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EFFECTS OF COUNSELOR-SUBJECT VALUE CONGRUENCE ON WILLINGNESS TO SELF-DISCLOSE IN AN ANALOGUE PSYCHOTHERAPY INTERVIEW SITUATION

by
Lance V. Suan

Bachelor of Arts, University of Hawaii--Manoa, 1987
Master of Arts, University of North Dakota, 1989

A Dissertation
Submitted to the Graduate Faculty
of the
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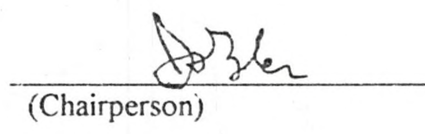
in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy

Grand Forks, North Dakota
December
1993

This dissertation submitted by Lance V. Suan in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota has been read by the Faculty Advisory Committee under whom the work has been done, and is hereby approved.



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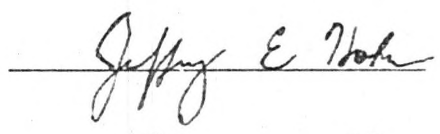

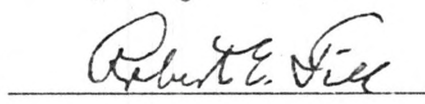

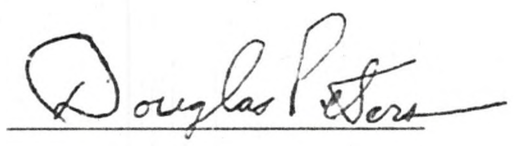

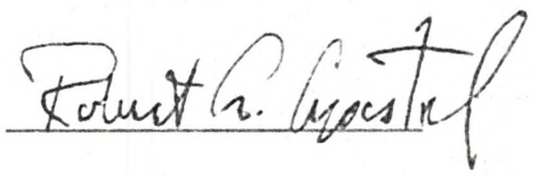

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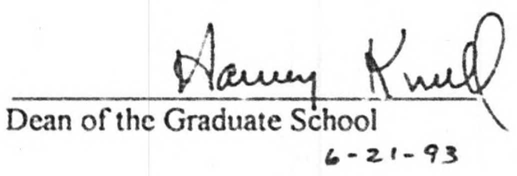

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ABSTRACT

A substantial amount of research has been directed towards identifying particular factors which contribute toward a positive psychotherapy outcome. One variable which appears to positively influence psychotherapy outcome is the "therapeutic alliance," or the establishment of a positive working relationship between client and counselor. The present study investigated the therapeutic alliance as a function of the degree of agreement between client and therapist about Affective Control values, or beliefs concerning whether emotional expression constitutes healthy or unhealthy emotional adjustment.

Subjects consisted of 111 undergraduate students; 64 subjects were identified as high scorers on the Affective Control Scale of the Mental Health Values Questionnaire (MHVQ), and 47 were identified as low scorers. Half of the high and low score subjects were exposed to a therapist on videotape who described affective control as a positive indicator of emotional adjustment (i.e., high on Affective Control). The other half of high and low score subjects were exposed to a therapist on videotape who described affective control as a negative indicator of emotional adjustment (i.e., low on Affective Control). Thus, half of all subjects experienced a therapist-value congruent condition while the remaining subjects experienced a therapist-value incongruent condition.

Results indicated that therapist-value congruent subjects rated the therapist as both more trustworthy and more comfortable to be with than did incongruent subjects. An unhypothesized finding indicated that high affective control-score subjects rated the therapist more positively on a number of traits than did low affective control-score subjects. It is possible that the more positive ratings by high affective control-score

subjects may be a function of a general reserve or reluctance to express openly negative opinions about others, thus resulting in "inflated" therapist evaluations. However, it is also possible that the Affective Control Scale of the MHVQ may actually be measuring a variable other than affective control values, such as a "Positive Outlook" or "Positive Appraisal Tendency." Further research utilizing the MHVQ will contribute to our understanding of the factors which are involved in a successful therapeutic alliance.

INTRODUCTION

A substantial amount of research has been directed towards identifying particular factors which contribute toward a positive psychotherapeutic outcome. One variable which appears to positively influence psychotherapy outcome is the therapeutic alliance. A number of studies (Morgan, Luborsky, Crits-Christoph, Curtis, and Solomon, 1982; Luborsky, Crits-Christoph, Alexander, Margolis, and Cohen, 1983; Luborsky, Mintz, and Auerbach, 1980; Eaton, Abeles, and Gutfreund, 1988; Marziali, 1984; Moras and Strupp, 1982; Gomes-Schwartz, 1978) suggest that the establishment of a positive therapeutic alliance between client and counselor is a significant predictor of positive therapy outcome. Such findings have stimulated interest in better understanding the nature of the therapeutic alliance and the mechanisms whereby positive rapport between client and therapist influence psychotherapy outcome. The present study was designed to investigate the therapeutic alliance as a function of the degree of agreement between client and therapist about "mental health values," or beliefs about what constitutes healthy emotional adjustment. Mental health values (Tyler, Clark, Olson, Klapp, and Cheloha, 1983) may be conceptualized as those particular personal traits or characteristics which an individual perceives to be indicative of good mental health.

There exists a long held notion that similarity or compatibility between a client and therapist enhances the therapeutic relationship, which in turn results in a relatively more successful therapeutic outcome. In a comprehensive review of the literature, Atkinson and Schein (1986) identified several counselor-client factors that were consistently examined in relation to treatment outcome: personality; cognitive style; and attitude similarity or congruence in a therapist-client dyad. Atkinson and Schein tentatively concluded that the

research indicates counselor-client personality, cognitive-style, and attitude/value compatibility are important contributors to counseling process and outcome. However, they cautioned that the literature indicated equivocal results, in that psychotherapeutic outcome was positively related to some variables while it was negatively related to others. In addition, several studies found no significant relationship between these variables and psychotherapeutic outcome. The literature in this area will be reviewed in the following section.

The present study entails the examination of mental health values (i.e., conceptualizations about mental health), and will be described after the general literature has been reviewed. To date, little research has been conducted with respect to the impact of mental health values similarity on the therapist-client relationship. Due to the scarcity of research investigating mental health values and its relationship to outcome, the literature review below will first address the findings of more thoroughly researched variables (i.e., counselor-client personality congruence; counselor-client cognitive style congruence; counselor-client attitude congruence) in regard to treatment outcome. Research findings related to the area of mental health values will then be described.

Counselor-Client Personality Congruence

Counselor-client personality congruence and its influence upon therapy outcome is a major variable of investigation (Atkinson and Schein, 1986). Cannon (1964) utilized the Omnibus Personality Inventory to assess personality similarity between counselors and clients on the dimensions of autonomy, schizoid functioning, and repression/suppression. In addition, objective measures of client affect expressed toward the therapist and therapist affect expressed toward the client were utilized. Results showed that similarity on guardedness (repression/suppression) was inversely related to the expression of affect by both counselor and client in a counseling session. There was no evidence that

autonomy and alienation (schizoid functioning) similarity between counselor and client were related to the expression of affect.

Carson and Heine (1962) used the MMPI to assess similarity of personality between patients and therapists who were medical psychiatry students under supervision. Therapists' supervisors rated the outcome of therapy which included changes in the clients' occupational adjustment, adequacy of interpersonal relations, and symptomatic status. Results indicated a curvilinear relationship with respect to patient-therapist personality and therapeutic success, with extreme congruence scores associated with poorer outcome. Carson and Heine proposed that with very high similarity the therapist might be unable to maintain suitable distance and objectivity, whereas in the case of great dissimilarity he/she would not be able to empathize with or understand the patient's difficulties. In a replication of Carson and Heines' study (1962), Lichenstein (1966) used identical procedures and found no relation between the measures of personality similarity between client and therapist and therapeutic success. Carson and Llewellyn (1966) made a further attempt at replication, but with certain modifications (e.g. therapists rather than supervisors providing outcome ratings). Results also failed to indicate any systematic relationships between personality similarity and outcome. Carson and Llewellyn argued that global personality similarity is not a productive research concept, and to consider abandonment in favor of more precise, analytical procedures.

Focusing on a specific personality variable, Tosi (1970) examined the effects of different levels of counselor and client dogmatism on clients' perceptions of the therapeutic relationship following an initial encounter. Previous research has suggested that dogmatic individuals are more prone to distort events occurring within the therapeutic context because of greater difficulties in self-communication (i.e. understanding their own thoughts, feelings, and desires) and its impact on understanding client feelings (Allen, 1967). Results indicated that highest client ratings of the therapeutic relationship occurred

when low-dogmatic counselors were paired with medium and low-dogmatic clients. Thus the variable of dogmatism showed an additive effect, in which client ratings of the relationship were progressively lower as less openness occurred in the dyad.

Mendelsohn (1966) utilized the Myers-Briggs Type Indicator (MBTI) to assess personality similarity between counselors and clients. The MBTI consists of four polarized scales; Judgment-Perception, Thinking-Feeling, Sensation-Intuition, and Extroversion-Introversion. Results indicated that overall similarity between client and counselor was associated with a greater number of counseling sessions. In addition, compared to a non-client sample, clients scored higher on the Intuition, Perception, and Thinking scales of the MBTI, but neither client nor counselor personality per se was related to duration of treatment. Another study (Mendelsohn and Geller, 1967) utilized the MBTI to examine the relationship between clients who dropped out of therapy and client-counselor personality similarity. Results were contrary to Mendelsohn's (1966) previous findings, indicating that compared to nonfailers, clients who failed to appear were significantly more similar to their counselors with respect to the MBTI. In addition, failure to appear was not related to client nor counselor characteristics per se. Mendelsohn and Geller proposed that similarity may facilitate communication between client and counselor, but encourages the exploration of personal or conflictual material before the client feels prepared to do so. Likewise, similarity may increase mutual attraction which leads to an excessive involvement in the personal interaction, and a resulting neglect of the client's concrete objectives. Thus, a missed session may reflect an ambivalent attitude toward counseling on the client's part.

Mendelsohn and Rankin (1969) measured client-counselor compatibility with the Fundamental Interpersonal Relations Orientation Behavior (FIRO-B) Scale. The FIRO-B consists of 3 scales - Inclusion, Control, and Affection - which attempts to measure both the extent to which someone expresses behavior toward others in each area, and the extent

to which he wants others to express the behavior toward him/her. Results indicated a significant relationship between FIRO-B compatibility in a counselor-client dyad and client ratings of therapy outcome, but for female subjects only. Specifically, compatibility in the Inclusion and Affection need areas was related to unfavorable client outcome ratings, while compatibility on the Control dimension was related to favorable outcomes. Mendelsohn and Rankin argued that results for Control were predictable and support the notion that the direction of the counseling process should be shared by both individuals. In addition, results for Inclusion and Affection suggested that conditions which encourage closeness may have an adverse effect upon the therapy process.

Malloy (1981) also utilized the FIRO-B to assess the relationship between therapist-client interpersonal compatibility and therapeutic outcome. Results were dissimilar from the Mendelsohn and Rankin (1969) study, and indicated that overall compatibility on the dimensions of Inclusion, Affections, and Control were significantly related to positive therapeutic outcome.

Cognitive-Style Congruence

Similarity of cognitive styles between counselor and client has been a less explored dimension than personality similarity. Fry and Charron (1980) investigated the effects of counselor-client cognitive style matching with respect to holism-serialism and field dependence-field independence on both interpersonal attraction ratings and client improvement on measures of self-exploration and self-awareness. In general, field-dependent perception is dominated by the overall organization of the field; there is relative inability to perceive parts of a field as discrete. In contrast, a field-independent style of perception experiences parts of a field as discrete from organized background rather than fused with it (Witkin et al., 1967). Results indicated that matching on field dependence-independence was related to greater client self-exploration and greater ratings of relaxed interactions with the counselor.

In examining another dimension of cognitive match, Heck and Davis (1973) reported that counselors expressed more empathy toward clients when they had a similar level of abstract conceptualization than when their conceptual levels were dissimilar. Contradicting this finding, Davis et al. (1977) found that counselor trainees, regardless of their own conceptual level, rated the client as more attractive when printed client statements were abstract rather than concrete. Atkinson and Schein (1986) argue that due to the scarcity of research on counselor-client cognitive similarity, it is very difficult to draw any definitive conclusions in this area.

Attitude/Value Congruence

The relationship between counselor and client attitude/value similarity and therapeutic outcome has been another important area of research. Landfield and Nawas (1964) assessed value similarity by having therapists and subjects rank order specific construct dimensions from the most important in understanding people to the least important. Results indicated that the greatest improvement in psychotherapy was associated with counselors and clients who ranked their constructs similarly with respect to their importance in understanding people. Cook (1966) had subjects rate the meaning of "me", "the ideal student", "my future occupation", and "education" on Semantic Differential evaluative scales (i.e. reflecting meaning on a valuable-worthless continuum, such as good-bad, clean-dirty, negative-positive, etc.) both before and after counseling. Results indicated that client ratings on "education" and "my future occupation" showed more positive changes for those who were seen by counselors with moderate value similarity than those seen by counselors with highly similar or highly dissimilar values. Cook suggested that a medium degree of value similarity enabled the counselor to differ enough in his own opinions to encourage exploration of new ideas on the part of the client, without causing tension or resistance. Edwards and Edgerly (1970) also utilized the Semantic Differential, which consisted of twelve concepts: My Academic Ability; My

Major; My Self-Confidence; My Father; My Friends; My Future; My Independence; Me; My Mother; My Motivation; My Interests; and Vocational Choice. Both counselors and clients rated each concept on three major dimensions: Evaluative (good-bad); Potency (hard-soft); and Activity (active-passive). Dissimilar to Cook's (1966) findings, Edwards and Edgerly discovered that low-congruence clients showed greater positive change than both the medium and high congruence groups. Beutler et al (1975) also found that low initial value similarity between counselor-client produced significantly more positive therapist influence than either high or medium initial similarity. To explain these findings, Beutler argued that although attitude change by the client per se does not relate to improvement, it is logical to assume that similarity and other variables that influence attitude change in the client may affect the perceived credibility of the therapist, and thus may affect outcome.

Lewis and Walsh (1980) utilized an analog procedure in which female subjects listened to an audio taped counseling interview in which the counselor was either explicit or implicit in expressing either a pro or con attitude toward premarital sex. Results indicated that subjects were more willing to see the counselor when they agreed on the values issue than when they disagreed. In addition, subjects hearing the explicit counselor value statement rated the counselor as more attractive and trustworthy when they agreed with her stated values than when they disagreed with them. In another analogue design, Good and Good (1972) found similar results when matching counselor-client values with respect to issues on college education, God, divorce, science fiction, and foreign language. Subjects received a form purportedly filled out by another undergraduate who was planning to enter the field of guidance and counseling. Subjects who shared similar values with the stimulus person rated him as having a higher probable level of sympathy, understanding, and effectiveness in dealing with psychological problems. In addition, they rated themselves as being more willing to discuss with this potential counselor academic,

family, heterosexual, and emotional problems. In another analog study by Good (1975), subjects received a packet that included the stated attitudes held by a hypothetical psychotherapist on the particular issues described above (Good and Good, 1972). Results indicated that when subjects were attitudinally similar to the therapist, they reported him to have greater open-mindedness, ability to promote feelings of ease, understanding of people, effectiveness as a psychotherapist, and personal attractiveness. In addition, subjects who were attitudinally similar were more willing to recommend the therapist to a friend experiencing personal problems.

In their review article, Atkinson and Schein (1986) drew several tentative conclusions with respect to personality and value similarity/compatibility in counselor-client dyads. They stated that personality compatibility between counselor and client is an important contributor to counseling process and outcome. Second, counselor-client compatibility for some personality traits is related to trait similarity and for other traits is influenced by trait dissimilarity. In addition, they suggested that some counselor and client personality traits are desirable in counseling regardless of counselor-client compatibility on these traits. Finally, the authors note that despite the potential importance of this area of research, investigators had apparently abandoned the topic before any definitive conclusions could be drawn.

In addressing attitude/value similarity research, Atkinson and Schein (1986) identified substantial evidence for a direct relationship between counselor-client attitude similarity and perceived counselor expertness, trustworthiness, and attractiveness (dimensions influencing the therapeutic process). However the relationship between counselor-client attitude similarity and counseling outcome is less clear, due to the scarcity of studies in this area and their conflicting results.

Mental Health Values Congruence

Although a number of studies have explored the relationship between

attitude/value similarity and psychotherapy process and outcome, the degree of counselor-client agreement in conceptualizing mental health has been largely neglected as a topic of investigation. This topic appears to be deserving of investigation because previous research has shown that there are significant differences in conceptualizations of mental health between ethnic groups (Suan and Tyler, 1990; Tyler and Suan, 1989) and with respect to gender (Tyler et al., 1983). In addition, Tyler, Clark, and Wittenstrom (1989) found that inpatient-chemical dependency treatment outcome was associated with the degree of agreement between counselor and patient in their conceptualizations of mental health.

Tyler et al. (1983) developed the Mental Health Values Questionnaire (MHVQ), a factor-derived instrument for measuring an individual's conception of good mental health. The MHVQ yields scores for eight factor scales: Self-Acceptance, Negative Traits, Achievement, Affective Control, Good Interpersonal Relations, Untrustworthiness, Religious Commitment, and Unconventional Reality. The instrument consists of 99 item-statements concerning beliefs about mental health. Responses to each item are made on a 5-point rating scale: a rating of 1 is given if the item indicates "very poor mental health"; 2 for "poor mental health"; 3 for "neutral, statement is not related to mental health"; 4 for "good mental health"; and 5 for "very good mental health".

Several studies have utilized the MHVQ to assess mental health values among different populations. Haugen et al. (1989) analyzed national samples of psychologists, psychiatrists, social workers, and psychoanalysts who completed the MHVQ. Results indicated a relatively high degree of consensus across professional disciplines with respect to mental health values. Sex differences indicated male psychologists viewed Affective Control as more strongly associated with good mental health than did female psychologists. In addition, female therapists viewed Self-Acceptance as more indicative of

good mental health than did males. This parallels previous MHVQ findings with undergraduate students (Tyler et al., 1983).

Cultural/ethnic differences have also been noted with respect to mental health values. In a comparison of Native-American and Caucasian undergraduate students on the MHVQ (Tyler and Suan, 1989) Caucasian subjects more strongly associated unconventional experiences of reality (e.g. having visions) with poor mental health than had Native American students. The latter group tended to perceive a neutral to positive relationship between such experiences and healthy emotional functioning. Another cross-cultural study sampling Caucasian and Japanese-American undergraduates (Suan and Tyler, 1990) revealed that Japanese-Americans more strongly related several MHVQ scales to good mental health (Good Interpersonal Relations, Trustworthiness, and absence of personal Negative Traits) than did Caucasians.

Researchers have also begun to explore the issue of whether agreement/disagreement between clients and therapists with respect to mental health values may influence psychotherapy outcome. Tyler, Clark and Wittenstrom (1989) examined patient response to alcoholism treatment as a function of patient-therapist mental health value congruence. Results indicated that positive treatment effects were associated with pretreatment agreement between counselor and patient on some mental health values (Negative Traits, Achievement, and Affective Control), but with pretreatment disagreement on others (Self-Acceptance, Good Interpersonal Relations, Religious Commitment, and Unconventional Reality). These findings indicate that the relationship between treatment outcome and counselor-patient value congruence is more complex than the notion of a simple positive function.

Therapeutic Alliance

Given the evidence that degree of client-therapist congruence on personality traits, cognitive style, and attitudes/values may be associated with psychotherapy outcome, a

question emerges. By what mechanism would such variables achieve their influence in the psychotherapy process? One very likely possibility is that congruence in personality traits, cognitive style, and attitudes/values could serve as mediating factors in the formation of a "therapeutic alliance" between a therapist and client. It has been suggested by both clinicians and clinical researchers that the therapeutic alliance is crucial in establishing a productive therapeutic process which will in turn determine therapeutic outcome (Luborsky, 1984). The present investigation is intended to explore this possibility with respect to mental health value congruence. Before a description of this proposal is presented, the therapeutic alliance concept will be examined more closely.

Luborsky (1976) has conceptualized the therapeutic alliance as consisting of two dimensions: Type I - the degree to which the patient experiences the therapist as warm, helpful, and supportive; and Type II - the sense of therapist and client working in collaboration against what is impeding the patient, and toward the attainment of treatment goals. Other researchers have taken a different position and argued that the therapeutic alliance should be defined exclusively as the patient's collaboration with the therapist in the tasks of psychotherapy, irrespective of the patient's subjective experience of the therapeutic relationship (Frieswyk et al., 1986). These researchers contend that taking such a position will allow one to distinguish underlying patient attitudes and experiences from the patient's actual collaboration in the process. A number of studies (Morgan et al., 1982; Luborsky et al., 1983; Luborsky et al., 1980; Eaton et al., 1988; Marziali, 1984; Moras and Strupp, 1982; Gomes-Schwartz, 1978) suggest that the establishment of a positive therapeutic alliance between client and counselor is one of the potent "non-specific" factors that account for therapy outcome. In view of such findings, it is worthwhile to investigate further the specific variables which are involved in the formation of a therapeutic alliance.

Measures of Therapeutic Alliance

A number of attempts have been made to develop useful measures of the therapeutic alliance concept. Workers associated with the Penn Psychotherapy Project have developed two instruments based upon the conceptualizations of Luborsky (1976): The Helping Alliance Rating Method (HAr) and the Helping Alliance Counting Signs Method (HAcs). The HAr method consists of various items covering both type I and Type II alliance dimensions. As described above, Type I refers to the patient's experience of receiving help or a helpful attitude from the therapist. Type II refers to the patient's experience of being involved in a joint or team effort with the therapist. The HAr method requires objective raters to review transcripts of two early and two late therapy sessions. Judges then rate the items for each scale on a 10-point Likert-type dimension, reflecting the degree to which each item descriptor was present in the therapy sessions. The Helping Alliance Counting Signs Method (HAcs) requires an objective rater to count in the therapy transcript all relevant patient statements (i.e., "signs") which fit either alliance Type I or II, classify them as positive or negative, and then rate their intensity on a 5-point scale. Each patient's score is the sum of the number of signs in each session weighted by the intensity of ratings.

Research has been conducted to assess the accuracy of HAr and HAcs methods as predicators of therapeutic outcome. Morgan et al. (1982) utilized the HAr method with a sample of non-psychotic patients recruited from the Penn Psychotherapy Project who were treated in psychoanalytical oriented therapy. Outcome was assessed by composite ratings of pre- and post-treatment adjustment, and were based upon such instruments as the MMPI scales for ego strength, hypochondriasis, and hysteria. Results indicated that both Type I and Type II alliance scores significantly predicted the outcome of psychotherapy. The greater Type I and II scores, the higher the composite ratings of success, satisfaction, and improvement from therapy.

Luborsky et al (1983) utilized both the Helping Alliance Rating (HAr) and Counting Signs (HAcs) methods with non-psychotic outpatients receiving psychoanalytical-oriented therapy. Results indicated that both HAcs and HAr measures showed a significant positive relationship with therapist-ratings of patient success, satisfaction, and improvement. The authors concluded that positive helping alliance signs are a significant predictor of therapeutic outcome, while negative helping alliance signs are not significant predictors. In a related study by Luborsky et al (1980), it was found that patients with better-rated outcomes established an increasing level of Type I alliance as treatment progressed. The level of Type II (i.e., collaboration) however, did not significantly change over the course of treatment for those who showed improvement. The above findings suggest that the client's subjective experience of the therapy relationship is an important determinant in therapeutic outcome.

Another instrument which has been developed for the purpose of assessing therapeutic alliance is the Therapeutic Alliance Rating System, initiated by Marziali et al (1981). This measure consists of four factor scales: Therapist Positive Contribution - the therapist is hopeful and encouraging; Therapist Negative Contribution - the therapist criticizes the patient and/or behaves in such a way that the patient may feel put down; Patient Positive Contribution - the patient indicates that he/she experiences the therapist as understanding and accepting; and Patient Negative Contribution - the patient acts in a hostile, attacking, and critical manner toward the therapist. Objective raters are required to review audio or videotape segments from individual sessions across the course of therapy. These observers then rate a list of 42 items which cover the four therapeutic-alliance scales described above. Each item is rated on an "intensity of presence" numerical scale, ranging from "not present" to "intensely present".

Researchers have attempted to utilize the Therapeutic Alliance Rating System as a predictor of therapeutic outcome. Eaton et al. (1988) utilized this measure of therapeutic

alliance with adult outpatients at a university counseling center. Therapy outcome was assessed by using the percentage of change on the Hopkins Symptom Checklist (SCL-90) subscales. Findings indicated that Somatization complaints declined when both therapist/patient positive alliance contribution increased and negative alliance contribution decreased. Second, as patient positive alliance contribution increased, reported Anxiety decreased, and as patient negative alliance contribution decreased, so did Depression, Paranoia, and Psychoticism. Third, as therapist positive alliance contribution increased, Paranoia and Psychoticism decreased. In addition it was found that the level of therapeutic alliance, regardless of length of therapy, was established within the first 3 sessions and remained largely constant throughout the course of treatment.

Marziali (1984) utilized the Therapeutic Alliance Rating System with clients seen in brief psychotherapy, and for the purpose of his study developed therapist and patient-rated versions of this measure to assess therapeutic alliance. Outcome was assessed by the change in clinical symptoms between pretherapy and 3 months following therapy termination. Results indicated that patients, therapists, and objective raters were in significant agreement in their ratings of patients' and therapists' positive alliance contributions. There was also agreement in their ratings of patients' negative input. Overall, therapist and patient estimates of positive contributions to the therapeutic alliance were the best predictors of outcome. The researchers suggested that therapist and patient ratings of the alliance are equal or better predictors of change than ratings by non-participant judges.

Surprisingly, other research has found that Therapist Positive Contribution to the alliance is not a significant predictor of therapy outcome (Marziali et al, 1981; Horowitz et al, 1984). One explanation suggested that patients who are unwilling or unable to establish an open and trusting relationship with their therapist find it more difficult to achieve symptom relief (Horowitz et al, 1984). It has also been suggested that patients

with poor outcome bring negative characteristics to therapy which persists across treatment, and are resistant to the therapist's efforts to establish an alliance (Marziali et al., 1981).

Another measure of therapeutic alliance is the Vanderbilt Psychotherapy Process Scale (VPPS), which has been developed by several researchers (Gomes-Schwartz, 1978; Moras and Strupp, 1982). This instrument consists of several Patient factors (Participation, Hostility, Exploration, Psychic Distress) and Therapist factors (Warmth, Negative Attitude, Exploration). Objective raters are required to review 10-minute random audio-taped segments of individual sessions across the course of therapy. These judges then rate 84 items on a Likert-type scale designed to assess the Therapist and Patient factors in the process of therapy.

Moras and Strupp (1982) have used the VPPS to predict therapy outcome with college males reporting anxiety, shyness, and problems with interpersonal relationships. Outcome was assessed by self-ratings of improvement and residual change scores on the Depression, Psychasthenia, and Social Introversion scales of the MMPI. Results indicated that the overall quality of therapeutic alliance was positively correlated with therapy outcome, with a significant reduction in reported symptoms of depression. Gomes-Schwartz (1978) utilized the VPPS with clients at a university counseling center who had elevated scores on the Depression, Psychasthenia, and Social Introversion scales of the MMPI. Outcome was assessed by ratings from objective judges and therapists' overall ratings of patient improvement, and with residual gain scores on an MMPI index of maladjustment. Results indicated that Patient Participation and Patient Hostility most consistently predicted therapy outcome (showing a positive and negative relationship to outcome, respectively). It was found that therapists' theoretical orientation and professional/non-professional status did not have a significant impact on therapy outcome. To explain these findings, the researchers contended that patients who were not hostile or

mistrustful and who actively contributed to the treatment interaction achieved greater changes than those who were withdrawn, defensive, or unwilling to participate in the therapy process.

In summary, the research exploring therapeutic alliance and outcome appears to warrant several tentative conclusions. Patient trust and acceptance of the therapist, and a willingness to positively engage in the therapeutic process are strong predictors of treatment outcome. Therapists' positive contributions (i.e., judged by raters as encouraging, hopeful, accepting, etc.) also appear to have predictive power with respect to treatment outcome. However, the research examining therapist contribution is equivocal; at this point patient contribution to the alliance seems to be a relatively more reliable predictor of outcome.

Relationship between Mental Health Values Congruence and Willingness to Engage in the Therapeutic Alliance

The research findings above suggest that therapeutic alliance is an important determinant of treatment outcome. Thus it is probable that further study of the specific variables influencing therapeutic alliance would help to more accurately predict treatment outcome. Mental health values congruence (i.e., agreement in the characteristics used to conceptualize good mental health) between a counselor and client would seem to be a likely contributor to the formation of a therapeutic alliance. The purpose of the present study was to investigate subjects' willingness to enter into a therapeutic alliance as a function of value congruence between subjects and a therapist on the Affective Control scale of the MHVQ.

It is plausible that individual beliefs regarding the role of emotional expression (i.e., Affective Control) in maintaining good emotional adjustment may help determine one's actions in various social settings, as well as influencing one's perceptions and judgments regarding the behavior of others. It is also plausible that discomfort may be

experienced by a client if he/she perceives the therapist as having dissimilar expectations with respect to affective control or emotional expression. Within the context of our present study, an analogue design was used to investigate subjects' experience of the therapy relationship and their degree of personal disclosure as a function of therapist-subject value congruence on the dimension of affective control.

METHOD

Overview

A 2 x 2 factorial design was used to investigate the effect of client-therapist congruence on the Affective Control Scale of the MHVQ on subject preparedness to enter into a therapeutic alliance. Selected high and low scoring subjects on the Affective Control scale of the MHVQ were exposed to a therapist on videotape. Value congruence between subjects and the therapist were manipulated by having 2 versions of the videotape. In one version the therapist described the importance of affective control as a positive indicator of healthy emotional adjustment. In the other version, the therapist described affective control as a negative indicator of emotional adjustment. There were 4 treatment conditions: Two groups (one high, one low on Affective Control) were exposed to the therapist condition which described affective control as a positive indicator of emotional adjustment (i.e., high on Affective Control). The other two groups (one high, one low on Affective Control) were exposed to the therapist condition which described affective control as a negative indicator of emotional adjustment (i.e., low on Affective Control). Thus for each of the two therapist-videotape versions, one half of the subjects experienced a therapist-congruent condition with respect to Affective Control while the remaining subjects experienced a therapist-incongruent condition.

Next, subjects were informed that they would have an opportunity to discuss a selected personal problem with the therapist whom they just viewed, in a live 45-minute interview. The willingness of subjects to enter into a therapeutic alliance with the therapist on videotape was assessed through two primary instruments. The Therapist Rating

Questionnaire (Appendix C) asked subjects to rate the therapist on various personal characteristics. A second measure, the Personal Problems Questionnaire (Appendix D) asked subjects to select from a list of personal problems - of graded severity - a given problem which they would be willing to discuss with the therapist. Both questionnaires are described in greater detail in the instruments section below.

Subjects

Psychology undergraduate students (127 males and 226 females) were first screened with the MHVQ to identify high and low scores on the Affective Control scale of the MHVQ. The highest 20% and lowest 20% of both male and female subjects on the scale (51 males and 90 females) were selected for inclusion in the research study. Separate Affective Control scale cut-off scores were utilized for selecting male and female subjects. Male subjects classified as "low" on Affective Control had scores of ≤36, while male subjects classified as "high" on Affective Control had scores of ≥42. Female subjects classified as "low" on Affective Control had scores of ≤33, while female subjects classified as "high" on Affective Control had scores of ≥42. Of the 51 male and 90 female subjects who were selected, 40 male and 71 female subjects actually participated in the study.

Videotape Manipulation

Subjects viewed a 10-minute videotape of a female psychotherapist who described her educational background and personal approach to conducting therapy. There were two versions of the videotape, for the purpose of manipulating subject-therapist value congruence on the Affective Control scale. With the exception of the tape segment in which this manipulation takes place (described below), the two videotape versions were identical in content.

In the high Affective Control videotape version, the therapist described affective control as a positive indicator of health emotional adjustment, as follows: "...I find that a hallmark of mental health is one's ability to regulate and control emotional expression.

Healthy individuals are able to control their emotions and analyze situations objectively, and as a result, they demonstrate adaptive behavior when solving personal problems. Some people believe that it is healthy to 'let your feelings out', but uninhibited emotional expression without an adequate degree of emotional reserve often results in negative consequences. Someone who is moody, angry, or irritable is demonstrating a lack of emotional control. They are letting their feelings influence their behavior with others, and it adversely affects their interactions with the world in general. It is clear that letting one's actions be controlled by impulses or feelings are often maladaptive. Ideally, healthy persons should possess an adaptive degree of emotional reserve in their everyday lives."

In the second videotape version (low Affective Control), the therapist described affective control as a negative indicator of emotional adjustment, as follows: "I find that a hallmark of mental health is one's ability to identify and express emotions. Healthy individuals are able to understand and acknowledge their feelings, and when problem situations are encountered, psychologically healthy people approach the problem with full awareness and expression of their feelings. This is because actions which ignore one's emotional needs are often maladaptive, and lead to negative consequences. The emotions we experience in our daily lives often serve as a valuable guide to whether we are following the correct course of action. Someone who identifies negative feelings in him/herself and attempts to express these feelings to others in an open, honest manner is demonstrating a high degree of psychological maturity. Negative emotions compel an individual to express important needs and to change an undesirable situation for the better. It is clear that allowing oneself to be guided by feelings is adaptive. Ideally, healthy persons should be able to identify, acknowledge, and express their feelings to bring about desired changes in their everyday life."

Instruments

The Affective Control Scale of the MHVQ was used to initially screen subjects for

inclusion in the research study. Tyler (1983) has developed the Mental Health Values Questionnaire which purports to measure an individual's conception of those traits or characteristics which are indicative of good mental health. The MHVQ yields scores for eight factor scales: Self-Acceptance, Negative Traits, Achievement, Affective Control, Good Interpersonal Relations, Untrustworthiness, Religious Commitment, and Unconventional Reality. The instrument consists of 99 item-statements concerning beliefs about mental health. Responses to each item are made on a 5-point rating scale: a rating of 1 is given if the item indicates "very poor mental health", while a rating of 5 indicates "very good mental health". In an unpublished study by Tyler and Cheloha in 1983, a total of 72 psychology undergraduate students were administered the MHVQ on two separate testing sessions. Test-retest reliability coefficients were subsequently computed for each factor scale of the MHVQ, and the following data were obtained: Self-Acceptance (.62); Negative Traits (.76); Achievement (.64); Affective Control (.59); Good Interpersonal Relations (.68); Untrustworthiness (.63); Religious Commitment (.63); and Unconventional Reality (.61).

At the outset of the present study, all subjects signed a consent form (Appendix A) which informed subjects that the researchers "...are attempting to study the therapeutic process by identifying specific factors which may lead to a positive, successful outcome." In addition, the consent form explained that subjects would watch the videotape of a female therapist, and that they would later have the opportunity to talk with this therapist about a personal problem in a live 45-minute interview.

After viewing the videotape described above subjects completed a booklet containing several questionnaires. These questionnaires assessed the degree to which subjects were willing to disclose sensitive information about themselves. It was hypothesized that the greater the correspondence between the values of the therapist and a subject on affective control, the more likely would a subject be willing to disclose sensitive

information.

The Therapist Rating Questionnaire (Appendix C) asked subjects to use a 7-point scale to rate the videotape therapist on several personal characteristics. These items assessed the interpersonal dimensions of attractiveness, expertise, and trustworthiness. It is noted that the Therapist Rating Questionnaire completed by subjects is an invalidated instrument constructed specifically for this study.

Instructions for a second questionnaire, referred to as the Personal Problems Questionnaire (Appendix D), first informed subjects that they would be scheduled to have a personal interview with the therapist. The questionnaire listed twelve personal problems which were graded with regard to its severity and perceived effect upon emotional adjustment. To insure a valid gradation of problem severity, two objective raters selected by the researchers assigned a number score ranging from 1 ("very easy to discuss") to 7 ("very difficult to discuss") to each problem in the list with respect to problem severity. The average of the two objective rater's scores for each problem in the list were then identified as the "severity" scores for those problems. Subjects were asked to place a check mark next to one problem in the list that they would want to discuss with the therapist seen on the videotape. In addition, subjects were asked to rate the list of problems regarding the degree to which they would be willing to talk with the therapist about them.

In addition to the twelve-problem list, the Personal Problems Questionnaire contained three additional items. One item asked subjects to provide background information on the problem that they had indicated as their first choice for discussion. Subjects were given the rationale that the therapist would read this form before conducting the interview. This item was included for the purpose of obtaining a direct behavioral measure of a subject's willingness to share or disclose personal information with a therapist. Two objective raters (psychology graduate students) were selected by the

researchers to assign points to subject's background information descriptions as a function of the degree of personal material disclosed. Raters could assign a maximum of twelve points for a background description, with a range of 1 (no disclosure) to 3 (significant disclosure) being assigned for each of the following four criteria: description of personal distress due to the selected problem; description of problem history and/or antecedents of problem; interpersonal and/or daily life stresses caused by the problem; and attempts by subject to resolve the problem. In addition, the objective raters assigned a global score to subjects' background descriptions with respect to the overall degree of self-disclosure, on a scale of 1 (no disclosure) to 3 (significant disclosure). The two objective raters initially used the rating system described above to evaluate five fictional problem vignettes. This served to familiarize the raters with using the system.

A second item of the Personal Problems questionnaire asked subjects to rate how difficult it would be to discuss their selected problem with the therapist. This item was included to serve as a direct measure of the level of problem difficulty a subject was willing to reveal to the therapist. A final item of the Personal Problems questionnaire asked subjects to indicate a preference with regard to how soon they would wish to schedule an interview with the therapist. This measure also served to assess the subjects' willingness to meet with the therapist. It is noted that the Personal Problems Questionnaire is an invalidated instrument constructed specifically for this study.

The final questionnaire (Life Situations - Appendix E) was intended to assess a subject's general tendency - in situations other than treatment - to delay or aggressively approach a problem (i.e., a subject's general tendency to avoid or deal quickly with a problem situation). This questionnaire required subjects to answer four items, three of which were filler items. Only the third item in this questionnaire was analyzed: "You have been told that you have an infected tooth. Although it does not hurt you the dentist says that the tooth must be pulled. When would you try to have it done?"

A final questionnaire (Background Information Questionnaire - Appendix B) obtained general background information from the subject. It inquired about the subject's sex, major, years of education completed by both parents, population of town or city of origin, and religious orientation. Subjects also reported whether they or their family members had ever seen a mental health professional.

Procedure

Subjects met as a group in a classroom where the researcher distributed a questionnaire booklet (described above). Subjects then read and signed the top sheet (Consent Form - Appendix A). After the consent forms were collected the researcher played the therapist videotape.

As described above, the present study utilized a 2 x 2 factorial design: two subject groups (one high, one low on Affective Control) were exposed to the therapist condition which described affective control as a positive indicator of emotional adjustment (i.e., high on Affective Control); and two other subject groups (one high, one low on Affective Control) were exposed to the therapist condition which described affective control as a negative indicator of emotional adjustment (i.e., low on Affective Control). After watching the videotape subjects were instructed to complete the questionnaire booklet. When subjects reached the Personal Problems Questionnaire (Appendix D) of the booklet, it stated that completing the following items before seeing the therapist would aid her in identifying which life issues or personal difficulties the subject wanted to discuss.

After all subjects completed the questionnaires, they were debriefed on the actual nature of the study. They were informed that the person on the videotape was not an actual therapist, and that subjects would not be seeing this person to discuss personal matters. It was explained that the deception was necessary to get a true response effect during the study. The researcher gave handouts to all subjects at the conclusion of the study which provided a list of resources offering psychological/therapeutic services within

the community. This aided subjects who were experiencing personal difficulties to find professional assistance.

RESULTS

Subject Demographics

Subjects consisted of 40 male and 71 female students. There were 56 subjects in the therapist-values congruent condition (17 males and 39 females) and 55 subjects in the therapist-values incongruent condition (23 males and 32 females). The therapist-values congruent subjects were M=19.34 years of age, with SD=1.52. Among the therapist-values congruent subjects, 80.3% (45) were 18-19 years of age, and the remaining 19.7% (11) ranged from 20-41 years of age. The therapist-values incongruent subjects were M=20.58 years of age, with SD=3.22. Among the therapist-values incongruent subjects, 76.4% (42) were 18-20 years of age, and the remaining 23.6% (13) ranged from 21-41 years of age. A t-test was conducted between therapist-values congruent/incongruent subjects with respect to age, and indicated no significant difference, $t(109)=1.51$, $p=.13$.

Among the mothers of therapist-values incongruent subjects, 34.5% (19) had completed high school, and the remaining 65.5% (36) had completed one or more years of college. Among the mothers of therapist-values congruent subjects, 30.4% (17) completed high school, and the remaining 69.6% (39) had completed one or more years of college. With regard to the fathers of therapist-values congruent subjects, 32.2% (18) completed high school, and the remaining 67.8% (38) completed one or more years of college. Among the fathers of therapist-values incongruent subjects, 30.8% (17) completed high school, and the remaining 69.2% (38) completed one or more years of college. T-tests revealed no significant differences between therapist-values congruent/incongruent subjects with regard to mother's and father's education level, $t(109)=-1.00$, $p=.32$, and $t(108)=.70$, $p=.48$, respectively.

With regard to therapist-values congruent subjects, 10.7% (6) reported that they had previously seen a mental health professional. Among therapist-values incongruent subjects, 29.1% (16) reported that they had previously seen a mental health professional. The number of professional visits made by therapist-value congruent subjects ranged from 2 to 30 sessions. The number of professional visits made by therapist-value incongruent subjects ranged from 1 to 104 sessions. A Chi-square test revealed that significantly more therapist-value incongruent subjects (16) than congruent subjects (6) had previously referred themselves to a mental health professional, $X^2(1, \underline{N}=111)=5.90$, $\underline{p}<.05$. Among therapist-value congruent subjects, 26.8% (15) reported that family members had previously seen a mental health professional. Among therapist-value incongruent subjects, 25.5% (14) reported that family members had previously seen a mental health professional. The number of professional visits made by the family members of therapist-value congruent subjects ranged from 2 to 12 sessions. The number of professional visits made by the family members of therapist-values incongruent subjects ranged from 1 to 104 sessions. A Chi-square test was conducted between therapist-values congruent/incongruent subjects, to compare the number of subjects whose family members had previously seen a mental health professional. Results indicated no significant difference between therapist-values congruent and incongruent subjects $X^2(1, \underline{N}=111)=0.02$, $\underline{p}=.87$.

Therapist Rating Questionnaire

A Manova was conducted to examine differences in therapist ratings between subjects who were congruent with therapists views on the Affective Control scale of the MHVQ and subjects who were incongruent with the therapist's views. The individual items of the Therapist Rating Questionnaire served as the dependent measures. Since therapist rating items were constructed to vary in whether positive therapist dimensions were associated with a value of 1 or a value of 7, data transformations were conducted to

establish uniformity in the scoring direction of Therapist Rating scales for all items. In order that a score of 7 would be associated with desirability for all items, for items on which a score of 1 was associated with desirability, values were transformed by the formula: 7 - (subject score) + 1. The following Therapist-Rating items were transformed: "likeable-not likeable"; "insightful-insensitive"; "sympathetic toward others-not sympathetic toward others"; "open minded-closed minded"; and "comfortable to be with-uncomfortable to be with". Means and standard deviations for the subject ratings of therapist characteristics appear in Tables 1, 2, and 3.

In addition to the data transformation described above, standard univariate homogeneity of variance tests were conducted for each of the twelve Therapist Rating items prior to conducting the Manova. Two Therapist Rating items were found to be non-homogeneous: "ineffective at helping others-effective at helping others", Cochran's $C=.45$, $p<.01$; and "unattractive-attractive", Cochran's $C=.51$, $p<.01$. These two items were excluded and a multivariate test for homogeneity was then conducted with the ten remaining Therapist Rating items, and indicated non-homogeneity; Box $M=253.45$, $p>.05$. One further Therapist Rating item was then removed in order to establish multivariate homogeneity: "closed minded-open minded", Cochran's $C=.38$, $p>.10$. A final multivariate test for homogeneity was then conducted with the nine remaining Therapist Rating items, and met the assumption of homogeneity; Box $M=192.01$, $p>.05$.

A Manova was conducted, with the nine remaining Therapist Rating items as dependent measures. Results indicated no significant main effects for subject congruence/incongruence and ratings of therapist personal characteristics, $F(9,107)=.11$, $p=.28$. Given the exploratory nature of this study and the fact that the Therapist Rating Questionnaire is an unvalidated instrument, constructed specifically for this study, univariate F-tests were conducted to identify any significant relationships for individual test items. Results indicated that therapist-values congruent subjects ($M=5.82$) rated the

TABLE 1

Ratings of Therapist Characteristics by Therapist-Values Congruent/Incongruent Subjects

Therapist Characteristics	Congruent Subjects (n=56)		Incongruent Subjects (n=55)	
	M	SD	M	SD
Likeable	5.32	1.25	4.91	1.47
Confident	5.58	1.15	5.16	1.23
Insightful	5.52	1.14	5.17	1.19
Interesting	3.72	1.51	3.64	1.33
Attractive	4.43	1.38	4.21	1.15
Trustworthy	5.80	.88	5.31	1.07
Sympathetic	5.42	1.33	5.01	1.45
Understands	5.58	1.18	5.39	1.17
Effective	5.66	.90	5.11	1.13
Open-minded	5.55	1.17	5.29	1.20
Comfortable	5.32	1.27	4.51	1.50
Unbiased	5.13	2.71	5.09	1.29

therapist as relatively more trustworthy than therapist-values incongruent subjects (M=5.36), $F(1,109)=5.93$, $p<.05$. In addition, therapist-values congruent subjects (M=5.37) rated the therapist as more comfortable to be with than therapist-values incongruent subjects (M=4.62), $F(1,109)=7.46$, $p<.01$.

A Manova revealed no significant main effects for high/low affective control values

TABLE 2

Ratings of Therapist Characteristics by High and Low Affective Control Subjects

Therapist Characteristics	High Affective Control Subjects (n=64)		Low Affective Control Subjects (n=47)	
	M	SD	M	SD
Likeable	5.53	1.22	4.70	1.50
Confident	5.59	1.10	5.16	1.29
Insightful	5.59	1.17	5.10	1.16
Interesting	3.87	1.41	3.49	1.44
Attractive	4.54	1.19	4.10	1.34
Trustworthy	5.78	.89	5.33	1.06
Sympathetic	5.48	1.31	4.95	1.47
Understands	5.78	.95	5.19	1.40
Effective	5.78	.74	5.00	1.29
Open-minded	5.72	1.03	5.12	1.34
Comfortable	5.42	1.25	4.41	1.52
Unbiased	5.37	1.24	4.85	1.40

of subject and ratings of therapist personal characteristics, $F(9,107)=.14$, $p=.12$. Again, due to the exploratory nature of the present study, univariate F-tests were also conducted to identify any significant trends for individual items. Results indicated that high affective control subjects ($M=5.53$) rated the therapist as more likeable than low affective control subjects ($M=4.70$), $F(1,109)=7.11$, $p<.01$. High affective control subjects ($M=5.59$) rated the therapist as more insightful than low affective control subjects ($M=5.10$),

TABLE 3

Subject Ratings of Therapist Characteristics by Therapist-Values Congruence/Incongruence and High/Low Affective Control Therapist Conditions

Therapist Characteristics	High Affective Control Therapist				Low Affective Control Therapist			
	Congruent Subjects (n=24)		Incongruent Subjects (n=32)		Congruent Subjects (n=32)		Incongruent Subjects (n=23)	
	M	SD	M	SD	M	SD	M	SD
Likeable	4.96	1.27	5.38	1.21	5.69	1.23	4.44	1.73
Confident	5.58	1.18	5.59	1.07	5.59	1.13	4.74	1.39
Insightful	5.33	0.96	5.47	1.02	5.71	1.33	4.87	1.36
Interesting	3.50	1.41	3.81	1.20	3.94	1.62	3.48	1.47
Attractive	4.25	1.22	4.47	0.84	4.62	1.54	3.96	1.46
Trustworthy	5.67	0.96	5.62	0.98	5.94	0.80	5.00	1.17
Sympathetic	5.25	1.39	5.37	1.36	5.59	0.80	5.00	1.17
Understands	5.38	0.96	5.78	0.75	5.78	1.16	5.00	1.60
Effective	5.29	1.16	5.53	0.84	6.03	0.65	4.70	1.43
Open-minded	5.29	1.20	5.63	0.91	5.81	1.15	4.96	1.49
Comfortable	4.92	1.35	5.12	1.31	5.72	1.20	3.91	1.70
Unbiased	4.83	1.49	5.31	1.26	5.44	1.22	4.87	1.32

$F(1,109)=4.62$, $p<.05$. High affective control subjects ($M=5.78$) rated the therapist as more trustworthy than low affective control subjects ($M=5.33$), $F(1,109)=5.34$, $p<.05$. High affective control subjects ($M=5.48$) rated the therapist as being more sympathetic than low affective control subjects ($M=4.95$), $F(1,109)=3.91$, $p=.05$. High affective

control subjects (M=5.42) rated the therapist as more comfortable to be with than low affective control subjects (M=4.41), $F(1,109)=13.26$, $p<.001$. High affective control subjects (M=5.72) rated the therapist as more open-minded than low affective control subjects (M=5.12), $F(1,109)=4.38$, $p<.05$. Finally, high affective control subjects (M=5.78) rated the therapist as being more understanding of others than low affective control subjects (M=5.19), $F(1,109)=5.22$, $p<.05$.

Results of the Manova indicated no significant interaction effects with regard to therapist values congruence/incongruence, affective control values of subject and ratings of therapist personal characteristics, $F(9,107)=.37$, $p=.12$. Univariate F-tests were conducted to identify any significant trends for individual items. Significant differences were found between the four experimental conditions with regard to subject ratings of therapist likeability, $F(3,107)=3.05$, $p<.05$; ratings of therapist trustworthiness, $F(3,107)=4.27$, $p<.05$; and ratings of subjects' comfort level with the therapist, $F(3,107)=7.77$, $p<.01$. Post-hoc tests were then conducted using the LSD procedure. Results indicated that for the two subject groups who were exposed to the high-affective control therapist condition, therapist-value congruent subjects (high-affective control subjects), M=5.69, rated the therapist as more likeable than therapist-values incongruent subjects (low-affective control subjects), M=4.44. In addition, for the two subject groups who were exposed to the high-affective control therapist condition, therapist-values congruent subjects (high-affective control subjects), M=5.94, rated the therapist as more trustworthy than therapist-value incongruent subjects (low-affective control subjects), M=5.00. Results further indicated that for the two subject groups who were exposed to the high-affective control therapist condition, therapist-values congruent subjects (high-affective control subjects), M=5.72, rated the therapist as more comfortable to be with than therapist-values incongruent subjects (low-affective control subjects), M=3.91. Results also indicated that among the two subject groups who were exposed to the

therapist-values incongruent conditions, therapist-values incongruent subjects who were high on affective control rated the therapist (low-affective control therapist condition) as more comfortable to be with than therapist-values incongruent subjects who were low on affective control and exposed to the high-affective control therapist condition, $M=5.12$ and $M=3.91$, respectively.

Personal Problems Questionnaire

An Anova was conducted between therapist-values congruent and incongruent subjects on the "severity" of problems which were selected for discussion with the therapist (severity being determined by the average of the objective raters scores). A Pearson Product Moment Correlation was conducted to assess the inter-rater reliability of the two objective raters. Results indicated significant agreement in ratings, $r=.87$, $df=12$, $p<.001$. Results of the Anova indicated no significant main effects for subject congruence/incongruence, nor for high/low affective control values, on the severity of the selected problem, $F(1,109)=.29$, $p=.59$, and $F(1,109)=.19$, $p=.66$, respectively. Results also indicated no significant interaction effects, $F(3.107)=.16$, $p=.92$.

As described in the Method section above, in addition to having subjects select one problem for discussion with the therapist, they were also asked to rate each problem on the Personal Problems Questionnaire regarding their "willingness" to discuss these problems with the therapist. These ratings were then summed across problems into one composite score (i.e., an overall willingness to discuss score). An Anova was then conducted comparing therapist-values congruent and incongruent subjects with overall willingness to discuss problems with the therapist as the dependent measure. Surprisingly, results indicated that therapist-values incongruent subjects ($M=32.38$) were more willing overall than therapist-values congruent subjects ($M=26.80$) to discuss personal problems with the therapist, $F(1,109)=5.35$, $p<.05$. There was no significant main effect for high and low affective control subjects on their overall willingness to discuss personal problems

with the therapist, $F(1,109)=.42$, $p=.52$. Results of the Anova also indicated no significant interaction effects with regard to subject congruence/incongruence, nor for high/low affective control values, on overall willingness to discuss personal problems with the therapist, $F(3,107)=2.07$, $p=.11$. An additional Anova was conducted comparing congruent and incongruent subjects on their "willingness" to discuss the most severe problems listed in the Personal Problems Questionnaire (Severity was determined by the average of the objective raters scores for the listed problems). Subject ratings for the three most severe problems ("difficulty dealing with feelings toward others"; "concerns about sexual matters"; and "depression or extreme sadness") were summed across problems into one composite score. Consistent with the results above, it was found that incongruent subjects ($M=8.29$) were more willing than congruent subjects ($M=6.66$) to discuss severe personal problems with the therapist, $F(1,109)=4.32$, $p<.05$. There was no significant main effect for high and low affective control subjects on their willingness to discuss personal problems with the therapist, $F(1,109)=.45$, $p=.50$. Results of the Anova also indicated no significant interaction effects, $F(3,107)=1.57$, $p=.20$.

Personal Problem Descriptions

A Manova was conducted between therapist-values congruent and incongruent subjects on the degree of personal material disclosed in subjects' problem descriptions. As described above in the Method section, two independent raters assigned points to subjects' problem descriptions as a function of the degree of personal material disclosed. Five criteria were used: description of emotional distress due to the problem; description of problem history and/or antecedents of problem; interpersonal and/or daily life stresses caused by the problem; attempts by subject to resolve the problem; and subjects' overall or global degree of self-disclosure. For each of the description criteria, the independent raters assigned a score which ranged from 1 (little or no disclosure) to 3 (high level of

TABLE 4

Problem Description Criteria Scores for Therapist-Values Congruent/Incongruent Subjects

Description Criteria	Congruent Subjects (n=56)		Incongruent Subjects (n=55)	
	M	SD	M	SD
Emotional Distress	1.59	0.59	1.55	0.52
Problem History	1.53	0.49	1.52	0.48
Interpersonal/ Daily Stresses	1.31	0.44	1.35	0.43
Resolution Attempts	1.11	0.25	1.13	0.29
Global	1.87	0.69	1.87	0.60

disclosure). Means and standard deviations of the problem description criteria scores for therapist value congruent/incongruent subjects appear in Tables 4, 5, and 6. Prior to completing the Manova, five Pearson Product Moment Correlations were conducted to assess the inter-rater reliability scores of the two independent raters who evaluated subjects' problem descriptions according to the criteria described above. Results indicated significant but relatively poor reliability between the two independent raters for all five problem description criteria scores: description of emotional distress due to the problem,

TABLE 5

Problem Description Criteria for High/Low Affective Control Score Subjects

Description Criteria	High Affective Control Subjects (n=64)		Low Affective Control Subjects (n=47)	
	M	SD	M	SD
Emotional Distress	1.54	0.54	1.60	0.56
Problem History	1.55	0.52	1.50	0.45
Interpersonal/ Daily Stresses	1.36	0.46	1.30	0.41
Resolution Attempts	1.10	0.29	1.14	0.24
Global	1.82	0.58	1.92	0.71

$r=.50$, $df=109$, $p<.01$; description of problem history and/or antecedents of problem, $r=.45$, $df=109$, $p<.01$; interpersonal and/or daily life stresses caused by the problem, $r=.35$, $df=109$, $p<.01$; and subjects' global degree of self-disclosure, $r=.52$, $df=109$, $p<.01$. A Manova was then conducted between therapist-values congruent/incongruent subjects on the degree of personal material disclosed (as specified by the five personal description criteria). Results of the Manova indicated no significant main effects for subject congruence/incongruence, nor for high/low affective control values, on the degree of personal material disclosed in the problem description, $F(1,107)=1.0$, $p=.92$, and

TABLE 6

Problem Description Scores of Subjects by Therapist-Values Congruence/Incongruence and High/Low Affective Control Therapist Conditions

Description Criteria	High Affective Control Therapist				Low Affective Control Therapist			
	Congruent Subjects (n=24)		Incongruent Subjects (n=32)		Congruent Subjects (n=32)		Incongruent Subjects (n=23)	
	M	SD	M	SD	M	SD	M	SD
Emotional Distress	1.58	0.63	1.61	0.58	1.60	0.55	1.50	0.46
Problem History	1.55	0.49	1.48	0.41	1.52	0.50	1.56	0.56
Interpersonal/ Daily Stresses	1.35	0.50	1.33	0.44	1.27	0.39	1.37	0.43
Resolution Attempts	1.08	0.23	1.13	0.22	1.15	0.27	1.13	0.36
Global	1.79	0.67	1.89	0.71	1.96	0.72	1.85	0.50

$F(1,107)=.05$, $p=.41$, respectively. Univariate F=tests indicated no significant trends for the individual description criteria with respect to the main effects of subject congruence/incongruence, nor for high/low affective control values. Results also indicated to significant interaction effects, $F(3,105)=.05$, $p=.95$. Univariate F-tests indicated no

significant trends for the individual description criteria with respect to interaction effects.

As described in the Method section, one item of the Personal Problems Questionnaire asks subjects to rate how difficult it would be to discuss their selected problem with the therapist. A Pearson Product Moment Correlation was conducted between this item and the severity scores assigned by the independent raters for the same problems, to assess for correspondence in the perceived severity of personal problems. Results indicated that subjects whose problems were rated as very difficult to discuss with the therapist were also more likely to be rated by the objective raters as a more "severe" problem, $r=.40$, $df=110$, $p<.01$, indicating significant correspondence in the perceived severity of personal problems.

As described in the Method section, one item of the Personal Problems Questionnaire asks subjects to indicate a preference for how soon they would wish to schedule an interview with the therapist. An Anova test could not be conducted comparing therapist-values congruent/incongruent subjects with appointment-time preference as the dependent measure, because the condition of normality was not met for this variable. A non-parametric test - the Kruskal-Wallis 1-way Anova - was conducted instead and revealed significance, $F(1,111)=6.39$, $p<.05$. Results indicated that therapist-values congruent subjects ($M=49.61$) preferred to schedule an appointment with the therapist at an earlier date than therapist-values incongruent subjects ($M=62.51$).

A Pearson Product Moment Correlation was also conducted with the third item of the Life Situations Questionnaire - which was intended to assess a subject's general tendency to delay or directly approach a problem - and a subject's time preference for scheduling an interview with the therapist (Personal Problems Questionnaire). Results indicated that subjects who preferred to schedule an interview with the therapist sooner were more likely in general to deal promptly with a problem situation, rather than to delay in responding, $r=.20$, $df=111$, $p<.05$.

However, an Anova was conducted between therapist-values congruent and incongruent subjects with the third item of the Life Situations Questionnaire as the dependent measure, to assess subjects' general problem-solving approach (to delay or directly approach a problem). Results indicated no significant difference between therapist-values congruent and incongruent subjects with regard to problem-solving approach, $F(1,109)=.03$, $p=.87$.

DISCUSSION

Subject Congruence/Incongruence with Therapist Values

The results of the investigation provide mixed support for the hypothesis that subject congruence/incongruence with therapist affective control values is predictive of subjects' tendency to positively evaluate the therapist. It should be noted that the findings discussed below must be interpreted with caution. The Manovas which were conducted for subject congruence/incongruence and subject affective control values on therapist ratings were non-significant. However, because of the exploratory nature of the present study, univariate F-tests were subsequently conducted and indicated some significant trends.

Several findings supported the hypothesized relationship between subject-therapist affective control congruence and positive evaluation of the therapist. Results which supported the hypothesis revealed that therapist-values congruent subjects rated the therapist as both more trustworthy and more comfortable to be with than did therapist-values incongruent subjects. In addition, interaction effects showed that for the two subject groups who were exposed to the high affective control therapist condition, congruent subjects rated the therapist as more likeable, trustworthy, and comfortable to be with than did incongruent subjects. Another finding indicated that congruent subjects preferred to schedule an appointment with the therapist at an earlier date than did incongruent subjects.

Other results of the investigation were not consistent with the hypothesis. No significant main effects were revealed for subject-therapist congruence/incongruence on the severity of personal problems which were selected for discussion with the therapist. In

addition, relative to congruent subjects, incongruent subjects were more willing "overall" to discuss personal problems with the therapist. Another finding revealed no significant main effects for subject congruence/incongruence on the degree of personal material which was disclosed in subjects' personal problems descriptions. The findings which support the hypothesized relationship between subject congruence/incongruence and therapist ratings are consistent with previous investigations (Lewis & Walsh, 1980; Good & Good, 1972; Good, 1975), which have employed analog methods and found that congruence between therapist and subject on a variety of attitudes/values resulted in more favorable ratings of therapist traits. The findings of these previous investigations are described in greater detail in the literature review. The present study also revealed that congruent subjects preferred to schedule an appointment with the therapist at an earlier date than incongruent subjects. Presumably, if a potential client feels more comfortable with a particular therapist, then that client would be more likely to schedule an early appointment with the therapist if given a choice. Also, no significant differences were found between congruent and incongruent subjects with respect to their general procrastination tendency (to delay or directly approach a problem). Therefore, the difference in scheduling preference between congruent and incongruent subjects do not appear to be the function of differences between the groups with respect to some general procrastination tendency.

However, inconsistent with the hypothesis was the finding that when willingness ratings were summed over all subject identified problems, incongruent subjects were more willing overall than congruent subjects to discuss personal problems. This finding is also inconsistent with previous research (Good & Good, 1972), which found that therapist-values congruent subjects rated themselves as being more willing to discuss with a potential counselor their academic, family, heterosexual, and emotional problems. A possible explanation of this inconsistency may be the fact that, in the present investigation,

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more incongruent subjects than congruent subjects had previously seen a mental health professional for personal problems. Perhaps greater familiarity with mental health professionals among these subjects made them generally more receptive to interacting with the pseudo-therapist in the present study. Or perhaps because of some other factor, greater willingness to disclose to a therapist accounts for both the higher rates of past use of mental health services and the present findings. In view of the fact that significantly more incongruent subjects than congruent subjects had previously referred themselves to a mental health professional, it is possible that as a group, the incongruent subjects may have been more familiar with the therapeutic process and thus more willing overall to discuss personal problems with the therapist. A t-test supported this hypothesis, and revealed that subjects who had previously referred themselves to a mental health professional - irrespective of subject group - were more willing overall than subjects without prior referrals to discuss personal problems with the therapist, $t(109)=3.40$, $p<.001$.

Other findings which were inconsistent with the hypothesis revealed that congruent and incongruent subjects did not significantly differ on the severity of personal problems which were selected for discussion with the therapist. In addition, no significant differences were found between congruent and incongruent subjects on the personal degree of self-disclosure in subjects' personal problems descriptions. However, both results may reflect the fact that in the present study a relatively homogenous sample of undergraduate college students was employed. With such a sample there is likely to be a restricted range of variability with respect to the personal problems which are selected for discussion with the therapist. An examination of subject group means revealed that both congruent and incongruent subject groups selected problems which were relatively less severe; $M=2.65$, $SD=1.82$ and $M=2.47$, $SD=1.69$, respectively, on a problem-severity scale ranging from a value of 1 to 7. As described in the Method section, this scale was

used by the independent raters to grade the severity of all 12 personal problems listed on the subject questionnaire. The relatively low group means for both congruent and incongruent subjects allowed little opportunity for group differences to be revealed, and suggests the possibility that the subjects did not significantly differ on the severity of personal problems which were selected because of the fact that they belong to a relatively homogeneous, emotionally-adjusted population with limited variability.

In summary, the data above provides some support for the hypothesized relationship between subject-therapist congruence and positive therapist evaluation. In addition, the findings which were inconsistent with the hypothesis may be explained by other factors. The relationship between subject-therapist congruence and therapist evaluation with respect to affective control values (and perhaps other factors of the Mental Health Values Questionnaire) may have a significant influence upon the formation of a "therapeutic alliance". In view of the fact that the therapeutic alliance has been identified as crucial in both establishing a productive therapeutic process and determining therapy outcome (Luborsky, 1984), it appears that further research is merited to assess the affect of subject-therapist mental health values congruence upon this important therapy variable.

Affective Control Values of Subject

An unhypothesized finding was that the affective control value scores of subjects - irrespective of congruence or incongruence with the therapist - were significantly related to subject ratings of therapist traits. Results indicated that high affective control subjects rated the therapist as relatively more likeable, insightful, trustworthy, sympathetic, open-minded, comfortable to be with, and more understanding of others than low-affective control subjects. Thus, subjects who had high affective control values (i.e., believed that emotional restraint or reserve is a positive indicator of emotional adjustment) tended to give more positive evaluations of therapist traits. A relationship between subject affective

control values and subject ratings of the therapist had not been hypothesized prior to the current study. A question emerges: by what mechanism would a specific variable - affective control values - influence one's overt evaluation of therapist characteristics? Perhaps individuals who have high affective control values are more cautious or reserved in their overt personal opinions about others. If such is the case, then perhaps the more positive ratings by high affective control subjects was partially the function of a general reserve or reluctance to express openly negative opinions about others. Thus, high affective control subjects may have given somewhat "inflated" evaluations of the therapist's traits in comparison to the evaluations of low affective control subjects.

However, there is another possibility for understanding the obtained relationship between subject affective control values and therapist ratings. The present results may indicate that "affective control" is a misleading label for the actual dimension measured by this factor scale, and therefore raises the issue of establishing construct validity. Upon a re-examination of the MHVQ content items which are included in the Affective Control Scale (items 1,4,5,11,15,21,37,51,56,83, and 89) - listed in Table 7 - it appears possible that alternative labels such as "Positive Outlook" or "Positive Appraisal Tendency" may be more appropriate. In light of this possibility, the higher therapist ratings given by high affective control subjects may be less a function of affective control than a tendency to be more positive or optimistic in interpersonal/environmental perceptions and beliefs. Determining precisely what the "Affective Control" Scale measures involved further establishing its construct validity, a task which will require further research utilizing this instrument.

At this point methodological shortcomings of the present study will be addressed. As discussed above, consistent support was not found for the hypothesized relationship between subject congruence/incongruence and subject ratings of the therapist. However, it remains possible that a relationship may exist, but that weaknesses in the present

TABLE 7

MHVQ - Affective Control Scale Content Items

Item #

1 __ The person never becomes violent.

4 __ The person likes everyone.

5 __ The person is very even-tempered.

11 _ The person seldom gets upset.

15 _ The person seldom complains about anything

21 _ The person is seldom depressed.

37 _ The person always keeps his or her cool.

51 _ The person says he or she doesn't have problems.

56 _ The person thinks money is very important.

83 _ The person is seldom fearful.

89 _ The person seldom cries.

---

investigation mitigated against finding support for this (it is also possible that no such relationship exists or is a weak phenomenon). Several possible methodological weaknesses should be noted in this regard.

First, the affective control values of the therapist may not have been effectively communicated to the congruent and incongruent subject groups. Thus, it is possible that a weak experimental manipulation was responsible for the equivocal findings with respect to therapist ratings. Second, it should be noted that the Therapist Rating Questionnaire completed by subjects is an unvalidated instrument constructed specifically for this study. For this reason, subject perceptions of therapist traits may not have been accurately assessed. Third, the subject groups were drawn from a relatively homogeneous, emotionally-adjusted college population, and this may have served to minimize the

potential differences between groups with respect to the severity of personal problems selected for discussion, in addition to the degree of personal sensitivity disclosed in subjects' personal problem descriptions. Finally, it should also be noted that the two independent raters who evaluated subjects' personal problem descriptions, following specific criteria, showed significant but relatively poor inter-rater reliability. In view of this finding, it is possible that any potentially significant differences between subject groups with respect to the personal degree of material disclosed may have been obscured by an unreliable rating system.

Future Research

The finding that affective control value scores were significantly related to the evaluation of therapist characteristics may have some implications with regard to the process by which a "therapeutic alliance" between therapist and patient is established. Luborsky (1976) has conceptualized the therapeutic alliance as consisting of two dimensions: Type I - the degree to which the patient experiences the therapist as warm, helpful, and supportive; and Type II - the sense of therapist and patient working in collaboration, and toward the attainment of treatment goals. It has been suggested by both clinicians and clinical researchers that the therapeutic alliance is crucial in establishing a productive therapeutic process, which will then determine therapeutic outcome (Luborsky, 1984). Results of the current investigation would suggest that individuals who have high affective control scores evaluate more positively the traits or characteristics of a potential therapist, which would facilitate the formation of a therapeutic alliance and presumably lead to a favorable outcome.

However, it has been suggested that individuals who have high affective control scores are simply more likely to be cautious or reserved in revealing/expressing their personal opinions about others. If such is the case, then it is possible that the more positive therapist ratings by high affective control subjects at least is partially the function

of reluctance to express negative opinions about others. Thus these subjects would tend to give relatively more "inflated" evaluations of therapist traits. If this were the case, then one could propose that the probability of establishing a successful therapeutic alliance between a therapist and high affective control score patient would not be significantly greater than for a low affective control score patient, other variables being held constant.

An alternative explanation was proposed for understanding the relationship between subject affective control values and therapist ratings. The "Affective Control" scale of the MHVQ may actually be measuring a construct other than the value an individual places upon affective control in appraising good mental health. The more positive therapist ratings given by high affective control score subjects may therefore be due to a tendency to be more positive or optimistic in their interpersonal/environmental perceptions (a "Positive Outlook" or "Positive Appraisal" tendency). If this were the case, then it is possible that high affective control score subjects may have a relatively better chance of establishing a successful therapeutic alliance which would presumably lead to a positive therapeutic outcome.

A possible area for future research would be to compare therapeutic outcomes between identified high and low affective control score individuals in a clinical setting. If high scorers on the affective control scale gave more positive initial evaluations of the therapist, but did not have therapeutic outcomes significantly better than low affective control patients, then this would suggest that high affective control score individuals simply tend to give more "inflated" evaluations of the therapist and do not go on to form a more positive or stronger therapeutic alliance.

The present study was conducted for the purpose of examining therapist-subject value congruence on the dimension of affective control and to assess its influence upon subject perceptions of the therapist. Results of the present investigation showed equivocal support fore the relationship between subject-therapist value congruence and the

establishment of a positive therapeutic alliance. In view of the inconclusive findings it appears that further research in this area is merited, which will contribute to our understanding of the therapeutic alliance process, and which will also serve to identify the factors which are involved in a successfull therapeutic outcome.

APPENDICES

Appendix A
Consent Form

The present study is being conducted by Lance Suan, a graduate student from the University of North Dakota Psychology Department. We are attempting to study the therapeutic process by identifying specific factors which may lead to a positive, successful outcome. You will view a 10-minute videotape of a psychotherapist who describes her educational background and personal approach to conducting therapy. You will then be asked to rate this therapist on various personal characteristics. In addition you will be asked to rate a list of personal problems, to indicate the degree to which you would want to discuss these problems with the therapist. Finally, you will be given the opportunity to select a topic to discuss with this therapist during a live 45-minute interview. All you responses will be kept confidential, and you are free to discontinue participation at any time. If you have any questions regarding our study, please contact Lance Suan at #777-3212.
Thank you for your participation.

____________________________ ____________________________

Signature Date

Appendix B

Background Information

Sex: Male_____ Female_____

Age: _____

Major:______________________

How large is the city (town) in which you lived longest during your childhood?

(check one): ____<1000 ____<10,000 ____<100,000 ____<500,000

____<1 million ____>1 million

How many years of education did your mother complete?

(circle number)

Elementary/secondary schools: 1 2 3 4 5 6 7 8 9 10 11 12

College (undergraduate levels): 1 2 3 4

Graduate/Professional school: 1 2 3 4 5

How many years of education did your father complete?

(circle number)

Elementary/secondary schools: 1 2 3 4 5 6 7 8 9 10 11 12

College (undergraduate levels): 1 2 3 4

Graduate/Professional school: 1 2 3 4 5

Have you ever seen a mental health professional (psychologist, social worker, or psychiatrist) for any reason? Yes_____ No_____

If so, approximately how many professional visits did you make to this person? _____

Have any of your family members seen a mental health professional (psychologist, social worker, or psychiatrist) for any reason? Yes_____ No_____

If so, approximately how many professional visits did he/she make to this person? _____

Please describe your religious orientation.

(circle number)

Strongly religious 1 2 3 4 5 not religious

Are you evangelical (fundamentalist)?

Yes____ No_____ Not religious_____

Appendix C
Therapist Rating

Now that you have seen the videotape, we would like you to rate the therapist on the following 7-point scales (circle one number only for each scale). Please give your honest impressions of the therapist. The therapist will not view your ratings. Please answer every question.
The therapist you have just seen on videotape is:

1	2	3	4	5	6	7
likeable						not likeable
1	2	3	4	5	6	7
unsure						confident
1	2	3	4	5	6	7
insightful						insensitive
1	2	3	4	5	6	7
dull						interesting
1	2	3	4	5	6	7
unattractive						attractive
1	2	3	4	5	6	7
untrustworthy						trustworthy
1	2	3	4	5	6	7
sympathetic toward others						not sympathetic toward others
1	2	3	4	5	6	7
doesn't understand others						understands others

1	2	3	4	5	6	7
ineffective at helping others						effective at helping others

1	2	3	4	5	6	7
open-minded						closed-minded

1	2	3	4	5	6	7
comfortable to be with						uncomfortable to be with

1	2	3	4	5	6	7
biased						unbiased

Appendix D
Personal Problems

You will later be scheduled to have an interview with the therapist you have just seen on the videotape. The interview will last approximately 45 minutes. Before seeing you for your interview, it would be helpful for the therapist to know which issue or personal problem you wish to discuss. On the list below place a check mark next to the problem that you would most wish to discuss with the therapist.
Please remember to check only one item.

Check only one:

_____difficulty dealing with feelings toward others

_____concern about alcohol/drug use

_____test anxiety

_____problems with spouse and/or children

_____choosing a major/career

_____concerns about your emotional state

_____trouble studying

_____concerns about sexual matters

_____social anxiety (difficulty handling social situations)

_____trouble with boss and/or co-workers

_____depression or extreme sadness

_____disagreements with parents

Since it may not be possible for the therapist to speak with you about your first choice, we ask that you please rate each of the same problems on the list below in terms of your willingness to talk with the therapist about these problems. Please remember to rate all items on the scales.

difficulty dealing with feelings toward others

1	2	3	4	5
unwilling				very willing
	0 (not applicable)			

concern about alcohol/drug use

1	2	3	4	5
unwilling				very willing
	0 (not applicable)			

test anxiety

1	2	3	4	5
unwilling				very willing
	0 (not applicable)			

problems with spouse and/or children

1	2	3	4	5
unwilling				very willing
	0 (not applicable)			

choosing a major/career

1	2	3	4	5
unwilling				very willing
	0 (not applicable)			

concerns about your emotional state

1	2	3	4	5
unwilling				very willing
	0 (not applicable)			

trouble studying

1	2	3	4	5
unwilling				very willing
	0 (not applicable)			

worries about sexual matters

1 2 3 4 5
unwilling very willing
0 (not applicable)

social anxiety (difficulty handling social situations)

1 2 3 4 5
unwilling very willing
0 (not applicable)

trouble with boss and/or co-workers

1 2 3 4 5
unwilling very willing
0 (not applicable)

depression or extreme sadness

1 2 3 4 5
unwilling very willing
0 (not applicable)

disagreements with parents

1 2 3 4 5
unwilling very willing
0 (not applicable)

Although we can not guarantee it, in most cases you will have the opportunity to discuss the topic that you have indicated above as your first choice. In order to make the most efficient use of your time with the therapist, please use the space below to provide some pertinent background information about the problem that you have selected for your discussion. Use the back of this sheet if necessary.

Please indicate on the scale below how difficult it would be for you to discuss your selected topic with the therapist.

1	2	3	4	5	6	7
not difficult						very difficult

In order to schedule you for your interview, we ask that you indicate a preference for how soon you would want to discuss your problem with the therapist.

as soon as possible____ within a month____

within a week____ no preference____

TURN PAGE

Appendix E
Life Situations

If you had a severe backache and wanted to find relief, which method of treatment would you choose? (check one only)

seek a medical doctor____ seek a chiropractor____

take non-prescription medications____ relax in bed____

In what region of the country would you decide to live if given the following choices? (check one only)

West Coast____ Southwest____

East Coast____ Mid-west____

Upper Mid-west____ South____

You have been told that you have an infected tooth. Although it does not hurt you the dentist says that the tooth must be pulled. When would you try to have it done? (check one only)

as soon as possible____ within a month____

within a week____ no preference____

If you were allowed to choose one of the following prizes from a game show, which prize would you select? (check one only)

$200,000____ 2-bedroom home in Bermuda____

round-the-world boat cruise____

Porsche or Ferrari sports car____

You have reached the end of the questionnaire.
Thank you for your participation.

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