THERAPEUTIC RESPONSE STYLES: CLIENT EXPECTANCIES AND PREFERENCES

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CHAPTER I

INTRODUCTION

While the number of different therapeutic systems continue to increase, one constant element stands out--the relationship. As far as this has been made specific, the relationship hints at certain effective therapist styles, that is, certain response styles of the therapist. A major style that has been the subject of a body of research has been that which communicates empathy, warmth, and genuineness. Insofar as one can talk about an already generally agreed on element in psychotherapy, it woul be this style. However, Reisman (Reisman and Yamokoski, 1974), in an investigation of response style preferences persons hold for friends and psychotherapists, suggests perhaps our assumptions about effective therapeutic style--in particular, the communication of empathy, and, response styles in general--need to be examined. A primary purpose of the present study was to identify the response style preferences clients and non-clients hold for psychotherapists and for friends with whom they discuss their personal problems.

Response Style in Psychotherapy

Psychotherapy is such an inclusive term covering such a broad range of approaches that no definition is likely to find general acceptance. It is possible, however, to define it at least well enough to delimit the subject matter under scrutiny; in this case, response style preferences of clients and non-clients, and participant

role expectations. Reisman's (1971) definition will be discussed in terms of its evolution and of its usefulness in the present investigation.

Reisman (1971) selected 31 definitions of psychotherapy as illustrative of the four major ways in which psychotherapy has traditionally been defined. These four primary categories involve (1) psychotherapy being defined by its goals; that is, psychotherapy is whatever is used to attain a certain objective, or serves a particular purpose; (2) psychotherapy defined by its type of procedures; these definitions state in a broad way the measures that are employed in psychotherapy; (3) psychotherapy defined by the practitioner; (4) psychotherapy defined by the relationship. Next, these 31 definitions were evaluated by Reisman in terms of three standards, namely, recognizability, precision, and independence from goals. Reisman concluded from this evaluation that

> The definitions of psychotherapy that have been examined have not identified this method of treatment in a way that is at once recognizable, precise, and independent of its goals or effects. Some appear to have confused psychotherapy with what is psychotherapeutic, while others, not entirely of a different genre, express the assumption that the method has been practiced only in cases where it has attained some favorable result. Moreover, some of these definitions, whether deliberately or not, are divisive, narrowly expressive of professional or theoretical interests that are badly asserted without any evidence to justify their acceptance. (p. 19).

Reisman next scrutinized the variables in the representative forms of psychotherapy. These variables included the setting in which therapy takes place, its duration, frequency, participant's roles, and qualities of both patient and therapist. From this examination

Reisman sifted out the commonalities to arrive at a definition of psychotherapy that conforms to the standards of recognizability, precision, and independence from the goals of treatment. The commonalities of psychotherapies point to its being "a treatment method that makes use of psychological measures in being of assistance to persons who experience feelings of distress and unhappiness. By implication they suggest that, at least on the part of the therapist, there is communication and a wish to be of help to someone else. Further, they connote an attitude of respect toward the person in need of assistance" (Reisman, 1971, p. 19). Thus, psychotherapy is the communication of person-related understanding, respect, and a wish to be of help. A discussion of the terms of the definition follows.

"Communication" refers to the transmission of a message. The definition allows for no specific mode of communication. The psychotherapist is one medium or delivery system among many. Other media can be motion pictures, tape recordings, non-professionals, or the client himself. In addition, the communication can be of any kind. Examples of the kinds of communication are inflections and tones of voice, actions, and all other non-verbal senders of messages, such as facial expressions, posture, and gestures. Reisman, while recognizing the importance of the medium of the transmission, nevertheless cautions that psychotherapy is not the medium. Rather, "psychotherapy is the message, and the structure of the psychotherapeutic message that every system seeks to send is: I understand you. I respect you. I wish to help you." (Reisman, 1971,

pp. 124-125).

"Person-related understanding" refers to all communication that attempt to comprehend the client's or other person's thoughts, feelings, or behaviors. This then is regardless of whether the understanding is based on Freudian or Skinnerian principles. It is generally accepted that under some circumstances, for instance, empathic understanding would be most effective, whereas under other circumstances another type of understanding would be appropriate. Obviously, it has not been unequivocally demonstrated that one form of understanding (empathy, for example) is in all instances more effective than another. Thus Reisman has described five types of person-related understanding: empathic, expository, interrogative, interpretive, and responsive. These person-related response styles are formally defined as follows, in which the person with the problem is referred to as A and the helper is referred to as B (Reisman and Yamokoski, 1974, p. 270).

1. Empathic. B communicates his understanding of what A seems to be saying, feeling, or thinking.

2. Expository. B communicates his expert analysis or explanation of A's problem, behavior, or possible course of action.

3. Interrogative. B asks A for clarification or for more information about B.

4. Interpretive. B relates A's message to the past or to seemingly unrelated situations.

5. Responsive. B communicates that he has received A's message and seems to understand it (e.g., "Um Hm, Yes, I see").

The term "respect" denotes a positive regard for the individual's dignity, rights, uniqueness, and capacities for constructive change.

The final term of the definition is "a wish to be of help." This simply designates that the professional, or any helper, is motivated by some desire to contribute to the welfare of the patient and is not concerned solely with self-aggrandizement; this is usually assumed to be the case in the professional-patient relationship.

From Reisman's definition, it becomes evident that any of these types of communication--e.g., the wish to be of help--may be found in any interpersonal situation. Unfortunately, psychotherapy, as defined by Reisman, is not usually found in human interactions. It is in the professional context that the probability of these types of communication's occurring in toto is maximized.

By definition, all three parts of the message would be necessary for the message to be regarded as psychotherapeutic. Nevertheless, it is not uncommon that the person to whom the message is transmitted perceives the message as complete even when it is not. Reisman's comments to this regard are particularly noteworthy (1971, pp. 134-135).

> Accordingly, there may not be understanding, respect, or a wish to be of help, but the person's assumptions and expectations may fill in what is lacking and transform an ordinary communication into psychotherapy for him...
>
> However, the usual pattern is to interact with others who do not communicate person-related understanding, respect, and a wish to be of help, and such communications are seldom expected in our customary interactions. In contrast, most people assume that professional therapists

> will transmit this message. After all, that is their job. They have been trained for that purpose, and their training has included not only a cultivation of their ability to communicate in that way, but also the development of their capacity to comprehend the reasons for nuances of behavior. Their understanding is probably more subtle, sophisticated, and accurate than the understanding of most non-professionals. Yet even where the words of the therapist are no different from the words that the client might hear elsewhere, they would be perceived with the weight ascribed to the pronouncements of an authority. Therefore, it is to be expected that the communications of the professional therapist will more frequently be psychotherapy and that they will more often be perceived as psychotherapy than the communications of others.

It has frequently been the observation by those familiar with the process of psychotherapy, that much of what characterizes a psychotherapeutic relationship is not dissimilar from that which typifies a friendship. These observers stress qualities of the therapist such as warmth, friendliness, likability, genuineness, empathy, etc., almost to the exclusion of his technical skills. The resulting therapeutic relationship is considered to be the sine qua non of psychotherapy, but at the same time not specific to psychotherapy. Thus any "good" intimate, friendly relationship could offer that which therapy offers. Two lines of evidence have supported this notion. Firstly, the successes claimed by therapists of diverse treatment approaches and philosophies suggest that the common and vital ingredient in all therapy is the therapist's seeking to establish a collaborative, understanding relationship with the patient (Rogers, 1951; Shostrom and Riley, 1968). The second line of evidence derives from the successful utilization of relatively untrained and non-professional individuals

as therapists (Kloch, 1966; Cowen, Gardner, and Zax, 1967; Beck, Kantor, and Gelineau, 1963). In addition, there has been a consistent failure to demonstrate that experienced therapists are more effective than inexperienced ones (Lerner, 1972; Posser, 1966). Related to these findings is the notion that treatment skills and techniques are, in the end, inconsequential when contrasted with therapeutic qualities such as friendliness and earnestness. The Rogerian group of psychotherapists are notable for their emphasis upon the friendly aspects of the therapeutic relationship. While it would be naive to equate the Rogerian therapeutic relationship with a good friendship, the relationship with the client is seen as at least somewhat similar to the usual friendly relationship.

Despite the ascribed importance of friendship in psychotherapy, little research has been reported on the similarities and differences of the relationship in psychotherapy and an ordinary friendship. Martin, Carkhuff, and Berenson (1965) asked subjects to discuss their current problem with an experienced therapist and their best friend available. The interaction was examined in terms of empathy, genuineness, and positive regard. They found that the therapists had significantly higher levels of these variables than did the friends. Truax and Carkhuff (1967, p. 120), in discussing this investigation, stated the implication as being that "counseling and psychotherapy proved a 'heightened' experience of the same dimensions present in friendship and have a more significantly constructive impact than other sources of nourishment in our environment."

Reisman and Yamokoski (1974), in a two part study, investigated the communications that occur among friends. In the first part, 14 pairs of friends (one of which was designated as the helper) discussed personal problems. In addition, two samples of client-therapist dialogue were taken from Rogers (1951) and Gordon (Shapiro, 1964), which represented exchanges during the middle stage of therapy. Both sets of exchanges (friends and therapists) were divided into message units and each unit was independently assigned to one of nine response style categories. Five of the response categories, empathic, responsive, expository, interrogative, and interpretive, have been discussed above in terms of person-related understanding. In addition to these categories of person-related understanding, four other categories of communication were employed which are at times used in psychotherapy but not expressive of person-related understanding of the client. These were (A is the person seeking help, and B is the helper):

Self-disclosure. B communicates information about B.

Suggestion. B tells A what to do; B gives advice or specific direction.

Evaluation. B comments on the goodness, smartness, or value of what A has said or done.

Other. Statements of B which do not seem to fit the other categories; for example, B responds by changing the subject or by asking questions about someone other than A.

Reisman and Yamokoski (1974) found that while empathic responses were infrequent in the repertoire of the friends trying to

be helpful, such responses constituted a major portion of the statements of the model Rogerian therapist. Further, each friend did not respond in a variety of ways. The authors found that friends had different modes of responding which would rely on one or two of the response styles.

The second part of the study was designed to examine the response style preferences of subjects for their friends and psychotherapists. The authors designed four forms of a script in which two friends, A and B were discussing a problem. The forms were identical except that B's responses to A were constructed to represent the different response styles of empathic, expository, interrogative, and mixed. Subjects were asked to rate their preference of each response style on a 5-point scale ranging from "At no time" to "Almost all the time" for each of three statements: (1) My best friend responds to my personal problems the way that B does; (2) I would like my best friend to respond to my personal problems the way that B does; (3) If I were to discuss my personal problems with a psychotherapist, I would like the psychotherapist to respond the way that B does.

Their results indicated that subjects regarded interrogative, and particularly empathic, responses as infrequent among their friends. The results also indicated that subjects did not want their friends to be empathic, but were less adverse to psychotherapists being emphatic. The response style most preferred for psychotherapists was expository. From this investigation the authors concluded (p. 273):

> Many people have decided preferences among forms of communication and the empathic form is not especially popular. This suggests that therapists who regard empathic responses as the cornerstone of a friendly relationship with their clients may be mistaken; a friendly relationship may develop despite their being empathic rather than because of it. If such therapists do seek to communicate as do friends, they could do so by being less empathic and more expository and varied in their forms of response.

While the results of this investigation reached statistical significance, the authors suggested several variables which may have influenced the outcome. Of main importance was the restricted sample. The study used only those Southern state university undergraduates who had no previous therapy experience. It may be that clients desire empathic responses more than normals.

The results of this investigation are striking in that they question the efficacy of what has long been considered a cornerstone of effective therapy. On this basis alone it would seem to merit replication. The limitations mentioned by the authors make replication, at least of critical segments of the study, even more vital. The present study thus involved a partial replication of the second stage of the Reisman and Yamokoski (1974) investigation. In the present study both undergraduates and clients were used as subjects.

The "mixed" response style category was replaced by that of "competitive" response style. This response style was suggested by Davis (1971) and Haley's (1963) model of psychotherapy. Psychotherapy, for Haley, is seen as an arena within which the behaviors of the patient and therapist are tactics for obtaining control of the relationship. Clinical symptoms, in turn, are seen as mal-

adaptive tactics for gaining control in a relationship. Thus, the therapeutic process consists of the therapist overcoming the patient's attempts at counterinfluence.

Social Competition

The theme of social competition has been developed mainly by humorists (Potter, 1948, 1951, 1952), populizers (Berne, 1964), and sociologists (Goffman, 1961; Weinstein and Deutschberger, 1963, 1964).

In the realm of empirical studies, social competition has been investigated primarily through the examination of games and bargaining, particularly, the study of the Prisoner's Dilemma and its variants. Davis (1971, pp. 7-8) described the Prisoner's Dilemma as follows:

> Its essential feature is that although each player has available a dominating strategy (one that provides him with his best possible outcome for any given strategy his partner adopts), if both players adopt their respective dominating strategies, both fare worse than if they both adopt nondominating strategies. The dilemma rests in the fact that a player can be exploited by his partner if he adopts a cooperative, nondominating strategy, while the players' mutual interests are best served if both adopt a nondominating strategy.

The most consistent and critical finding that has emerged from this line of research has been that players tend to adopt competitive rather than cooperative strategies, regardless of incentive magnitude (Bixenstine, Potash, and Wilson, 1963; Bixenstine and Wilson, 1963; Deutsch and Krauss, 1960; Flood, 1958; McClintock, et al., 1963; McClintock and McNeel, 1966a, 1966b; Messick and Thorngate, 1967; Minas, et al., 1960; Scodel,

et al., 1959; Gumpert, Deutsch, and Epstein, 1969). This line of evidence has given prima facie support to the notion that competition is a generalized social drive. From this evidence also one may conclude that subjects in experimental games are unable to establish "helping relationships" even in the service of their mutual profit (Davis, 1971).

The notion of social competition was investigated by Davis (1971) and particularly dealt with social competition in a standardized interview. Social competition was defined in terms of the interviewer administering negative, or at least challenging, evaluations to the interviewee according to a prearranged schedule. The results demonstrated that interviewees showed a marked tendency to engage the interviewer in response to negative evaluations, but did not seek to engage him if he consistently delivered positive evaluations. In addition, interviewee topic persistence was greater following negative than following positive evaluation. It was also greater when followed by negative evaluation than when rewarded by a positive evaluation.

Because of the seemingly divergent views of therapeutic response styles presented by Haley and Davis, as opposed to Reisman, an effort was made in the present investigation at further clarifying the preferences of clients and non-clients. According to the results of Reisman and Yamokoski (1974), it was expected that clients and non-clients would not prefer the competitive response style. The results of Davis (1971) indicate that clients would vigorously engage in a dialogue when faced with a competitive

response style. The reasons for this remain unclear. One could suppose that the individual may actually like, that is prefer, this response style, particularly if one considers psychotherapy and human interaction in terms of Haley's (1963) model. Nevertheless it is a response style not uncommon to psychotherapy, often taking the form of confrontation. For these reasons, then, it was decided to include this response style in the present investigation.

Expectations in Psychotherapy

Expectancy has long been thought to play a role in psychotherapy. Although the importance attributed to it has varied, its parameters have yet, however, to be thoroughly explored (Meltzoff and Kornreich, 1970). Expectancy has often been thought of, sometimes wrongly so, as faith, belief, credulity, anticipation, confidence, conviction, set, trust, reliance, promise, hope, and wish (Cartwright and Cartwright, 1958; Frank, 1958, 1959, 1961). Goldstein (1962), in a comprehensive monograph devoted to expectancies, has differentiated between prognostic and participant role expectancies of both patient and therapist.

Patient Prognostic Expectancies

Meltzoff and Kornreich (1970) have summarized prognostic expectancy as "an outcome that is looked for with the belief, faith, confidence, or conviction of being found. It is essentially a prediction anchored in a belief that may or may not be warranted" (p. 258). Cartwright and Cartwright (1958) hold that the concept

of patient expectation, that is, belief in psychotherapy, is a complex concept involving at least four different kinds of belief. These are a belief that certain effects will result, a belief in the therapist as the major source of help, a belief in the techniques or procedures as the major source of help, and, finally, a belief in oneself (the patient) as the major source of help. The first three of these classes of expectancies are viewed by Cartwright and Cartwright as not linearly related nor positively related to improvement of the patient. In part, this is a result from their impression that what the patient deems as wrong with him initially diverges considerably from what eventually is changed as the result of psychotherapy. Further, those patients entering psychotherapy with the expectation that the therapist will be a major source of help often is the type of patient who shuns the responsibilities of what is traditionally thought of as successful psychotherapy and merely sits back to wait to be helped. Those patients with the strong expectation of improvement based on a belief in the techniques of psychotherapy are seen as those individuals who also have a generalized belief in the "saving properties of disembodied procedures and practices divorced of interpersonal meaning and personal responsibilities" (Cartwright and Cartwright, 1958, p. 175). The behavior of this individual in psychotherapy typically is impersonal, thereby hindering progress. The Cartwrights consider only the belief in oneself as the major source of help as linearly and positively related to progress in that this patient can be expected to be a serious, hardworking patient.

Meltzoff and Kornreich (1970) discuss four aspects of therapeutic expectancies which differentiate them from the previously mentioned list of faith, belief, hope, promise, etc. The first major characteristic is that therapeutic expectancy has an object. The object of therapeutic expectancy is that of symptom relief, conflict resolution, or the attainment of some objective or subjective positive state. Conversely, the expectation may also be of failure in psychotherapy. A second aspect is that therapeutic expectancy has direction and this involves, simply, either the expectation of positive, negative, or no gain from the therapy experience. Instrumentality is the third characteristic of expectancy and is defined as that which brings about the anticipated goal, the person or process in whom the belief or faith is placed. This may take the form of belief or faith in the patient himself, the therapist, the therapeutic process, or external forces alone or in combination.

> The patient who sees himself as the instrument says, "I have faith in myself, I can snap out of it with perhaps a little guidance," or "No one can help me, I have to do it myself." For him therapy and the therapist may actually be seen as intruders. Another patient has expectancies characterized by faith in the therapist as the instrument. Regardless of the approach, "the right doctor" is expected to be able to cure him. The same techniques in the hands of another would have little chance of success. The next patient is therapy oriented. His expectations are that the techniques of <u>therapy</u> will bring about relief. The last places his <u>faith</u> outside therapy--in time, circumstances, environmental conditions, other people in his life, or spiritual forces (Meltzoff and Kornreich, 1970, p. 258).

The final characteristic of therapeutic expectancies is that they

have a temporal schema. This involves, simply, the expectation of how long it should take to obtain the goal.

Obviously, both patient and therapist have expectancies which may conflict with each other, complement each other, or influence each other in some other way. In addition, it is important to distinguish between expectancies at the beginning of therapy and expectancies at a later point, since they are fluid and subject to modification.

Jerome Frank has elaborated considerably on the probable factors contributing to favorable patient expectations (1958; 1959; 1961; Frank, Gliedman, Imber, Nash, and Stone, 1957). A major influence discussed by Frank is cultural. That is, with the possible exception of members of the lower socioeconomic groups, psychotherapy is the treatment of choice and the psychiatrist is the therapeutic agent of choice for mental illness. Thus, there is a cultural endorsement of psychotherapy and of the psychotherapist which, in effect, reinforces the favorable expectations of patients seeking psychotherapy. Once the patient has sought such help, the influence of intake procedures and referral are next in line to enhance expectations of improvement. These take the form, for example, of respect for psychotherapy evidenced by the referring physician, the patient's positive impression of the intake social worker's ability, and of the intake psychologist testing the patient. Attitudes of the therapist next serve to foster positive expectations and in general consist of the therapist's willingness to accept the individual as a patient, the therapist's zealousness

and confidence in his theoretical position and method of treatment. Lastly, as Goldstein has suggested on the basis of level of aspiration data, expectation and change may be related in a curvilinear fashion. That is, those possessing moderate expectation will be likely to show more improvement than those at the extremes. To restate, the expectancy of success may be more powerful than the expectancy of failure may be negatively effective; or, the converse may be true (Meltzoff and Kornreich, 1970).

Empirical Studies of Patient Prognostic Expectancy

Lipkin (1954) examined patient attitudes in relation to therapeutic outcome in client-centered therapy. It was hypothesized that there would be a positive relationship between therapy outcome and patient expectations regarding the therapeutic experience. Lipkin's data were pre- and post-therapy TAT protocols, ten-minute post-interview recordings in which the patient was requested to express his feelings toward himself, the therapist, and the therapeutic process, and recordings of final focused interviews with each patient. His data on nine cases led him to conclude that more successful clients entered therapy with more favorable feelings toward therapy and therapists than did less successful clients. His data also supported Frank's (1959) hypothesis that the degree of favorable expectancy varies positively with the degree of the patient's distress.

Frank, Gliedman, Imber, Stone and Nash (1959) investigated the relationship of expectancy to improvement and utilized symptom

relief as the partial criterion of improvement. Three treatment conditions were examined: (1) group therapy one and one-half hours per week, (2) individual therapy one hour per week, or (3) individual minimal contact therapy one-half hour every two weeks. Results indicated that diminution of subjective discomfort was independent of the amount of treatment. It was concluded that this drop in subjective discomfort was due to one common feature of all three treatments, namely, the patient's expectation and belief that he was being treated and helped.

Gliedman, Nash, Imber, Stone, and Frank (1958) provide indirect but suggestive evidence of the importance of positive patient expectancies for the subsequent reduction of subjective distress. Their treatment conditions consisted of either short-term psychotherapy or placebo administrations, and the results indicated significant reduction of distress occurring with both treatments.

Lest the reader be misled into thinking that all results in the area of patient prognostic expectancies are unequivocal, it is appropriate to review here some negative findings. Brady, Reznikoff, and Zeller (1960) attempted to circumvent the problems of relying solely on self-reports by employing projective techniques to assess expectancy and they used therapist's ratings as measures of improvement. Their results indicated no statistically significant differences between expected and patient improvement. Goldstein (1962) concluded, however, that uncontrolled influences may have been primarily responsible for the findings of Brady, et al.

and thus is as plausible an explanation as that suggesting no relationship exists.

Goldstein (1960), using a Q-sort technique, examined the relationship between client and therapist expectations of personality change and perceived change due to therapy. The client's expectation of personality change was defined as

> the feelings held by the client prior to and during his psychotherapeutic experience relating to anticipated nature and intensity of his personality problems upon completion of psychotherapy (Goldstein, 1962, p. 24).

Thus, operationally, this variable was defined as the difference between Q-sorts under present-self orientation and expected-self orientation. Goldstein, however, was unable to demonstrate an expectancy effect. As an explanation, he suggested that the measures of personality may have been too global.

Goldstein summarized the preceding body of research by stating that (1) there is a considerable amount of theoretical material which points to the influence of patient's prognostic expectancies on outcome in psychotherapy; (2) indirect or suggestive evidence also points to the existence of this relationship, and (3) some studies (Brady, et al., 1960, Goldstein, 1960) have shown no such relationship in either highly heterogeneous and highly homogeneous research samples. Wilkins (1973a) stated in his summary of this body of literature:

> In spite of the profound conclusions made regarding the expectancy trait on therapeutic outcome, no one, to this reviewer's knowledge, has conducted the critically important study of successfully relating expectancy trait to objective measures of symptom

> reduction. The only study attempting this produced equivocal results (Brady, et al., 1960) (p. 71).

The above discussed research has dealt primarily with prognostic expectancy as trait. That is, as Frank (1959) suggested, the effectiveness of a therapeutic procedure is due to its success in fostering an expectancy of benefit. Bednar (1970) has suggested that expectancy may be manipulated as a state wherein the specific methods employed are irrelevant as long as the expectation of improvement is imparted to the client. A treatment approach, then, should include procedures to increase the client's expectancy of improvement. Research in this area has sought to demonstrate that a treatment approach which includes procedures designed to increase the patient's expectations of improvement should be more effective than a similar treatment approach which either does not include such expectancy enhancing procedures or includes procedures designed to induce low expectancy of improvement. Evidence consistent with this notion has been presented by several investigators.

Typically, in these investigations, high-expectancy subjects are instructed that they are participating in a study dealing with a therapy technique which has been demonstrated to be effective, while low-expectancy subjects are either not told that they are in a therapy study or that the therapeutic technique which they are to receive is ineffective (Wilkins, 1973a). Leitenberg (1969) and Oliveau (1969a, b), using such procedures in addition to desensitization procedures, found that subjects in the high-expectancy

instruction group improved significantly more than the low-expectancy therapy instruction group. Borkovec (1972), using a similar design in conjunction with implosion therapy, obtained similar results. Marcia, Rubin, and Efran (1969) found that when subjects were told to expect improvement from a laboratory procedure, they improved significantly more than when instructions of no expectation were given. Krause, Fitzsimmons, and Wolf (1969) obtained marginal effects in a design that used discussions during the first few group therapy sessions which focused upon the client's expectations of treatment.

While the above studies provide strong evidence for the effectiveness of expectancy induction, Wilkins (1973a) issues a striking indictment of the research:

> Without exception, in the expectancy state studies where expectancy effects were reported, the therapists were not experimentally blind; in the studies failing to demonstrate expectancy effects, therapists were blind.
>
> In summary..., in spite of the popular opinion that therapeutic gain is determined by S's expectancy of improvement, very little empirical evidence has been generated which demonstrates the effect of expectancy state (p. 72).

Wilkins has further argued against the attribution of causality to expectancy. It is argued that although high-expectancy instructions given to patients may lead to both an increase in expectancy and an increase in therapeutic outcome, it is not valid to conclude that prognostic expectancies cause improvement; that personality and situational variables contribute to therapeutic gain via their capacity to produce or enhance the prognostic

expectancy of the client. As evidence in support of this contention, Wilkins suggests that a number of variables have been confounded with either trait or state expectancy.

Viewing expectancy as trait and the relationship to therapeutic gain, Wilkins further argued much of the data on this has been correlational. Thus, cause-effect statements cannot be made with any degree of validity. It may be added that both expectancy and therapeutic gain may be caused by some other factor or factors. Furthermore, expectancy as trait is an organismic variable which may be correlated with a large number of other organismic variables (e.g., friendliness, happiness, anxiety level), each of which may be the cause of therapeutic gain. This confounding then makes it inappropriate to attribute causality to prognostic expectancy trait. Wilkins has argued in regards expectancy as state that, despite methodological difficulties, the definition of expectancy state used by the researchers has typically been circular. That is, the presence or absence of expectancy state has been identified by the outcome which the state is said to have produced. Yet, for expectancy to stand as a valid construct, it must be identified by criteria independent of therapeutic outcome which it is said to produce. In conclusion, Wilkins has stated that what has been shown is that the therapist's awareness of the client's prognostic expectancy does influence outcome of therapy. In turn, the client's communication of the expectancies he holds may influence the therapist's behavior. "Thus, while client expectancies, per se, do not appear to contribute directly to therapeutic gain, the client's communication of his

expectancies may affect therapeutic outcome indirectly by influencing the behavior of the therapist" Wilkins, 1973b, p. 188). Thus, a direction which the research in the area of patient prognostic expectancies should take is in the identification of those manners and behaviors of the therapist which may be influenced by the patient's communication of his expectancies.

Participant Role Expectancies

Participant role expectancies cover a broad range of specific expectations. Role expectations, in general, are those expectations held by a person in a given social status vis-a-vis a person in another specified status. Kaplan (Stein and Cloward, 1959, p. 83) has defined the concept of role as "...the expectations of people in general about appropriate behavior for individuals occupying a certain position." Sarbin and Jones (1955, p. 256) provided a definition closely related to that of Kaplan:

> A role expectation is a cognitive structure inferred, on the stimulus side, from the person's previous commerce with regularities in others' behaviors, and, on the response side, from the person's tendency to group a number of descriptions of actions and qualities together with the name of a specific social position. A role is defined as the content common to the role expectations of the members of a social group.

From these definitions it can be gleaned that there is the implication of a set of reciprocal expectations regarding the rights and obligations of the role partners. The sociological viewpoint emphasizes that role expectations are defined by the social norms applicable to the situation. Thus, if person A acts in a particular

way, then person B will respond in a specified way. Parsons and Sills (1951, p. 154), in a similar vein, have commented:

> The essential element in the role is complementarity of expectations. The outcome of ego's actions, in terms of its significance to him, is contingent on alter's reaction to what he does. This reaction in turn is not random, but is organized relative to alter's expectations of what is "proper" behavior on ego's part.

Research Evidence of Participant Expectations

A first step in recognizing the probable importance of participant role expectations in psychotherapy was made in the investigations of Seeman (1949), Kamm and Wren (1950), and Cameron and Margeret (1951). Kelly (1955) has provided an early conceptualization of participant role expectancies in regards to the psychotherapeutic process.

As Kelly has observed, a patient entering into psychotherapeutic relationship is capable of conceptualizing in advance the impending situation. In the early sessions, particularly, this initial conceptualization will, in all liklihood, influence his behavior in the session itself. As Kelly states (1955, p. 575): "From the client's conceptualization of psychotherapy comes the role he expects to play and the role he expects the therapist to play." Kelly suggested several specific patient expectations regarding the psychotherapeutic process. These include:

1. Psychotherapy as an end in itself rather than a means to an end.

2. Psychotherapy as a way to produce a fixed or rigid "healthy

state of mind."

3. Psychotherapy as a noble or virtuous act through which the patient will be rewarded by alleviation of his distress.

4. Psychotherapy as a way of altering one's circumstances.

5. Psychotherapy as a confirmation of one's mental illness.

6. Psychotherapy as proof of the objective difficulty of the patient's circumstances.

7. Psychotherapy as an environment in which already imminent change can/may take place.

Kelly further stated that the patient's expectations concern the role or roles which his psychotherapist will assume. These include the roles of parent, protector, absolver of guilt, authority figure, prestige figure, a possession, a stabilizer, a temporary respite, a threat, an ideal companion, and a representative of reality.

Wolberg (1954) has discussed patient's expectations of the therapist along similar lines similar to those of Kelly. Wolberg has suggested that the patient may be seeking something other than mental health. This may be, for the patient, a means to power, success, or perfectionism; or it may be that the patient is seeking a social relationship, a parental figure, or an idealized figure with whom he can identify.

Lennard and Bernstein (1960) discussed role expectations in psychotherapy as falling into three categories. Firstly, there are those expectations of the patient which are normative in nature. These expectations concern how the therapist should behave and are determined by the medical and/or psychiatric training of the

therapist. Secondly, there are those expectations which are anticipatory. That is, for example, a patient may anticipate rejection of the therapist because of the patient's early experiences. Finally, there are those expectations which are, in a sense, wishes. Here, then, although the patient knows that he should not expect the therapist to make decisions for him, he nevertheless wants, wishes, or desires him to do so.

An initial step in abstracting and clarifying the basic dimensions of role expectations in psychotherapy has been made by Apfelbaum (1958). Using 100 patients in a university outpatient psychiatric clinic, Apfelbaum obtained Q-sort responses designed to measure their pre-therapy expectations regarding the personality of their prospective psychotherapists. A cluster analysis of the patient's Q-sort responses revealed three relatively independent clusters or dimensions of patient role expectations (Goldstein, 1962, p. 57):

1. Nurturant. Patients falling into this grouping expect a guiding, giving, protective therapist who is neither businesslike, critical, nor expects his patients to shoulder their own responsibilities.

2. Model. Patients of this type expect a well-adjusted, diplomatic therapist who neither judges nor evaluates his patients and who plays the role of a very permissive listener. The therapist is expected to be neither protective nor critical.

3. Critic. The third cluster of patient role expectancies involves patients who expect the therapist to be critical and analytical, to want his patients to assume considerable responsibility and, further, they anticipate he will be neither gentle or indulgent.

Apfelbaum elaborates further on these expectancy clusters (1958, p. 57).

> One can surmise...that the critic patients need to perceive the therapist as an analyzer, as someone who will not try to nurture them, but will relate to them in a businesslike and impersonal way. They seem to be handling strong passive trends in a counter-active manner. For them the role of patient apparently has implications of passivity which threaten their counter-active stance. Although the nurturant patients' case material does not as readily assume a pattern, they seem freer to express feelings of helplessness and passive longings, handling strong passive needs by making them part of their identity...The model group is less concerned about themselves, pursuing a more reserved and safer path. In a sense they have no expectations; they are merely "interested". They seem to see themselves as rather normal individuals, making this fairly clear as soon as they arrive. Perceiving their therapist as a neutral figure perhaps enables them to maintain their relative lack of self-concern in the therapeutic situation.

Apfelbaum reported several significant findings regarding the expectancy cluster and other variables. Examination of the obtained distribution of males and females into the three role expectancies revealed a marked tendency for female patients to have model type role expectations and for males to expect a critic role for the psychotherapist. A second finding relates the degree of psychopathology, as measured by MMPI mean profile differences, to the three categories. The data strongly suggested that those patients who entered psychotherapy with a great degree of distress or maladjustment fell into either nurturant or critic categories. In addition, the degree of distress was greater for those patients in either nurturant or critic categories than that for patients who anticipated a model therapist. Of the 34 drop-out patients, model patients were significantly different from both nurturants and critics in that model expectors showed significantly less

drop-outs. A fourth general finding of Apfelbaum's research concerns the 66 patients who remained in therapy. His results indicated that nurturant expectors tended to be seen for larger number of therapy sessions than critic expectors; model expectors showed no significant difference on this variable. It thus appears that model expectors have the lowest rate of premature termination, yet those nurturant expectors who remained tended to remain in therapy longest.

Ruesch (1948), in a study of ulcer patients, analyzed responses to such questions as: "What kind of people are doctors?", "What kind of people should doctors be?", etc. His results bear close relatedness to Apfelbaum's clusters:

> 1. "Answers expressing the need for affection, attention, being loved, being nurtured, receiving encouragement, and being the focus of interest, were listed under the heading of nurturance."
> 2. "Answers containing references to intelligence, knowledge, and skill of a medical man, as well as their negative counterparts, were listed under authority."
> 3. "Features listed under this heading (ideal personality) made no reference to medical ability but reflected 'halo' factors surrounding physicians, thus elevating them to a celestial platform in order to admire their high ethical behavior" (Ruesch, 1948, p. 74).

Deskins, Herbert, Gorman, and Singer (1960) examined the expectations of 494 normal subjects regarding their physicians. Their factor analysis of projective and non-projective techniques yielded three major clusters, again greatly similar to Apfelbaum's triad.

Additional clarification of the role expectancy influences in psychotherapy has been provided by the investigation of Chance (1959). In this investigation, Chance obtained both role and

prognostic expectations from both patients and therapists via psychometric and semistructured review sessions at selected intervals in the course of one year of treatment. Six therapists were part of this investigation, three of which had a great deal of psychotherapeutic experience and the rest were relatively inexperienced. Chance found that there was a tendency for therapists in general to have expectations of patient behavior which were relatively constant across patients. This tendency was more pronounced for the inexperienced therapists and was related to positive outcome. Of importance to this discussion, however, is the finding regarding the patient's expectancies concerning the therapist. These patient expectancies were markedly similar for the six therapists. The major expectancies of the therapists were of his advice-giving, being helpful, leading, being sympathetic and affectionate. The second most frequent expectancies were appreciativeness, liking to be liked, cooperativeness, trustworthiness. Only in a few instances were the expectancies feelings of resentment, nagging, or tendency to accuse. Of major interest and importance was Chance's finding that role expectancies of the patient were generally similar to those values and behaviors which the therapist expected were desired by their patients.

Given that such expectancies exist, it is safe to say that initially in psychotherapy patient and therapist role expectancies are oftentimes incongruent. Lennard and Bernstein (1960) discussed several reasons for this absence of congruence. Psychotherapy, unlike marital, friendship, or work relationships, has not been

open to public scrutiny so that prospective patients have little detailed information about the nature of psychotherapy. A second reason is that the very nature of the psychotherapeutic relationship makes it difficult to fully grasp its requirement unless one has had the experience before. Typically, those problems which bring people to psychotherapy reflect one, an inability to adequately grasp and function appropriately within role relationships and, two, a rigidity of anticipation for these relationships. Thus, a third reason is that the individual's problems hinder his acquisition of initial expectations even though the opportunity has previously presented itself. Fourthly, the transference dimension of the therapeutic process elicits expectations which have no possibility of being met within the professional setting. Finally, those normative expectations that are held by the therapist are more clearly defined and structured than those of the patient. Lennard and Bernstein (1960, p. 24) conclude, then, that "discrepancies in role expectations are thus a natural condition of therapeutic systems of role relations."

Accepting, then, the notion that discrepancies exist between patient and therapist at the outset of therapy, the question arises as to what influence these discrepancies have for psychotherapy, and what would be the influence of matched expectancies in psychotherapy.

Lennard and Bernstein (1960) investigated the nature and interrelations of role expectations and communication in psychoanalytically oriented psychotherapy. A major finding of this investigation concerned the relationship between the degree of dissimilarity of

participant expectancies and the degree of strain and disequilibrium in their relationship. Lennard and Bernstein (1960, p. 153) report:

> When both members of a dyad are in agreement regarding their reciprocal obligations and returns, there is consensus or similarity of expectations, and harmony or stability occurs in their interpersonal relations... But when there is any degree of discrepancy or lack of consensus between the participants, and their expectations are dissimilar...manifestations of strain appear in their interpersonal relations. If expectations are too dissimilar, the...system disintegrates unless the differences can be reconciled.

In fact, expectational discrepancies may have deleterious effects on the therapeutic relationship (Lennard and Bernstein, 1960, p. 118):

> If the patient expects to make a rapid progress within a few sessions and does not learn that this expectation is unrealistic, he may become so discouraged that he will terminate treatment...If he expects the therapist to be a parent figure toward him...he may terminate treatment when the disappointment reaction sets in, or he may enter a stage of resistance until his misconceptions are exposed and corrected. If a patient expects to tell the therapist only those things of which he is proud and hides those things of which he is ashamed, the patient will make little progress until he learns to do otherwise. Thus, unrealistic role expectations tend to increase strain and destroy equilibrium.

Heine and Trosman (1960) proposed that a lack of complementarity of patient and therapist expectations was a disruptive factor in the early stages of therapy which could have led to termination. It was suggested that those patients whose expectations were complementary to those of the therapist found this to be rewarding and those whose expectations were not met experienced rejection and thus terminated. Specifically, patients whose expectation was active collaboration in psychotherapy tended to continue. Patients who saw their role

as passive cooperation tended to terminate, as did those patients who expected medication or diagnostic information, in contrast to help, in changing behavior. The authors concluded:

> The variable which appears to be significant for continuance is that of mutuality of expectation between patient and therapist. We have found that the model expectations of therapists treating the sample of patients in this study were as follows: (1) The patient should desire a relationship in which he has an opportunity to talk freely about himself and his discomforts. (2) The patient should see the relationship as instrumental to the relief of discomfort to be relieved by an impersonal manipulation on the part of the therapist alone. (3) Hence the patient should perceive himself as in some degree responsible for the outcome.
>
> Therapists also had well-defined reservations in advance of meeting their patients. For example, they did not intend to give diagnostic information or drugs, nor did they intend to be led into an active, directive role if the patient adopted a passive attitude. Thus a situation is created in which a patient with one set of expectancies is rewarded with the therapist's interest and attention while a patient with another set of expectancies--no less realistic in a medical setting--is, in effect, rejected. Our findings indicate that as many noncontinuers as continuers were hopeful about their anticipated experience with psychiatric treatment. The continuers, however, apparently conceptualized the experience in a manner more congruent with the therapists' role image, and were, therefore, in one sense more gratifying to the therapist (Heine and Trosman, 1960, p. 278).

Clemes and D'Andrea (1965) examined the effect of compatibility and incompatibility of patient and therapist expectations upon patient anxiety in an initial interview. It was found that both therapist and patients considered the interview in which expectations were compatible to be less difficult and less anxiety arousing. Patients with role expectations of active participation in therapy tended to remain in therapy, tended to remain in therapy longer, to terminate

on a mutual basis, to have had more previous therapy experience, and to be more similar to the therapist's ideal patient.

Severinsen (1966) examined the proposition that the counselor's role conformance to the client's expectations results in client satisfaction. The findings suggested that dissatisfaction was related to the dissimilarity of expected and perceived counselor behavior.

Overall and Aronson (1963) found that patients who failed to return for a scheduled interview, after an initial interview, showed greater discrepancies between their expectancies of the therapist and their perception of the initial interview than those who did return. The patient's role expectations of the therapist were classified as either active, medical, supportive, passive, or psychiatric (focus on the emotional or dynamic). A large portion of the discrepancy between expected and perceived behavior arose in that the therapist's behavior was less than anticipated; most of the discrepancy was in the categories of active, medical, and supportive.

Hypotheses

While the evidence reviewed has not been unequivocal, the literature taken as a whole, does point to a relatively strong influence of participant role expectancies on continuation in psychotherapy, patient satisfaction in psychotherapy, and psychotherapeutic outcome. The usefulness of Apfelbaum's triad of role expectations has been demonstrated and, in addition, the

significance of mutuality of this class of participant role expectations in the patient-therapist interaction has been emphasized.

With this as background, however, a review of the literature has revealed no investigations of the relationship between participant role expectations and patient response style preferences. Given that the client entering psychotherapy is equipped with a set of expectancies and preferences for his prospective therapist, several questions come to mind. What are the client's response preferences? That is, were Reisman and Yamokoski correct in their findings? What are the client's expectancies of his prospective psychotherapist? Does the client, in actuality, prefer the therapist to behave congruent to his expectancies?

Reisman's (1971) definition of psychotherapy and Apfelbaum's (1958) triad of participant role expectancies can be applied to answering these questions. Based upon the theoretical approach to psychotherapy and upon the empirical studies of participant role expectations, certain hypotheses would appear justified.

Expectation I: Reisman and Yamokoski have demonstrated that non-clients see empathic response styles as being uncommon and not preferred for both friends and psychotherapists. The response style most preferred for psychotherapists was the expository response style. They have suggested that perhaps the empathic response style would be more preferred by clients for their therapists.

Hypothesis I: Reisman and Yamokoski's (1974) findings for non-clients will be replicated; the client group will greatly prefer

the empathic response style from their therapist and friend with whom they discuss personal problems.

Expectation II: Both clients and non-clients have specific expectations of a psychotherapist. It would be expected that clients, by virtue of their subjective distress, expect a therapist to be a nurturant type. Non-clients, on the other hand, would not be expected to have as precise an expectation, and so as a group would differ widely among the three types of therapists.

Hypothesis II: Clients and non-clients will differ significantly in their expectations of psychotherapists.

Hypothesis IIa: Clients will expect a nurturant therapist significantly more so than non-clients.

Expectation III: Those individuals with nurturant role expectations will expect their therapist to be a guiding, giving, protective therapist who is neither businesslike, critical, nor expects his patients to shoulder their own responsibilities. The response style, described by Reisman, most characteristic of the nurturant therapist is the empathic style. It would be expected, then, that those patients whose expectancies are of a nurturant therapist would prefer their therapist to respond empathically.

Hypothesis III: For both patients and normals, the nurturant category of participant role expectations will correlate significantly and positively with the empathic response style preference.

Expectation IV: Those individuals with model participant role expectations will expect their therapist to be a well-adjusted diplomatic individual who neither judges nor evaluates his patients and who plays the role of a very permissive listener. The therapist is expected to be neither protective nor critical. The response style most similar to the description of the model therapist is the expository response style. It would be expected that those individuals whose expectancies are of a model therapist would prefer their therapist to respond in an expository manner.

Hypothesis IV: For both patients and normals, the model category of participant role expectations will correlate significantly and positively with the expository response style preference.

Expectation V: Those individuals with critic participant role expectations will expect their therapist to be critical and analytical, to want his patients to assume considerable responsibility and further, they anticipate he will be neither gentle nor indulgent. The response style, described by Reisman, of the critical therapist is the interrogative response style.

Hypothesis V: For both patients and normals, the critic category of participant role expectations will correlate significantly and positively with both interrogative and competitive response style preferences.

CHAPTER II

METHOD

Thirty clients and thirty non-clients completed four questionnaires designed to measure their preferences for their friends' and psychotherapists' competitive, empathic, expository, and interrogative response styles. In addition, the two groups completed an adjective checklist to ascertain their expectations of psychotherapists in terms of Apfelbaum's (Goldstein, 1962) triad of participant role expectations.

Subjects

Subjects consisted of thirty clients at the Texas Tech University Psychology Clinic and thirty college undergraduates enrolled in an abnormal psychology course at Texas Tech University. Median age for the client group was 26.9 years with a range of 19 - 44 years. Median age for the non-client group was 21.2 years with a range of 19 - 30 years. No effort was made to precisely match the two groups--clients and non-clients--as to age and educational level. There is reason to believe that the difference in median age from 26.9 to 21.2 should be particularly meaningful as regards response style preferences and role expectations of psychotherapists. In addition, it might be expected that the possible differential education of the client and non-client groups would influence the outcome of the present study to some extent. These considerations are discussed

in greater length in Chapter IV.

Measures

Response Style Questionnaire (RSQ)

The response styles to be examined were classified as empathic, expository, interrogative, and competitive. For their measurement four forms of a questionnaire were used. The questionnaires measuring empathic, expository, and interrogative response styles were those used by Reisman (1974; see Appendix A). As was discussed earlier, these derive from his definition of psychotherapy as the communication of person-related understanding, respect, and a wish to be of help (Reisman, 1971). Definitions of these response styles follow in which the person with the problem is referred to as A, and the therapist or helping individual is referred to as B:

1. Empathic. B communicates his understanding of what A seems to be saying, feeling, or thinking.

2. Expository. B communicates his expert analysis or explanation of A's problem, behavior, or possible course of action.

3. Interrogative. B asks A for clarification or for more information about A.

(Reisman, 1974, p. 270)

The fourth questionnaire, which measured preference for a competitive response style, was not included in the original study by Reisman (1974), but was designed after his questionnaires. This response style was suggested by Davis (1971) and derived for Haley's model of psychotherapy (Haley, 1963) discussed earlier. The closest

fit, in terms of Reisman's classification of communication styles, is that with the evaluation category:

Evaluation. B comments on the goodness, smartness, or value of what A has said or done (Reisman, 1974, p. 270).

In the competitive response style, though, the strategy of the helping person is a form of verbal combat with the helper:

4. Competitive. B comments in opposition to, or in disagreement with what A has said or done.

The competitive response style questionnaire used as B responses were those used by Davis (1971, pp. 159-160).

Each questionnaire began with a script in which two friends, A and B, discussed A's difficulties in school. All forms were identical except that B's responses to A were constructed to represent the four different types of response styles to be examined.

In Reisman's study (1974) it was reported that there was 93% agreement among two judges as to the intended classifications of the responses. Thus it was deemed unnecessary to repeat this procedure for his forms of the questionnaires that were used. The questionnaire in which the competitive response style preference was measured was submitted to two judges both of whom had had considerable experience as psychotherapists. There was 100% agreement between the judges that the B responses on the form were of the type of communication intended. B responses on the four forms consisted of approximately the same number of words and statements.

The scripts were introduced with the following paragraph:

> This is a study about how friends talk over their problems and what implications this might have for how psychotherapists talk with their clients. In the paragraph you are about to read one friend, A, is telling a friend, B, some personal problems. Pay particular attention to the way that B responds to A since the questions that you will answer concern B. Thank you for your help.

After reading the script, the subject responded to three statements by marking along a five-point rating scale ranging from "At no time" to "Almost all the time." The questions were as follows:

1. My best friend responds to my personal problems the way that B does.

2. I would like my best friend to respond to my personal problems the way that B does.

3. If I were to discuss personal problems with a psychotherapist, I would like the psychotherapist to respond the way that B does.

Each subject read and responded to all four questionnaires, thereby giving a repeated measures design.

Role Expectations Checklist (REC)

For the second part of the study a checklist was generated, consisting of 37 adjectives, which was derived from Apfelbaum's triad of patient role expectations of psychotherapists (Goldstein, 1962). The triad, which was discussed in greater detail earlier, is as follows:

1. Nurturant. Patient expects a guiding, giving, protective therapist who is neither businesslike, critical, nor expects his

patients to shoulder their own responsibilities.

2. Model. Patient expects the therapist to be a well-adjusted diplomatic individual who neither judges nor evaluates his patients and who plays the role of a very permissive listener. The therapist is expected to be neither protective nor critical.

3. Critic. Patients expect the therapist to be critical and analytical, to want his patients to assume considerable responsibility and further, they anticipate he will neither be gentle or indulgent.

(Goldstein, 1962, p. 57)

The list consisted of 15 adjectives falling into the nurturant category, 11 adjectives falling into the model category, and 11 adjectives falling into the critic category. This list was submitted to the same two judges used for the response style questionnaire for informal judging. There was no disagreement as to the adjectives falling into their respective categories.

The adjective checklist was next randomly ordered using a table of random numbers. The completed checklist was then introduced by the following:

> Below is a list of some personality characteristics of psychotherapists. Place a check mark by those characteristics which you would find desirable in a psychotherapist.

Design and Analysis

Two groups of subjects (n=30 in each group) were administered the RSQ and the REC. While groups were not matched, the subjects in the client group were selected from those seeking services at the

Texas Tech Psychology Clinic. Non-clients were selected from a Texas Tech University undergraduate psychology course. Median age for clients was 26.9 years with a range of 19-44 years and median age for non-clients was 21.2 years with a range of 19-30 years.

Scores on the RSQ were analyzed according to a 2x4x3 split plot factorial (SPF) analysis of variance (Subject Status x Response Styles x Situations). In addition, product-moment correlations were obtained between subject status, response styles, and situations. Scores on the REC were analyzed according to a 2x3 SPF analysis of variance (Expectancies x Subject Status). Finally, product-moment correlations were obtained between scores on question 3 of the RSQ for each of the four response styles and scores on the REC; correlations were obtained for clients, non-clients, and total Ss.

Procedure

The subjects in the Experimental group were selected consecutively from those persons requesting services from the Psychology Clinic. These subjects were asked to read and respond to the RSQ prior to completing any intake forms or initial interview. Having completed this, the subject then completed the standard intake interview forms used by the clinic. Within these forms was placed the REC which the subject completed as part of the regular intake procedures of the clinic. It was deemed necessary that the client-subject complete these forms prior to having any contact with a psychotherapist or intake interviewer to prevent any influence which these persons might have had on the subject's expectations and preferences.

After the subject completed the intake procedures the two sets of data were collected.

The subjects in the Control group were administered the RSQ during a regular class meeting and in the succeeding class period were administered the REC. Subjects who indicated that they had or were currently seeing a psychotherapist were eliminated from the study.

CHAPTER III

RESULTS

Response Style Preferences

It was hypothesized that the findings of Reisman and Yamokoski (1974) would be replicated and, in addition, that the client group would greatly prefer the empathic response style from their therapists.

The ratings on the RSQ were analyzed according to a 2x4x3 split plot factorial (SPF) analysis of variance (Subject Status x Response Style x Situations), Situations being defined as ratings of friend's actual responses, preferences for friend's responding in the particular style, and preferences for a psychotherapist's responding in the particular style (see Table 1). As indicated in Table 1, there was significant main effect for subjects, clients rating all items significantly higher than non-clients, $F(1,58)=51.480$, $p < .001$. These differences derived from the competitive response style being rated low while all other response styles were rated both higher and approximately equally. The response style-subject interaction was not significant. This suggests that clients and non-clients have no differential preference for the type of helping behavior exhibited by their friends and therapists, although, as mentioned, as long as neither is competitive, clients rate the variety of response styles more highly than non-clients. These mean ratings across all response styles and situations are summarized in Table 2.

There were no differences found across subjects for the three situations, $F(2,58)=.527$, $p > .05$, nor was there an interaction effect of subject status and situations, $F(2,58)=.912$, $p > .05$.

TABLE 1

ANALYSIS OF VARIANCE OF RSQ

Variable	df	MS	F
Subjects (client v. non-client) A	1	18.688	6.172*
Response Styles (B)	3	103.342	51.480**
Situations (C)	2	0.205	0.527
AxB	3	0.559	0.279
AxC	2	0.355	0.912
BxC	6	1.220	3.189
AxBxC	6	0.414	1.084
Subjects within groups	58	3.028	
BxS	174	2.007	
CxS	116	0.389	
BCxS	348	0.382	
Total	719		

**$p < .01$

*$p < .001$

TABLE 2

MEAN RATINGS - RESPONSE STYLES AND SUBJECTS

	All Subjects				All Response Styles	
	Competitive	Empathic	Expository	Interrogative	Clients	Non-clients
Mean	1.78	3.37	3.30	3.18	3.07	2.75
St. Dev.	0.98	1.00	1.05	1.00	1.25	1.13

Table 3 summarizes the results of a simple main effects analysis of the response style-situations interaction and Figure 1 graphically illustrates this data. It shows that there is a reversal of preference for response styles and situations. The empathic and expository response styles appeared to be equally preferred. The expository response style, however, is recognized as more common with friends than is the interrogative style. Not only is it more common, but it is also more preferred than the interrogative style when friends are cited as the helping person. To the contrary, the preferred response for the therapist is to respond interrogative rather than expository. These differences maintained regardless of subject status (client v. non-client).

TABLE 3

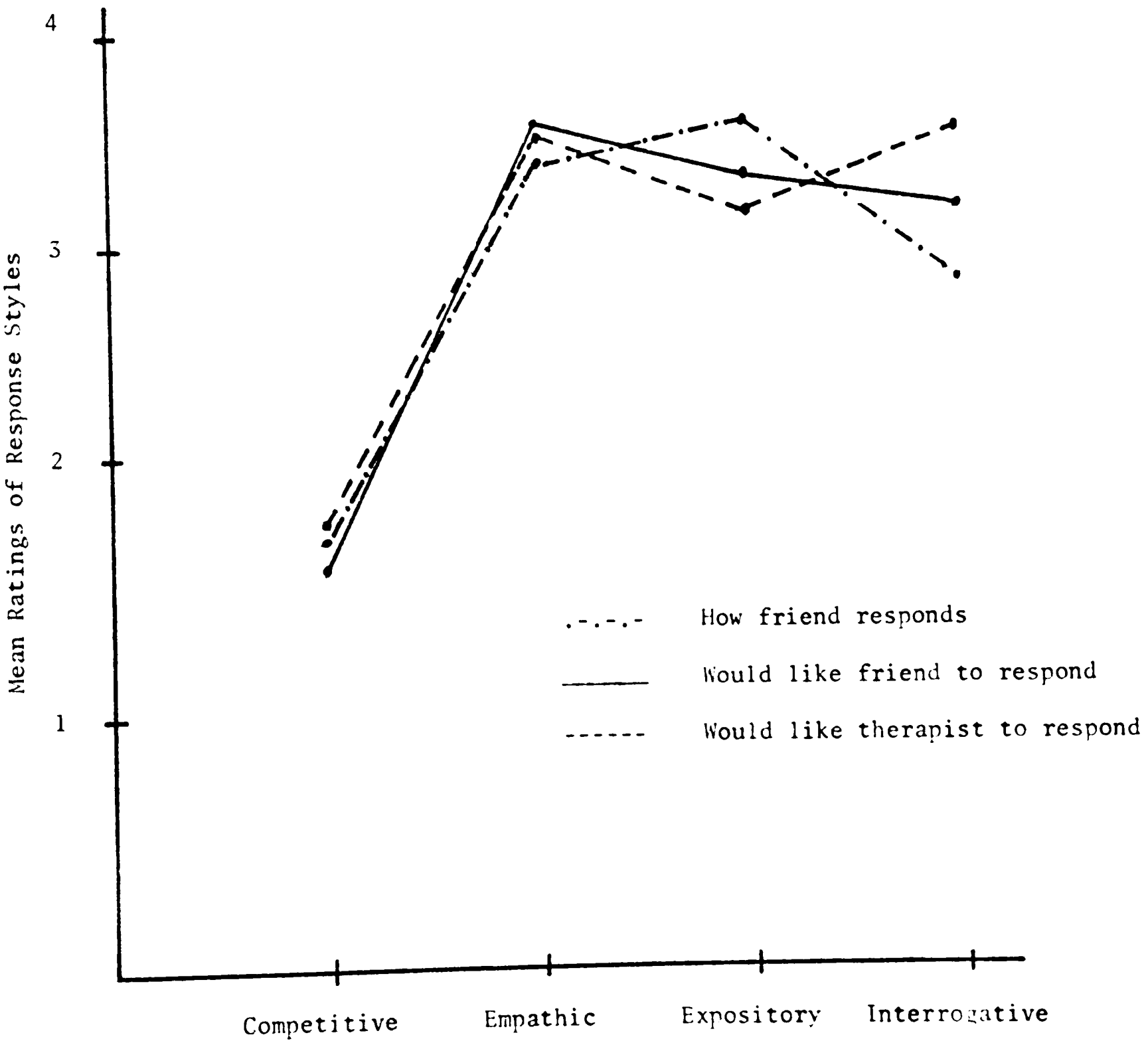
TEST OF SIMPLE MAIN EFFECTS

	SS	df	MS	F
SS B at C_1	97.242	3	32.414	20.34*
SS B at C_2	113.495	3	37.83	23.79*
SS B at C_3	106.272	3	35.424	22.23*
Error term			1.593	
SS C at B_1	1.242	2	.621	1.07
SS C at B_2	.364	2	.182	.314
SS C at B_3	1.956	2	.978	1.68
SS C at B_4	5.292	2	2.646	4.567*
Error term			.579	

*$p < .01$

FIGURE 1

RESPONSE STYLE-SITUATIONS INTERACTION-TOTAL SUBJECTS



As a further check on the nature of the response style preferences, Pearson product-moment correlations were computed between the ratings on the three questions (concerning the nature of the helper) and the four response styles, for the client, non-client, and total Ss groups. Tables 4, 5, and 6 present the obtained correlations for clients, non-clients, and total Ss, respectively. It can be seen that the strongest correlations are between questions 2 and 3 (response style preferences for helping friends and psychotherapists, respectively). From this it can be seen that regardless of their client or non-client status, the response preferred (or not preferred) corresponded highly with the preference for psychotherapists.

TABLE 4

PRODUCT-MOMENT CORRELATION MATRIX OF QUESTIONS WITHIN RESPONSE STYLES - CLIENT GROUP

	Competitive			Empathic			Expository			Interrogative		
Questions within response category	1	2	3	1	2	3	1	2	3	1	2	3
1	-			-			-			-		
2	.58	-		.62	-		.54	-		.69	-	
3	.47	.78	-	.49	.88	-	.58	.85	-	.60	.89	-

$p < .05$, two-tailed test, all correlations

TABLE 5

PRODUCT-MOMENT CORRELATION MATRIX OF QUESTIONS WITHIN RESPONSE STYLES - NON-CLIENT GROUP

	Competitive			Empathic			Expository			Interrogative		
Questions within response category	1	2	3	1	2	3	1	2	3	1	2	3
1	-			-			-			-		
2	.48	-		.72	-		.74	-		.42	-	
3	.34	.86	-	.74	.82	-	.55	.85	-	.41	.79	-

$p < .05$, two-tailed test, all correlations

TABLE 6

PRODUCT-MOMENT CORRELATION MATRIX OF QUESTIONS WITHIN RESPONSE STYLES - TOTAL SUBJECTS

	Competitive			Empathic			Expository			Interrogative		
Questions within response category	1	2	3	1	2	3	1	2	3	1	2	3
1	-			-			-			-		
2	.56	-		.66	-		.65	-		.71	-	
3	.45	.81	-	.59	.84	-	.53	.85	-	.54	.73	-

$p < .05$, two-tailed test, all correlations

From the results presented it was concluded that Hypothesis I was not supported. Excepting the competitive response style which was not preferred, there were no differential preferences between clients and non-clients; for all subjects the response style preferred for psychotherapists was the interrogative style and for friends as helpers, the expository. While the hypothesis reflecting Reisman and Yamokoski's (1974) findings was not supported, it should be noted that, as in their study, the empathic mode was not preferred. This finding is contradictory to traditional conceptualizations of psychotherapy and is considered in detail in the next chapter.

Participant Role Expectancies

It was hypothesized that clients and non-clients would differ significantly in their expectations of psychotherapists, and that clients would expect a nurturant therapist while non-clients would have a more diverse set of expectancies. The REC was analyzed according to a 2x3 split plot factorial (SPF) analysis of variance (Subject Status x Expectancy Model) and the results are summarized in Table 7. The table indicates no significant effects for treatment groups, $F(1,58)=.496$, $p > .05$. With regard to the expectancy categories, there were significant differences. As shown in Table 8 and illustrated graphically in Figure 2, the nurturant category received the most number of words checked followed by the critic and model categories, $F(2,58)=28.917$, $p < .001$. There was no significant Subject Status-Expectancy interaction, $F(2,58)=1.342$, $p > .05$.

Thus while Hypothesis II and IIa were not supported, it was shown

that of the three categories, the nurturant category was the most preferred for all subjects.

TABLE 7

ANALYSIS OF VARIANCE OF REC

Variable	df	MS	F
Subjects (client v. non-client) (A)	1	5.447	0.496
Expectancy (B)	2	111.624	28.917*
AxB	2	5.180	1.342
Subjects within groups	58	6.952	
BxS	116	3.860	
Total	179		

*$p < .001$

TABLE 8

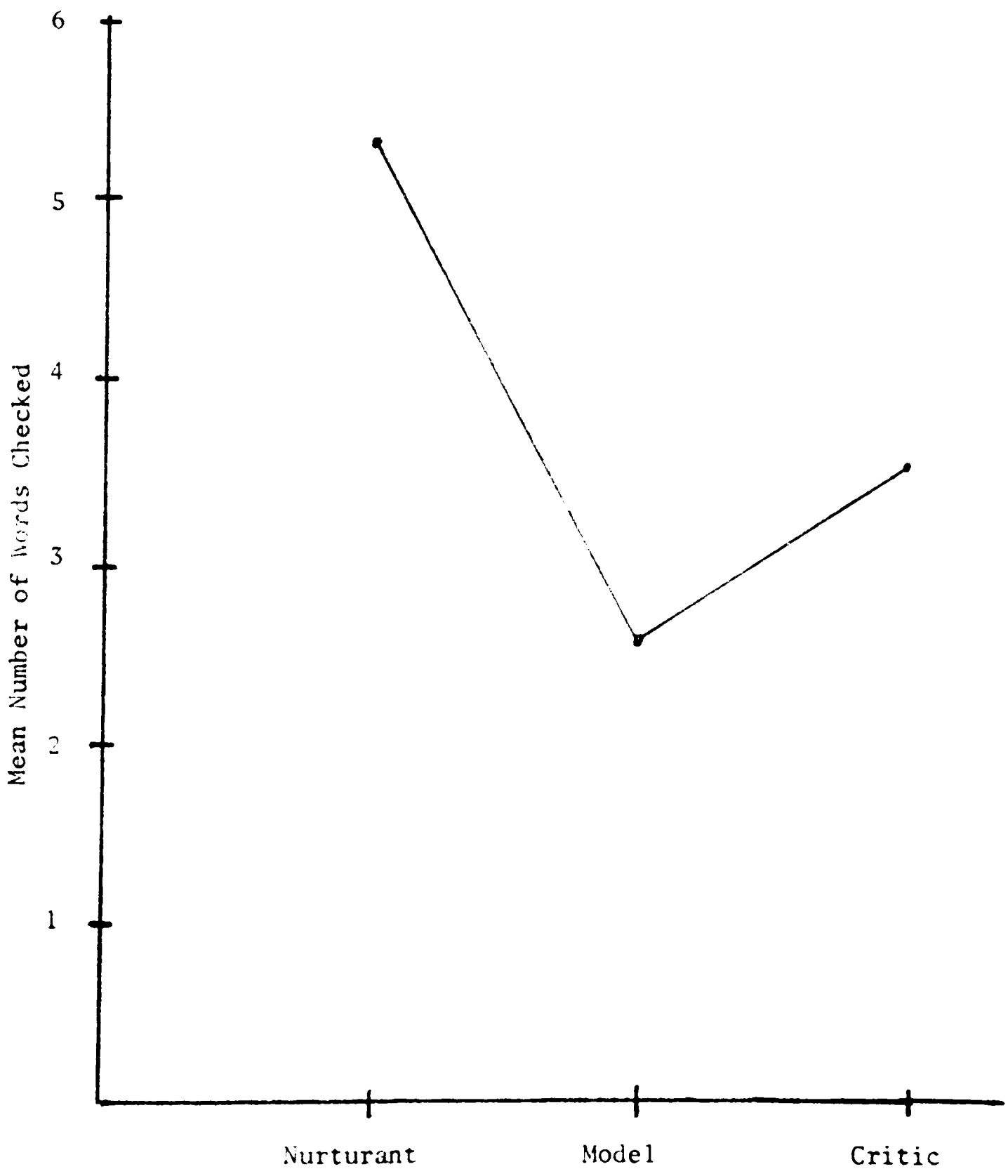
MEAN NUMBER OF WORDS CHECKED IN EACH OF THE EXPECTANCY CATEGORIES

	Mean	Standard Dev.
Nurturant	5.32	2.53
Model	2.63	1.88
Critic	3.60	2.15

($F=28.917$, $p < .001$)

FIGURE 2

MEAN NUMBER OF WORDS CHECKED-TOTAL SUBJECTS



Response Style Preferences and Participant Role Expectancies

In order to determine the nature of the relationship between response style preferences for psychotherapists and the participant role expectancies, Pearson product-moment correlations were obtained between the ratings on question 3 (response preference for the psychotherapist) of the RSQ and the number of words checked for each of the three expectancy categories. The correlations were determined for clients, non-clients, and total Ss.

Tables 9, 10, and 11 illustrate the obtained correlations for these three groups, respectively. Of the correlations obtained, only two reached statistical significance. For the non-client group, the nurturant category correlated significantly with the empathic response style preference ($r=.44$, $p < .05$, two-tailed test), and with the interrogative response style preference ($r=.45$, $p < .05$, two-tailed test). It can be recalled that it was hypothesized that for both groups of subjects, the nurturant category would correlate significantly with the empathic response style preference; the model category would correlate significantly with the expository response style preference; the critic category would correlate significantly with both interrogative and competitive response style preferences. Excepting the two significant correlations already mentioned, none of the expected correlations were obtained. Thus, from this evidence, it is that an individual's expectations of a psychotherapist had no relationship to a behavioral index of these expectations.

TABLE 9

CORRELATION MATRIX OF EXPECTANCY CATEGORIES WITH RESPONSE STYLE PREFERENCES FOR PSYCHOTHERAPISTS - CLIENTS

Statement #3 RSQ	Nurturant	Model	Critic
Competitive	-.03	-.13	.19
Empathic	-.13	-.06	.27
Expository	.16	.08	.26
Interrogative	.18	.31	-.03

TABLE 10

CORRELATION MATRIX OF EXPECTANCY CATEGORIES WITH RESPONSE STYLE PREFERENCES FOR PSYCHOTHERAPISTS - NON-CLIENTS

Statement #3 RSQ	Nurturant	Model	Critic
Competitive	-.24	-.03	.23
Empathic	.44*	.10	.02
Expository	.18	.04	.27
Interrogative	.45*	-.23	.15

*($p < .05$, two-tailed test)

TABLE 11

CORRELATION MATRIX OF EXPECTANCY CATEGORIES WITH RESPONSE STYLE PREFERENCES FOR PSYCHOTHERAPISTS - ALL SUBJECTS

Statement #3 RSQ	Nurturant	Model	Critic
Competitive	-.11	-.13	.20
Empathic	.12	.02	-.14
Expository	.16	.00	.26
Interrogative	.29	-.02	.04

CHAPTER IV

DISCUSSION AND CONCLUSIONS

Response Style Preference

It is clear from the results of this investigation that neither clients nor non-clients have particular preferences for the style of helping behavior offered by friends or therapists, as long as neither is competitive. In terms of the Reisman and Yamokoski (1974) study the results are somewhat inconsistent. Those investigators indicated that subjects (non-clients) regarded interrogative and, particularly, empathic responses as infrequent among their friends and that subjects did not want their friends to be empathic. They were less adverse, however, to the psychotherapist being empathic. In addition, the response style most preferred for psychotherapists was expository. The results from the present investigation indicated that while clients tended to rate all response styles consistently higher than non-clients, there were no distinct preferences between the two groups (excepting, of course, that neither group experienced the competitive response style from their friends, nor did they prefer it from friends or psychotherapists). One could suppose that, as a function of the client's distress, the tendency is to consider any helping behavior as useful. Some respondents, it has been shown, characteristically make extreme responses to all items, regardless of content. The extreme response set, while the subject of considerable research, remains relatively unclear; moreover, its diagnostic significance

and the personality correlates associated with it are not as yet fully documented (Lemon, 1973; O'Donovan, 1965, and Hamilton, 1958). The notion that an extreme response set is related to the degree of subjective distress thus remains a distinct possibility.

Another result contradictory to the findings of Reisman and Yamokoski (1974) is that, for all subjects, the expository response style on the part of the friend was seen as more common than the interrogative response style; and it is also more preferred for peers in a helping situation. On the other hand, it was preferred that the therapist respond in an interrogative manner rather than in an expository manner. Here, then, it may be inferred that subjects, regardless of client-non-client status, view the helping relationship of a friend and that of the psychotherapist as two similar, but quite different events. From the correlation matrices involving specific response styles it was seen that the correlations were strongest between the ratings on the statement "I would like my best friend to respond the way that B does" (r ranged from .71 - .89). Clearly the overall preferences for friends' and psychotherapists' behavior are very similar. Yet the response style preference for peers' behavior in a helping situation is expository and for the psychotherapist is interrogative. Thus persons, in discussing their problems with friends, can be thought of as wanting advice. Yet from their psychotherapist they want questions asked; that is, they want the therapist to engage in an exploration of the reasons for their behavior.

Like Reisman and Yamokoski's results, empathic responding,

while an acceptable response style, was not seen as being particularly common or preferred in either a friendship or a psychotherapeutic relationship. This is a most significant finding, especially as it replicates the Reisman and Yamokoski results, in that it calls into question a major foundation of non-directive psychotherapy. It suggests that the communication of empathy by the therapist is not particularly sought by the client and may, in that it is contrary to his expectations, be the source of some discomfort. Thus the relationship may develop in spite of this disconfirmation of preference rather than because of empathy. It may be that only later in the relationship does empathic responding become the preferred mode. In terms of those who consider psychotherapy as friendship, and empathy as the basis of both, it would seem again that their assumptions are at least open to serious doubts. Persons do make similar demands on helping friends and therapists. In neither case, however, do they prefer that the helper respond empathically.

The preferred response style for psychotherapists can be considered as a form of expectation. These findings here indicate that persons have a notion about how they should be helped. This is consistent with other results (Garfield and Nolpin, 1963). Friedman (1963) examined the relation of patient's expressed expectations from psychotherapy to their reported improvement after the initial interview. There was a positive relation between expected and reported reduction in symptoms. In light of the notion that lack of similarity of expectations and preferences may exist initially in therapy, it may be useful to attempt to prepare patients for therapy. Hoehn-Saric,

Frank, Imber, Nash, Stone, and Battle (1964) attempted this using the role-induction interview. A group of outpatients was divided into two groups, one of which received a role-induction interview. Psychotherapy was explained and realistic goals were mentioned. The group with the role-induction interview appeared to show more improvement. Nash, Frank, Imber, Stone, and Battle (1965), in a similar study found that patients who were prepared for psychotherapy by a role-induction interview progressed better in treatment. Thus, one function of the role-induction interview might be to realize a correspondence between client's response style preferences and likely therapist's behavior.

The possible variables on which a client and therapist may be matched are numerous and many have not been thoroughly explored. Indeed, the response style preferences of clients need to be further explored in terms of those that may be ignored by the therapist without any detrimental effect on the course of therapy and those which must be fulfilled to enhance the therapeutic process.

Participant Role Expectancies

The results from the analysis of the REC showed that clients and non-clients did not differ in their expectations. Important, though, is the finding that, for the total subject group, the most frequently checked category was the "nurturant" followed by the "critic" and "model" categories. These results are in disagreement with those of Wallach (1962) who found that most college students prefer the therapist labeled as "critic" by the author. Hutcherson (1968) also found that subjects prefer therapists who allow them more responsibility (this is,

in essence, Apfelbaum's definition of the critic category). Considering the range of ages obtained in the present sample, and the client-non-client distinction that was made, it does not appear reasonable to assume that the present results are limited by the restricted sample. It may be that there are no clear-cut criteria for assuming that a certain population would be expected to have certain preferences. Obviously, further investigation is needed to more precisely delimit the specific populations having specific expectations.

Relationships Between Response Style Preferences and Participant Role Expectancies

From the hypotheses offered in Chapter I, it was expected that significant correlations would obtain between response style preferences and participant role expectancies. Of the twelve correlations obtained only two reached statistical significance while the remainder of the correlations were approximately zero. It was concluded that the hypotheses proposed were not supported. There was no correspondence between expected personality characteristics of psychotherapists and a more behavioral index of these expectancies. It can be concluded that clients and non-clients do not really know what they prefer or expect from a psychotherapist. On the one hand, persons expect their therapist to be warm, empathic, and nurturant, but when presented with a script of the actual behavior of such a therapist, they show no particular preference for his response style. This conclusion must be tempered by the following considerations.

The classic studies by LaPiere (1934), Saenger and Gilbert (1950),

Kutner, Wilkins, and Yarrow (1952) and others have demonstrated the inconsistencies between verbal measures and behaviors; an examination of the literature in this area points to the lack of correspondence which has been observed between verbal and behavioral measures of attitude (Lemon, 1973). One of the two instruments utilized in the present investigation may be considered as being a measure of attitude (REC) and the other as an indirect behavioral measure (RSQ). If this differentiation is accepted, the lack of significant correlations is better understood and, indeed, might have been anticipated. This contention, thus, does not deny the importance of patient expectations for psychotherapy which has been consistently demonstrated. Nor does it call into question the results which indicate that congruence of patient and therapist expectations has a favorable effect upon the process and duration of therapy. Rather, it points to methodological difficulties which may arise in research examining patient expectancies or preferences in psychotherapy. Reisman (1971), in a study of preferences for Rogerian, analytic, and behavioral therapies, found that the use of a tape recording of the representative therapies did much to increase the attractiveness of the methods of treatment. Further research in this area would appear to require a measure of preferences which is based upon a behavioral representation of the therapist's behavior which is as close as possible to the actual therapist's behavior. The point is that clients, required to enumerate or select the traits they seek in a therapist, may respond with the kinds of warm, friendly traits they might designate for any relationship. Actually, however, they anticipate and prefer a

therapist who behaves in quite a different, more authoritative, manner. It is only when therapist behavior descriptions, or tapes, are available that their specific stylistic expectancies can be determined.

Another consideration which may account for the failure to obtain significant correlations involves the words used for the adjective checklist. It may be that adjectives such as "interpretive," "purely receptive," "aloof," and others may have been unclear to the subjects. Since no effort was made to control for educational levels, this may have adversely affected the selection of certain words by the subjects.

Conclusions

These findings and the results of other studies previously considered suggest that: (1) there are differences among persons in the way they conceptualize the role of the psychotherapist; (2) these role expectations are related to the preferences which they may hold about the type of treatment they receive and their impression of the therapist; (3) there are apt to be at times discrepancies between the way the client and the psychotherapist view their respective roles. When a person comes in contact with a psychiatrist, psychologist, clinic, or psychiatric hospital his expectations have been largely determined by the radio, TV, press, and other media, and without *a priori* endowment of the therapist with some healing powers by the person and society, the person would never begin or even know about psychotherapy (Ruesch, 1961; Frank, 1959).

It is commonly held that psychotherapeutic methods should be

adapted to specific circumstances and patients, rather than patients being forced into the molds for which they are not fitted. The failure of the psychoanalytic method in the treatment of schizophrenics, psychopaths, immature people, and OBS patients serves as an unfortunate example of such considerations being ignored. It can be assumed that similar problems in psychotherapy are, at least in part, the result of a failure to match patient expectancies with actual therapist behaviors. Therapeutic communication requires adaptive behavior on the part of the therapist and/or re-education of the client such that his expectancies are brought into congruence with actual therapist behaviors. In this regard Reisman (1971, p. 120) states:

> It is reasonable to suppose that an undetermined proportion of clients make an active attempt to match themselves with therapists they believe will be congenial. Probably this happens more frequently among a sophisticated and relatively wealthy clientele that has the opportunity to pick and choose among therapists. However, even among the less well-to-do this matching surely does go on. It may partially explain why so many clients break off from what starts out to be long term psychotherapy after about five interviews, and why they stop with one therapist only to turn up immediately thereafter to seek the help of someone else.

But what are the highly important therapist-client variables to be used as criteria for matching? The answer to this remains unclear and complex. Additional research in this area must be concerned with such questions regarding the client's needs, the therapist's needs, and the therapist's beliefs about the appropriate client. It appears that the decision is not whether matching is appropriate. The critical points are (1) that therapists must become more aware of the client's

expectancies and preferences; and (2) that they must vary their styles or induction procedures in accordance with this information.

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APPENDIX A

Response Style Questionnaires

1. Competitive
2. Empathic
3. Expository
4. Interrogative

This is a study about how friends talk over problems with one another and what implications this might have for how psychotherapists talk with their clients. In the paragraph that you are about to read one friend, A, is telling a friend, B, some personal problems. Pay particular attention to the way that B responds to A since the questions that you will answer concern B. Thank you for your help.

A: I've been having a hard time studying.
B: Not many people find that studying is much of a problem.
A: Well, I read a book and when I'm all through I don't remember a thing.
B: I find that hard to believe.
A: I wonder what's the matter with me ...why I don't get it?
B: I understand what you're saying, but that question doesn't bother most people.
A: Yes, I figure what am I doing here?...I don't really belong here.
B: It's fairly unusual for someone who comes in here to say that.
A: That's right...I know a lot of people are counting on me.
B: That may be so but that's a peculiar way of looking at it.

* *

1. My best friend responds to my personal problems the way that B does

Almost all the time	Most of the time	Some of the time	Hardly ever	At no time

2. I would like my best friend to respond to my personal problems the way that B does

Almost all the time	Most of the time	Some of the time	Hardly ever	At no time

3. If I were to discuss personal problems with a psychotherapist, I would like the psychotherapist to respond the way that B does

Almost all the time	Most of the time	Some of the time	Hardly ever	At no time

4. I have one or more friends with whom I feel I can discuss personal problems. Yes____ No____

5. I have seen, or am going to see, a counselor or psychotherapist for help with my personal problems. Yes____ No____

____ I would never see a psychotherapist.

Male____ Female____

A: I've been having a hard time studying.
B: You mean you've had a hard time concentrating on your work.
A: That's right. I read a book and when I'm all through I don't remember a thing.
B: That probably gives you a scary feeling.
A: I wonder what's the matter with me...shy I don't get it.
B: Kind of a panic, I guess, especially when an exam is coming up.
A: Yes, I figure what am I doing here...I don't really belong here.
B: It sounds like a lot of doubts pop into your head. You even wonder if you should be in college.
A: That's right...I know a lot of people are counting on me.
B: So college is a big responsibility for you and I guess it puts a lot of pressure on you to do well. Yet all this pressure doesn't seem to help you to study, but just makes you feel that much more upset when you can't study.

* *

1. My best friend responds to my personal problems the way that B does

Almost all the time	Most of the time	Some of the time	Hardly ever	At no time

---

2. I would like my best friend to respond to my personal problems the way that B does

Almost all the time	Most of the time	Some of the time	Hardly ever	At no time

---

3. If I were to discuss personal problems with a psychotherapist, I would like the psychotherapist to respond the way that B does

Almost all the time	Most of the time	Some of the time	Hardly ever	At no time

---

A: I've been having a hard time studying.
B: You and me both.
A: I'll read a book and when I'm through I don't remember a thing.
B: That happens to me sometimes, but if I take a break, I can usually go back and study.
A: I wonder what's the matter with me...why I don't get it.
B: Maybe you're pushing too hard just before exams. Take it easy.
A: Yes, I figure what am I doing here...I don't really belong here.
B: Listen, you're no dummy. You're as smart as anybody else in this school. Don't go knocking yourself.
A: That's right...I know a lot of people are counting on me...
B: Same with me. My parents are giving up a lot to send me to school so I know how it is. You've got to do the best you can, but there's no sense in making it all work and no play.

* *

1. My best friend responds to my personal problems the way that B does

Almost all the time	Most of the time	Some of the time	Hardly ever	At no time

---

2. I would like my best friend to respond to my personal problems the way that B does

Almost all the time	Most of the time	Some of the time	Hardly ever	At no time

---

3. If I were to discuss personal problems with a psychotherapist, I would like the psychotherapist to respond the way that B does

Almost all the time	Most of the time	Some of the time	Hardly ever	At no time

---

A: I've been having a hard time studying.
B: What seems to be the matter?
A: Well, I'll read a book and when I'm all through I don't remember a thing.
B: Is that the way it is in all your subjects? How do you feel about it?
A: I wonder what's the matter with me...why I don't get it.
B: Does it seem to be worse just before you have to take a test or exam?
A: Yes, I figure what am I doing here...I don't really belong here.
B: With all those doubts popping into your head, do you also wonder if you should be in college?
A: That's right...I know a lot of people are counting on me...
B: Who? Is it your parents and family? Do you think it's helping you to study to worry yourself about them? Doesn't that just make you more upset?

* *

1. My best friend responds to my personal problems the way that B does

Almost all the time	Most of the time	Some of the time	Hardly ever	At no time

---

2. I would like my best friend to respond to my personal problems the way that B does

Almost all the time	Most of the time	Some of the time	Hardly ever	At no time

---

3. If I were to discuss personal problems with a psychotherapist, I would like the psychotherapist to respond the way that B does

Almost all the time	Most of the time	Some of the time	Hardly ever	At no time

---

APPENDIX B

Adjectives Generated for the Role Expectation Checklist

NURTURANT

SUPPORTIVE
PROTECTIVE
WARM
CONCERNED
CARING
FATHERLY
GUIDING
EMPATHIC
SYMPATHETIC
INDULGENT
TOLERANT
COMPASSIONATE
ADVICE-GIVING
ENCOURAGING
KIND

Patient expects a guiding, giving, protective therapist who is neither businesslike, critical, nor expects his patients to shoulder their own responsibilities.

MODEL

TACTFUL
WELL-ADJUSTED
DIPLOMATIC
NON-CRITICAL
NON-JUDGEMENTAL
NON-EVALUATIVE
PURELY RECEPTIVE
PERMISSIVE
ACCEPTING
PASSIVELY PARTICIPATING
PASSIVE LISTENER

Patient expects the therapist to be a well-adjusted, diplomatic individual who neither judges nor evaluates his patients and who plays the role of a very permissive listener. The therapist is expected to be neither protective nor critical.

CRITIC

CRITICAL
ANALYTICAL
OBJECTIVE
JUDGEMENTAL
EVALUATIVE
CONFRONTIVE
INTERPRETIVE
HARD
ALOOF
BUSINESSLIKE
IMPERSONAL

Patient expects the therapist to be critical and analytical, to want his patients to assume considerable responsibility and further, they anticipate he will be neither gentle nor indulgent.

APPENDIX C

Role Expectation Checklist

Below is a list of some personality characteristics of psychotherapists. Place a check mark by those characteristics which you would find desirable in a psychotherapist.

* *

_____EVALUATIVE

_____OBJECTIVE

_____WARM

_____COMPASSIONATE

_____INTERPRETIVE

_____SUPPORTIVE

_____SYMPATHETIC

_____IMPERSONAL

_____KIND

_____NON-CRITICAL

_____FATHERLY

_____JUDGEMENTAL

_____CONFRONTIVE

_____GUIDING

_____ALOOF

_____BUSINESSLIKE

_____INDULGENT

_____TACTFUL

_____DIPLOMATIC

_____PROTECTIVE

_____PURELY RECEPTIVE

_____PASSIVE LISTENER

_____HARD

_____CRITICAL

_____PASSIVELY PARTICIPATING

_____ADVICE-GIVING

_____TOLERANT

_____PERMISSIVE

_____EMPATHIC

_____CARING

_____ACCEPTING

_____WELL-ADJUSTED

_____CONCERNED

_____NON-EVALUATIVE

_____ANALYTICAL

_____NON-JUDGEMENTAL

_____ENCOURAGING