

(c) Review Clint's medication with the staff psychiatrist and present recommendations with the father.

(d) Allow the father to direct the course of the session.

5) You are interviewing the parents of three children. The children have been removed from the home for clear indications of child abuse. The parents were referred to you as a part of the evaluation process for the court determination. They both maintain that nothing is wrong with them as individuals or as a couple. The court just has it in for them and they want their kids back. You believe that they did abuse the kids and they want the kids back to save face with the family.

(a) Tell them that if they maintain their "bullshit" stance they'll never get their kids back.

(b) Indicate that cooperating in treatment with you may not only help them individually and as a couple but also improve their chances of the kids being returned.

(c) Communicate understanding of their frustration with the system and share a frustrating parenting story of your own.

(d) Wait them out by not responding to their complaints.

6) You are known for your work in the area of sex roles. You have helped many women develop a more positive self-concept and take charge of their own lives. A new client, Frank, with whom you are meeting is a prominent middle-aged executive in town, who has come to you and wants to get some help understanding his wife's problem. "She's just not like she used to be. She's gone back to school, lost 25 lb.. of fat, and is expressing dissenting opinions at social gatherings." You would:

(a) Indicate a willingness to help him look at how and why he's struggling with these changes.

(b) Restate his feelings of confusion, anger, and threat.

(c) Indicate that she will snap out of this phase sooner or later.

(d) Tell him he had better look at himself and change before his wife starts looking around.

7) Recently a case was transferred to you from another therapist who left the community. The client and the previous therapist had been working, with a high degree of success, on expanding social skills and social relationships. The client has expressed some reluctance to get involved with a new therapist. However, the client keeps the first scheduled appointment. During this first appointment you would:

(a) Get a commitment from the client to continue therapy and then assign the task of meeting one new person before the next session.

(b) Indicate your interest in the client and encourage the client to discuss the course of previous therapy.

(c) Discuss with the client previous therapy and recent successes and outline a new program for behavior change.

(d) Suggest to the client to terminate therapy.

8) As a part of your consultation practice, you are asked to evaluate a day-care center and provide the board of directors with recommendations. You have observed staff and children interacting and have interviewed parents individually. In addition, you have reviewed the program guide for the center and compared it to state and federal guidelines, which it meets without reservation. The center has been operating for 7 years with the same director. Staff turnover is low and there is a waiting list for future openings. During your four hours of observation you did see one staff member handle a behavior problem with one of the children in a less than desirable fashion. Otherwise, indication are that the center is above satisfactory in all areas. You would:

(a) Recommend a program on teacher effectiveness for staff members.

(b) Meet with staff as a group and praise them for their performance overall while encouraging them to come up with a program for managing behavior problems.

(c) Meet with staff and director to praise their work and have them outline their long-term goals.

(d) Circulate your findings to the board and staff.

9) You have been working with a client for more than a month around her expressed unhappiness with her current situation. Much of her content in therapy has a theme of other people just don't understand and agree with her. You have been sharing observations and making suggestions that she seems to accept but does not apply. Not much of any positive change has taken place. You would:

(a) Confront her with her unwillingness to change and use her behavior in the therapy relationship as a focus.

(b) Continue listening and reflecting

(c) Continue listening, raise questions about her role in problem situations, but don't push.

(d) Continue to propose ways she can improve her situation, pointing out the benefits of proposed changes while appreciating her efforts in this regard.

10) The client, referred by a former client, states in an initial interview that recently he has been having problems in going to sleep at night, feeling tired all the time, has lost interest in activities, and has recurrent thoughts of death. The problems seem to have begun about 2 months ago, concurrent with new additional responsibilities at work. His brother died about this time as well. You would:

(a) Indicate a willingness to see him if he thought he needed to talk to someone.
(b) Reinforce him for coming to see you and recommend weekly therapy focused on reactive depression and grief.
(c) Recommend he talk to his friends about his new problems.
(d) Recommend he read two books, one on grief and the other on job stress. Weekly therapy sessions would focus on learning to apply the concept to his life.

11) You are seeing an elderly retired professional woman. She recently moved from her life-long home, several hundred miles away, to be near her youngest daughter. Her friends in the former community had either died or moved away. She has joined two social groups and a political action group and occasionally takes group vacations. Her older daughter has been in and out of state institutions for the past 5 or 10 years and has been diagnosed schizophrenic. She complains of occasionally waking up and feeling worthless and having lived her life for nothing, because of her older daughter's situation. She does not want to burden her younger daughter, who is empathic to her sister's situation. She and the younger daughter have a good relationship otherwise. Client gets tearful during sessions when discussing her older daughter. You would:

(a) Refer her to an older group and give her reading material on the aging process.
(b) Tell her these feelings of worthlessness are quite common complaints of the elderly.
(c) Indicate your understanding of her feelings and allow her to talk about her daughter in a nonjudgmental atmosphere.
(d) Encourage her to examine her life for positive relationships and work with her on a plan to expand her self-worth through volunteer work.

12) You have been seeing this client for several months. Treatment has centered around improving the quality of his relationships with coworkers. He has accepted and applied insights he gained during the sessions most satisfactorily. During the current session he suggests terminating the therapy. You would:

(a) Allow him to make that decision.
(b) Tell him to prepare a list of benefits he believes he has gained for review in the next session.
(c) Praise him for meeting the goals of his current therapy contract, reviewing the specific goals as you do so.
(d) Share with him your feelings about his progress in therapy.

Form B **Code_____**

In answering the twelve questions below assume that you are the therapist involved in that situation described. Think about what action you would choose in that situation, and circle the response that most closely resembles the action you would take. Please circle only one response to each situation. Remember to answer as you think you would if you were the therapist, not as you think an ideal therapist should respond. Please answer the questions in order, without spending too much time on any situation. Finally, do not go back over your answers or make changes.

1). You have been seeing Paul for five interviews. He complains of being depressed and lonely. As you have come to understand his current situation, being depressed and lonely matches his isolated, inactive life. Considerable overweight and socially inept, Paul sees little likelihood of change. You would:

(a) Ask him what he's getting out of his depression. Raise the issue of his experiencing secondary gain from remaining in current circumstances.
(b) Let him continue to explore and talk about his depression and isolation.
(c) Propose a program of exercise and weight loss via a social, structured weight watchers program.
(d) Try to develop a very supportive relationship to decrease Paul's isolation.

2) A couple comes to you for marital counseling. They both report their previously good marriage is now in considerable trouble and both are experiencing a lot of pain. The husband also reports being depressed. During the interview you have determined that the relationship started deteriorating when the husband's 14-year-old son came to live with his father. Frequent conflict in the house centered around the son's surly attitude, choice of friends, and loud rock music. The couple have two children, 3 and 5 years old, who seem to be doing fine. After the initial hour of information gathering, they begin the second hour by pleading with you to save their marriage and saying they will do whatever you think is best. You would:

(a) Acknowledge and understand their desire for answers from you but give no specific directions.
(b) Share your view of the problem and recommend a series of specific changes in their behavior.
(c) Indicate that any answers will be the result of insights they come to as part of the therapy process.
(d) Reassure them that they seem to have a basically OK relationship. Begin to work with them around skills for parenting a teenager.

3) The parents of a mentally retarded child have come to you for help. New to the community, they feel at a loss in their new environment. They had coped well with parenting when they had family support close by. After exploring the issue with them, you feel that the Parents of Special Children (PSC) program in your community would be an excellent referral source. As you mention the program, they seem unfamiliar with it and the husband makes a comment that they aren't "joiners." You would:

(a) Discuss with them their unique needs and various options they have been considering and don't push the PSC.

(b) Indicate that your recommendation remains that they contact the PSC program but leave the contacting up to them.

(c) Encourage them to give the PSC program a try and make the referral call with them still in the office to get specific information on time, location, and contact person.

(d) Tell them if they care about themselves and their child they should let nothing stand in their way from going to the PSC meetings.

4) You have been seeing Nancy, a young professional woman, for over 4 months. She originally came due to mild depression, which subsided after several weeks. Since that time, Nancy requests appointments whenever she feels the need to talk. She continues to do well as work and has increased her social activities and recently began a satisfying personal relationship. During the appointment you would:

(a) Require Nancy to make regular appointments and to set specific goals for therapy.

(b) Suggest that she might be using therapy to avoid close relationships with others and work with her to explore this area further.

(c) Be supportive and empathic about whatever subject she brings to the session.

(d) Allow Nancy to continue making the decisions about scheduling appointments.

5) Mike is seeking help due to pressure from his wife. She is threatening to leave if he doesn't get therapy. The client has for 10 years seen and heard things that other persons couldn't. This is a gift rather than a problem from the client's perspective. The incident that created the ultimatum from his wife was one in which she found him sitting in the corner of the living room late one night with a loaded gun. He pointed the gun at her and accused her of being a creature imitating his wife in order to kill him. Mike is hoping that through his coming for help the wife will learn to appreciate the reality of his gift. You would:

(a) Support Mike's belief in his gift and work with him to persuade his wife.

(b) Tell Mike directly that *he* has a problem and you will try to help him understand and cope.

(c) Let him tell you all about his visions and make no attempt to have him admit that he has a problem.

(d) Label the behavior as you see it and tell him he has a serious problem and you will have him committed unless he agrees to treatment.

6) The client, who grew up in a physically and emotionally abusive family, has been living with the current "friend" for 3 months. The "stupid" and "ugly" messages from the family are reinforced by this friend. You have for 4 months been focusing on building the client's confidence and self-esteem. In reporting a recent incident, the client becomes aware of how he lets his friend put him down. He becomes very angry and proclaims, "I don't have to take that abuse from anyone." You would:
   (a) Tell the client, "I see how difficult it is to admit these things to yourself."
   (b) Reinforce the statement and point out how the client has been repeating the family pattern in the current relationship.
   (c) Make no effort to focus on the statement.
   (d) Strongly reinforce the client's anger and tell him that he should do something about it.

7) After actively working on assertiveness training for a month, including reading a book and role playing and also successfully completing outside therapy homework assignments in the therapy session, Maria comes in very excited and pleased at her successful assertion with her supervisor. She also reports how much her interaction with her supervisor reminded her of her father. You would:
   (a) Get excited with her and celebrate her success.
   (b) Ask Maria to recount specifically what had taken place with the supervisor and reinforce the learning points.
   (c) Recommend a book on advanced assertiveness techniques.
   (d) Let Maria decide what direction the session would go.

8) You are called in to consult with a talented, dedicated staff of a residential home for delinquent adolescents. The home has been using a token economy program in which the consequences for all target behaviors are published. Each resident receives a copy upon admission to the program and knows the rules. The staff has successfully administered this program for several years. After excellent performance for over 3 months, the current group of residents have been "back sliding" in the last month.
   (a) Support the staff in their frustrations and draw out from them the options they see.
   (b) Praise their willingness to examine their system. Present your recommendations and seek their reactions.
   (c) Suggest that the staff brainstorm about possible solutions to the problem.
   (d) Analyze the current program and present your recommended changes.

9) Fred, diagnosed as paranoid schizophrenic, has been doing pretty well for 6 months since his last hospitalization on a program of medication and weekly outpatient therapy with you. You have been mostly supportive in the therapy sessions. In the last 2 weeks Fred has become increasingly delusional and has just informed you he has stopped taking that medication because the pharmacist cannot be trusted. You would:

(a) Tell Fred that he is slipping badly and you have arranged for him to be hospitalized. Tell him to call his home to arrange for additional clothes to be brought to the hospital.

(b) Try to support his efforts to sort out thoughts and feelings in areas he brings up. Express your concern over his current state of mind.

(c) Listen to the delusional content to try to better understand Fred's dynamics. Don't challenge or even engage around the delusions.

(d) Indicate your concern for Fred's current state of mind. Sell the need for taking medication as an alternative to hospitalization.

10) You have supported a client through a painful divorce process. You have been primarily empathic and affirming. As the client accepts the divorce as fact and begins to talk of getting on with life, he or she expresses considerable anxiety about the prospect of dating. The ex-spouse was a childhood sweetheart. The client has denied any interest in dating but complains of loneliness. The level of affect toward you as a therapist is rising. You believe the person is afraid of dating due to lack of experience. There are no other factors that would suggest it would be difficult to date. What would you do?

(a) Share your interpretation of the avoidance and make the client focus on it while affirming your confidence in him or her.

(b) Figure he or she can choose to date if he or she wishes to and not press the issue.

(c) Tell the client that by next week he or she must have made one step toward dating.

(d) Reflect and empathize with the client and raise the questions about fear of dating but don't push.

11) Juanita, a client who terminated therapy more than 6 months ago, called for an appointment. The prior therapy had been very successful in resolving some major anxiety and self-esteem issues. In the session she describes herself as continuing to do well at home and at work but has begun to experience some anxiety prior to beginning work on Mondays, particularly when the weekend has been meaningful or enjoyable. You would:

(a) Reassure her about her feelings and ask her how she plans to handle the feelings when they crop up.

(b) Let Juanita talk about her feelings but provide little active support or direction.

(c) Design, with her input, an anxiety management program to handle the Monday morning anxiety.

(d) Listen to the description of the situation and tell her specifically how to proceed when the anxiety occurs.

12) You receive a phone message that Ho, a client who lacks confidence, has called saying he "has a question about how to handle a 2:00 p.m. meeting with the boss." The client has in the past 3 months done well in such meetings even though anxious. For the last month you have been mostly reassuring Ho on this issue. You would:

(a) Not return the call until after the meeting.
(b) Call Ho back reaffirming your confidence in his ability.
(c) Call the client. Reassure and review the points to be kept in mind.
(d) Call and indicate it's time Ho stopped depending on you and stood on his own two feet.

Appendix D

INSTRUMENT B Code_____

Directions:

On the next page is a series of attitude statements. Each represents a commonly held opinion. There are no right or wrong answers. You will probably agree with some items and disagree with others. We are interested in the extent to which you agree or disagree with such matters of opinion.

Read each statement carefully. Then indicate the extent to which you agree or disagree by circling the number following each statement. The numbers and their meanings are indicated below:

If you agree strongly:	circle +3
If you agree somewhat:	circle +2
If you agree slightly:	circle +1
If you disagree slightly:	circle -1
If you disagree somewhat:	circle -2
If you disagree strongly:	circle -3

First impressions are usually best. Read each statement, decide if you agree or disagree and the strength of your opinion, and then circle the appropriate number. GIVE YOUR OPINION ON EVERY STATEMENT.

If you find that the numbers to be used do not adequately reflect your own opinion, use the one that is *closest* to the way you feel. Thank you.

1. Whether or not I get to be a leader depends mostly on my ability.

-3 -2 -1 +1 +2 +3

2. To a great extent my life is controlled by accidental happenings.

-3 -2 -1 +1 +2 +3

3. I feel like what happens in my life is mostly determined by powerful people.

-3 -2 -1 +1 +2 +3

4. Whether or not I get into a car accident depends mostly on how good a driver I am.

-3 -2 -1 +1 +2 +3

5. When I make plans, I am almost certain to make them work.

-3 -2 -1 +1 +2 +3

6. Often there is no chance of protecting my personal interests from bad luck happenings.

-3 -2 -1 +1 +2 +3

7. When I get what I want, it's usually because I'm lucky.

-3 -2 -1 +1 +2 +3

8. Although I might have good ability, I will not be given leadership responsibility without appealing to those in positions of power.

-3 -2 -1 +1 +2 +3

9. How many friends I have depends on how nice a person I am.

-3 -2 -1 +1 +2 +3

10. I have often found that what is going to happen will happen.

-3 -2 -1 +1 +2 +3

11. My life is chiefly controlled by powerful others.

-3 -2 -1 +1 +2 +3

12. Whether or not I get into a car accident is a matter of luck.

-3 -2 -1 +1 +2 +3

13. People like myself have very little chance of protecting our personal interests when they conflict with those of strong pressure groups.

-3 -2 -1 +1 +2 +3

14. It's not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune.

-3 -2 -1 +1 +2 +3

15. Getting what I want requires pleasing those people above me.

-3 -2 -1 +1 +2 +3

16. Whether or not I get to be a leader depends on whether I'm lucky enough to be in the right place at the right time.

-3 -2 -1 +1 +2 +3

17. If important people were to decide they didn't like me, I probably wouldn't make many friends.

-3 -2 -1 +1 +2 +3

18. I can pretty much determine what will happen in my life.

-3 -2 -1 +1 +2 +3

19. I am usually able to protect my personal interests.

-3 -2 -1 +1 +2 +3

20. Whether or not I get into a car accident depends on the other driver.

-3 -2 -1 +1 +2 +3

21. When I get what I want, it's usually because I worked hard for it.

-3 -2 -1 +1 +2 +3

22. In order to have my plans work, I make sure that they fit in with the desires of people who have power over me.

-3 -2 -1 +1 +2 +3

23. My life is determined by my own actions.

-3 -2 -1 +1 +2 +3

24. It's chiefly a matter of fate whether or not I have a few friends or many friends.

-3 -2 -1 +1 +2 +3

Appendix E

By signing this document I attest to the following statements:

•I have not been pressured in any way to take part in this study and have made this decision of my own free will.
• I understand that my participation in this study is completely voluntary and that I may refuse to participate at any time.
•I understand that the information gathered will be completely confidential and that at no time will I be required to identify myself.
•I have been advised of the purpose of this study and have been given contact information should I wish to learn more.

_____

Signature

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