The Personal Theory of the Counselor: Some Biographical and Psychometric Correlates of Selection of a Theory of Personality and a Method of Counseling by Selected Counselors

By
LESLIE KENNETH ROTHMAN

A DISSERTATION PRESENTED TO THE GRADUATE COUNCIL OF
THE UNIVERSITY OF FLORIDA
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE OF DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA
1970

To Louise, Torsten, and Britt

ACKNOWLEDGMENTS

No matter how individual an endeavor, other persons may facilitate and expedite, if not actually make possible, its completion. So it is with this dissertation. Many more persons than could reasonably be mentioned here have contributed their ideas, encouragements, criticisms, and support to make this effort a success.

First, committee chairman and friend, Dr. James L. Lister, spent many hours sharing ideas with the author and thinking through the difficulties attendent in translating a conception into a workable inquiry. Dr. A. Garr Cranney, committee member and friend, was, among many other things, particularly helpful in assisting in the development of the principal instrument of measurement. The other committee member, Dr. Richard J. Anderson, was particularly generous with his time and, in addition to his valuable comments about the manuscript, lent his expertise to the selection of the appropriate statistical treatment of the results.

As the nature of the study was such that it could not have been easily completed without the assistance of the

following groups, sincerest thanks are due to the: Department of Clinical Psychology, Department of Counselor Education, Department of Rehabilitation Counseling, Reading Laboratory and Clinic, Student Mental Health Services, and the University Counseling Center.

Finally, note is taken of both the outstanding particular and general contributions of Dr. William E. Kline, psychologist and friend, Mrs. Arden P. Goettling, the patient typist of this manuscript, and Mrs. Leslie Kenneth Rothman, wife of the author and mother to his two young sons, for efforts extended above and beyond the call of those two roles.

If a man does not keep pace with his companions, perhaps it is because he hears a different drummer. Let him step to the music which he hears, however measured or so far away.

Henry David Thoreau

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By

Leslie Kenneth Rothman

June, 1970

Chairman: Dr. James L. Lister
Major Department: Counselor Education

The general problem examined by this dissertation was the following: With the myriad theories of learning and the process of behavior changing, personality development and counseling and psychotherapy extant, and assuming some merit in all of them, how does one go about either choosing or developing the most appropriate one for one's own use as one becomes a professional counselor. An extensive review of the literature led to the conceptualization of this problem under the rubric, The Counselor's Personal Theory. The major proposition from which the hypotheses tested were derived is that the theory and practice of counseling is the articulated intellectual understanding the counselor has of his own development and successful life patterns formally stated as a theory of human behavior and development and implemented in practice by the counselor who helps the client find more effective ways of dealing with his internal and external worlds.

Thirty practicing counselors and teachers of counselors, all of whom had obtained the doctorate, voluntarily completed four instruments designed to assess their theory and practice of psychotherapy (Therapist Orientation Questionnaire), their degree of cognitive complexity in the interpersonal realm (Construct Repertory Test), their A-B Scale score (Whitehorn-Betz A-B Scale), and aspects of their life histories (Biographical Information Blank).

Nine hypotheses, which predicted specific relationships among groups of individuals differentiated by their scores on the above instruments, were evaluated with appropriate correlational and analysis of variance techniques.

Results basic to the main problem indicate that it will be possible to predict a counselor's orientation to both theory and practice from his biography. Cognitive complexity was found to be correlated with both the therapeutic position taken and aspects of past experiences. Specifically, it was found that those with a relatively high cognitive complexity score tended to take an experiential orientation, as opposed to an analytic orientation, to counseling theory and practice and to have experienced relatively a greater number of interpersonal experiences during their lives than those whose cognitive complexity scores were relatively low. Additional evidence supportive of the general proposition was afforded

by the significant relationship found to exist between A-B Scale scores and Biographical Information Blank items described as "social dependent conformity" and "social independent nonconformity." Specifically, a significant correlation was found to exist between "A" scores of counselors on the A-B Scale and "social dependent conformity" scores on the Biographical Information Blank and between "B" scores of counselors on the A-B Scale and "social independent nonconformity" scores on the Biographical Information Blank. It was suggested that these designations are very closely related to the concepts of "field dependence" and "field independence" noted by other investigators in A-B research. The factor of complementarity was mentioned as a possible explanation of the oft-noted differential therapeutic success of "A" and of "B" therapists.

It was concluded that the results were promising enough to support further research on a larger and more geographically dispersed sample toward the end of establishing the limits of the predictability of a device to measure counseling orientation from biographical information. Development of such an instrument with at least moderate predictive power would find certain use in counselor education programs, both in the selection and advising of students and in counseling practice for the assignment of a client to a counselor most likely to assist him efficiently.

CHAPTER I

INTRODUCTION

Man who lives in a world of hazards is compelled to seek for security. He has sought to attain it in two ways. One of them began with an attempt to propitiate the powers which environ him and determine his destiny. It expressed itself in supplication, sacrifice, ceremonial rite and magical cult. In time these crude methods were largely displaced. The sacrifice of a contrite heart was esteemed more pleasing than that of bulls and oxen; the inner attitude of reverence and devotion more desirable than external ceremonies. If man could not conquer destiny he could willingly ally himself with it; putting his will, even in sore affliction, on the side of the powers which dispense fortune, he could escape defeat and might triumph in the midst of destruction.

The other course is to invent arts and by their means turn the powers of nature to account; man constructs a fortress out of the very conditions and forces which threaten him. He builds shelters, weaves garments, makes flame his friend instead of his enemy, and grows into the complicated arts of associated living. This is the method of changing the world through action, as the other is the method of changing the self in emotion and idea. It is a commentary on the slight control man has obtained over himself by means of control over nature, that the method of action has been felt to manifest dangerous pride, even defiance of the powers which be. People of old wavered between thinking arts to be the gift of the gods and to be an invasion of their prerogatives. Both versions testify to the sense of something extraordinary in the arts, something either superhuman or unnatural. The souls who have predicted that by means of the arts man might establish a kingdom of order, justice and

> beauty through mastery of nature's energies and laws have been few and little heeded (Dewey, 1960, pp. 3-4).

One of the more conspicious "arts" invented during the twentieth century and of particular concern to the following discourse is that of scientific explanation and controlled alteration of human behavior known respectively as personality theory and counseling and psychotherapy. To be sure, the explanation and control of human behavior has occupied man's endeavors throughout history to which prisons and witchcraft bear partial witness. However, the scientific approach to this effort is, by and large, of this century. Science aspires to, and indeed has often been successful in, obtaining unitary, nonoverlapping explanations for the data extracted from the phenomena of interest. In the area of personality theory, we find that Hall and Lindzey (1957) are able to present 15 personality theories, while Ford and Urban (1964) explicate 10 systems of behavior change without claiming to have exhausted the possibilities. Coan (1968) using multivariate procedures to study basic trends in psychological theory was able to extract a number of dimensions. He labeled his six first-order factors: subjectivistic--objectivistic, holistic--elementaristic, transpersonal--personal, quantitative--qualitative, dynamic--static, and endogenist--exogenist. He named his two second-order factors: synthetic--analytic and

functional--structural, while he called his third factor: fluid--restrictive.

What do these multiple theories and the dimensions along which they are constructed mean for the traditional scientific goals of explanation, prediction, and control of behavior? Is it a truism here too, as it is accepted in medicine, that when there are so many cures extant, the disease is probably incurable? Are none of the proposed theories or, at best, only one of the proposed theories, as its author would have you believe, correct? As Coan points out, "theoretical orientations are at least in part a faction of temperament" (1968, p. 719). It is the contention of the present writer that all the more or less scientific explanations offered of behavior development and change are valid within limits, and that these limits are set by the direct and vicarious experiences of the theoretician/therapist. Kelly (1964) in "The Autobiography of a Theory" describes the course of certain psychological experiences which led him to formulate personal construct theory, wherein he suggests that the means by which man has coped most successfully with his obstacles are in some general way the basic devices he can extend and improve in coping with his personal distress. Robert Watson's (1963) chapter, "Freud: Psychoanalysis and Related Views," clarifies the zeitgeist as well as the personal development of Freud, Alder, and Jung.

Boring and Lindzey (1967) afford Rogers and Skinner, among others, the opportunity to present themselves in autobiography, and it is not difficult to "get a feel for" and, thereby, make some hypotheses about the thought processes and behaviors of these two contemporary influential thinkers.

Rather than assuming all previous personality theorists to have been fools, we will assume the option that all, in fact, have had much of value to offer in understanding man in a particular mode of existence and at a particular level of conceptualization of that existence; their error lies in failing to recognize the limited generalizability of their own experiences.

> The investigator uses a method and becomes its captive. So do his students. He develops a theory which can only predict phenomena elicited by that method or a closely related one. What is not amenable to study by those methods ceases to influence the theory. In turn, all theories whose methods do not apply to the realm of phenomena in question are somehow considered "wrong," and if they are tested at all, it is by method alien to them, and so they are obviously found wrong. Usually, however, they are ignored altogether. As a result, certain methods become "canonized," the study of a limited range of phenomena becomes the only "proper study of man," and those who try to reunite the field of psychology, so fragmented by a few methods, are regarded as "philosophers" in a pejorative sense of the word (Rapaport, 1959, p. 166).

To encompass the multiple theoretical positions, this dissertation shall make use of the rubric, the personal theory or the implicit theory of the counselor. Specifically, an

attempt will be made to offer evidence, both quantitative and qualitative, of the relationship between the life experiences of the theoretician/therapist and said theoretician/therapist's theory of human development and his practice of behavior changing.

At least three assumptions underlie this position: (a) all present models of man are oversimplified and, therefore, inadequate to the task of dealing effectively with the whole person;[1] (b) all theories of personality and psychotherapy are "true" to some functional degree;[2] and (c) while theoreticians, for the most part, speak as though they possessed the truth, those who engage in therapy are successful to the degree that their clients are like or have the potential of becoming like themselves and/or have congruent value systems and/or that they, the therapist, have a wide acquaintance with life's experiences enabling them to more flexibly (eclectically)

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[1]Hitt (1969), after reviewing both experimental and logical evidence for both the behavioristic and phenomenological models of man, concluded that (a) the acceptance of either model has important implications for the everyday world, (b) truth in both views indicates it is premature to accept either model now, (c) one or both models may be useful depending on the problem under investigation, and (d) both systems' proponents should communicate with each other.

[2]i.e., they all legitimately claim to be effective. Razran (1965) suggests, in a similar vein, that the present multiple learning theories are probably part of a whole learning model which has developed in the evolution of man (see p. 48).

engage the client in the problem solving, i.e., therapeutic endeavors.

This point of view leads to the position that any theory of personality/behavior and counseling/behavior changing (including thoughts and feelings) is the articulated intellectual understanding the theoretician has of his own development, mental experiences, and the solutions to his own personal exigencies, abstracted so as to be generalized to be applicable to the theoretician's model of man qua Man. The practice of counseling and psychotherapy is the teaching of the implementation by the therapist to the client of the more or less successful ways the therapist discovered and conceptualized as he learned to solve his own experienced difficulties.

If this position has substance, the problem then becomes one of discovering the contingencies in the theoretician/therapist's history that led him to his present theory/practice. This information should then make it possible to better predict counseling outcome from counselor and client biographies as well as permitting more effective control of the products of therapy training programs by the matching of students with counselor educators for projected theoretical compatability. It goes without saying that this matching will never wholly subsume all the available variance because the dynamics of a

culture so change the life experiences of each generation that the best matching of teacher and student as well as of client and therapist will only approximate similarity.

Definitions

Relatively few terms are in need of defining to render clarity to what is to follow. Specific notation should be taken of the fact that for the purposes of this dissertation the author has chosen to view as synonymous the terms grouped as follows:

(a) Counseling, psychotherapy, personal problem solving, personal teaching, behavior altering;

(b) Counselor, psychotherapist, therapist, teacher, mentor, priest, witch doctor, shaman;

(c) Client, patient, counselee; and

(d) Neurotic, psychotic, mentally ill, problems in living, crazy, insane, deranged, possessed.

In the text, the terms counseling, psychotherapy, client and patient will most often be found, while the conceptualization "problems in living" (Szasz, 1961) will be, unless otherwise stated, the focus of their discourse.

CHAPTER II

REVIEW OF RELATED LITERATURE

Insofar as these assumptions contradict more traditional positions of behavior altering and, in addition, may appear in some degree "unscientific" in their personalistic approach, the following evidence is presented in support of this outlook.

That present models of man are oversimplified and inadequate to account for the observed facts of psychological processes had been explored by Coan (1968) and Hitt (1969) as noted above. Opler (1967) proposed that an adequate model of man must be capable of at least accounting for "the supreme ability of men to bring to bear upon conscious and unconscious motivations the past, present and future, as if these were immediately available . . ." (p. 139). Lawrence La Fave (1969), in a short philosophical analysis entitled, Why Psychology Is Not Yet A Science, said among other things:

> Any science worthy of the name contains a body of theory which enjoys such properties as 1) comprehensiveness, 2) consistency, 3) nullifiability, 4) parsimony, and 5) precision.
>
> Any psychological theory is either a) cognitive, b) behavioristic, or c) both. If both, then that

> psychological theory is self-contradictory -- . . . .
>
> Thus a psychology which preaches self-contradictory, hodge-podge eclecticism is a transvestite -- scientism bedecked as a science.
>
> The struggle is between positivism and phenomenology -- . . . . Psychology can only resolve its basic dilemna by defuzzing phenomenology -- by adequately formalizing cognitive theory (p. 2).

Much contemporary difficulty is generated by the battle between behaviorism and phenomenology for the allegiance of psychologists. Much of the heat is generated by the naiveté of the combatants who while superficially appearing to do battle for "humanity" against "science" are in fact representing, on the one hand, classical Aristotelian essence philosophy and, on the other, classical Lockian empiricism which depends on nature as it is as the ultimate reality which unaided perception can come to know. Modern science, however, is interested in the interrelationships among data, essentially abstractions, with phenomenal experience by reducing human experience to "nothing but" systems, thereby reifying the existence of synthetic concepts and thus subtly smuggling back in "essences."

> It is unnecessary that knowledge should be concerned with existence as it is directly experienced in its concrete qualities. Direct experiencing takes care of that matter. What science is concerned with is the <u>happening</u> of these experienced things. For its purpose, therefore, they <u>are</u> happenings, events. Its aim is to discover the conditions and consequences of their happening. And this discovery can take place only by modifying the given qualities in such ways that <u>relations</u> become manifest. . . . these relations

> constitute the proper objects of science as such. We are here concerned to emphasize the fact that elimination of the qualities of experienced existence is merely an intermediate step necessary to the discovery of relations, and that when it is accomplished the scientific object becomes the means of control of occurrence of experienced things having a richer and more secure equipment of values and qualities (Dewey, 1960, p. 104).

With due awareness for the dangers of eclecticism and scientism, clinicians and a number of recent theoreticians are also profoundly conscious of real people with real problems pressing for immediate solution. Increasingly, experienced clinicians' eclectic points of view and behaviors are being corroborated by both process and outcome studies which have led to formulations transcending single theories of behavior change. While this at first, understandably, leads to a "hodge-podge eclecticism," it also holds out real hope for an eventual powerful new synthesis, perhaps along the lines of cognitive phenomenology proposed by Levy (1968).

The recent professional literature of greatest relevance to the presented position will be reviewed under five categories: Counselor Personality and Behavior, The Effects of Training, Counselor-Client Similarity, Commonalities in Theory and Practice, and The Counselor's Personal Theory.

Counselor Personality and Behavior

Empirical Approaches

Studies in this area have taken a limited though interesting

variety of strategies. Empirically, valuable stimulation has come from Whitehorn and Betz at Johns Hopkins Medical School who, in 1960, reviewed their series of studies of 1954, 1956, and 1957 in which they had discovered that differences in therapeutic effectiveness of psychiatrists with schizophrenic patients were predictable from their responses to the Strong Vocational Interest Blank. They presented validation criteria and a shortened form, 23 items, which predicts the successful "A" therapists from the nonsuccessful "B" therapists just as reliably as did the 400 items. They attempted to explain the demonstrated differences by suggesting that "A" type therapists have a problem solving approach to patients rather than a regulative or coercive approach and that this is acceptable to patients who typically feel controlled or influenced. They see the "B" type therapist as one who is likely to view the patient as a "wayward mind" needing correction, an alienating approach. "A" therapists are preceptive of the individualistic inner experiences of the patient while functioning themselves in responsible individualistic roles. While the "B" therapist's value structure is weighted toward deference and conformity, the "A's" expecting and respecting spontaneity evoke self-respectful social participation.

McNair, Callahan, and Lorr (1962) studied the "A-B" variable with two groups of 20 Veterans Administration

psychotherapists at seven mental hygiene clinics. Using both therapists and patient reports, they found that psychiatric outpatient neurotics treated four months by "B" therapists improved significantly more than those treated by "A" therapists and that this improvement continued to manifest itself one year after treatment had begun. These results were opposite to the Whitehorn and Betz results with hospitalized schizophrenics. There was little indication that "A" and "B" therapists in the McNair et al. study reacted differently to their patients. An analysis of the internal consistency of the A-B Scale suggests that "B" type therapists had more interests in common with their patients, more similar life backgrounds, or were more familiar with the daily living problems encountered by their patients. McNair et al. suggested that a similar interpretation could account for the success of the "A" therapists in the Betz studies, since the two patient samples differed markedly in socioeconomic levels.

These studies were followed-up by Carson, Harden, and Shows (1964) with two laboratory experiments involving analogues of psychotherapy using untrained subjects selected on the basis of their performance on the A-B Scale. They tested the idea that the responses of the subjects in the therapist role would be an interactional function of their A-B typing as well as certain patient characteristics. The patients

were experimentally varied on a trust-intropunitive versus distrust-extrapunitive dimension. Results indicated statistically significant interactions in the predicted directions in regard to depth directedness and degree of exploratory activity in the behavior of the experimental therapists. They interpreted their findings as confirming an hypothesized differential sensitivity among A-B type individuals to differing forms of behavior pathology. Specifically, "A's" in relation to patients who turn against others or avoid others and "B's" in relation to patients who turn against self tend to be interpretative and depth oriented in therapeutic behavior because "A's" in relation to persons exhibiting distrustful-extrapunitive behavior and "B's" in relation to persons exhibiting trusting-intropunitive behavior are more sensitized and alerted to and, at the same time, are more capable of understanding and formulating what the other is saying and doing.

Betz (1967) reviewed all previous research with the 23-item scale and after discounting the possibility that either "A" type or "B" type therapists were better therapists in one study or another, suggested that the <u>therapist's style</u> is important to the specific patient group involved and supported the McNair, Callahan, and Lorr interaction hypothesis.

Berzins and Seidman (1969) tried to account for the

differential effectiveness of "A" and "B" therapists with schizoid and neurotic patients, respectively, by studying behavioral differences that emerged with untrained subjects in the appropriate interpersonal contexts. "A" and "B" groups were selected with the A-B Scale, which asked them to indicate their liking for manual technical activities; "B's" like these activities while "A's" do not. In a 3 x 2 factorial design, 72 male undergraduates rated "A," "AB," or "B" responded to tape-recorded schizoid and neurotic communications by writing self-chosen helpful responses. Analyses of these responses confirmed the predicted therapist-by-patient interaction. When "A's" were paired with the schizoid and "B's" with the neurotic patients, relative to the opposite pairings, the subjects gave longer responses and emitted more responses of a declarative rather than a questioning form and showed more positive and fewer negative Bales social-emotional reactions. The intermediate "AB" subjects did not react differentially to the two patient types.

Research with the A-B Scale continues to produce a variety of interesting data. Dublin, Elton, and Berzins (1969) were able to relate personality and intellective scores of undergraduates to their A-B status such that the differences between "A's" and "B's" involved largely the joint effects of masculinity-femininity scores with verbal and numerical

abilities measured respectively by the Omnibus Personality Inventory and the American College Test. They also found differences in "cognitive style," consistent with previous research. Their correlational and factor analytic data suggested that the A-B variable cannot be regarded as linearly related to those measures which discriminated "A's" from "B's."

Segal (1970) studied the therapeutic behavior of "A's" and "B's" and found that "A's" were more direct and interpretive and seemed willing to assume responsibility for the structure of the therapeutic process by providing the client with information or a frame of reference. "B's" tended to be more facilitative, less direct, and more encouraging of greater client experssion. Segal suggested that the anxiety-plagued neurotic using defensive reactions requires a more facilitative experience to gain self-awareness while the schizophrenic client who is experiencing a breakdown in his ability to interact with the world around him requires a direct, active approach to stimulate him to self-awareness.

Berzins, Seidman, and Welch (1970) used an analogue format to evaluate the differential reactivity to patient-communicated hostility by "A" and "B" type therapists. Testing the notion that therapist-patient "complementarity" with respect to extrapunitive versus intropunitive modes of handling anger is an important aspect of noted "A" and "B"

successes, they found only limited support in analyzing "self-selected helpful responses to brief tape recorded patient communications" written by 90 male "A's," "B's," and "AB's." However, the predicted interaction effects were supported for subjects' evaluations of their helping performances. That is, "A's" paired with extrapunitive and "B's" paired with intropunitive patients were more satisfied than oppositely paired subjects. Moreover, satisfaction ratings varied inversely with the subjects' perceived similarity to the patients.

In an attempt to clarify some of the diversity of findings in A-B studies, Anzel (1970) included severity of pathology and socioeconomic background data along with her neurotic and schizophrenic patient variables. Using 48 experienced therapists and 80 undergraduates as subjects, her results suggested that severity of pathology and socioeconomic background as well as avoiding-of-others and turning-against-self were related to "A-B" typing. There was some evidence that "A" therapists responded more favorably than "B's" to avoiding-of-others, severely disturbed, and upper-class patients while "B's" responded more favorably to turning-against-self, mildly disturbed, and lower-class patients. Student "A's" and "B's" were neither consistently nor inconsistently similar nor dissimilar to therapist "A's" and "B's" in their ratings of patients. Anzel noted that among her student subjects,

significantly more "A" than "B" students expressed an interest in psychology or psychiatry as a profession. She noted that Witkin reported that field-dependent children as compared to field-independent children are more socially oriented and probably go into socially oriented professions and indicated that two studies (Pollack & Kiev, 1963; Shows & Carson, 1966) have shown that "A" persons are more field dependent than "B" persons.

In summary, the empirically valid A-B Scale does indeed separate therapists who work more successfully with one diagnostic classification of patient than with another, but why this is so or what it means in a personality theoretical framework is only beginning to be understood.

Theoretical Approaches

Counselor personality and behavior in therapy has also been approached from the theoretical spectrum yielding mixed results. In 1963, Mueller studied 11 counselors, attempting to predict their need structure from their counseling behavior and hoping to account for these predictions with Horney's three modal personality types. He was unsuccessful.

A 1964 doctoral dissertation by Chapline utilized 163 graduate students in counseling and guidance from both the departments of psychology and education. They were measured

for cognitive complexity using the Construct Repertory Test, demographic data from a biographical inventory blank, and an experimental tape recording of client statements to which they responded in writing to obtain "counseling behavior samples." Those subjects who measured high on cognitive complexity were also high on evaluative responses while the low cognitive complexity scorers were high on understanding responses as measured using Porter's categories of 1950. This difference was also evidenced when measured by curriculum groups; i.e., those students from education made higher-than-chance use of evaluative responses while those from psychology made higher-than-chance use of understanding responses. The type of response was found to be unrelated to sex, age, training level, previous personal counseling, or teaching and/or experience at counseling.

Freedman, Antenen, and Lister (1967) found a strong predictable relationship between counselor personality characteristics and counselor verbal-response patterns. After the California Psychological Inventory, the Guilford-Zimmerman Temperament Survey, and the Porter Interview Analysis Scale, essentially Rogerian, were administered to 37 counseling students and applied to typescripts of their 15-minute role-played interviews, they suggested among other things that this might be a useful procedure for both selection of students

for counseling potential and evaluation of student counselor learning.

Using a Freudian framework, Gordon (1967) was able to confirm her findings of 1966 in that she again found that high "anal" clinicians have less confidence in their clinical interpretations, make fewer specific predictions, and find less pathology in their patients than do low "anal" clinicians.

In a client-centered framework, Gruberg (1969) tested the concept that the construct "tolerance for ambiguity" would significantly relate to effective counseling. Using the complexity scale of the Omnibus Personality Inventory, he took the extremes, 10 highest and 10 lowest, and the mean, 5, of 137 certified counselors and recorded them interviewing a counselee-actress. Data analysis revealed a significant relationship between the high tolerance for ambiguity construct and client-centered, little-counselor-talking approach and effectiveness; low tolerance was associated with directive, much-counselor-talking approach and ineffectiveness.

Other Approaches

A statistical approach was taken to the problem of counselor effectiveness and counselor personality by McClain (1968). He administered the Sixteen Personality Factor

Questionnaire to 137 counselors in five NDEA Counseling Institutes. The effectiveness ratings of the counselor education supervisors were correlated with the questionnaire, and those correlations were used as weights in separate specification equations for men and women. In four out of six tests the equations were able to differentiate competence levels. The authors indicated that most competent males and most competent females reflect their respective sex-cultural stereotypes.

Spilken, Jacobs, Muller, and Knitzer (1969) summarized recent studies of the significance of the psychotherapist's personality and arrived at 10 variables which they then used to assess the conscious attitudes of 54 psychiatrists, 77 psychologists, and 78 social workers toward these variables. They found that 5 of the 10 qualities were valued by all therapists, with the other 5 differentially valued according to the training of the psychotherapist. Comparison with other "related" professions indicates that psychotherapists differ from them in personality. The authors hypothesized that this is due to either self-selection or to the type of training received and suggested that these values may reflect either actual behavior or merely goals. The data only allow one to state that there are certain general patterns of overall agreement among a broad range of psychotherapists regarding

the concepts in the abstract.

In summary, then, counselor personality and behavior is measurable and becoming increasingly used to effectively predict counseling outcome. However, most of the instruments which have proved effective have been derived empirically, and the plethora of personality theories extant to predict client behavior have not been found in any consistent way to be efficacious in predicting counselor effectiveness. Kiesler (1969), while proposing a research model, presented his hope that ultimately we will be able to say to a particular student pursuing a counseling degree:

> It is very unlikely with your personality type that you'll ever work effectively with psychopathic patients. Instead, it seems likely that you will do very well with obsessive-complusives and with paranoid schizophrenics. Further, we know that a relatively rational approach of "confrontation of contradictions" and focus on patient role-playing behavior outside the interview are the treatments of choice for these patient types. Hence, we will focus our supervisory efforts primarily with these types of patients. We're going to make you an effective specialist -- an expert in interpersonal relationships for obsessive-compulsive patients and paranoid schizophrenic patients. You'll not be all things to all patients, but you will be one hell of a specialist as we have described (in Eron & Callahan, 1969, p. 142).

Kiesler sees the effect on patient diagnosis and placement both in clinics and private practice as taking the following tack:

> Patient X is obviously a hysteroid personality. Dr. B, you're a specialist with hysteroids -- we've already established that your personality and techniques are the best for this type of patient. Hence, we are

> assigning Patient X to you. We certainly don't want to assign him to Dr. E, since we know that pairing has to be incompatible and the patient would terminate after three interviews (in Eron & Callahan, 1969, p. 143).

The Effects of Training

The effects of training have been approached from the points of view of initial student selection, student change during the educational program, evaluation of the effectiveness of student counselors as well as the effectiveness of minimally-trained nonprofessionals. Personality and knowledge variables as well as communication process variables have been most prominent in the literature.

Selecting Students

Dispenzieri and Balinsky (1963) studied the relationship between authoritarianism and manifest anxiety and hypothesized a relationship of them to the ability to acquire interviewing skills. Using 50 students in a counseling program, they administered the Porter Interview Analysis Scale, the California F Scale, and the Taylor Manifest Anxiety Scale at the commencement and the conclusion of a semester. Their hypotheses that students with high anxiety measures and high authoritarianism scores would have greater difficulty in obtaining interviewing skills were not confirmed. They felt this failure to confirm was an instrument rather than a theoretical failure.

Allen (1967) predicted that "psychological openness" is a construct useful in predicting the effectiveness of student counselor trainees. Over an academic year, 26 students who had been evaluated with the Rorschach Index of Repressive Style in October were seen in group supervision and in May were evaluated on their responses to a filmed counseling interview. Counseling effectiveness as rated independently by two supervisors was shown to be related to the counselor's psychological openness to his own feelings concerning the process. Parenthetically, the authors stated that the Miller Analogies Test and the Graduate Record Examination did not predict these results and suggested the variable "psychological openness" as useful for counselor-student selection purposes.

Studying attitudes and attitude change, Patterson (1967) measured 54 NDEA Institute counselors, 25 regular counseling students, and 26 noncounseling students with the Baron Ego Strength Scale, the California F Scale, and a counselor attitude scale at the beginning and end of an academic year of full-time study. While only slight differences were in evidence between NDEA Guidance Institute and regular counseling students, expected differences did manifest themselves between counseling and noncounseling students. Although all groups showed increases on the counseling attitude scale and decreases on the F scale, the total counseling group was higher

on the first and lower on the second, both at the beginning and end of the year.

To assess the persistence of attitude change, Rochester (1967) studied 126 counselor trainees, in eight one-year NDEA Institutes, with the Porter Test of Counselor Attitudes and the Allport, Vernon, and Lindzey Study of Values, administering the instruments at the beginning and end of the Institutes and one year later. The results suggested that the permanency of attitudes, significantly changed during the Institutes, was minimal. The trainees appeared to revert to attitudes present prior to training, and attitudes appeared similar to pretraining attitudes one year after training except for the drop in religious value which did not recover.

Education Outcomes

Joslin (1965) was unable to find a relationship between knowledge of counseling and guidance and judged counseling competence for 39 students.

After McGreevy (1967) factor analyzed the commonly used counselor-candidate selection data and evaluated the 14 extracted factors against the performance of 86 enrollees in three NDEA Institutes, he concluded that only the Miller Analogies Test was predictive of performance, but served only to identify the academically talented.

Schumacher (1967) examined the interjudge reliability in rating the competence of professional counselors. Seventeen college counselors rated each other and themselves on administrative and counseling competence and revealed that they were not able to more reliably rate those colleagues with whom they closely worked than they were with whom they had considerably less contact. Correlation between the two rated variables was .56, significant at the 5 percent level of confidence, and this low reliability coefficient was explained in part by the wide divergence of theoretic viewpoints among the relatively large number of judges.

Subprofessionals

With the constantly increasing demand for psychotherapists and their services and the equivocal results obtained by highly trained professionals, a number of educators and practitioners have turned to minimally trained nonprofessionals. Korsen and Hayes (1966) reported using "buddy teams" of student nurses trained in using the relationship to understand themselves and their patients who were severely chronically-regressed males hospitalized for an average of six and one-half years. The 126 patients were seen in groups of eight and the authors reported impressive improved percentages (so impressive, in fact, that they add up to more than 100 percent and, therefore,

are not herein reported). If nothing else, this study shows the positive effects attractive, young girls enthusiastic to help have on old men.

Magoon and Golann (1966) reported above average to average ratings by supervisors of eight "bright, mature women" age 40 to 44 all holding at least a B.A. degeee who were trained for a period of two years as mental health counselors.

Poser's (1966) study compared the effects of therapy by young, untrained, college girl volunteers with that of trained psychiatrists and psychiatric social workers, with 5 to 17 years experience, on 343 patients in 34 groups. Of these, 6 groups were designated as untreated controls, and the other 28 were randomly assigned to therapists. All groups were equated on pretherapy status by means of psychological tests and met one hour per day, five days per week, for five months. In terms of therapeutic effectiveness, while test score measures at the end of treatment showed the lay therapists to have obtained superior results to the professionals, there was no difference for the 3 groups in the discharge rate from the hospital. This study likewise shows that young college girls get better results, i.e., test taking behavior changes, from chronic male schizophrenics than a group of mixed-sex, older professionals. Rioch (1966) commented on the foregoing article that the low-status college girls were

better able to bridge the social distance gap than were the professionals, while Rosenbaum (1966) suggested that the enthusiasm of the volunteers raised the activity level of the patients.

A process study, by Carkhuff, Kratochvil, and Friel (1968), compared clinical and nonclinical trainees cast as counselors in their ability to communicate the therapeutic facilitative conditions of empathy, warmth, genuiness, concreteness, and self-disclosure. There was a nonsignificant decline in the levels communicated by the clinical students from the beginning of training to advanced stages of training. Ratings of nine clinical professors suggest that, in general, the trainees moved in the direction of the level of functioning of their professors. While there was evidence that trainee discrimination of the therapeutic conditions improved with training, the ability to communicate these conditions deteriorated. Carkhuff (1968) said the evidence indicated that with or without training or supervision the patients of lay counselors do as well or better than the patients of professional counselors.

Opinions of Counselor Educators

In turning to counselor educators and their conceptions of what they think should be done and/or what they are trying

to do, we note a variety of concerns.

Blöcher (1966) proposes a science of human effectiveness in which the counselor, uniquely interested in human effectiveness, would be well grounded in sociology and anthropology as well as psychology and would see counseling as organized around the dimensions of social roles, coping behaviors, and developmental tasks.

Ofman (1967) notes the disparity between what counselors really do and what they were taught, and proposes: first, proper selection to get students who will be growth facilitators; second, a through grounding in counseling psychology; and third, basic confrontation group experiences to aid the development of empathic understanding.

Lister (1967) laments his observation that counselor candidates reject theory. Listing a number of possible sources of theory aversion, he suggests that it could be minimized by, among other things, matching personal views of students with those of university programs and by assigning philosophically compatible advisors within university programs, providing opportunities for the examination of personal attitudes and values, researching the question of how theory and technique are integrated, and by helping the counselor conceptualize his work environment within an appropriate theoretical framework.

Carkhuff (1968) claims that no assumptions can be made about counseling as a helping relationship because all of the evidence points to the opposite effect. Counselor educators must be high-level facilitators to produce adequate professional counselors.

Knowles and Barr (1968) reviewed the stressed integration of the subjective and objective in counselor education but found the literature of ideal counselor characteristics heavily loaded with emphasis on the subjective; studies of effective and ineffective counselors on the subjective/objective continuum appeared inconclusive. However, studies of effective people in general show them to be characterized by objectivity toward themselves, others, and the world. Counselor educators would do well to bring into their programs objectively oriented students as well as objectifying experiences for the subjectively oriented.

Ames (1968) reported the development of an instrument for assessing the philosophical positions of counselors and suggested its use in counselor candidate selection, counselor education staff self-selection, and self-study in describing the program's influence.

Miller (1969) demonstrated the feasibility of inducing "understanding" type verbal responses in prepracticum students by allowing practice in responding to a tape of a client,

having a supervisor model the understanding response when emitted by a student. Thus, a technique is available to educators to create the desirable outcome in their students.

In summary, we find that personality variables outweigh intellectual variables in judged counseling effectiveness by supervisors but, at the same time, professional counselors have difficulty in reliably rating their own and their colleagues competence. Programs may change values and attitudes, but these changes are transitory. Minimally trained counselors often do as well or better than professionally trained experienced therapists but their success is probably due to incidental social factors. Counselor educators are concerned with the disparity between theory and practice, the rejection of theory by students, and the lack of integration of the subjective with the objective. Finally, counselor educators must be able to communicate high levels of facilitative conditions in their contacts with students, or the students' ability to communicate these conditions to their clients will deteriorate both during and after training.

Client-Counselor Similarity

The following review of the recent literature relative to client-counselor similarity and its effect on psychotherapeutic outcome is remarkable in both its research and commentary

in its unitary approach and singular findings within defined chronological periods. The early 1960 studies contrast sharply with those of the later part of the decade in finding no advantage for patient-therapist similarity.

Early Studies of Similarity

Currier (1963) using graduate students in clinical psychology and patients of a university counseling center and a mental health service attempted to test whether greater patient change would occur if the patient and the therapist have initially similar values, if the therapist is not conflicted over a patient-need conflict, and if the therapist is more sensitive to a patient need than is the patient himself. Findings were opposite to those expected in that attitudes changed most when client-counselor attitudes differed, and the conflict and sensitivity variables did not relate to the criterion. The combination of the hypothesized variables did produce more patient change, but this was confounded by the interaction of the uncontrolled sex variable in that opposite-sex pairs were rated higher on change than same-sex pairs, and opposite-sex pairs were also less likely to miss appointments.

Ourth (1963) tested the hypothesis that the degree of similarity of therapist-client pairs as measured on a

researcher developed internal-external orientation instrument determines the length of stay in counseling and the therapist-rated improvement. Using 42 student patients and 6 staff therapists at the mental hygiene clinic, the predictions were not supported. The data indicated that positively judged patient movement was related to an internal orientation by the "external" judge. A therapist approaching the patient's ideal self tended to keep the patient in therapy. Additionally, less disturbed patients were more internally motivated and could move toward or away from the therapist model while the more disturbed patients tended to accept the therapist as a model indiscriminately.

Stefflre and Leafgren (1964) hypothesized that clients tend to choose counselors like themselves. Eleven pairs of mutual choices, 11 pairs of mutual rejections, and 11 pairs randomly determined were compared on age, intelligence, dogmatism, vocational values, and personality. All observed differences were attributable to chance, and the hypothesis was not confirmed.

Later Studies of Similarity

At this juncture in time, 1964, studies began to appear that supported the hypothesis of therapeutic efficacy due to patient-therapist similarity. Beatty's (1964) dissertation

clearly indicated that both the sex and the sexual identification of the counselor as measured by the MMPI Mf scale play a significant role in the development of communication in the counseling interview. When the sex and the identification of the counselor-client pair were the same, there were no differences in agreement to the topics discussed. However, when the counselor identified with his opposite-sex parent, differential impact occurred. Male counselors with mother identifications had greater ability to communicate with a client no matter what the client's sex and identification, whereas father-identified female counselors showed poorer ability to communicate.

Wolf (1966) in discussing short-term group therapy argues in favor of diagnostic testing in assigning patients to therapists "best suited by talent and experience, to treating the particular problems involved" (p. 223). He continues by saying that "Therapists, no matter how much they deny it, often make unconscious choices in choosing patients to treat and methods to use" (p. 223).

Keith-Spiegel and Spiegel (1967) asked 74 patients upon being discharged from a mental hospital who was most and least helpful to them and found a significant relationship between the intelligence level of the patient and the chosen group. The more intelligent and sophisticated patient tended

to choose the psychiatrist and psychologist while the less sophisticated patient tended to choose aides and other patients as most helpful. An opposite relationship was found for the least helpful choice.

Gabbert, Ivey, and Miller (1967) examined client attitudes toward the counselor by means of the Counseling Evaluation Inventory, short form. Strong support was found for their major assumption that counselors vary in their ability to work with different types of clients. Sex differences, diagnostic categories, and duration of counseling were found to be important factors which were related to the attitudes that clients held toward counselors. It was suggested that the ability of a counselor to obtain positive client attitudes may partially relate to his capability to relate to both sexes, work with problems of a vocational or personal nature, and to maintain meaningful long-term relationships.

Bare (1967) found that counselor personality characteristics and counselor-client similarity on personality measures were related to counselor's general effectiveness, empathy, and facilitation of a close relationship. Clients and counselors agreed that these criteria of counseling success are best met when (a) counselor characteristics include high original thinking, high vigor, low achievement

needs, and low order needs, and (b) counselors are unlike clients on original thinking, vigor, and responsibility.

Freeman (1967) studied patients' and therapists' reciprocal need compatibility, their judgment of the psychotherapy relationship, and their estimate of patient improvement. Using the FIRO-B Scale of interpersonal needs, she tested three hypotheses concerning the relationship of patient-therapist compatibility to (a) patient improvement, (b) the quality of the therapy relationship, and (c) premature termination. With patient-therapist compatibility the predicted positive variable, she found her first hypothesis was not confirmed, her second only partially confirmed, and her third untested because of the small sample size. Her general summary curiously argues favorably for the patient-therapist goodness-of-fit hypothesis.

In 1968, Ivey, Miller, and Gabbert, in a follow-up to Gabbert, Ivey, and Miller (1967), again used the Counseling Evaluation Inventory to examine client attitudes toward their counselors in individually varying patterns. Those counselors with more experience and those who maintained interviews over a long period of time tended to have clients with more favorable attitudes toward them. Attitudes toward counseling varied with the client-counselor combination.

In the Annual Review of Psychology for 1968, Rosalind

Dymond Cartwright reviewed 14 studies of effective patient-therapist dyads and found that (a) different patients must be approached in different ways, and (b) patient-therapist similarity in regard to social class (i.e., expected behaviors), level of adjustment, values, and intelligence/education is important to successful therapy outcome. Cartwright presented her own recent research in which pairs of patients were matched on age, sex, presenting symptomatology, and the total number of interviews they would have. The therapists were matched on age, sex, and experience level (all were highly experienced senior therapists); one group was analytic and the other client centered. The question she asked was, Will there be more similarity in the process of therapy across different patients in the same treatment or across similar patients in different treatments? Results indicated that similar patients move similarly despite marked differences in the techniques used. The therapists were homogenous within treatments while school differences were extreme; that is, matched patients in two different treatments responded similarly in their movement process. On three different scales, an open affective experiencing (Rogerian) scale, a self-observing (ego-analytic) scale, and a Bales interaction scale, matched patients behaved similarly and reached similar levels. This study, Cartwright pointed out,

suggested that commonalities of the two treatments are far greater than is usually acknowledged. She concluded that the techniques are not as important as the quality of the therapist's confidence in his ability to use the techniques to produce behavior change.

Patton (1969) simulated a treatment situation in a laboratory to test the effects of positive versus negative interpersonal attraction and of communication similarity versus communication discrepancy. Using 3 male counselor accomplices and 72 male subjects, he found that a client's response to a counselor who attempted to modify the client's behavior was contingent upon how personally attracted the client was to his counselor and on how congruent their discussion was with the client's prior expectations.

A similar study with similar findings was carried out by Hurst, Weigel, Thatcher, and Nyman (1969). They used the Missouri Diagnostic Classification Plan to evaluate the relationship of counselor-client diagnostic agreement and client-perceived outcomes of counseling. The counseling services assessment blank was developed to elicit from clients a self-diagnosis corresponding to the Missouri scale. Counselors used the Missouri scale to diagnose clients, and a self-diagnosis and perceived growth index was obtained from the same clients using the counseling services blank. Results

indicated a positive relationship between diagnostic agreement and perceived growth in the specific categories of the counseling services assessment blank that corresponded to the Missouri Diagnostic Classification Plan. The authors suggested in conclusion that essential, accurate, agreed-upon diagnosis leads to perceived improvement, and suggested that counselors and clients should communicate explicitly their diagnostic judgments to avoid working at diverse goals.

Finally, we look at Houts, MacIntosh, and Moos (1969) who had each of seven patients interviewed by each of four therapists twice. After each session, the therapists rated how they thought the patient and the therapists should behave during psychotherapy. In addition, these patient and therapist behaviors were independently rated from tapes of the meetings. Utilizing a balanced 4 by 7 design, behavior-rating data indicated that therapists were more influenced by patients than patients were by therapists. Comparisons of the questionnaire and the behavior-rating data indicated that differences among therapists were more evident in how therapists think than in how they or the patients behave. Differences between patients were a major determinant of both patient and therapist behaviors. Differences between therapists were more evident in how they thought about patient and therapist strategies to achieve therapeutic goals (a cognitive

process) than they were in either patient or therapist behaviors during therapy sessions (a behavioral process). These differences are probably due to different role expectations for therapists when they are with patients than when they are with colleagues (a phenomenal process). This study provides an interesting umbrella under which the studies of Fiedler (1950a, 1950b), Strupp (1955a, 1955b, 1957), and Sundland and Barker (1962) can be related. The reports of these research projects will be undertaken in the following section.

In summary, we may say that it appears that in regard to counselor-client dyads certain aspects of similarity are important; i.e., social class, adjustment level, values, intelligence/education, and diagnostic agreement, while others might better be dissimilar to achieve therapeutic effect; i.e., sexual identification and original thinking.

Commonalities in Theory and Practice

As already alluded to in the last section, there is some evidence to suggest that commonalities in practice as assessed by both client and counselor behaviors are more readily discernible than are commonalities in theoretical therapeutic positions. There is, in fact, a surprising amount of research that lends itself to this interpretation, as well as some to

the contrary, and it is to this research we shall now turn.

The by-now-famous Fiedler studies (1950a, 1950b) first demonstrated that expert therapists of various schools, when forced to use the same language, agree more with experts of other schools than they do with the nonexpert, i.e., less experienced, of their own school in describing their concept of the ideal therapeutic relationship and, second, that expert psychotherapists of three differing schools create a relationship more closely approximating the ideal therapeutic relationship than one created by nonexperts, that this relationship created by experts of different schools is more alike than relationships created by nonexperts of the same school, and that the most important dimension of those measured which differentiates experts from nonexperts is the therapist's ability to understand, communicate with, and maintain rapport with the patient. Fiedler speculated that the relationship itself may be the therapy and that a theory gives a therapist security by providing an integrated framework, a cognitive crutch, if you will.

Strupp in an initial 1955 study was able to conclude that professional affiliation exerts a relatively minor influence upon the kinds of techniques used by psychiatrists, psychologists, and social workers. With theoretical orientation held constant, all therapists adhering to psychoanalytic

principles employ similar techniques. When experience level was taken into account, however, psychologists emerged as the most homogenous group, while psychiatrists evidenced more conspicuous differences between experienced and inexperienced therapists. Strupp stated that intensive training in psychotherapy leads to a general diversification of technique. In a later article in 1955, Strupp reported studying the effects of personal analysis upon the verbal responses of therapists to patients' communications and found that analyzed practitioners (a) tended to be more active, (b) preferred interpretation, silence, and structuring in dealing with transference, and (c) gave fewer silent responses to schizoid productions of seriously disturbed patients, in comparison with nonanalyzed therapists. Strupp (1957) compared two nationally renowned therapists of the client-centered and analytic schools, Rogers and Wolberg, respectively, in a multidimensional analysis and found that the therapist's personality and his theoretical orientation and techniques intercombine predictably. Indicating that some combinations may be better than others, he suggested that psychotherapeutic techniques may be studied by analyzing therapeutic communications. In the 1957 study, data indicated clear-cut differences between the two therapists in their therapeutic behaviors in treating two different patients they both judged to have had successful outcomes.

Hobbs (1962), writing of sources of therapeutic gain, said that the relationship allows symbols to be divested of their anxiety-provoking nature while the patient's understanding of the transference leads to his learning to be responsible for making decisions. The therapist provides a cognitive structure for the client to construe his world and build a personal cosmology. Hobbs went on to suggest that the cosmology the therapist's theory implies should be somewhat compatible with the patient. For example, psychoanalysis, being cognitive, cogent, and mundane might be for the pragmatic man; existential analysis for those who suspect all institutionalized solutions to the problem of meaning; rational emotive therapy for the bright, articulate, nonreligious, well educated, not too disenchanted who find the process and model appealing and convincing; client centered for those who have well developed but conflicting cognitive structures, and Kelly's fixed-role therapy for those who need a cognitive structure for construing the world. This writer would add to Hobb's list, behavior therapy for those who feel like objects needing repair or whose symptoms are disowned or have no meaning in the individual's cosmology.

Sundland and Barker (1962), in an attempt to develop a measure of psychotherapeutic orientation and to obtain actuarial information on the methods and attitudes of therapists,

constructed the Therapist Orientation Questionnaire (Sundland, 1960) and administered it to a sample of American Psychological Association psychotherapists. Analysis of the data revealed, contrary to Fiedler's (1950a, 1950b) findings, that experienced and inexperienced therapists of the same orientation were more similar in attitudes than were those of the same experience level but of different theoretical persuasions. The authors commented that while Fiedler used items generally agreed upon they had used more controversial items. Additionally, neither study gave any evidence for changes over time, i.e., with increasing experience. A longitudinal study would be necessary to adequately test the attitude change hypothesis.

Schwebel (1962) said that causes of problems appear to be the important missing links in counseling and this makes all theories suspect. He suggested directing research toward what kinds of problems we can and cannot alleviate, what the nature of these problems are, what their causes are, and what new methods can be developed in light of new formulations to solve these problems, and finally which problems are not remedial by any known methods. Schwebel concluded by saying, "what we listen for, hear, and respond to, and how we respond depends on our orientation . . ." (p. 328).

The effect of philosophical commitment to psychic determinism on the behavior of the psychotherapist was investigated

in 1963 by Gatch. Typescripts of therapeutic hours of psychoanalysts and existential therapists were compared with a modified Strupp Multidimensional System. Findings indicated no differences between the two on the number of verbal statements which referred to the patient's past experiences nor in the number of verbalizations of interpretations in the form of hypothesized causal mechanisms. Differences were found in the number of statements which referred to choice, decision, and responsibility, with existential analysts exceeding the orthodox.

Truax and Carkhuff (1964) and Carkhuff and Truax (1966) said that recurring themes more and more supported by research indicate that across all theories the variables that account for over half the variance in therapeutic outcome, for better or worse, are empathy, nonpossessive warmth, and genuineness and that these "facilitative conditions" can be taught to teachers and counselors by educators who possess them themselves. They also suggested that the rest of the variance in the therapy equation will be accounted for by the therapist's personality, role concept, and by his specialized techniques and by the patient's degree of disturbance, situational variables, and the "atmosphere" of the therapy.

Gardner, in a 1966 paper devoted to developing the point that the following basic principles are common to all

psychotherapies, including behavior therapies, discussed establishing rapport with the patient, trying to influence the patient by such interventions as reassurance, catharsis, suggestion, interpretation, and manipulation of interpersonal events between the patient and therapist as well as between the patient and other individuals, and the alteration, if possible, of environmental forces which affect adversely the patient's functioning. This writer must point out the obvious fact that many therapists would reject in theory, if not in practice, Gardner's contention that these are common to all theories.

Ehrenwald (1967) in a similar attempt took a different tack in offering the following three ingredients of which each school makes use of one or more as a guiding rational: (a) the therapist's motivation to help and the patient's corresponding hopes and, at times, self-fulfilling expectations to be helped; i.e., these dovetailing and mutually reinforcing patterns of attitudes form the virtually ubiquitious core of the treatment situation; (b) rational guidance and education, ranging from persuasion to analytic "working through" and Pavlovian or Skinnerian conditioning; and (c) the deliberate application of psychodynamic principles ranging from insight and interpretation to management of the transference neurosis. All schools have the common denominator of primitive healing

called the "effective myth" for education and reeducation. Psychoanalysis has added insight dynamics. This core may not be stated by the different positions. The treatment may be countered by the patient's severity and doubts and by the patient's and the therapist's resistances and by the culture.

These "armchair essays" continue with Patterson (1967) who, after first documenting divergence in theories, pointed to convergence which he sees in the fact that all schools report cures, see man in pain as undesirable and as a state capable of alteration, and of the influence of the future on the present. All therapists expect the client to change, believe in their own method as the best to elicit that change, and hold to an honest relationship with the patient. All patients need and recognize that need for help, believe they can change, and that the counselor can help them and engage in some activity. Although different approaches may be synthesized along the dimensions of rational-cognitive-planned and personal-effective-spontaneous, all of them rest on (a) a relationship with a therapist which offers the opportunity for extinction of unrealistic anxiety, of desensitization of threatening stimuli by offering understanding and acceptance while keeping the external threat level at a minimum, thereby allowing the initial anxieties to be expressed; (b) the reinforcement of behaviors which are therapeutically productive

by interest, attention, and praise; and (c) the provision of the opportunity to learn how to relate in a good relationship by experiencing one which is honest and upon which the patient can model his future behavior.

Arbuckle (1967) summarized a lengthy review and analysis of counseling theory by saying, "All counseling is client centered as long as there is a client; all counseling involves ego . . .. There is analysis . . . interpretation . . . and reflection . . .. There are cognitive elements . . ." (p. 222). Arbuckle continued by saying that thinking and feeling cannot be separated, that all counseling is developmental, and that counselors are conditioning agents with patients and in this sense may be considered behavior therapists. The real question, he argues, is "What sort of person are you?" (p. 222).

Carkhuff (1967) proposed that after assessing "the central core of interpersonal functioning" one may make differential predictions concerning the potential value of particular interactions. For example, clients at developmental level one (his scale) may need touching and other physical communication; those at level two may respond to nondirective and psychoanalytic listening; clients at level three may respond best to trait-factor and other educational approaches; while level-four and five clients may need questioning, stimulation, agitation, and a sharing experience.

Carkhuff and Alexik (1967) performed an experiement and thereby illustrated how a client could manipulate a non-facilitative counselor but not one operating at high levels of empathy, warmth, concreteness, and genuineness which would seem to be one answer to the question posed by Arbuckle above.

Berenson and Carkhuff (1967) summarized a voluminous amount of research to illustrate that no matter what the orientation of the author, the implications are that the facilitative conditions must always be present for therapy to take place. Carkhuff and Berenson (1967) then proposed how this knowledge might be utilized in theeducation of all those concerned with the human development of others.

Dreyfus (1967), existentially oriented, agreed with the foregoing and said simply that the relationship is therapy. He wondered whether behavior therapists might have different personality characteristics than relationship therapists because doing something takes the pressure off establishing a relationship. Parenthetically, however, Ford and Urban (1964) observed "that they (the existentialists) have developed a new way of thinking about patients, but it does not lead them to do anything different in treatment" (p. 469). Furthermore, Gelder, Marks, and Wolf (1967), after first demonstrating that speedier and greater relief of phobic symptoms was achieved with desensitization than with psychotherapy by

group or individual treatment of 42 patients in three groups, concluded that the effects of the doctor-patient relationship and of the transference were important in desensitization as in "talking" therapy. However, relationship variables do not formally get "worked on" in desensitization, but they act to motivate the patient to carry out the tasks which help overcome the phobias. In talk therapy, the relationship is central and contributes to nonspecific personality changes.

These contentions were specifically contradicted by a study conducted by Krapel and Nawas (1969) who matched 40 snake-phobic female subjects on the degree of behavioral avoidance and subjective fear and then randomly assigned them to one of four groups: (a) a conventional desensitization group using standard interpersonal procedures; (b) a semi-automated desensitization group in which treatment was delivered by tape recording; (c) a pseudo-desensitization control group; and (d) a no treatment control group. The subjects in both desensitization groups showed significantly greater improvement than did subjects in either of the two control groups. No differences were found between conventional and semiautomated procedures. It was concluded by the authors that the relationship was neither a primary nor a critical factor in desensitization.

Thus, the controversy continues. Shapiro, Krauss, and

Truax (1969) were able to demonstrate that the "facilitative conditions" lead to personal disclosure outside of therapy among friends and relatives. Interestingly, while most disclosure of all kinds was given to understanding, warm, and genuine persons, females were given least negatively toned behavior disclosures by both males and females, although, they elicited the greatest disclosure. These results are similar to those found by Beatty (1964), reviewed above.

Greenberg, Kagan, and Bowes (1969) asked 31 professional counselors to rate the client's feelings as presented in 11 filmed scenes of counseling. Each scene was rated on 26 semantic differential scales. Factor analysis of the scales yielded a three-factor first-order solution and a four-factor second-order solution. The first-order factors were dependency, anger, and avoidance. The second-order solution contributed the additional factor of apprehension while maintaining the former three factors. Together, these factors accounted for more than 50 percent of the variance in clinical judgment of the counselors. This indicates a relatively tight conceptual frame of reference in counselor assessment of clients.

Finally, Eron and Callahan (1969) in their book, The Relation of Theory to Practice in Psychotherapy, had in summary, this to say:

As practitioners of an applied science, it would be

> well if we could claim that our procedures stem directly from a comprehensive body of theory and research. As pragmatic American psychologists, coming from a tradition of behaviorism and functionalism, we would like to demonstrate that our theory points directly to operations and it is through these operations that reconstruction and modification of personality and behavior are effected (p. 147).
>
> [A] summary of the relevant research indicates not only that therapist variables are important in determining what happens in psychotherapy but also that what the therapist does is related to his theoretical orientation, despite the fact that many therapists, especially the more experienced ones, do much the same thing regardless of theoretical orientation. . . . the possibility that those differences that do emerge are a function not of the specific theories and the operations to which they lead but rather of the personality of the practitioners who choose one theory over another must be considered (p. 148).

The Counselor's Personal Theory

This final section of the review of the literature relative to the assumptions of the theory herein presented leans heavily on social perceptual theory and expert opinion.

In 1954, in attempting to explain observed differences in people's perception of other people, Brunner and Tagiuri suggested that the important question to ask was "what kinds of naive, implicit 'theories' of personality do people work with when they form an impression of others" (p. 649).

Cronbach (1955) reviewed 34 studies designed to reveal various aspects of perceiver and perceived, in an attempt at

examining the variables relative to accurate judgment of others, and concluded that "the judges implicit personality theory" was one such aspect.

McGowan (1956) reviewed 12 studies relative to the counselor's style, personality, techniques, and client satisfaction and outcome and concluded that:

> It would seem advisable for educators engaged in the training of counselors to give less emphasis to the development of response techniques, as identified with a particular school of counseling, and to encourage their students to develop response methods in line with their own past experience and natural style of speech (p. 249).

This was not to imply that counseling was the same as any other social relationship or that the needs of the counselor were to take precedence over those of the client but was only meant as a suggestion to capitalize on the basic interpersonal skills already acquired.

Alexander (1962) suggested that we understand others because of common experience, but that this understanding is limited by conscious distortions in the narrator, unconscious distortions in the narrator, differences in age, sex, race, social class, nationality, and perceptual distortions in the observer. The observer's, e.g., counselor's, distortions are easiest for him to eliminate by his own self-observation and analysis. Distortions in the narrator are reduced by free association.

Moving far afield from the analytic point of view, one finds Williamson (1962) writing:

> I refer to the counselor himself as a technique of counseling, not only what he does or says in the interview, but how he conducts himself is an extremely important and effective technique in counseling. I shall argue . . . that consideration of the counselor as technique leads us at once to the phenomenon of the student's perception of the counselor as he directly observes and actually experiences the counseling relationship (p. 108).

Williamson went on to spell out the role model he would like to see the counselor represent. As a "hero-model," the counselor should show the student an optimistic philosophy of human development, self-acceptance, integrity, academic virtues, professional virtues, and personal excellence. To do this, he must relate as an equal, have full development as an aim, be broadly cultured, have a commitment to academic freedom and convictions, and unequivocally exhibit the non-avoidance of ethical questions.

Mueller, Gatsch, and Ralston (1963) found that counselors do not maintain a consistent counseling relationship with their clients. Their 12 certified counselors and 24 clients differed with judges of the taped interviews in their perceptions of the relationship. Counselors and clients consistently described their relationship more like Fiedler's therapeutic ideal than did the judges listening to tape recordings of the

same interviews. No presently available commonly used mechanical device of which this writer is cognizant can perceive all that is communicated in a dyadic interaction and this would be particularly true if at least one of the participants were Williamson's "hero-model," as above. As Opler (1967) suggested, man being the only symbol-using animal tends to forget that he also communicates on other levels and that he learns without awareness in his culture. Robinson (1963) said that "The counselor as a person is the most important variable in in the conference room" (p. 673). Questioning whether neutral ambiguity is the only mode for a counselor to follow, he prescribed a likeable, integrated person with definite characteristics and views who can take on different roles so that the client can learn. These suggestions by Robinson have been obliquely supported by research already cited and are similar to Williamson's propositions (cf. Betz, 1967; Cartwright, 1968).

Shoben writing in 1962 said that theory is inevitable but is bound to have a less than perfect fit to a particular client. The theory of choice is an internally consistent system of ideas that conforms to our own previously developed ideas about the ways in which men behave, as well as our own set of values. Therefore, a counselor's explicit theory is related to his implicit one. This, Shoben claimed, is a cognitive trait which both facilitates and inhibits understanding just as affective

attitudinal characteristics can.

In a slightly different vein, Slavson (1964) discussed the qualifications and functions of the group psychotherapist.

> Ironically, one of the requirements for a good therapist is a difficult childhood which has been adequately worked through in an analytic procedure. This gives him not only knowledge and wisdom, but aids the essential empathy with his patients. A person who has not suffered cannot emotionally "understand" the suffering of others and the outcomes of that suffering. However, the therapist must have overcome the effects of his own difficulties, resentments, hostilities and the like, without residual bitterness or cynicism, or he may reinforce such feelings in his patients on the one hand, or he may over-identify with them, on the other (pp. 402-403).

It is important to note that recent research by Carkhuff and others cited above has shown that empathy can be taught.

Lister (1964) stated that the counselor's personal theory refers to the hypotheses he has come to view as reliable guides to personally effective and satisfying relationships, and that the formal theories chosen by counselors are probably related to their personal theories (cf. Shoben, 1962).

In writing of "The Counseling Experience as Personal Development," Shoben (1965) quoted a study by Rosenthal (1955) in which it was demonstrated that patients judged improved were those who had become like their clinicians, whereas unimproved patients showed no such movement. Shoben went on to say that the counselor, as a model of the kind of person

that is effective and self-fulfilling, uses his professional role to benefit another human being as a representative of a decent person.

The effects of modeling have been demonstrated by Thoresen, Krumboltz, and Varenhorst (1967) wherein they were able to increase information-seeking behavior in junior high school students. Their data yielded definite interaction variance between the sex of the model counselor and the client, and it also supported the "innate therapeutic qualities" idea.

While Crisp (1966) made a reasonably logical attempt to account for the success of behavior therapy via the rubric of "transference," Truax (1966) preferred to interpret the behavior therapy success data to mean that those psychotherapists who are high on the conditions of empathy, warmth, and genuiness are more effective because they themselves are more potent positive reinforcers.

Williamson (1966) faced the value imposition question in counseling by stating that the "good" is determined only by its worth in developing human lives. He suggested the counselor explicate his own value hierarchy so that the client may perceive his as one of many possible desirable role models. All counseling aids the individual to become aware of alternatives, so as to form his own cosmology, a

statement congruent with Kelly (1955) and Hobbs (1962), examined above.

On the same theme, Mowrer (1966), after a cogent review of Wolpian, Skinnerian, and modeling therapies, concluded that all therapies require relearning by the patient. However, he rejected the position of Wolpe, for example, who only wants to relieve distress without any concern for the social utilization of anxiety for changing behavior. Mowrer strongly stated that ethics and morals must be considered and that the community is the standard to apply.

Lister (1967), in discussing the advantages of theoretical eclecticism, said that it enables the counselor to work out for himself an internally consistent, coherent rationale for his counseling behavior. But, he warned that "home-grown" theories do not generate research hypotheses and often mix incompatible elements unknowingly. Since a counselor behaves in terms of what he believes to be true, he must examine his personal beliefs about people and the nature of the helping task. He may then find a compatible theory, or, if not, may synthesize one out of external and internal elements.

Brammer (1969) offered a point of view he described as emerging eclecticism which he posits as a position for a practitioner faced with the need to be comprehensive, flexible,

and open in theory and method. He said the emerging eclectic is a skilled observer in the scientific behavioral tradition who knows the history of counseling theory and contemporary views and is aware of his own unique style and the demands of his counseling setting. From these the emerging eclectic forges his own comprehensive evolving view of behavior change.

Finally, in turning to an intriguing study by Bednar and Parker (1969), we see theory looked at as a belief system which affords placebo effect. A randomized design with a 2 x 2 x 2 factorial arrangement of treatments was employed to investigate the role of susceptibility to persuasion, expectations for personal growth, and divergent counseling treatments in the process of behavior change. The results indicated that (a) the divergent counseling treatment procedures, rational-emotive and self-theory, were equally effective in producing change of equivalent magnitude, but in divergent directions; (b) there were no differences in client satisfaction between the two counseling treatments in spite of opposite directions of change, i.e., control versus expression of feeling; (c) susceptibility to persuasion and heightened expectations did not significantly influence the magnitude of change; and (d) the high persuasibility subjects perceived the counseling treatments as more valuable to themselves and to others and expressed greater interest in continuing

treatment as well as attempting new behaviors. Essentially, belief in a system as a cure gives the desired "placebo" effect. It would seem that all systems accurately report success because they impart the expectation of improvement along with a belief system.

In summary, we have a surprising commonality of agreement on the counselor's personal theory especially among the "talk" therapists, with a few trying to incorporate the behavior therapist's position into the scheme also. Little research evidence is available to directly support these positions taken by some of the most prominent men in the counseling field.

A recapitulation of the foregoing recent history leads us to conclude that (a) counselor personality definitely effects client and counselor behavior in the counseling setting, although the degree and direction of the effect needs significantly more specification than it has had to date; (b) the effects of training in relation to values and attitudes are minimal at best, and personality variables outweigh intellectual variables in judged counseling effectiveness, by supervisors, who must be able to communicate high levels of facilitative conditions in their contacts with students, for the students to be able to communicate them, in turn, to their clients; (c) client-counselor

similarity is important in some aspects of the relationship and harmful in others; (d) commonalities in theory and practice are apparent among experienced therapists but not to the exclusion of real differences based upon theoretical orientation; and (e) many leaders in both the theoretical and practical aspects of counseling agree that the counselor's personal theory is of singular importance in determining which formal theory a counselor will choose to render his therapeutic interactions meaningful and how, in fact, he will conduct himself in (and out of) the therapeutic situation.

CHAPTER III

THE PROBLEM

The contemporary literature clearly indicates both convergence and divergence in theory and practice (Patterson, 1967). Whether similarities or differences are stressed is clearly a function of the theory chosen. While evidence other than ancedotal accounts for the efficacy of psychotherapy was lacking, Eysencks (1952, 1961) charges of ineffectiveness of verbal psychotherapy, which essentially amounted to charges of fraud or a large-scale professional "confidence game," further stimulated the already ongoing research (Betz, 1967; Whitehorn & Betz, 1954, 1956, 1957, 1960) into the sources of therapeutic gain so that Carkhuff and Truax (1966) could report that therapists indeed do have a significant impact on their patients and that this impact could be for better or for worse. Research, as it had been conducted with groups of patients for treatment and groups for controls, often showed no mean differences, as the positive and negative changes tended to cancel each other; however, the variances measured were found to be significantly higher in the treated group. The measurement

and control of the therapeutic facilitative conditions lead to predictable therapy changes (Truax & Carkhuff, 1964). However, only a portion of the variance in the data is accounted for by the facilitative conditions, and this remains true even when specific theories and techniques are considered. Among the other important variables to be considered is the person of the counselor himself that he brings to the counseling situation.

Originally, and still primarily, theorists were of western European origin (Ford & Urban, 1964). They were and, in America, are primarily of Anglo-Saxon orientation and share the Greco-Judeao-Christian heritage. Most were medically trained. The theorist was a practicing therapist using naturalistic observations in clinics treating adults of middle- and upper middle-class social status. These and other limitations not noted combine to bias the generality of the generated theories. One bias engendered by the observation of troubled adults exclusively for the generation of data from which to construct theories is the ease with which learned behavior is intepreted to be genetically determined. The "oedipus complex" is a most obvious of numerous examples. Another bias evidencing itself in theoretical emphasis is that due to the fortuitous experiences of theoretician's clinical encounters. Additionally, most theoreticians lose

sight of the relativity of values from culture to culture and age to age, especially in construction of their explicit or implicit models of healthy man. Even within the confines of the continential United States there are an astonishing number of subcultures which largely determine the observed behaviors of their members, symptoms included (Opler, 1967).

It is safe to say at this juncture in our knowledge that man is both a pilot and a robot. It is further alleged that to the degree that man's vegetative, that is, life support, systems are functioning as a robot, on automatic control, and to the degree that his cognitive-conative self-awareness systems are under the pilot control, that is, self-control, he will be capable of solving most of his encountered problems using his learnings from experience creatively. Freedom is the subjective phenomenon of knowing your determinants and acting within them to your own best perceived advantage. Some suggest we study which kinds of behaviors function according to which laws (Ford & Urban, 1964; Kiesler, 1969). This valuable nomothetic molecular approach is studying the robot. This writer prefers to look at the pilot.[1]

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[1]Sometime after the original writing of this paragraph, the author was most gratified to discover an essay by Gregory Razran called Evolutionary Psychology which clearly sets forth the evidence gathered in both American and Russian

Levy (1968), in attempting the development of a cognitive theory of counseling, said the following:

> Postman (1955) has stated that the defining characteristic of a cognitive theory of behavior is its attempt to explain regularities of behavior in terms of how the organism discriminates and categorizes its environment. Kelly (1955) has suggested the unit of analysis which might be applied in such a theory: the personal construct. Each person is assumed to evolve a system of personal constructs by means of which he structures his experience and anticipates events. These constructs are dichotomous and arranged in a hierarchial system so that they bear certain inferential relationships to each other. In Kelly's view, behavior is largely governed by expectancies. As he puts it in his Fundamental Postulate: "A person's processes are psychologically channelized by ways in which he anticipated events" (p. 46). By an analysis of the structure of an individual's system of personal constructs -- the kinds of constructs used as well as their number and ordinal relations with each other -- Kelly maintains that it is possible to account for his behavior and his experience (p. 66).

Levy went on to say that:

> Personal construct systems evolve so as to help the

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experimental laboratories which is interpreted as supporting the view of the existence of an evolutionary hierarchy of four levels of learning. The view propounded suggests that all levels co-exist with the highest normally dominating the others and with the ability for successively lower levels to become manifestly dominant when for some reason the next highest is not fully functioning. It seems clear, though nowhere is it noted by Razran, that these proposed learning levels are isomorphic with counseling called cognitive (cf. trait-factor; rational-emotive), affective (cf. client-centered; analytic), behavior modification (cf. modeling plus certain Gestalt techniques) and conditioning therapies (cf. reciprocal inhibition as well as the various operant and respondent techniques).

> person anticipate events. If he finds himself trapped by the facts, if he has run out of alternatives, it is because of the way he has construed events. The point of personal construct theory is that what is taken as a fact and what are considered possible alternatives are entirely dependent upon the individuals system of personal constructs. In effect, the structure of his construct system determines the structure of his experience. But personal construct repertoires, like scientific theories, are also responsive to validating and invalidating evidence. Thus, the counselor, by explicating the constructs his client has been using, by bringing into juxtaposition events which had previously been separated in his client's thinking, by the kind of experience he provides his client through his relationship with him in counseling, helps the client re-evaluate his constructs, try out new orderings among them, and possibly expand his construct repertoire. And as construct repertoires change, so changes behavior (pp. 67-68).

The final remarks to be used here from Levy are these:

> The means for doing all these are many and run the gamut from free association to role-playing and from providing normative information to psychological interpretation. They depend upon the client, his problems and the setting . . . . The client is responsible for his own life and his choices; the counselor is there to help him explore new ways of construing them (p. 68).

At this point it is appropriate to restate the two propositions, assumptions, or working hypotheses which, if substantiated, will, in good measure, account for the previously unaccounted for variance in the reviewed process and outcome studies and which this writer will call, after Lister (1964, 1967), the counselor's personal theory (cf. McGowan, 1956; Shoben, 1962; Williamson, 1962).

> Proposition I. Any theory of behavior and behavior changing (personality and counseling/psychotherapy/education) is the articulated intellectual understanding the theoretician has of his own experiences in living and in learning the solutions to his own life's exigencies abstracted and generalized to apply to the theoretician's conceptual model of man "qua Man."
>
> Proposition II. Any application of a theory of behavior and behavior changing (personality and counseling/psychotherapy/education) is the teaching of the implementation by one more knowledgeable to one less knowledgeable (counselor--client; therapist--patient; teacher--student; parent--child; native--alien; friend--friend) of the variety of more or less successful ways of meeting and successfully coping with life's vicissitudes the more knowledgeable person discovered through his own developmental experience as he learned to meet and solve his own life's perplexities.

Proposition I and Proposition II are to be understood as of equivalent and related status. The word theory in Proposition I answers the question why does one propose such a point of view in explaining human behavior and the word application in Proposition II answers the question how one goes about transmitting one's beliefs about successful living. It is quite possible to move from Proposition II onto Proposition I as has been done by a number of clinicians as it is for the reverse procedure to take place as is evidenced by their more academic brethren. It is to be noted that the first postulate delineates an intellectual understanding as is apropos for the presentation of a theory. This is not meant to imply that emotional factors are absent in the theoretician but

only that the presentation of a scientific theory is an intellectual exercise. The second proposition which relates to a different mode of human activity, i.e., implementation, clearly does not limit the therapist's understanding of the ways of solving or at least dealing with life's contigencies to an intellectual mode, but rather allows both cognitive and conative factors full play. For example, some situations might best be met with the expression of grief such as crying, etc. when confronted by the death of a loved one. The expression of grief is a conative behavior clearly a part of the application discussed in Proposition II; the understanding of the expression as a tension relieving activity necessary for the maintainance of the organism's physical and emotional integrity is the intellectual theorizing noted in Proposition I. Thus, the mode of activity is at least one of the differences between theory and practice.

Now, if these assumptions indeed do account for both convergence and divergence in the theory and practice of psychotherapy, that is, the variance not accounted for by the "facilitative conditions" in the research findings discussed above, it should be possible to deduce testable hypotheses which would then lend inferential support to the validity of these assumptions. Essentially, we are required to relate the experiences of learning to live-in-the -world of the

theoretician and/or his implemented practices in regard to the whys of behavior and the hows of communicating one's beliefs concerning behaviors leading to successful patterns of living. Furthermore, Proposition I, the theory of theories, states that theorizing is essentially an intellectual activity, developmental in character, and thus implies continuous adjustive modification. Under "normal" circumstances, the variability would be expected to diminish over time, as new experiences would have proportionately less potency against previously validated lifetime learnings. Radical alteration of theoretical position would be expected when and if the theoretician undergoes "abnormal" experiences. Proposition II says that implementation includes both emotional and intellectual behaviors and is otherwise characterized by the same strictures delineated for Proposition I. Proposition II may be called the theory of therapies.

Thus, we are now in a position to operationally define our variables and to construct the attendent testable hypotheses. The theoretical orientation to which a counselor/theorist subscribes shall be assessed by the Sundland and Barker Therapist Orientation Questionnaire (TOQ), Form 1960. This method is deemed superior to simply asking for a statement of theoretical commitment as it permits a degree of emphasis intensity variability on an interval scale continuum

not afforded by a label of a "school" alligence.

The intellectual understanding of his experience that our theory says the theoretician has is viewed in terms of the "personal constructs" it is assumed the theoretician has developed to explain his experience to himself and to anticipate the future. Personal constructs relate to many different aspects of one's human experiences and are useful in forecasting future experiences. Since we are concerned with both theoretical and operational aspects of human behavior and because we are assuming that most, but not all, of the vicissitudes of life involve interpersonal relations, we shall measure the variety of interpersonal constructs available to the counselor/theoretician to construct his theory of behavior. This shall be accomplished with the Construct Repertory Test (REP Test), wherein "interpersonal relations" will be the focus of construct assessment. This instrument follows the work of Kelly (1955).

The experiences in living and learning through which the personal constructs develop to give the articulated intellectual understanding our theory calls for shall be assessed with an author-constructed Biographical Information Blank (BIB). The BIB assesses both descriptive and experiential material, and the experiential material may be evaluated both qualitatively and quantitatively. For the purposes of

this study, the quality of experience will not be considered. Attention will be directed toward the descriptive data and the quantitative data, the latter of which may be made to yield a frequency count of the particular experiences under consideration. The descriptive data will be used for classificatory purposes, e.g., an item analysis, and as a source of alternative explanations which will be offered if the quantitative data do not yield the expected outcome that the greater the frequency of interpersonal experiences and potential experiences in the interpersonal realm an individual indicates he has had, the greater will be his cognitive complexity in the interpersonal realm and the greater his tendency to score in the Sullivanian realm of the TOQ. That is, the greater the complexity of life's situations with which one must deal, the more different people with whom one would have faced,[1] the more cognitively complex the person will be in the interpersonal realm and, thereby, will have a greater variety of interpersonal constructs with which to construe behavior and to assist others in their construing. This is defined as eclecticism.

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[1]For example, without detailed information on each specific instance, it is assumed that on the average, urban living provides more of these than does rural living. Of course, any particular example may contradict this assumption.

We have stated in the second proposition that conative as well as cognitive aspects of human interaction are involved in effecting behavior modification. To measure the emotional life style of a counselor, his long-range affective approach with which he has learned to habitually face the world, the A-B Scale has been chosen. This measure, derived from the Strong Vocational Interest Blank, is composed of questions related to interests such that there is a clear inferred distinction between the modes of interaction in the interpersonal behaviors of those scoring "A" and those scoring "B" to the extent that psychotherapeutic success may be unambigiously predicted. Research already reviewed indicated that distinctly different emotive reactions were required to achieve successful therapeutic outcomes with schizophrenics and with neurotics; the A-B Scale can make this distinction. The research conducted to date with this scale suggests that "A" therapists might be characterized as social-independent-nonconforming individuals while those therapists achieving a "B" rating could fairly be described as social-dependent-conforming individuals. Since it is assumed that interests are learned developmental phenomena, A-B disposition should be predictable from the BIB.

It is important to note that the TOQ is used herein to assess both the stated orientation and the practiced approach

to counseling; that is, when measured with this instrument and in accord with the assumptions of this study, theory and practice are congruent. It is further recognized that to measure cognitive complexity in terms of interpersonal constructs weights the Sullivanian position on the TOQ more favorably than the analytic or experiential ends of the continuum. To begin with, Sullivan's theory claims to be an interpersonal theory and, therefore, theoretically, one should expect a stronger relationship between cognitive complexity measures in the interpersonal realm and said theory. While it is true that analytic and experiential thinkers, notably Freudian and Rogerian, concentrate considerable attention on the individual often seemingly suspended from any interaction with his culture, both note the efficacious and deleterious consequences social-cultural interaction may have on an individual and both prescribe a social solution to the variety of difficulties noxious interpersonal experiences can engender. Additionally, it is this writer's position that most distress-causing factors of life can be traced to a failure in learning to solve the difficulties generated by the ambiguities in interpersonal relations. Therefore, interpersonal constructs are most germane to all counseling theory and practice. Of practical consideration, interpersonal experiences are, in principle, publicly

observable phenomena more readily investigated than those hypothetically constructed concepts, e.g., ego, self, etc., of which only inferential evidence, at best, can be obtained.

At this point, hypotheses are offered whose terms have just been defined and which, if substantiated, hold promise of supporting the assumptive propositions.

Hypothesis 1. There will be a significant positive relationship between the total number of potential and actual interpersonal experiences reported on the BIB and a medium score (m.s.$< \pm .4333\sigma$; $\pm .4333\sigma$ = 33.3% of the area under the normal probability curve) on the TOQ by theoreticians and/or therapists.

Hypothesis 2. There will be a significant negative relationship between the total number of potential and actual interpersonal experiences reported on the BIB and an extreme score (e.s.$> \pm .4333\sigma$) on the TOQ by theoreticians and/or therapists.

Hypothesis 3. There will be a significant positive relationship between the total number of potential and actual interpersonal experiences reported on the BIB and the degree of cognitive complexity as measured on the REP Test by theoreticians and/or therapists.

Hypothesis 4. There will be a significant positive relationship between the total number of potential and actual interpersonal experiences reported on the BIB and a medium score (m.s. $<$ A; m.s. $<$ B; m.s. = AB) on the A-B Scale by theoreticians and/or therapists (since the A-B Scale contains 23 items its mean is 11.5; with the standard error = $\sqrt{Npq}$ if N = 30 the standard error = 2.74; therefore, A = 15 or more, B = 8 or less, and AB = 9 through 14, inclusive).

Hypothesis 5. There will be a significant negative relationship between the total number of potential and actual interpersonal experiences reported on the BIB and an extreme score (e.s. = A; e.s. = B; A $\geq$ 15;

$B \leq 8$; c.s. $\neq$ AB) on the A-B Scale by theoreticians and/or therapists.

Hypothesis 6. There will be a significant postitive relationship between the scores at the experiential end of the TOQ (exp. $\leq -.4333\sigma$) and an "A" score ($A \geq 15$) on the A-B Scale by theoreticians and/or therapists.

Hypothesis 7. There will be a significant positive relationship between the scores at the analytic end of the TOQ (ana. $\geq +.4333\sigma$) and a "B" score ($B \leq 8$) on the A-B Scale by theoreticians and/or therapists.

Hypothesis 8. There will be a significant positive relationship between "A" scores ($A \geq 15$) on the A-B Scale and socially independent behaviors on the BIB by theoreticians and/or therapists.

Hypothesis 9. There will be a significant positive relationship between "B" scores ($B \leq 8$) on the A-B Scale and socially dependent behaviors on the BIB by theoreticians and/or therapists.

The following schematic diagram and equation is a summary of the hypothesized outcomes of this study:

social independent — BIB — social dependent
interpersonal experiences

experiential — TOQ — analytic
Sullivanian

"A" type — A-B Scale — "B" type

cognitive complexity — REP Test — cognitive simplicity

$$\cdot \; BIB = f(TOQ^{k} + CC^{m} + A\text{-}B^{q})^{n} + e$$

This equation states that some nonlinear function of the measures provided by the three instruments (TOQ, REP Test, A-B Scale) plus measurement error are accounted for by the

Biographical Information Blank, the fourth instrument.

Procedure

This section will explicate the details of the subjects to be studied to make inferences relative to the aforementioned hypotheses, the methodology to be used to implement this assessment, and the instruments with which the subjects will be assessed.

Subjects

Thirty male counselors and teachers of counselors with a variable number of years of post doctoral professional experience were drawn from the fields of education, psychology, psychiatry, social work, and rehabilitation counseling.

The sample was restricted as indicated for three reasons. First, the restriction to males will control the sex interaction variable noted as a contaminant in previous research in general and which has a particular effect upon one of the instruments of assessment. Second, most theoreticians and practitioners[1] of counseling are male. Third, experts, as they are defined by academic degree and years of experience, are expected to more clearly manifest the hypothesized characteristics than would those less expert and/or still in training,

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[1]Social work excepted.

as the experts possess more autonomy from social pressures which could contribute to the inhibition of expressing a point of view by the less expert.

Subjects were drawn from the local environment. The assumption made was that the University of Florida and its home city of Gainesville is shelter to as large an assortment, in theory and practice, of psychotherapists as one would find in the Southeastern United States. Since it was expected that a good number of these people would be represented in this research, a claim for representativeness of the diversity of viewpoints in the counseling field has been made. This is not to gainsay the lack of random sampling from the universe of counselors, counselor educators, and theoreticians which might have been included.

Methodology

A survey of professional and academic associations, area facilities, and knowledgeable recommendations was utilized to develop a register of the names of prospective subjects. These subjects were then contacted by telephone and in person and asked to participate in this research. They were approached in the vein of "co-experimenters" for they were, after all, the experts.

The research was explained to the subjects to the degree

that each was told the basic assumption that their life history determines their theory and practice and that an attempt was being made to isolate some of these determinants. Their agreement or disagreement with this point of view was solicited during the data collection.

In some instances, it was necessary to gather the data from each subject on an individual basis. However, whenever feasible, the data collection took place in small groups. Recognition of the nonsystematic bias interjected into the data collection by such nonstandard procedures is here noted, and its possible effects upon the outcomes of the research will be considered in the discussion of the results.

Since it was not possible to pay these "co-experimenters" for their valuable time and effort, and because of their assumed interest in the study's outcomes, they were offered a copy of a summary of the study when it was completed as well as an invitation to attend its oral presentation. For those individuals curious as to their individual scores on the particular instruments, they were instructed to code number their instrument packet and contact this investigator after scoring was completed. All participants were guaranteed the choice of anonymity.

Instruments

Four instruments were chosen to gather data relevant to

the hypotheses. These instruments were (a) the Therapist's Orientation Questionnaire, Form 1960, developed by Sundland and Barker, 1962; (b) the Construct Repertory Test following the work of Kelly (1955) as modified by Bieri, Atkins, Briar, Leaman, Miller, and Tripodi (1966); (c) the A-B Scale following the work of Whitehorn and Betz (1960) as modified by Betz (1967); and (d) a Biographical Information Blank constructed by the present author after the work of Glennon, Albright, and Owens (1966).

The Therapist's Orientation Questionnaire

The Therapist's Orientation Questionnaire, Form 1960, was developed by Sundland and Barker (see Sundland, 1960) to obtain a measure of psychotherapeutic orientation and to gather actuarial information relative to the methods and attitudes of practicing psychotherapists. Using therapy theories to construct controversial items, they administered their questionnaire to a sample of psychologists who listed psychotherapy as their primary occupation in the directory of the American Psychological Association. The questionnaire based on these replies contains 94 items which are grouped into 16 scales of attitudes and methods. The 16 subtests yielded six factors and a general factor labeled analytic versus experiential. The subtests were used to characterize

the methods and attitudes of the sample and three major therapy orientations were described, orthodox analytic, Sullivanian, and Rogerian.

Subjects were asked to respond to each item, which is couched in the form of a declarative statement, by indicating their relative degree of agreement or disagreement by checking one of five positions on a Likert type scale.

The thrust of the present study requires the dimensioning of the respondant's therapeutic orientation along the analytic-experiential continuum. This task was accomplished by defining each of the three orientations as though it occupied 33.3% of the continuum. Assuming a normal array of scores, one is able to define the three orientations thus: analytic $\geq +.4333\sigma$; experiential $\leq -.4333\sigma$; $-.4333\sigma <$ eclectic midrange $< +.4333\sigma$.

It was expected that this instrument would yield adequate behavioral data to differentiate therapeutic procedures though it is noted that this method is at best inferential in nature and, therefore, less accurate than direct observation and rating of ongoing therapeutic interactions.

The Construct Repertory Test

The Construct Repertory Test, abbreviated REP Test, has been used to assess the degree of complexity of a person's

construct system with which, it is assumed, one construes the world. Bieri (1961) reviewed a number of studies of the complexity-simplicity dimension as a personality variable. A structural concept of personality, which emphasizes both the process used and the manner in which various types of organizations of these constructs lead to either more or less efficient anticipation and prediction of the social environment, cognitive complexity (CC), reflects relative differentiation of a person's construct system. This is presumed to mediate perception of others and anticipation of their behavior; the cognitively complex person has more constructs to construe others' behavior than does the cognitively simple. Studies show that those persons who are high on CC are better able than low CC persons to predict others' behavior, predict others as being different from themselves, judge others' attitudes toward authority, and to show social intelligence. High CC persons, in relation to persons relatively lower on the dimension measured stress differences rather than similarities, are less likely to change an attitude or behavior in light of new information and also are more moderate in and show less confidence in their judgments. The relative degree of complexity a person shows is not uniform across all stimulus domains. Crockett (1965), in his discussion of cognitive complexity and impression formation, said, among other things,

that the impressions formed from a standard set of stimulus information suggest that perceivers use an "implicit personality theory" to predict their own and others' behaviors and that this theory is a cognitive system composed of interpersonal constructs whose degree of complexity relates to the number of extended inferences the perceiver makes relative to attributes not observed. The complexity depends upon the number of elements as well as the hierarchial integration which is a developmental, i.e., learning, process. Those valuing interpersonal relations should have more complex systems than those less valuing, but any individual may show differential complexity relative to different categories of people depending upon the context of his interaction with them. Research supports the contention that high CC people more than low CC people use both favorable and unfavorable information in their descriptions of acquaintances and are able to entertain the possibility of unbalanced interpersonal relationships. Additionally, high CC persons are able to view others ambivalently and assimilate contradictory information into a unified impression. This is another way of defining what in other contexts has been called "tolerance for ambiguity." The relative differences are limited by differential experiences with categories of people as well as by values and motivational states. Bieri,

Atkins, Briar, Leaman, Miller, and Tripodi (1966) summarized the CC and judging research. For our purposes it is relevant to note that low CC judges show greater discriminability as the dimensionality of the stimulus increases when the additional dimensions are congruent with the previous information. High CC judges, on the other hand, are more certain of judgments of incongruent information and discriminate among it better. Therefore, the internal structure and the sequential mode of presentation are important also. High complexity judges are "set" to seek diversity in terms of the social environment; low complexity judges prefer to emphasize regularity and recurring uniformities.

The modified group version of the REP Test will be employed in this study.

> Each judge is presented with a 10 x 10 grid. Each of the ten columns is identified by a different role type selected to be representative of the meaningful persons in the judge's social environment. The ten rows of bipolar constructs which are provided were selected on the basis of being representative of the dimensions elicited from college-trained subjects. After the judge has listed the name or initials of each of the ten persons who best correspond to the ten role types, he is instructed to use a six-step Likert-type scale in rating all ten persons he has listed on the first provided construct. For example, the first construct dimension is "outgoing-shy." Each judge rates each of the ten persons on a scale of +3 (outgoing) to -3 (shy). Following this, the judge rates all ten persons on the second construct dimension and so on through all 10 rows. Thus each subject makes ten ratings for each of the role types, for a total of 100 ratings.

> Cognitive complexity is measured by comparing each rating in a row with the rating directly below it (i.e., for the same person) in the other rows on the matrix. In comparing any two construct rows, a score of one if given for every exact agreement of ratings on any one person. This matching procedure is carried out for all possible comparisons, and the scores for each comparison are added to give one total score. Since there are 45 possible row comparisons in a 10 x 10 matrix, the highest possible score is 450. A score of 450 would indicate that the judge gave the same rating on all bipolar constructs to all of the role types. This judge would be relatively congitively simple because he is using his construct dimensions in an identical manner to construe all the individuals on the grid. On the other hand, a person with a score as low as 100 is presumed to be relatively cognitively complex because he uses constructs differently in discriminating among people (Bieri et al., 1966, pp. 190-191).

Because the position presented herein could be characterized as a cognitive one (cf. Kelly, 1955; Levy, 1968), it was expected that a measure of cognitive complexity would yield important information in relation to therapists' preferred theories as a personality theory is, after all, a way of predicting others' behavior.

The A-B Scale

The A-B Scale developed by Whitehorn and Betz in the early 1950's and used extensively in research since then (Whitehorn & Betz, 1960; McNair, Callahan, & Lorr, 1962; Carson & Harden, 1964; Betz, 1967; Berzins & Seidman, 1969) is a 23-item instrument derived from the Strong Vocational Interest Blank. It has been empirically determined that

psychotherapists called "A" type therapists respond to the 23 items differently than do those psychotherapists called "B" type therapists, and that "A" therapists more successfully treat schizophrenic patients while "B" therapists are more successful assisting neurotic individuals. No differential therapeutic outcomes are reported for a third group of therapists whose responses to the scale lie midway between those of the other two groups; the therapists who respond thus are called "AB" types. As the above cited research has been discussed on pages 10 through 17, it will not again be reviewed here.

Since we desired to separate our sample of therapists on the A-B dimension, we assumed the dimension to have an underlying distribution of scores that was both normal and continuous and, thereby, was able to define the three types of therapists in terms of the standard error as follows. The mean of a 23-item scale with scores normally distributed about the mean is 11.5. The standard error of measurement is computed by taking the square root of the product Npq. With N equal to 30 and p equal to q equal to $\frac{11.5}{23}$, the standard error is equal to 2.74 (std. err. = $\sqrt{Npq}$ = $\sqrt{30 \times \frac{11.5}{23} \times \frac{11.5}{23}} = 2.74$). Therefore, type "A" therapists were herein defined as those therapists who responded to the

A-B Scale by choosing 14 or more of the 23 items shown to select "A" type counselors in previous research. "B" type counselors would select 8 or fewer "A" type responses (i.e., they will select 15 or more "B" type responses). "AB" type therapists would choose between 9 and 14 "A" type responses inclusive. Briefly, A = M + 1 std.err. and B = M - 1 std.err. while - 1 std.err. $\angle$ AB $\angle$ + 1 std.err. The probability of anyone obtaining a type "A" or a type "B" rating by chance is less than 1 in 100.

Little integration of the empirical findings obtained with the A-B Scale has been made with theories of personality and counseling. The findings do support the efficacy of matching patients and therapists at least along the specific dimension of interests and perhaps more generally in "style of living." It was included here as an empirical finding for which theoretical understanding is being projected.

The Biographical Information Blank

The Biographical Information Blank had been constructed by the author along the lines laid out by the Research Conference On the Use of Autobiographical Data as Psychological Predictors sponsored by the Creativity Research Institute of the Richardson Foundation and held at the Sedgfield Inn, Greensboro, North Carolina, June 10-11, 1965, with Edwin R. Henry as chairman.

It has long been a dictum in the behavioral sciences that the best single predictor of future behavior is past performance. Due to its efficacy as the "single best predictor" (Henry, 1965), in combination with the growing awareness that the limit of statistical prediction may well have been reached with standardized tests, and prodded as well by the generalized reaction on the part of the public and the federal government that is antithetical to testing, the Biographical Information Blank (BIB) has grown in popularity. Many psychological theoreticians have long contended that a person's past determines his future (Freudians and behaviorists). Others (phenomenologists, Gestaltists, and existentialists) contend that present experience is the determining factor in behavior but still admit to the effect of the past on the future when they find the locus of perceptual distortion in the no-longer-viable expectations of the perceiver.

The BIB used herein had been constructed by selecting from A Catalog of Life History Items (Glennon, Albright, and Owens, 1966) those questions which bore some theoretical relationship to one or more constructs in the various systems of personality and counseling as well as items whose predictive validity has been empirically established. These items met criteria established by Owens and Henry (1966).

After a review and evaluation of the use of biographical data in industrial psychology, of both theoretical formulations and empirical research, they established the following criteria to maximize validity and reliability of biographical items: (a) brevity, (b) numeric gradation to define options and alternatives, (c) total coverage of all response options, and (d) neutral or pleasant item conotation.

Each item had been keyed *a priori* to yield measures of (a) potential and actual interpersonal experiences, (b) attributes that have the supposed potential of producing an "A" type or "B" type therapist, and (c) descriptive data for identification and categorization.

Potential and actual interpersonal experiences were thought to be assessed by those items which indicate that the subject was confronted by interpersonal situations demanding his attention. This obviously is a relative measure as everyone faces greater or fewer of these. Therefore, comparisons were to be made between, for example, urban and rural living, as a child with urban-living experience will rate higher than his rural counterpart in the number of potential and actual interpersonal situations with which he has been confronted. The words potential and actual were given equal weight as modifiers of the concept interpersonal experience, as the assumption was made that the chosen

situations (e.g., some siblings--no siblings, many changes of residence--no changes of residence) in comparison to both their opposites do indeed provide, on the average, more interpersonal experiences. However, any single instance may contradict this assumption. The interpersonal experiences assessed by the BIB had been assigned weights of zero, one, two, and three.

The attributes of "A" type and "B" type therapists, culled from the literature, had been labeled herein social-independent-nonconforming and social-dependent-conforming, respectively. A number of the descriptive items of the BIB had been keyed to be scored either as indicating its conduciveness to "A" type or "B" type individuals or to the "AB" interface. For example, the response to the religious preference or a personal religion is noted. In general, the rule followed was one of defining the average as a "B" type response and the atypical as an "A" response. Even the height and weight items are scored subject to this rule which in this particular instance relies on the Statistical Abstract of the United States for average height and weight tables for the middle 50 percent of the population.

The descriptive data, which was otherwise uncoded in most cases, referred to habitual practices (e.g., smoking) or to persons and/or situations only passively involving the

subject (e.g., father's education). Many of these items not controllable by the subject have been shown nevertheless to be potent predictors in certain research and were, therefore, included here.

Since theorizing about and practicing psychotherapy is clearly a human behavior, it was expected that the BIB would account for some of the variance in the choice of the theory and practice modes of counselors.

It is worth noting here, parenthetically, that the direct "paternity" of this instrument's use for the herein described purposes was a study by Sherwood and Nataupsky (1968). They successfully accounted for 30 percent of the variance in the conclusions of the scientists who had conducted studies of Negro-white intelligence test differences. It was found that seven biographical items supplied by the researchers allowed a clear differentiation of those who tried to account for observed intelligence test differences by reference to differing environments and those who attempted to account for the same observed differences by reference to presumed hereditary differences.

Treatment of the Results

The hypotheses were tested in the following manner.

Hypotheses 1 and 2 were tested by computing the F ratio using the fixed effects, simple (one-way) unbalanced analysis

of variance model classifying the frequencies of interpersonal experiences of the subjects obtained from their BIB scores by their group affiliation obtained from their analytic-experiential score on the TOQ.

Hypothesis 3 was tested by computing a Pearson product-moment correlation coefficient between the cognitive complexity scores and the frequencies of interpersonal experiences from the REP Test and BIB, respectively.

Hypotheses 4 and 5 were tested by computing the F ratio using the fixed effects, simple (one-way) unbalanced analysis of variance model classifying the frequencies of interpersonal experiences of the subjects obtained from their BIB scores by their group type obtained from their A-B Scale score.

Hypotheses 6 and 7 were tested by computing a Pearson product-moment correlation coefficient between the score on the A-B Scale and the score on the TOQ.

Hypotheses 8 and 9 were tested by computing a Pearson product-moment correlation coefficient between the score on the A-B Scale and the social-dependent-conformity/social-independent-nonconformity score on the BIB.

The significance of the statistics computed above was evaluated by means of a one-tailed test with alpha set at .10. The rationalefor the use of such a "loose" rejection rule is simply that the researcher was primarily interested in

identifying any relationships which might exist, even at the risk of misinterpreting a sampling anomaly. That is, with such a small and geographically restricted sample, it was deemed most important to minimize type II errors.

Additionally, stating directional rather than non-directional hypotheses usually implies some knowledge from theory and empirical research supporting the point of view the hypotheses represent. In other words, doctrinaire orientations as well as data lend credence to the use of directional hypotheses. In this research, the review of related literature supports the claim to the right to make statements of relationships, i.e., hypotheses, of particular concern while ignoring alternative relationships.

Hays (1963), in discussing the relative merits of one- and two-tailed tests, suggests that "In deciding whether a hypothesis should be tested with a one- or two-tailed rejection region, the primary concern of the experimenter must be his original question. Is he looking for a directional difference . . . or a difference only in kind or degree?" (p. 285). Hays is also of relevance here when he says:

> The powers of one- and two-tailed tests of the same hypothesis will be different, given the same α level and the same true alternative. If a one-tailed test is used, and the true alternative is in the direction of the rejection region, then the one-tailed test is more powerful than the two-tailed over all such possibly true values of μ. In a way, we get a little

> statistical credit in the one-tailed test for asking a more searching question. On the other hand, if the true alternative happens to be on the tail opposite the rejection region in a one-tailed test, the power is very low . . .. If you will, we are penalized for framing a stupid question (p. 285).

CHAPTER IV

RESULTS

Descriptive Data of the Sample

The first 30 "co-experimenters" to return the completed packets of instruments compose the subjects from whom the following results were obtained. All the subjects held either teaching or direct service positions with the University of Florida. Since their cooperation had been solicited, in person, by the investigator, in their natural work groups, this tended to facilitate their initial volunteering, as this writer had obviously obtained the tacit support of the particular groups' supervisor to be able to address them en masse in the first place. The enthusiasm to participate apparently dwindled as each volunteer faced the instruments in privacy. At the end of three months, only 30 of the 43 packets distributed had been returned, although weekly inquiries in person had been made to the departments concerned.

The groups whose members supplied the data to test the hypotheses, the number who volunteered to participate, and the number and percentage returning the completed instruments

are shown in Table 1.

TABLE 1

Subjects' Professional Affiliation, Number Volunteering to Participate, and Number and Percentage Completing Instruments

Participating Group	Number of Volunteers	Number Completing Instruments	Percentage Completing
Department of Clinical Psychology	10	3	30
Department of Counselor Education	10	8	80
Department of Rehabilitation Counseling	3	3	100
Reading Laboratory and Clinic	2	2	100
Student Mental Health Services	10	6	60
University Counseling Center	5	5	100
Miscellaneous[a]	3	3	100
Total Group	43	30	69.7

[a]Persons from the Departments of Psychology and Special Education.

While no claim is made for this sample of theoreticians/ teachers/ counselors to be representative of anything but themselves, Table 2 shows that the sample includes a wide range of ages, academic backgrounds, experience, and responsibilities. The most glaring weakness of the sample's representativeness

apparent from Table 2 is the underrepresentation of counselors holding the M.D. degree and the underrepresentation of persons of all academic backgrounds whose professional commitment is primarily to research and theorizing.

Descriptive and Sampling Data of the Instruments

Table 3 presents the possible range and mean scores of the four assessment instruments as well as the observed range, mean, and standard deviation of the scores on each instrument made by the above described 30 participants.

It is particularly important to note the restricted range of scores observed in comparison with the potential distribution. While the A-B Scale potential range, 0 to 23, is reasonably represented by the observed range of scores, 6 to 19, the Therapist Orientation Questionnaire range of observed scores, 224 to 332, is less than one-quarter that of its potential range, 93 to 465. In like manner, the Construct Repertory Test range of observed scores, 86 to 249, is less than half that of its theoretical range, 40 to 450. In this case, however, it must not be overlooked that the high educational level obtained by the sample whose major expertise is human interaction would alert us to expect relatively high cognitive complexity scores in the interpersonal realm. Similarly, while the Biographical Information Blank score range of its observed A-B measures adequately covers the

TABLE 2

Thirty White Male Subjects by Age, Degree, Years of Experience, and Primary and Secondary Responsibility

Age[a]			Degree[b]			Experience[c]		
Mean	Medium	Range		N	Mean Age	Mean	Medium	Range
41.42	42.00	28-56	Ph.D.	19	33.10	8.32	5.00	0-20
39.13	36.50	29-55	Ed.D.	8	30.50	8.63	5.50	1-18
45.33	46.00	37-53	M.D.	3	24.30	21.00	25.00	11-27

[a]Age in years.
[b]Last academic/professional degree earned and average age when received.
[c]Years of practice since receiving last degree. This disregards experience prior to receipt of degree.

TABLE 2

(Extended)

Responsibility[d]							
%Teaching & Supervision		%Counseling		%Administration		%Research & Theory	
I	II	I	II	I	II	I	II
N	N	N	N	N	N	N	N
(12)	(5)	(6)	(4)	(3)	(3)	(0)	(6)
57.50	29.00	53.33	27.50	45.00	28.33	0.00	29.16
(4)	(2)[e]	(3)	(1)	(1)	(1)	(0)	(3)
87.50	20.00	70.00	15.00	75.00	20.00	0.00	18.33
(1)	(1)[e]	(1)	(1)	(1)	(0)	(0)	(0)
60.00	30.00	100.00	30.00	60.00	0.00	0.00	0.00

[d]Percentage of total professional time devoted to each activity as I = primary and II = secondary responsibility by number who participate.

[e]In two instances, community involvments were noted next to one of the four activities selected as secondary. These were added to the main categories.

TABLE 3

Theoretical Range and Mean of Scores and Observed Range, Mean, and Standard Deviation of Scores for the 30 Subjects on the Four Instruments

	A-B Scale[a]	TOQ[b]	REP Test[c]	BIB[d]		
				f	A	B
Theoretical						
Range	0 - 23	93 - 465	40 - 450	0 - 79	0 - 22	0 - 22
Mean	11.50	279.00	205	39.00	11.00	11.00
Observed						
Range	6 - 19	224 - 332	86 - 249	23 - 42	5 - 16	6 - 17
Mean	11.14	275.43	151.43	33.43	8.98	13.00
Standard Deviation	3.34	24.84	35.23	5.08	2.53	2.57

[a] Scores above mean called "A"; scores below mean called "B".
[b] Therapist Orientation Questionnaire; high scores indicate "analytic" orientation; low scores indicate "experiential" orientation to counseling.
[c] Construct Repertory Test; low scores indicate relatively greater degrees of "cognitive complexity" than high scores.
[d] Biographical Information Blank; f is the frequency of interpersonal experiences, A is the "social-independent-nonconformist" behaviors and B is the "social-dependent-conformist" behaviors.

potential range (observed "A" range 5 to 16; observed "B" range 7 to 17; potential range of "A" and of "B" 0 to 22), the observed range of scores for the frequency of interpersonal experiences, 23 to 42, is less than one-fourth that of its potential range, 0 to 79. As we shall see, this has particular implications for testing the hypotheses as originally planned.

Testing the Hypotheses

Hypotheses 1 and 2 stated that a relationship would exist between the frequency of interpersonal experiences reported on the Biographical Information Blank (BIB) and the orientation to counseling as measured by the Therapist Orientation Questionnaire (TOQ) such that those persons with extreme orientations would have experienced significantly fewer interpersonal experiences than would have those persons scoring in the middle therapeutic orientation group.

As planned, these hypotheses were evaluated with the fixed effects, simple, unbalanced analysis of variance (Hays, 1963), and the results are shown in Table 4.

With the alpha level set at .10, the probability of obtaining this F ratio lies between .75 and .90 or between 25 percent and 10 percent of the area under the F curve (Owen, 1962). That is, chance alone dictates the occurrance of this large an F ratio from 10 to 25 times in every 100

randomly drawn samples. Therefore, no support for research hypotheses 1 or 2 is apparent in the data, and the alternative hypotheses of no relationships are accepted.

TABLE 4

Therapist Orientation Questionnaire
X
Frequency of Interpersonal Experiences

Source	Sum of Squares	d.f.	M.S.	F
Therapeutic Orientation (between groups)	82.88	2	41.44	1.62
Error (within groups)	690.48	27	25.57	
Totals	737.37	29		

Hypothesis 3 suggested that a positive relationship would exist between the number of interpersonal experiences reported on the BIB and the degree of cognitive complexity (CC) measured in the interpersonal realm by the Construct Repertory Test (Rep Test). As planned, a Pearson product-moment correlation coefficient was computed, the results of which lend support to the hypothesized relationship. Table 5 shows the computed r equal to .2834. Although this accounts for somewhat less than 9 percent of the total variance in the relationship, it is judged significant as the critical ratio

of 1.5269 indicates a correlation of this magnitude would occur by chance alone about six times in 100 random samples by a one-tailed significance test when alpha is set equal to .10. Therefore, the research hypothesis is tentatively accepted.

TABLE 5

Cognitive Complexity
X
Frequency of Interpersonal Experiences

r	o_r	z	p	Variance accounted for
.2834	.1856	1.5269	.064	.08

Hypotheses 4 and 5 asserted that there would be a relationship between the BIB reported frequency of interpersonal experiences and the A-B Scale scores of the sample such that "AB's," the middle group, would report relatively more interpersonal experiences during their life than either those persons scoring "A" or those scoring "B". The results of the planned analysis of variance appear in Table 6. The F ratio indicates there is no support for the hypotheses to be found in the data, and the alternative hypotheses of no relationship are accepted. Since alpha is set at .10, the probability of this F ratio is not in the lower tail of the F distribution.

Hypotheses 6 and 7 stated a relationship would exist

TABLE 6

Frequency of Interpersonal Experiences
X
A-B Scale Score

Source	Sum of Squares	d.f.	M.S.	F
A-B Score (between groups)	18.77	2	9.38	.3357
Error (within groups)	754.60	27		
Totals	773.37	29		

between the subject's A-B Scale score and his score on the TOQ. No support was found for these hypotheses as is immediately apparent from Table 7 which summarizes the results of the planned, Pearson product-moment correlation coefficient computation. When the alpha is .10, the probability of an r equal to or greater than .0224 is .99. Therefore, we reject the research hypotheses and accept the alternative null hypotheses of no relationship.

The final hypotheses, 8 and 9, indicated that scores of A and B from the A-B Scale would be predictable from the BIB items labeled "socially independent" behaviors and "socially dependent" behaviors.

A Pearson product-moment correlation coefficient was computed as planned, the results of which are summarized in

TABLE 7

Therapist Orientation Questionnaire
X
A-B Scale Score

r	σ_r	z	p	Variance accounted for
-.0224	.3012	.0079	.99	.005

Table 8. Indeed, a significant relationship does exist between the two variables and accounts for more than 22 percent of the total variance, but that relationship is opposite from that originally hypothesized. An alpha of .10 is greatly exceeded by this r of -.4696 for which the probability of occurrance by chance alone is less than .005 by a one-tailed test. Therefore, reject the research hypotheses and reject the alternative null hypotheses of no relationship, and accept, instead, the reverse hypothesized relationships.

TABLE 8

A-B Scale Scores
X
Biographical Information Blank A/B Scores

r	σ_r	z	p	Variance accounted for
-.4696	.1856	-2.5301	.005	.220

Discussion and Implications of the Results

The failure to confirm hypotheses 1 and 2 might be due to a number of reasons, at least two of which suggest themselves to this writer. First of all, it may very well be that the hypotheses in question are simply in error. If this be true, it seriously undermines the rationale of the rubric, the counselor's personal theory. Secondly, a technical difficulty involving the sample and/or the instruments may have obscured the existing relationship. Evidence to support this position will be immediately offered.

In line with the latter proposition, it was earlier noted that the range of TOQ scores of this sample was highly restricted in comparison with the possible range of scores. Reference to Table 2 indicates that these 30 subjects used less than one-fourth of the possible range of the scale in describing their orientation to counseling. While Sundland's (1960) data used to develop the TOQ approached a nationally representative sample, the present subjects, though of divergent geographical and educational backgrounds, are presently members of the same university community. In accord with the overall deterministic position of this paper, we must assume that more than "chance" was involved in their selection of their present employment. Additionally, and covariant with this, is the possibility that a prevailing mini-Zeitgeist

pervades this academic/intellectual community whose location does not afford the intellectual diversity of a metropolitan environment.

More positive, yet still indirect, evidence for the relationship of therapeutic orientation and interpersonal experience exists, however. As hypothesis 3 was confirmed, the relationship between the frequency of interpersonal experiences and the degree of cognitive complexity prompted further analysis not originally planned. Consequently, a Pearson r was computed between the TOQ and CC scores and a correlation of .2851 was recorded. A critical ratio computed at 1.536 suggests that this correlation may be considered significant at the .063 level of significance using a one-tailed test.

It is interesting to note that high cognitive complexity is associated with the experiential end of the TOQ and relatively lower cognitive complexity is associated with the analytic position. This seemingly contrasts with Chapline's (1964) findings, reviewed above, which indicated that high cognitively complex subjects give more evaluative responses to clients while low cognitively complex subjects respond to clients with more understanding type responses.

Although the correlations represent relationships rather weaker in degree and less assured of deviation from chance

occurrence than one would like, the small size and geographically restricted sample combined with the dual relationship of cognitive complexity and TOQ and cognitive complexity with the frequency of interpersonal experiences argues in favor of pursuing with a more adequate sample the TOQ and frequency of interpersonal experiences relationship. Additionally, it is unrealistic to expect large correlations, for example on the order of .60 to .80, to occur, as the theory predicts that background contributes to, but does not fully account for, variation in orientation. The training institution, the research literature, the personality of the supervisor and of fellow students and colleagues are all unmeasured inputs which should be reflected in a therapist's orientation. Finally, as already noted above, the imprecise instruments used have a restricted range within this sample.

In line with this but somewhat broader in scope is one of the two basic assumptions underlying this study; namely, that a person's life history determines, in part, his behavior as a counselor. This led the writer to perform an item analysis of the BIB based on the assumed differentiation afforded by the TOQ.

It was decided that initially a predictive efficiency of 66.6 percent would be pursued in attempting to separate via the BIB those scoring at the analytic end of the TOQ from

those scoring at the experiential end of that measure. Consequently, the 30 subjects were divided at the mean of the TOQ and separate tallies made of their responses to the multiple-choice items on the BIB. This produced a BIB with questions tallied by analytical respondents and a BIB with questions tallied by experiential respondents. These tally sheets were then compared question by question, choice by choice. Using the formula $a/a+b \geq .666$, where a is the total number of responses per choice for either group and b the total number of responses per choice for the other group, any choices to which responses equalled or exceeded the established ratio were labeled as either A, analytic, if the a of the numerator of the formula was derived from the tallies on the analytic BIB tally, or E, experiential, if the a of the numerator of formula was obtained from the experiential BIB tally.

This analysis has yielded a BIB of 56 items which is only a rough first approximation and needs cross validation upon a different and geographically disperse sample.

A similar item analysis has been carried out on the BIB hoping to be able to distinguish low from high cognitive complexity. Thus far, 49 items have been tentatively identified as potential discriminators.

For these reasons, hypotheses 1 and 2 will not be abandoned immediately but will form the basis for further research.

Hypotheses 4 and 5 predicted a relationship would exist between the BIB measured frequency of interpersonal experiences and the A-B Scale score such that a significantly larger frequency would be associated with "AB" scores than with either "A" or "B" scores. This hypothesis was based on the assumption that both "A's" and "B's" had had differing experiences and with a relatively limited number of people while "AB's" would have had more and varied experiences with people and, therefore, they would have developed a more balanced approach to them. Undoubtedly, what this assumption overlooked was that the A-B Scale is, after all, derived from a measure of vocational interests and the items within the scale may only bear a secondary relationship, if any, to interpersonal experience. These hypotheses were not confirmed, as the data of Table 6 illustrate.

Hypotheses 6 and 7 predicted a relationship between A-B Scale scores and TOQ scores such that "A's" would score at the experiential end and "B's" at the analytic end. This was predicated on the assumption of psychoanalytic theory in its classical form which was a method for treating neurosis and not psychosis. Additionally, a variety of information ranging from the Wisconsin psychiatric studies of Rogers and his co-workers to the literature reporting successful work by lay therapists using the "relationship" and related

techniques to treat hospitalized schizophrenics led to the predicting of this relationship which the data failed to confirm.

Apparently, the A-B Scale is independent of these measures, or one or more of a variety of factors is obscuring any relationship that may exist.

The final hypotheses, 8 and 9, concerned the underlying developmental aspects of the A-B Scale. From the impression one gains from a knowledge of the scale items and from an understanding of the behavior and presumed dynamics of psychotic and neurotic persons, the A-B success evidence was combined with the concept of patient-therapist similarity as therapeutically efficacious to predict a positive relationship between "A" scores from the scale and "socially independent" behaviors from the BIB. Similarly, "B" scores were thought to be related to "socially dependent" behaviors illustrated by BIB responses.

Statistical analysis revealed a strong relationship existed between the variables which was highly unlikely to be a product of sampling error. However, the negative correlation obtained indicated the relationship to be the opposite of that predicted. Thus, in the relationship of these two variables,at least, the assumption of similarity is not tenable.

An explanation favored by this writer is that in this particular situation the differential success of the A-B variable to predict therapeutic outcomes with different diagnostic groups of patients may well be due to the factor of complementarity of counselor and client wherein the counselor is able, through the relationship, to offer a model of the intra- and interpersonal skills the client lacks. This explanation is congruent with the various behavior modification approaches which emphasize the therapeutic value of teaching the client skills with which he may more adequately deal with his world. In a sense, it is not too far fetched to think of "A" therapists and "B" therapists as general "A programs" and "B programs." "AB" therapists, the group that the literature has shown to exhibit no differential therapeutic effect relative to the client they are counseling, may not offer a clear enough model of the particular social skills involved for rapid acquisition by a client.

Limited support for the explanatory concept of complementarity between "A" counselors with schizophrenic clients and "B" counselors with neurotic clients is to be found in Berzins, Seidman, and Welch (1970), reviewed above. Among their findings, they report that satisfaction ratings by counselors with their clients varied inversely with the subjects' perceived similarity to the patient.

If complementarity rather than similarity of client-counselor dyads is closer to the true explanation of the differential success, then we begin to gain a little understanding of the development and typical behaviors (personality) of therapists so dichotomized. In this investigation, the BIB has allowed us to think of the "A" type therapist as the "socially dependent conformist" person and the "B" type therapist as the "socially independent nonconformist" individual.[1] It may be that the former can lend a few external anchors to the schizophrenic person, who doesn't trust the physical realities, by modeling a person who very obviously takes his cues to behave from the field of experience "out there." Conversely, the "B" type therapist can help shake loose the over-anchored, neurotic individual by modeling a person who is able to listen to himself, ignore some of the field, and still not be "destroyed." Here one is reminded of Anzel (1970), reviewed above, who noted in her research findings studies which have shown "A" type persons to be more field dependent than "B" type persons.

Speculation leads this writer to suggest that the "AB" type therapist, which research has shown to yield no differential success related to diagnostic category of client, may

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[1]Neither of these appellations is meant to be pejorative.

have integrated the qualities of field dependence and independence to a degree just great enough to cause a client, searching for stability, to perceive said therapist, at least initially, as an enigma, thus precluding rapid change through modeling. At the same time, the literature offers no evidence that the "AB" therapist is responsible for poorer therapeutic outcomes than his "A" and "B" type counterparts (see pages 10-17). If we then presume the reported lack of differential success implies the "AB" type counselor is as good with either group, he must be offering other qualities important to client outcome. This offers interesting research possibilities not, to this writer's knowledge, yet pursued.

As the superordinate raison d'etre of this investigation was to attempt to define the vaious life experiences leading to specific counseling theories and practices, and since graduate education is reputed to be one of the formative influences in this direction, one further analysis of the data was undertaken.

Table 9 exhibits the distribution of responses to questions 13, 14, 15, and 16 of the BIB which deal specifically with education and training. An interdependent scoring system was devised wherein each response was evaluated against the responses to the other questions on the basis of agree or disagree for each subject. For example, if the response to

question 13 was client-centered and to question 14 was Freud, this was scored as a disagreement. On the other hand, if one responded to question 14 with the name Maslow and to question 15 with humanistic, this was scored as agree. Responses such as "eclectic," "none," "many," etc., were always scored as agree among questions 13, 14, and 15 and always scored as disagree between question 16 and the other three.

The similarities and differences are so outstandingly obvious from mere inspection of the table that no statistical test of frequency differences was applied.

What does Table 9 tell us? Comparing questions 13 and 14, we find that, not surprisingly, the subjects see their orientation to counseling as similar to that of the author most influential with them and this is true five times as often as its converse.

In comparing the subjects on questions 13 and 15, we find almost an even division between those who subscribe to an orientation similar to that of their training institution and those who subscribe to an orientation different from the one in which their graduate education was couched. This has, perhaps, a variety of meanings. It may be that departmental orientations are irrelevant to those which their students assume over the years. Growth and change occur in therapists as well as clients. These data could also be construed to

TABLE 9

Frequency of Responses of BIB Questions 13,[a] 14,[b] 15,[c] 16,[d] Tallied as Either "Same" or "Different," as Measures of Counseling Orientation for 30 White Male Participant Counselors

13 = 14	13 = 15	15 = 16	14 = 15	14 = 16	13 = 16
25	14	6	14	2	2
13 ≠ 14	13 ≠ 15	15 ≠ 16	14 ≠ 15	14 ≠ 16	13 ≠ 16
5	16	24	16	28	28

[a] 13. To what school or theory of personality and behavior change do you subscribe?

[b] 14. What author's writings have most influenced your thinking about the practice of counseling/psychotherapy?

[c] 15. To what school or theory of personality and behavior changing did your training institution subscribe?

[d] 16. With what schools of counseling/psychotherapy do you take issue?

indicate support for the orienting power of education, as 50 percent of the students follow the position in which they were trained while the other half are dispersed over 10 or 15 other therapeutic positions. It certainly contradicts the oft heard complaint of "brain washing" leveled by beginning students at counseling professors; or, at least, it does not support the long-term effects of such alleged manipulation.

Comparison of question 15 with 14 shows, as did the comparison of 15 with 13, an even division of influence between personally influential authors and training program commitment, and similar commentary is relevant.

Questions 15 and 16 indicate that one-fourth of this sample oppose the very therapeutic position their training institutions promulgated.

Initially, tallying responses to the comparison of question 16 with those of questions 13 and 14 seemed to be logically absurd. Nevertheless, it was done pro forma and produced the surprising result that two subjects managed to indicate that they took issue with the very school of thought to which they subscribed and with the authors who they deemed most influential. This writer suggests that either finer distinctions in position were being made by these two respondents than was evident in their answers or they represent an extreme position in self-examination and open-mindedness.

In toto, these data indicate that education certainly is important to the formulation of a counseling theory and practice, but perhaps this education is more self-education through the available literature and informal experiences and produces as effective or, at least, as viable a counseling orientation in theory and practice as does the formal, instructor-presented, institutionalized outlook. At least, in some instances, students will take their degrees and then oppose the very outlook the degree in part represents. Or, perhaps, this is the only way to articulate one's opposition to the particular presenters of a theoretical position.

Education, both formal and informal, is part of one's biography, and the singling out of these four questions for detailed analysis was not meant to place undue emphasis on them. Rather, it is thought that some supporting data have been offered to point to a broadly based, eclectic position in all counselor education as offering more to the most often heterogenous student bodies rather than the all too often closed, dogmatic orientations taken by the many institutions preparing professional counselors in medicine, psychology, education, social work, etc.

Some Possibilities for Future Research

Research, it is often said, generates as many questions

as it answers. This study was no exception. The following are by no means all of the possibilities suggested here but merely a brief notation of three.

Whether or not the BIB is capable of predicting the TOQ score at more than trivial levels remains to be seen. Sundland and Barker (1962) report 16 subtest scores which compose the total score of the TOQ. Perhaps the BIB has differential predictability for each subtest? When this is known, a more powerful prediction will be possible from the BIB to the TOQ. When this tool becomes available, research into the efficacy of mixing and matching clients and counselors as well as students and advisors in counselor education programs might be undertaken.

Is the A-B variable really independent of therapeutic position? At this moment, it seems to be. If this proves to be the case, revisions in both the theory and "myths" of therapy are in order. Along with the "facilitative conditions," the A-B typing, identifying relative field dependence/independence, as well as the preferred intellectual conception of human behavior, its development and alteration, isolated by the BIB, should make the totality of counseling/psychotherapy more controllable. In other words, independent predictors of successful therapeutic outcome will be powerful aids in assigning clients to counselors.

What is the form of the relationship among these variables? A theoretical question, it has the potential of leading to the formulation of a new encompassing theory of human learning and behavior changing.

CHAPTER V

SUMMARY

The general problem examined by this dissertation was the following: With the myriad theories of learning and the process of behavior changing, personality development and counseling and psychotherapy extant, and assuming some merit in all of them, how does one go about either choosing or developing the most appropriate one for one's own use as one becomes a professional counselor. An extensive review of the literature led to the conceptualization of this problem under the rubric, The Counselor's Personal Theory. The major proposition from which the hypotheses tested were derived is that the theory and practice of counseling is the articulated intellectual understanding the counselor has of his own development and successful life patterns formally stated as a theory of human behavior and development and implemented in practice by the counselor who helps the client find more effective ways of dealing with his internal and external worlds.

Thirty practicing counselors and teachers of counselors all of whom had obtained the doctorate, voluntarily completed

four instruments designed to assess their theory and practice of psychotherapy (Therapist Orientation Questionnaire), their degree of cognitive complexity in the interpersonal realm (Construct Repertory Test), their A-B Scale score (Whitehorn-Betz A-B Scale), and aspects of their life histories (Biographical Information Blank).

Nine hypotheses, which predicted specific relationships among groups of individuals differentiated by their scores on the above instruments, were evaluated with appropriate correlational and analysis of variance techniques.

Results basic to the main problem indicate that it will be possible to predict a counselor's orientation to both theory and practice from his biography. Cognitive complexity was found to be correlated with both the therapeutic position taken and aspects of past experiences. Specifically, it was found that those with a relatively high cognitive complexity score tended to take an experiential orientation, as opposed to an analytic orientation, to counseling theory and practice and to have experienced relatively a greater number of interpersonal experiences during their lives than those whose cognitive complexity scores were relatively low. Additional evidence supportive of the general proposition was afforded by the significant relationship found to exist between A-B Scale scores and Biographical Information Blank items described

as "social dependent conformity" and "social independent nonconformity." Specifically, a significant correlation was found to exist between "A" scores of counselors on the A-B Scale and "social dependent conformity" scores on the Biographical Information Blank and between "B" scores of counselors on the A-B Scale and "social independent nonconformity" scores on the Biographical Information Blank. It was suggested that these designations are very closely related to the concepts of "field dependence" and "field independence" noted by other investigators in A-B research. The factor of complementarity was mentioned as a possible explanation of the oft noted differential therapeutic success of "A" and of "B" therapists.

It was concluded that the results were promising enough to support further research on a larger and more geographically dispersed sample toward the end of establishing the limits of the predictability of a device to measure counseling orientation from biographical information. Development of such an instrument with at least moderate predictive power would find certain use in counselor education programs, both in the selection and advising of students and in counseling practice for the assignment of a client to a counselor most likely to assist him efficiently.

APPENDICES

The instruments which appear in these appendices were reproduced for the subjects (without the herein added scoring keys) by mimeograph process. The Biographical Information Blank was stapled into a booklet and together with the Construct Repertory Test, the Therapist Orientation Questionnaire and the A-B Scale all were inserted along with a pencil into a 9 x 12 envelope to form an instrument packet for each subject.

APPENDIX A

The A-B Scale

The 23 items which follow are used to measure vocational interests. Research has shown that counselors with certain interest patterns have greater therapeutic success with a particular group of clients while other patterns of other counselors indicate superior therapeutic success with another group of clients. It also happens that there is a third pattern of interests associated with a type of counselor who shows no differential therapeutic success with different types of clients. To discover to which if either group you belong, respond quickly to the items by indicating which one of the three choices most closely describes yourself. The first 19 items may be answered either as (L) like, (I) indifferent or (D) dislike and the final four questions with either the Yes, ? (if unsure) or No. Please respond to every item with your first thought.

Building contractor	L	*I	*D
Carpenter	L	*I	*D
Marine engineer	L	I	*D
Mechanical engineer	L	I	*D
Photoengraver	L	I	*D
Ship officer	L	*I	*D
Speciality salesman	L	I	*D
Tool maker	L	I	*D
Manual training	L	*I	*D
Mechanical drawing	L	*I	*D
Drilling in a company	*L	*I	D
Making a radio set	L	I	*D
Adjusting a carburetor	L	*I	*D
Cabinet making	L	*I	*D
Entertaining others	L	*I	*D
Looking at shop windows	L	*I	*D
Interest public in a new machine through public addresses	*L	*I	D
President of a society or club	*L	I	D
Many women friends	*L	I	D
Accept just criticism without getting sore	*Yes	?	No
Have mechanical ingenuity	Yes	?	*No
Can correct others without giving offense	*Yes	?	No
Follow up subordinates effectively	*Yes	*?	No

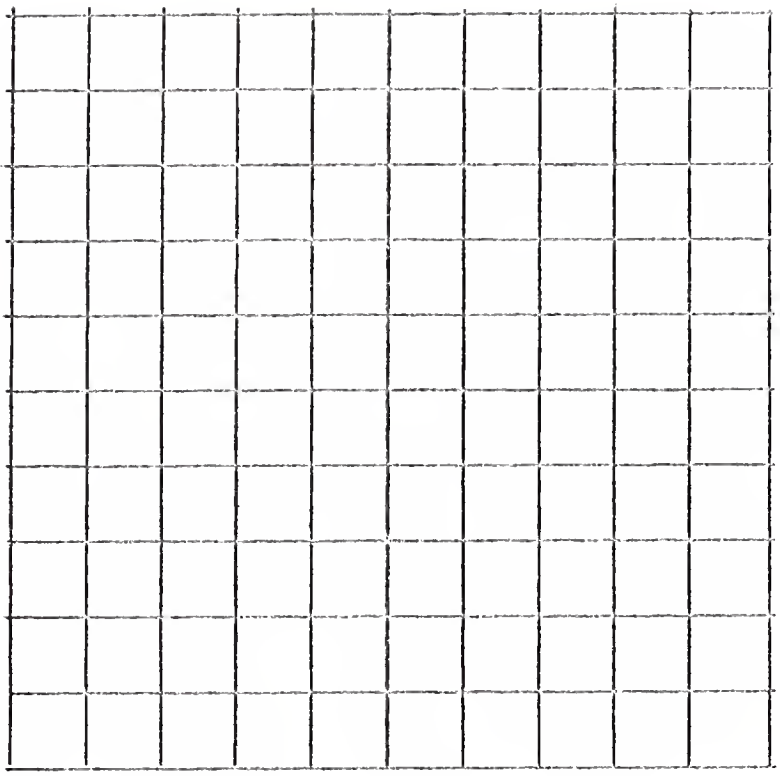
* Signifies characteristic "A" response.

APPENDIX B

Construct Repertory Test

In the figure below, a ten by ten grid, each of the ten columns is represented by a different role type and each of the ten rows is provided with ten bipolar constructs which represent some of the ways in which people think of one another, scaled to permit subjective differences in degree. After you have listed the names or initials of each of the ten persons who best correspond to the role types heading the columns, use the six step scale to rate all ten persons you have listed on the first provided construct. For example, the first construct dimension is "outgoing - shy." Rate each of the ten persons on the scale of +3 (outgoing) to -3 (shy). Following this, rate all ten persons on the second construct dimension and so on through all ten rows.

(see next page)



1. Yourself
2. Person you dislike
3. Mother
4. Person you'd like to help
5. Father
6. Friend of same sex
7. Friend of opposite sex (or spouse)
8. Person with whom you feel most uncomfortable
9. Boss
10. Person difficult to understand

Note: zero is not a permissible response.

+3	+2	+1		-1	-2	-3
outgoing				shy		
adjusted				maladjusted		
decisive				indecisive		
calm				excitable		
interested in others				self absorbed		
cheerful				ill humored		
responsible				irresponsible		
considerate				inconsiderate		
independent				dependent		
interesting				dull		
+3	+2	+1		-1	-2	-3

APPENDIX C

Therapist Orientation Questionnaire

This questionnaire is designed to elicit your attitudes, feelings, thoughts, and opinions concerning the conduct of psychotherapy as you personally conduct it. As there are few absolutes in this endeavor, a relative scale has been provided for you to record your responses to the 93 items. As you can see from the answer sheet, the answer for each item may be indicated in one of five positions:

Strongly agree	/ Agree /	Undecided	/ Disagree /	Strongly disagree

Check your personal reaction to each item relative to your practice of counseling in the appropriately corresponding place provided on the answer sheet.

1. It is quite acceptable to interrupt a patient while he is talking.

2. I point out connections between behaviors and attitudes, both those expressed in therapy and those described from present and past life situations.

3. It is all right for the therapist to experience strong emotional feelings concerning a patient.

4. I do things during the therapy hour for which I have no reasoned basis, but merely a feeling that it is right.

5. With most patients it is important to lead the interview into fruitful areas of discussion.

6. I do not feel that it is necessary to formulate for myself the psychodynamics of the patient's relationship with me.

7. As a therapist, I have certain long range goals for my patients.

8. My own attitude towards some of the things my patients say or do stops me from really understanding them.

9. Inherent in human beings is a natural propensity toward health, both physical and mental.

10. Understanding why one does things is a highly effective factor in modifying behavior.

11. It is not possible for a patient to understand his current relationships without understanding his relationships with his parents as a child.

12. The major cause of neurotic behavior consists of internalized overly restrictive inhibitions of personal desires.

13. It is important for a patient to be helped to make a social adjustment.

14. In every person there are experiences of which they are unaware, which actively affect their perception of reality.

15. No matter how emotionally mature and sensitive a person is, he cannot be a good therapist without training.

16. I interrupt a patient while he is talking.

17. I interpret my patient's behavior, in the sense of telling him its real significance--meanings of which he is unaware.

18. I try to maintain an attitude of detachment towards my patients.

19. I say things to my patients, for which I have no rational, thought-out, basis for saying, but merely feel at the time it is the right thing to say.

20. I make an overall treatment plan.

21. I try to understand the patient's psychodynamics.

22. Whatever direction the patient chooses to move, short of murder, suicide, etc., should be satisfactory to his therapist.

23. I am secure and comfortable in my relationship with my patients.

24. Therapy, by removing the deterrents to a person's growth, allows for the natural realization of the potentialities of the individual.

25. The patient's greater understanding of his past and present life experiences will be one of the most important therapeutic results.

26. When a patient brings a dream into the therapy hour, I try to help him understand its meaning.

27. Having the patient move in the direction of the goals of society is a desirable therapeutic aim.

28. Although there may be unconscious motives, they play a minor role in daily behavior and in shaping a person's life.

29. I believe that my patients get better largely because I am the kind of person that I am, rather than because of my knowledge.

30. A deeper "experiencing" of himself will be one of the most important profits which the patient will derive from therapy.

31. I am a fairly passive therapist, compared to most therapists.

32. The most important cause of neurotic behavior is a strict super-ego rather than a lenient super-ego.

33. Most people are unable to give a full account of the motivations for their behavior, due to the role of unconscious experiences.

34. I accept the patient's formulation without introducing into the interview a new frame of reference, a new way of looking at what he is saying.

35. It is important to share emotionally a patient's joys or sorrows as they are expressed during the therapy hour.

36. A treatment plan is not important for successful therapy.

37. The overall goals of therapy should be set by the patient only.

38. A therapist should make his doubts known to his patient when the patient seems to be on the verge of making what the therapist feels is an unwise decision.

39. I am uncomfortable when a patient asks me something about myself.

40. There is no basic human nature; man will be what his culture makes him.

41. One of the most important therapeutic gains to the patient will be a greater awareness of his emotional life.

42. It is necessary that a patient realize how early childhood experiences have left their mark on him.

43. In psychotherapy, I employ the analysis of the transference.

44. A mature, mentally healthy person will necessarily move in the direction of society's goals.

45. When I think about how a patient is behaving, I try to take into account his unconscious motives.

46. The most important variable in the outcome of therapy is the therapist as a person, rather than as a trained, skilled professional.

47. I do a lot of talking during the therapy hour with my patients.

48. One of the primary functions of the therapist is to interpret to the patient the meaning of the patient's communications, that is, tell him of the meanings of which he is unaware.

49. It is best for a therapist to leave the decision of when to terminate up to the patient.

50. I attempt to keep my personal characteristics in the background throughout the course of therapy.

51. A therapist's remarks and reactions to a patient are, at best, unplanned, spontaneous, not thought-through.

52. A thorough case history and/or a proper diagnosis are important to treat a case effectively.

53. It is very important for a therapist to conceptualize, think through, how a patient is relating to him.

54. It is important that a therapist not influence his patients in their decisions.

55. A patient can be very critical of me or very appreciative of me without any resulting change in my feelings toward him.

56. As a therapist, I do not feel that people have an inherent "drive toward health."

57. A very important benefit which the patient will derive from therapy will be a greater understanding of himself.

58. I leave it entirely up to the patient as to when to terminate.

59. It is important that a therapist has long range goals for his patients.

60. It is possible to make sense in understanding a patient's behavior, without assuming motives of which he is unaware.

61. A good therapist must have a thorough knowledge of psychopathology and training in psychotherapeutic techniques.

62. I would not interrupt a patient during a therapy session as I might if I were having merely a social conversation.

63. I try to inhibit the verbal or non-verbal expression of my own emotions during a therapeutic hour.

64. I deliberately assume different therapeutic roles with different patients.

65. The patient knows better than I the best directions for him to move, i.e., those which will allow him most to actualize his potentialities.

66. For a patient to improve his current way of life, he must come to understand his early childhood relationships.

67. I am a fairly active therapist, compared with most therapists.

68. It is necessary for a therapist to employ interpretive remarks, that is, remarks that show the patient meanings of his behavior of which he is unaware.

69. Detachment rather than involvement is the preferred attitude for a therapist.

70. As a therapist, my participation is thought-out.

71. A therapist should try to influence a patient to decide not to terminate, if he - the therapist - does not feel that the time is right.

72. I set broad goals of therapy and attempt to influence the patient's behavior and feelings in that direction.

73. In all human beings there is a "life force," a striving for perfection, which will show itself in a favorable environment.

74. The most important learning in therapy is affective, non-verbal, and non-conceptual in nature.

75. An important goal of therapy is a successful adjustment to the social environment.

76. People can be understood without recourse to the concept "the unconscious determinants of behavior."

77. I feel that the expression of my personal feelings has no place in the therapy hour.

78. As a therapist, I avoid asking probing questions.

79. I attempt to remain anonymous.

80. A therapist's remarks and reactions to a patient should be spontaneous.

81. It is important for a therapist to understand his patient to the extent that he can predict how the patient will react both to statements of his and to life situations.

82. I show my emotional sharing of my patient's joy and sorrows as they are expressed during the therapy hour.

83. I introduce topics during the therapy hour, which I have decided need to be discussed.

84. I try to express spontaneously my thoughts about our relationship during the therapy hour.

85. As a therapist, I usually know what I am doing, and why, and where I am going.

86. At times, I feel contempt for the patient.

87. The most important learning in therapy is verbal and conceptual in nature.

88. It is desirable that the therapist and the patient experience and express their mutual feelings for each other.

89. Psychotherapy ideally provides those conditions in which the patient is freed to "self-actualize his potentialities."

90. What ever the intensity or nature of the patient's emotional expression, it is best to maintain a reserved, objective, impersonal attitude.

91. A therapist who is emotionally involved with a case is defeating his own purpose.

92. The relation between myself and my patient is a close emotional one.

93. During a therapy hour, I sometimes express my feelings of anger.

THERAPIST ORIENTATION QUESTIONNAIRE ANSWER SHEET
(Scoring Key)

	SA	A	U	D	SD		SA	A	U	D	SD		SA	A	U	D	SD
1.	1	2	3	4	5	32.	1	2	3	4	5	63.	5	4	3	2	1
2.	5	4	3	2	1	33.	5	4	3	2	1	64.	5	4	3	2	1
3.	1	2	3	4	5	34.	1	2	3	4	5	65.	1	2	3	4	5
4.	1	2	3	4	5	35.	1	2	3	4	5	66.	5	4	3	2	1
5.	5	4	3	2	1	36.	1	2	3	4	5	67.	1	2	3	4	5
6.	1	2	3	4	5	37.	1	2	3	4	5	68.	5	4	3	2	1
7.	5	4	3	2	1	38.	5	4	3	2	1	69.	5	4	3	2	1
8.	1	2	3	4	5	39.	5	4	3	2	1	70.	5	4	3	2	1
9.	1	2	3	4	5	40.	1	2	3	4	5	71.	5	4	3	2	1
10.	5	4	3	2	1	41.	1	2	3	4	5	72.	5	4	3	2	1
11.	5	4	3	2	1	42.	5	4	3	2	1	73.	1	2	3	4	5
12.	1	2	3	4	5	43.	5	4	3	2	1	74.	1	2	3	4	5
13.	5	4	3	2	1	44.	5	4	3	2	1	75.	5	4	3	2	1
14.	5	4	3	2	1	45.	5	4	3	2	1	76.	1	2	3	4	5
15.	5	4	3	2	1	46.	1	2	3	4	5	77.	5	4	3	2	1
16.	1	2	3	4	5	47.	1	2	3	4	5	78.	1	2	3	4	5
17.	5	4	3	2	1	48.	5	4	3	2	1	79.	5	4	3	2	1
18.	5	4	3	2	1	49.	1	2	3	4	5	80.	1	2	3	4	5
19.	1	2	3	4	5	50.	5	4	3	2	1	81.	5	4	3	2	1
20.	5	4	3	2	1	51.	1	2	3	4	5	82.	1	2	3	4	5
21.	5	4	3	2	1	52.	5	4	3	2	1	83.	5	4	3	2	1
22.	1	2	3	4	5	53.	5	4	3	2	1	84.	1	2	3	4	5
23.	5	4	3	2	1	54.	1	2	3	4	5	85.	5	4	3	2	1
24.	1	2	3	4	5	55.	5	4	3	2	1	86.	1	2	3	4	5
25.	5	4	3	2	1	56.	5	4	3	2	1	87.	5	4	3	2	1
26.	5	4	3	2	1	57.	5	4	3	2	1	88.	1	2	3	4	5
27.	5	4	3	2	1	58.	1	2	3	4	5	89.	1	2	3	4	5
28.	1	2	3	4	5	59.	5	4	3	2	1	90.	5	4	3	2	1
29.	1	2	3	4	5	60.	1	2	3	4	5	91.	5	4	3	2	1
30.	1	2	3	4	5	61.	5	4	3	2	1	92.	1	2	3	4	5
31.	5	4	3	2	1	62.	5	4	3	2	1	93.	1	2	3	4	5

APPENDIX D

Biographical Information Blank

Answer every question with only one response unless otherwise specifically instructed. Most questions have been provided with multiple-choice responses from which you are to choose the most accurate by placing a check mark in the space provided to the left of the item. Where underlined blank spaces appear you are to write in the correct answer. A few multiple-choice items also have this option; when it is elected no other provided choices are to be checked.

		f	d	A-B
1.	Your age to nearest birthday: ____yrs.		*	
2.	Your height: ____ft. ____ins.		*	*
3.	Your weight: ____lbs.		*	*
4.	Your religious preference: (none is A; any is B)		*	*
5.	Number of times married:	*		
	__ a. 0	0		
	__ b. 1	1		
	__ c. 2	2		
	__ d. 3 or more	1		
6.	Number of children:	*		
	__ a. 0	0		
	__ b. 1	1		
	__ c. 2	2		
	__ d. 3-4	3		
	__ e. 5 or more	3		
7.	Present marital status:		*	
	__ a. single			
	__ b. married			
	__ c. widower			
	__ d. separated			
	__ e. divorced			
8.	Your age when you received your bachelors degree: ____yrs.		*	

		f	d	A-B
9.	What was your undergraduate major _____ _____ and minor _____		*	
10.	Your age when you received your latest degree: ____yrs.		*	
11.	Your latest degree is a:		*	
	__ a. M. D.			
	__ b. Ph.D.			
	__ c. Ed.D.			
	__ d. D. D.			
	__ e. D. S. W.			
	__ f. M. S. W.			
	__ g. something else _____			
12.	Since receiving your last professional degree, how long have you been engaged in the practice of counseling/psychotherapy:	*	*	
	__ a. less than one year	0		
	__ b. one to two years	1		
	__ c. two to five years	2		
	__ d. five to ten years	2		
	__ e. more than ten years	3		
13.	To what school or theory of personality and behavior change do you subscribe: (none/eclectic is A; any one is B)		*	*
14.	What author's writings have most influenced your thinking about the practice of counseling/psychotherapy: (no one is A; any one is B)		*	*
15.	To what school or theory of personality and behavior changing did your training institution subscribe: _____		*	
16.	With what school(s) of counseling/ psychotherapy do you take issue: (none/ all is A; any one is B)		*	*

	f	d	A-B
17. Your present primary professional responsibility is:		*	
__ a. counseling/psychotherapy			
__ b. teaching/supervision			
__ c. research/theory building			
__ d. administration			
to which you devoteabout ____% of your time.		*	
18. Your present secondary professional responsibility is:		*	
__ a. counseling/psychotherapy			
__ b. teaching/supervision			
__ c. research/theory building			
__ d. administration			
to which you devote about ____% of your time.		*	
19. When you were ill as a child, what action did your family generally take:		*	*
__ a. they called a physician			B
__ b. they applied home remedies			B
__ c. they let nature take its course			A
__ d. none of these			A
20. Have you ever suffered from (mark all that apply):		*	
__ a. allergies		-1	
__ b. asthma		-2	
__ c. high blood pressure		-1	
__ d. ulcers		-1	
__ e. headaches		-1	
__ f. none of these		0	
21. At what stage in your life has your physical health been best:			*
__ a. preschool period			
__ b. grade school period			
__ c. high school period			
__ d. college period			
__ e. adult life			
__ f. no noticeable difference			

	f	d	A-B
22. At what stage in your life has your mental health been best:		*	
__ a. preschool period			
__ b. grade school period			
__ c. high school period			
__ d. college period			
__ e. adult life			
__ f. no noticeable difference			
23. How many accidents or injuries have you had in the last ten years:	*		
__ a. none	0		
__ b. one	1		
__ c. two or three	-1		
__ d. four or more	-2		
24. How long does it usually take you to fall asleep:		*	
__ a. right away			
__ b. within 15 minutes			
__ c. 15 minutes to a half hour			
__ d. a half hour or more			
__ e. no consistant pattern			
25. Under usual conditions, how often do you attend church:	*		*
__ a. almost every day	3		A
__ b. every Sunday	1		B
__ c. at least three times per month	1		B
__ d. once or twice per month	0		B
__ e. on special occasions such as Easter	0		B
__ f. do not attend church	0		A
26. At what age did you start drinking alcoholic beverages:		*	*
__ a. 12 or younger			A
__ b. 13 to 16			A
__ c. 17 to 21			B
__ d. 21 or older			B
__ e. never drank			A

		f	d	A-B
27.	At what age did you begin to smoke:		*	*
	__ a. 12 or younger			A
	__ b. 13 to 16			A
	__ c. 17 to 21			B
	__ d. 21 or older			B
	__ e. never smoked			A
28.	Which do you now smoke most often:		*	*
	__ a. cigar			A
	__ b. cigarette			B
	__ c. pipe			A
	__ d. don't smoke			A
29.	Before you were 18 years of age, in what part of the country did you live most of the time:		*	
	__ a. Northeast (incl. Penn. & N. J.)			
	__ b. South			
	__ c. Southwest (incl. Okla. & Texas)			
	__ d. Midwest (incl. Rocky Mt. area)			
	__ e. Pacific coast (incl. Alaska)			
	__ f. outside of the continential U. S.			
30.	Most of this time was spent:	*		
	__ a. on a farm	0		
	__ b. in a town of less than 2,000	1		
	__ c. in a town of less than 10,000	1		
	__ d. in a city of less than 100,000	2		
	__ e. in a city of more than 100,000	3		
31.	Before you were 18 years of age, how many times did your family move from one house to another:	*		
	__ a. never	0		
	__ b. once	1		
	__ c. two or three times	2		
	__ d. four ot more times	3		
32.	Before you were 18 years of age, with whom did you live:	*		*
	__ a. both parents	0		B
	__ b. one parent	1		A
	__ c. one or more relatives	2		A
	__ d. foster parents and/or non-relatives	3		A
	__ e. in a home or institution	0		B

	f	d	A-B
33. With how many brothers and sisters did you grow up:	*		
__ a. one or more brothers, no sisters	1		
__ b. one or more sisters, no brothers	1		
__ c. both brothers and sisters	2		
__ d. none	0		
34. With regard to brothers and sisters you are:		*	
__ a. oldest			
__ b. youngest			
__ c. next to youngest			
__ d. other			
__ e. no siblings			
35. Which of the following did your father help you with most before you were 18 years of age:		*	
__ a. learning to use tools			
__ b. learning to play baseball			
__ c. homework from school			
__ d. none of these			
36. Where did your father or his ancestors come from:		*	
__ a. U. S. and Canada two generations			
__ b. other American country			
__ c. Northern Europe (incl. British Isles)			
__ d. Southern Europe			
__ e. Eastern Europe			
__ f. some other place			
37. How much education did your father have:		*	
__ a. grade school or less			
__ b. high school or less			
__ c. college liberal education at least two years			
__ d. professional or scientific education at least two years (college equivalent)			
__ e. graduate degree holder			

	f	d	A-B
38. Where did your mother or her ancesters come from:		*	
__ a. U. S. and Canada two generations			
__ b. other American country			
__ c. Northern Europe (incl. British Isles)			
__ d. Southern Europe			
__ e. Eastern Europe			
__ f. some other place			
39. How much education did your mother have:		*	
__ a. grade school or less			
__ b. high school or less			
__ c. college liberal education at least two years			
__ d. professional or scientific education at least two years (college equivalent)			
__ e. graduate degree holder			
40. For commendable behavior as a child, how were you usually rewarded:			*
__ a. praised			
__ b. given a gift			
__ c. allowed a special privilege			
__ d. given no special attention			
__ e. something else _____			
41. Which of your parents did the disciplining:	*	*	*
__ a. father	1		B
__ b. mother	1		A
__ c. both	2		B
__ d. neither	0		A
42. Which of your parents handled the money:		*	*
__ a. father			B
__ b. mother			A
__ c. both			B
__ d. neither			A

		f	d	A-B
43.	How were you usually punished as a child:		*	
	__ a. punished physically			
	__ b. reprimanded verbally or deprived of something			
	__ c. told how you should act			
	__ d. warned not to do it again but seldom punished			
	__ e. sent to bed			
44.	During your early teens when you wanted to do something like go swimming or go to the movies, from whom did you get permission:	*		*
	__ a. mother only	1		B
	__ b. father only	1		B
	__ c. both parents	2		B
	__ d. someone else	1		A
	__ e. nobody	0		A
45.	While in high school, who usually helped you select your clothes:	*		*
	__ a. mother only	1		B
	__ b. father only	1		B
	__ c. both parents	2		B
	__ d. some other relative	1		B
	__ e. a friend	1		A
	__ f. nobody	0		A
46.	As a little child when you were hurt or worried to whom would you usually go for sympathy:	*		*
	__ a. an older brother or sister	1		B
	__ b. mother	1		B
	__ c. father	1		B
	__ d. someone else	2		A
	__ e. nobody	0		A
47.	During your youth when teams were being chosen for games were you usually chosen:	*		
	__ a. near the beginning	2		
	__ b. around the middle	1		
	__ c. near the end	1		
	__ d. was usually one of those doing the choosing	3		

		f	d	A-B
47.	During your youth when teams were being chosen for games were you usually chosen: (continued)			
	__ e. very seldom had time to play games	0		
	__ f. very seldom had friends to play with	0		
48.	How old were you when you went on your first date:	*		*
	__ a. 10 to 13	3		A
	__ b. 13 to 15	2		B
	__ c. 15 to 17	1		B
	__ d. older than 17	1		A
	__ e. never dated	0		A
49.	With regard to taking risks, which best describes you:		*	
	__ a. hardly ever take a risk			
	__ b. sometimes take a risk			
	__ c. generally take a risk			
	__ d. I'm a gambler at heart			
50.	Decision making as a major part of a job:		*	*
	__ a. is your meat			A
	__ b. you can take it or leave it			A
	__ c. you like to narrow things down to two or three alternatives but prefer someone else to take it from there			B
	__ d. definitely not for you			B
51.	Which one of the following techniques of disciplining a child would you use most often:		*	
	__ a. denying the child material pleasure			
	__ b. encouraging the child by pointing out good behavior			
	__ c. leaving decisions up to the child after discussion			
	__ d. trying to reason with the child			
	__ e. punishing and spanking the child and letting him know why			

	f	d	A-B

52. For your own children, in which one of the following ways do you want to do more for them than your father did for you: *

__ a. don't have any children
__ b. give them a better standard of living
__ c. give them more freedom to make their own decisions and plans
__ d. give them more affection and companionship
__ e. give them a better start on their careers
__ f. something else _____

53. In regard to your home, who makes most of the decisions: * *

__ a. wife takes most responsibility B
__ b. decisions are shared equally B
__ c. you make most of the important ones A
__ d. not married A

54. In any argument with your wife, who has the last word: * *

__ a. you more often than not A
__ b. your wife more often B
__ c. you each think you do A
__ d. you never argue B
__ e. there never is a last word A
__ f. not married A

55. How do you usually spend your leisure time: * *

__ a. reading professional literature 0
__ b. reading novels 0
__ c. going to the movies and dances 1
__ d. participating in sports 2
__ e. observing sports 0
__ f. viewing T. V. 0
__ g. pursuing hobbies 0
__ h. family activities 1
__ i. house and yard work 0
__ j. none of the above 0

		f	d	A-B
56.	What kind of recreation do you like most and engage in most often:	*	*	
	__ a. participation in competitive team sports	2		
	__ b. participation in competitive individual sports	1		
	__ c. being a sports event spectator	0		
	__ d. social relaxation with others at parties, etc.	2		
	__ e. attending performances of plays, concerts and other events	0		
	__ f. reading, listening to records or other things where you can be alone	0		
57.	Which of your high school subjects did you enjoy the most:		*	
	__ a. physical sciences and math			
	__ b. natural sciences			
	__ c. history, economics and civics			
	__ d. English literature & foreign language			
	__ e. bookkeeping & typing			
	__ f. shop courses			
58.	As an undergraduate in college, how many times did you change your major before selecting the one in which you finally graduated:	*	*	
	__ a. never changed it	0		
	__ b. once	1		
	__ c. twice	2		
	__ d. three times	3		
	__ e. four or more times	3		
59.	What percent of your undergraduate expenses did you earn (include scholarships & loans):		*	
	__ a. none			
	__ b. up to 10%			
	__ c. up to 25%			
	__ d. up to 50%			
	__ e. up to 75%			
	__ f. 100% paid own way through college			

f d A-B

60. What percent of your graduate/professional school expenses did you earn (include scholarships & loans): *

__ a. none
__ b. up to 10%
__ c. up to 25%
__ d. up to 50%
__ e. up to 75%
__ f. 100% paid own way ghrough graduate/ professional school

61. Which do you feel has been your most outstanding positive school experience throughout your academic life: *

__ a. popularity with male peers 1
__ b. popularity with female peers 1
__ c. popularity with teachers 1
__ d. making close friendships 2
__ e. achieving in sports 0
__ f. achieving in academics 0

62. How many students were there in the undergraduate college or university that you attended: *

__ a. less than 500 1
__ b. 500 to 1,999 1
__ c. 2,000 to 4,999 2
__ d. 5,000 to 9,999 2
__ e. over 10,000 3

63. How many students were there in the graduate/professional school or department you attended: *

__ a. fewer than 25 1
__ b. fewer than 50 1
__ c. fewer than 75 2
__ d. fewer than 150 2
__ e. over 150 3

64. Can you recall having a grade school teacher that you strongly disliked: *

__ a. yes, more than one 2
__ b. yes, but only one 1
__ c. no, none that you recall 0

	f	d	A-B
65. In your field, how much freedom do you think a student should have in planning his undergraduate college curriculum:		*	*
__ a. very little, he should have a definite program planned for him			B
__ b. some, he should have a general program planned with a number of electives			B
__ c. a good deal, he should be required to take a few basic courses choosing the remainder for himself			A
__ d. complete freedom in determing a program of study			A
66. Which of the following statements best expresses your feelings concerning the proctoring of college examinations:		*	*
__ a. examinations should be closely proctored because few students are completely honest in all situations			B
__ b. examinations should be closely proctored although most students are honest a few need to be closely watched			B
__ c. close proctoring is not necessary since cheating is not really much of a problem			A
__ d. the best way to handle this is by use of the honor system in which students themselves are responsible to each other			A
67. How do you usually act when you are angry:	*	*	
__ a. storm around for a while letting off stean	0		
__ b. try not to show that you are angry at all	0		
__ c. never let your temper get the best of you	0		
__ d. talk it over with someone	1		
__ e. try to keep away from everyone for awhile	0		
__ f. something else _____			

f d A-B

68. In which of the following settings did your most outstanding negative experience occur: *

__ a. family setting
__ b. school setting
__ c. social setting
__ d. work setting
__ e. religious setting

69. Which of the following types of work have you done for pay (check all that apply): *

__ a.	unskilled labor	0
__ b.	semi-skilled labor	0
__ c.	skilled labor	0
__ d.	clerical or office work	1
__ e.	sales clerk, door to door canvassing	2
__ f.	personal service, valet, housekeeping	2
__ g.	policeman, fireman, etc.	1
__ h.	camp counselor, YMCA work, etc.	3
__ i.	social work	3
__ j.	librarian	0
__ k.	factory or shop foreman	1
__ l.	surveying, drafting, etc.	0
__ m.	farm work, ranch hand	0
__ n.	auto or realestate selling	2
__ o.	reporter, advertising man, P.R. work	1
__ p.	semi-professional, photographer, etc.	1
__ q.	research worker	0
__ r.	small business operator	1
__ s.	executive	3
__ t.	teacher, instructor	3

f d A-B

70. To what extent do you believe that the behavior exhibited by human beings is completely determined by previous experience and heredity: *

__ a. 100%, I am a complete determinist
__ b. a large amount but I still think there is room for some choice
__ c. very little as I see man as an active creater of his own life
__ d. I really can't decide, it depends on semantics, all the evidence isn't in yet, the question is meaningless, etc.

Weight Range of Men, by Age and Height: 1960-62[a]

(Height without shoes; weight, in pounds, partially clothed. Clothing weight estimated at 2 lb. Values shown represent range of weight within which 50 percent of the population of a given height would fall. Approximately 25 percent would weigh less and 25 percent more than these values. Based on a nationwide sample of persons 18 to 79 years of age selected for the Health Examination Survey conducted Oct. 1959 - Dec. 1962.)

Height (feet and inches)	Weight, by Age Groups						
	18-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-79 years
5'2"	120-154	121-161	131-167	130-167	128-168	125-163	116-151
5'3"	123-157	126-165	134-170	134-171	131-171	128-167	121-156
5'4"	127-161	130-170	138-174	138-175	135-175	132-170	126-161
5'5"	130-164	135-174	142-178	142-179	138-178	135-174	131-166
5'6"	134-168	139-178	146-182	146-183	142-182	138-177	136-171
5'7"	137-171	144-183	150-186	150-187	146-186	142-180	142-176
5'8"	141-175	148-187	153-189	154-191	149-189	154-184	146-181
5'9"	144-178	153-192	157-193	158-195	153-193	149-187	151-186
5'10"	148-182	157-196	161-197	162-199	156-196	152-191	156-191
5'11"	151-185	162-201	164-200	166-203	160-200	156-194	162-196
6'	155-189	166-205	168-204	170-207	163-204	159-198	167-201
6'1"	158-192	170-210	172-208	174-211	167-207	162-201	172-206
6'2"	162-196	175-214	176-212	178-215	171-211	166-204	177-212

[a]Statistical Abstract of the United States 1969.

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BIOGRAPHICAL SKETCH

Leslie Kenneth Rothman was born on the 22nd of December, 1938, in the City of New York. Having been graduated from the DeWitt Clinton High School in June, 1956, he entered, in September of that year, the City College of New York where he majored in Psychology. A Bachelor of Science degree was conferred upon him in February, 1961, whereupon he entered the State University of New York at Buffalo, completing the requirements for the degree Master of Education in Rehabilitation Counseling in June, 1963. Following a brief period of post master's study, he entered the employ of the Children's Rehabilitation Center in Buffalo in February, 1964, and served there as an educational/vocational counselor. From September, 1964, until August, 1966, he served as the psychological counselor with the Niagara County Community College at Niagara Falls, New York. From there, he journeyed to Cleveland, Ohio, to join the counseling staff of the Cuyahoga Community College. September, 1967, saw him enroll in the College of Education of the University of Florida. During that first academic year, he worked as a graduate assistant

in the Department of Rehabilitation Counseling. That affiliation afforded him the opportunity of obtaining a "traineeship" from the Rehabilitation Services Administration, United States Department of Health, Education, and Welfare. From July, 1968, to the present, that "traineeship" has made it possible to pursue full-time study with the Department of Counselor Education toward the degree of Doctor of Philosophy.

Leslie Kenneth Rothman is married to the former Louise Johnette Sundberg and is the father of two sons. He is a member of the American Psychological Association and the American Personnel and Guidance Association.

This dissertation was prepared under the direction of the chairman of the candidate's supervisory committee and has been approved by all members of that committee. It was submitted to the Dean of the College of Education and to the Graduate Council, and was approved as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

June, 1970

B Stanley by M. C. Baker
Dean, College of Education

Dean, Graduate School

Supervisory Committee:

James L. Linter
Chairman

C. Jan Kinney

Richard A. Anderson