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A Comparison of the Approach-Avoidance Verbal Behavior and Attitudes of Non-Professionally Trained and Professionally Trained Subjects in a Quasi-Therapy Situation.

Robert Lovitt

Louisiana State University and Agricultural & Mechanical College

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A COMPARISON OF THE APPROACH-AVOIDANCE VERBAL BEHAVIOR AND ATTITUDES OF NON-
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Louisiana State University and Agricultural and Mechanical College, Ph.D., 1968
Psychology, clinical

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AND ATTITUDES OF NON-PROFESSIONALLY TRAINED
AND PROFESSIONALLY TRAINED SUBJECTS
IN A QUASI-THERAPY SITUATION

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
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Doctor of Philosophy

in

The Department of Psychology

by

Robert Lovitt
B.A., City College of New York, 1961
M.A., Temple University, 1963
May, 1968
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The purpose of this investigation was to provide further knowledge of the psychotherapeutic potential of non-professionally trained groups. Current trends in the mental health movement and manpower shortages necessitate a broadening of traditional concepts as to what psychotherapy is and who may engage in its practice.

Responses investigated included subjects' approach-avoidance verbal behavior, during therapeutic interviews, and subjects' clinical assessments and personal attitudes towards patients. These responses were studied in relation to the following:

1. subjects variables, i.e., psychotherapy experience, education, age, and socio-cultural background.
2. patient variables, i.e., hostility, neutrality, and friendliness.

Non-trained groups in the experiment were adult women, undergraduate college students, and psychiatric attendants. Responses of these groups were compared to a group of professionally trained therapists representing the three major mental health professions. Assuming the role of therapist, subjects listened to tape recorded psychotherapy interviews with three patients representing hostile, neutral, and friendly characteristics. At pre-selected stopping points in the interview, subjects indicated their choice of responses to the patients. Response choices included both approach and avoidance.
alternatives. After listening to each interview subjects rated the
patients on attitude scale comprised of clinical assessment and per-
sonal attitudinal factors.

Experimental findings may be summarized as follows:

1. Attendents obtained lower approach scores than did other
groups. Average approach scores for adult women and college
students did not differ significantly from those of trained
therapists.

2. Average approach scores were related to variations in
patient type. The friendly patient attained the highest
score and the neutral patient the lowest score; the hostile
patient occupied an intermediary position.

3. Approach scores for subject groups were differentially
related to variations in patient type. Approach scores for
trained therapists did not vary as a function of patient
type. Approach scores for non-trained groups were related
to variations in patient type.

4. There was a significant interaction, upon verbal approach
behavior, between subject group and patient type. Mean
approach scores for subject groups did not differ for the
friendly patient. Approach scores for subject groups dif-
fered for other patient types.

5. All subject groups were comprised of individuals who
emphasized approach responses in their overall reaction to
patients.

6. There was minimal evidence to support the hypothesis stating
there would be a correlation between subjects' attitudes and
their approach scores. Trained therapists did not have a greater relationship between attitude and approach scores than did non-trained groups.

7. A correlation between scores on clinical assessment and scores on personal attitudinal factors was found for selected factors. The neutral patient elicited a significantly greater number of correlations than other patient types.

8. Minimal differences were found between personal attitudes and clinical assessments of trained vs. non-trained subjects. Trained subjects did not differ from non-trained subjects any more than did the latter differ among themselves.
CHAPTER I
INTRODUCTION

Man power shortages in all professions dealing with the mentally ill and mentally retarded have been a long-standing problem in the United States. The widespread occurrence of mental illness and the shortages of trained personnel became so acute that the National Mental Health Act was passed in 1946 in which the United States government accepted a major responsibility for combating mental illness. This responsibility was primarily manifested in supplying funds for research and training and in attempting to educate the public as to facts regarding mental illness and retardation. However, despite concerted efforts by the government recent surveys reveal that the man-power shortage is still a serious problem.

In 1959 Albee conducted a comprehensive survey of man power needs as part of a study by the Joint Commission on Mental Illness and Health. Albee found significant personnel shortages in services of state and county hospitals often amounting to as much as a twenty-five per cent. Albee stated at one point, "We must conclude this survey with the prediction that our country will continue to be faced with serious personnel shortages in all fields related to mental illness and mental health for many years to come. Barring the possibility of a massive national effort in all areas of education, with all the social changes such an effort would imply, or the possibility of a sharp breakthrough in mental health research, prospects are pessimistic for significant improvements in the quantity or quality of professional
services in these fields" (1959, page 259). Finally, the comprehensive survey by the Joint Commission on Mental Illness and Health (1961) concluded with the opinion that a great majority of state institutions for the mentally retarded and mentally disturbed were understaffed.

In 1964 the Mental Health Manpower Studies Committee, a subdivision of the National Institute of Mental Health, was established to provide current data and information on mental health manpower. It was generally agreed (National Health Manpower Studies Committee, 1966) that in the foreseeable future the need for qualified mental health manpower will continue to be greater than the supply. As one of their suggestions they recommended "incorporating into the formal training of professional mental health personnel subject matter concerned with the efficient utilization of sub-professional personnel and others with whom professionals will come into contact both informally and in a supervisory capacity . . ." and in "expanding the concept of mental health manpower to include the trained, non-professional who is able . . . to work with certain types or levels of the emotionally disturbed."

On the basis of the report of the Joint Commission on Mental Illness and Mental Health, John F. Kennedy in a message to the Congress of the United States stated "... we must strengthen the underlying resources of knowledge, and above all, of skilled manpower which are necessary to mount and sustain our attack on mental disability for many years to come... We must increase our existing training programs and launch new ones ... until we increase by severalfold in the next decade the number of professional and sub-professional personnel who
work in these fields" (1963).

W. Schofield (1964) has articulately expressed a similar point of view which has relevance for the emotionally troubled who are capable of functioning in society but who often receive therapeutic services on an out-patient basis. As our society has become more sophisticated as regards psychological processes and discomfort more people are turning to professionals for help in dealing with chronic and acute emotional problems. According to Schofield there are not enough trained therapists to deal with these people. He believes that many of these individuals could just as readily receive assistance from a good friend, a physician, an attorney, or a clergyman. Schofield further suggests that those interested in manpower problems in the United States take the lead in establishing training programs for the establishment of a new professional, the "non-specialized psychotherapist" who would be trained to deal with people with less serious emotional problems, under the supervision of the professional.

Schofield's argument as regards the psychological distress of large portions of our seemingly normal population receives support from a number of studies.

Srole (1962), in his Midtown Study in Manhattan, interviewed a large proportion of people in respect to their psychological health and emotional distress. He found that fewer than 20% of his sample reported being free of psychological distress. A great majority of his sample expressed the need for some form of psychological assistance.

A nationwide interview survey by Gurin, et al. (1950) of a
sample of the "normal" adult population of the United States for the Joint Commission on Mental Illness and Health investigated the perceptions of this sample as to their emotional condition and the means that they used to deal with emotional problems. Twenty-five per cent of this group reported that at some time in their lives they had had an emotional problem for which professional help would have been useful. This survey also indicates that a high proportion of normal Americans have at one time in their lives been troubled by psychological distress for which they felt they needed assistance.

These studies indicate that there is presently a widespread need for expansion of "psychotherapeutic services" on both an out-patient and an in-patient basis. The following section will be a review of some of the steps that are being taken to deal with this problem.

Changing Conceptions of the Psychotherapeutic Encounter

Newly emerging conceptions of the functions of mental hospitals, personnel, and changing conceptions of the role of the private citizen in preventing mental illness are partially related to manpower shortages (Greenblatt and Levenson, 1965). One of the most significant recent trends is the efforts to move from custodial to therapeutic care within hospitals. Attempts are being made to maximize the therapeutic potential of all individuals--patients as well as all staff members--who come in contact with patients.

The attempts to make efficient use of the therapeutic potential of non-professionally trained groups rests on the assumption that the therapeutic qualities of human interaction are kindness, acceptance,
warmth, understanding. Therapeutic persons in this sense "abound in nature and are not limited to those enrolled or graduated from schools for professional practice in the field of mental health. . . ."

(Greenblatt, 1962)

Carl Rogers (1957) has had a powerful and often disturbing influence on professional groups because of his belief that a successful therapeutic encounter is primarily a heightening of the constructive qualities which exist in many relationships. Rogers believes that it is not necessary to receive special intellectual professional training--psychological, medical, or religious--to be a successful therapist. Rogers has emphasized the experiential qualities of the individual as being the crucial therapeutic agent. By experiential Rogers means the ability to have unconditional positive regard and to experience empathy for a patient as opposed to any special clinical or intellectual qualities the therapist may possess.

The beliefs conceptualized by Greenblatt and Rogers are being substantiated by an ever growing body of research and practice which is bound to have considerable effects on our thoughts as to what psychotherapy is and who may practice it.

Non-Professional Therapists

M. Rioch, et al. (1963) have established a psychotherapy training program which has produced process and outcome data as regards the efficacy of using non-professionally trained people in therapeutic settings. Rioch, et al., recruited and trained, over a two-year period, in didactic and clinical methods eight college-educated housewives to
function as psychotherapists. After their training four experienced therapists made "blind" ratings of the therapy hours of the trained therapists. The trainees were evaluated on a number of criterion and their performance was considered satisfactory on all criteria. Outcome data collected shortly after completion of training indicated that their patient success ratio was comparable to that achieved by more experienced therapists. Subsequent data indicates that these women have been rated by their supervisors and colleagues as average to above-average in their clinical work when compared to other professional psychotherapists and mental health workers (Golann and Magoon, 1963). Golann, et al. (1966) evaluated the clinical judgment and clinical knowledge of these therapists from their written responses to a questionnaire concerning a filmed psychiatric interview. The housewives were compared to a group of mental health volunteers, medical students, psychiatric residents, and experienced psychiatrists. Housewives performed as well as second year residents indicating they acquired considerable capacity to effectively utilize the concepts associated with their training.

A number of Rogers' students and associates have found significant correlations between some process variables and therapeutic outcome. Three critical process variables have been identified as a) the therapist's accurate empathetic understanding of the patient, b) the therapist's warmth or unconditional positive regard for the patient, c) the therapist's genuineness or self-congruence. It has been demonstrated that those therapists who are rated high with respect to these
variables in their therapy hours achieve high rates of success while doing therapy in a variety of situations (Barrett-Lennard, 1962; Truax, 1963; Gross and De Ridder, 1966). Carkhoff (1966) has suggested that these variables are in fact non-academic factors which are unrelated to the techniques and clinical procedures which are learned in graduate or medical schools. He believes that non-professional workers rated high in these qualities could most probably do effective and valuable psychotherapeutic work. Carkhoff and Truax (1965a) proceeded to demonstrate that an inexperienced group of graduate students and a small group of lay hospital personnel (four attendants and one volunteer) could be brought to function at levels of therapy nearly equal to those of experienced therapists as measured by the three critical process variables. The training period lasted for sixteen weeks and was composed of didactic and experiential training. Of the three critical variables, the experienced therapists performed significantly better only on the dimension of self-congruence. Thus if one accepts the relevance of these variables for successful therapeutic outcome it appears that non-professionals if properly trained, may perform nearly as well as experienced therapists.

Poser (1966) conducted a study in which he compared the outcome of a group therapy program with chronic schizophrenics as carried out by trained vs. untrained therapists. The untrained therapists were undergraduate students with no training or experience in psychotherapy. The trained therapists were psychiatrists, social workers, and occupational therapists. Improvement in outcome was
assessed on differences in two simple psychomotor tests, two perceptual-motor tests and two verbal tests. It was found that the group conducted by the untrained therapists showed significantly greater improvement on four of the six tests when compared to a group of untreated controls.

A comparison of the "untrained" to the "trained" groups showed that the former showed a significantly better performance on three of the six tests.

**Attendents**

In seeking to maximize the therapeutic potential of every person in the milieu concerted efforts have been made to increase the therapeutic usefulness of attendants. Many authorities agree that often attendants exert the most influential effect upon a patient's behavior in an "in service" setting and particularly in the constricted social milieu of a back ward (Greenblatt, et al., 1957; Schwartz, et al., 1951). Attempts are often made to undertake group sessions with attendants, led by psychiatrists, nurses, and psychologists, in attempts to understand the behavior of patients and the relevance of the attendants' feelings to the management of the patient (Jones, 1953; Greenblatt, 1957).

There have been a number of attempts to involve attendants in intensive activity programs involving the purposeful manipulation of the entire milieu of hospitalized patients. They may play a variety of roles in these programs which vary from the initiation of intensive one-to-one relationships which focus on the introduction and maintenance of adaptive behavior, the initiation of games and social activities, to the
responsibility of directing their own therapeutic groups. A number of controlled studies have reported significant adaptive changes in experimental groups of chronically ill schizophrenic patients involved in these studies (Appleby, 1963; Jones, 1953; Greenblatt, et al., 1957; Gallioni and Adams, 1952-1953; Sines, et al., 1952). Changes vary from significant increases in hospital discharge rates to improved social behavior on the wards. However despite these favorable reports it is difficult to estimate the specific roles played by attendants in these programs as the experimental condition is the total hospital milieu. However a number of attempts have been made to focus more exclusively on the attendant as a therapeutic agent.

In an early venture Kaldeck (1951) used nurses and attendants as group leaders in a group psychotherapy program. Although he did not use appropriate controls and reported no quantitative data he did report that patients often showed significant improvements in behavior as a result of group treatment using such personnel.

Ayllon and Azrin (1965) made use of attendants in a highly structured manner consistent with behavior therapy principles. They trained attendants to administer an operant reinforcement schedule in their interactions with psychotic patients in an attempt to increase their adaptive behavior. They found that the procedure was effective in maintaining desired behaviors for considerable periods of time.

Christmas (1966) and Mendel and Rapport (1963) reported projects in which former attendants functioned as lay therapists in outpatient clinics. In both of these investigations the attendants
focused their counseling on the social and reality problems the patients were encountering on their return to the community. Although Christmas' observations are not controlled she does report highly successful results. Mendel and Rapport (1963) reported that 70% of severely chronically ill schizophrenics could be maintained in the community at an adequate level of functioning for a fifty-one month period of observation. The treatment results of the attendants compared favorable to that of a group of psychiatrists involved in the same project.

Carkhoff and Truax (1965b) compared behavioral changes in a group of schizophrenics who were seen by five volunteer attendants in a therapeutic relationship to changes in a group of control patients. Attendants were given brief didactic and experiential training which focused on their attitudes and feelings towards the patient. They reported significant improvements in behavior of the experimental group as compared to control subjects.

In spite of recurrent statements as to the importance of the attendant in the mental hospital and the need to develop and use their skills more effectively very little is actually known as regards interaction of attendants and patients. Too few studies have examined the process of patient-attendant interaction and not enough research has attempted to isolate those characteristics of attendants' attitudes and verbal behavior associated with success in dealing with patients. Additional research on the typical verbal behavior and attitudes of attendants is critically needed.
Volunteers have become an integral part of the mental health movement. They function as aides to occupational and recreational therapists or as social work aides (Greenblatt, 1965). At times they engage in intensive interpersonal relationships with individual patients over long periods of time with the explicit goals of improving the social responsiveness of patients (Holzberg, 1963; Schäibe, 1965).

Volunteers have been engaged in direct therapeutic patient contact with the mentally retarded (Cytron and Uselion, 1965), chronic and acute schizophrenic patients (Beck, et al., 1963), psychotic children (Reinherz, 1963), patients seen at out-patient clinics (Mendel and Rapport, 1963), and adolescent drug addicts (Elia soph, 1959).

Although the ages of volunteers vary from teenagers to people in their fifties and sixties the most widely reported work has been published on college student volunteers in mental hospitals. Effectiveness of these programs has been predominately assessed by uncontrolled qualitative observations. These observers have enthusiastically reported significant beneficial changes in many patients (Umbarger, et al., 1962; Greenblatt and Kantor, 1961; Reinherz, 1964; Holzberg, 1963). A need for more adequate assessments of these programs is definitely needed as there are few published reports citing controlled evidence.

Beck, et al. (1965) compared changes in social behavior of chronic schizophrenic patients exposed to student volunteers over an eighteen month period to a group of control patients. Students spent-
their time talking to patients, playing games, and taking walks. Statistically significant increases in social behavior of the experimental group were found.

Beck, et al., (1963) did a follow-up study of 120 chronic schizophrenic patients who were seen by college volunteers on a case aide basis between 1954-1961. It was found that 31% of these patients were discharged from the hospital while working with the students. According to Beck other sources indicate that only 3% of similar populations of patients are ever released from the hospital. The discharge of patients associated with the volunteer program is thus significantly greater than the base rate figures for normal discharge. Unfortunately this study does not allow precise comments to be made as to the role of volunteers, as their activities did take place in a heightened milieu program.

Beck and Kantor (personal communication) have carried out a study in which they have attempted to relate process variables, as measured in college volunteers, to the therapeutic outcomes of groups of patients. Each student volunteer was rated on a scale designed to characterize the ideal volunteer therapist. Successful patient outcome was found to be significantly correlated with scores on the scales. Items composing the questionnaire were less concerned with academic and intellectual factors but instead stressed personality and attitudinal traits.

Despite the widespread use and need for volunteer workers little is actually known of their verbal behavior and attitudes in relation to people with emotional problems. Furthermore the ranks of college students
from which many of these volunteers are drawn are a group with which relatively little research has been done in this area.

Training in Psychotherapy

Verbal Behavior

There is extensive evidence to indicate that training and experience in psychotherapy is related to the verbal behavior of the therapist. Much of this evidence comes from experimental analogues of psychotherapy sessions in which different therapists are presented with the same objective patient-stimuli and are asked to respond. Experimentors have made use of cards with patients' statements on them, tape-recorded and filmed psychiatric interviews, and actors impersonating clients.

Using the Porter Test of Counselor Attitudes, a multiple choice test which measures five dimensions of therapists' responses to patients' statements, it has been found that inexperienced guidance counselors use a great many evaluative and probing types of responses when addressing clients (Munger and Johnson, 1960; Demos and Zuwaylif, 1963). With brief training in a course in counseling and guidance, lasting six to eight weeks, the counselors became less evaluative and probing and more interpretive and understanding (Demos and Zuwaylif, 1963; Munger and Johnson, 1963). Jones (1963) administered a lengthy questionnaire to guidance counselors before and after a brief training course in counseling and guidance. The questionnaire assessed the means by which counselors attempted to help students with their
problems. Jones concluded that the counselors' attitudes had shifted toward greater acceptance, understanding, permissiveness, and listening after completion of their training.

Bohn (1965) and Parsons (1966) studied the verbal behavior of therapists by presenting them with tape recordings of therapy interviews and asked them, at selected points, to indicate what they would say to clients by choosing responses from a set of response alternatives--two directive and two non-directive responses. The former compared male psychology graduate students to undergraduate males in an introductory psychology course. The latter compared male undergraduates and medical students to psychiatrists. Both studies found inexperienced therapists to be more directive in their statements.

Experienced therapists made greater use of restatement of content and clarification of feelings and made less use of direct questions, persuasions, forcing the topic and reassurance. These investigations indicate that with training therapists become more accepting and less directive towards patients.

Grigg (1961) had clients evaluate their therapists, who were graduate students and experienced psychologists, after termination of therapy. Inexperienced therapists were rated as more active in beginning the interviews, more prone to give advice and suggestions and more controlling of the therapeutic situation.

Therapist's Attitudes

It has been found that the attitudes of a psychotherapist or of significant persons in the milieu of a patient are often related
to the successful treatment of the patient (Stanton and Schwartz, 1954; Greenblatt, 1957). Attempts to infer the attitudes of therapists towards patients have been made by examining retrospective reports of patients towards their therapists, measuring therapists' attitudes on various personality tests, and by asking them direct questions as to what they thought or how they felt about patients.

Strupp, et al., (1964) in a survey of retrospective reports of patients who had terminated therapy found a marked positive relationship between reports of successful outcome and the degree to which therapists were perceived as friendly interested persons. Unsuccessful outcomes were correlated with negative relationships. Strupp, et al., concluded that the therapist's personality or his ability to become warmly involved with his patient was as important, in the report of successful outcome, as the "technical" skills of the therapist. Strupp and Wallach (1965) found a significant relationship between measured attitudes and therapists' verbal communications. Therapists who express greater empathy, liking and willingness to treat patients used a greater number of words in their comments, gave more "complex" responses and advanced a smaller number of "non-giving" comments.

Grigg (1961) found that although patients reported significant technical differences between experienced and inexperienced therapists no differences in successful outcome were reported which were related to these technical differences. Thus it is likely that despite their lack of technical skill inexperienced therapists were able to establish some type of relationship with their patients which the latter
Lorr (1965) attempted to identify the major dimensions along which clients perceive their therapists. A dimension of "acceptance and understanding" was isolated which was significantly related to patients' and therapists' ratings of improvement. Hiler (1958) investigated those characteristics of therapists thought to be associated with the ability to keep patients in treatment. It was found that those therapists who were rated as most friendly and warm had significantly longer relationships with their patients than those who were rated low on this dimension. Stoler (1963) had judges rate patients on a dimension of "client likability." A significant relationship was found between the client's likability score and his success in therapy. The more likeable a client the more he benefited from psychotherapy.

And finally Mills and Abeles (1965) investigated the relationship between Edwards Personal Preference Scores on the scale for "nurturance" and the ability to adequately cope with hostile and dependent comments made by patients. Therapists rated high in nurturance were able to tolerate or approach hostile comments more than therapists rated low on this variable. To these studies could be added the work of Rogers and his students which also stresses the importance of experiential or attitudinal variables as opposed to purely technical variables in the outcome of psychotherapy.

Research on therapists' attitudes has been carried out primarily with professionally trained groups and makes it difficult to draw clear hypotheses concerning attitudes of non-professionally trained subjects. In comparing the extremity of attitudes towards patients of
college students vs. psychiatrists Parsons (1966) found that the former entertained more extreme attitudes on certain clinical appraisal variables than the former. Parsons reasoned that a lack of professional training was associated with less acceptance of patients and greater extremity of attitudes.

In studying a variety of professionally trained populations Strupp (1958a, 1958c), Strupp and Williams (1960), and Strupp and Wallach (1965) have consistently found a significant correlation between therapists personal attitudes towards patients and their clinical appraisals of patients. This correlation did not vary with patient types. Invariably favorable personal attitudes towards patients accompany favored clinical assessments. Strupp has found this correlation while inter-correlating single items (1958a, 1958c) or when examining relationships between factors representing clinical versus attitudinal variables (Strupp and Wallach, 1965). In the latter study it was found that the correlation between attitudinal and clinical variables was correlated to the therapist's level of experience.

Parsons (1966) used a slightly modified version of the Strupp-Wallach attitude scale to investigate the relationship between clinical and attitudinal variables among undergraduate college students. Parsons grouped his items into three categories: 1. positive attitude 2. negative attitude and 3. clinical appraisal variables. He then correlated scores on the first two groups with individual items from the last group. Parsons found no differences in the magnitude or number of significant correlations when comparing college students to
a group of psychiatrists and thus agreed with Strupp's conclusion that level of experience has no effect upon the correlation. However the obtained correlations were fewer than to be expected on the basis of the hypotheses; many items logically considered to be clinical appraisal items, and on the basis of Strupp's work expected to correlate with attitudinal variables, did not correlate with personal attitudes. Parsons concluded that there was only minimal evidence to suggest a positive correlation between clinical and attitudinal variables for both professional and non-professional populations. In addition there was evidence to suggest that the correlation between these categories was related to patient type. A greater number of correlations appeared for a neutral patient than for a dependent and hostile patient. The relationship between attitudinal and objective clinical appraisals is thus relatively unexplored for non-professional groups as it has only been explored for college undergraduates.

Theoretical Orientation

The effect of theoretical orientation upon therapists' behavior is not as clearly documented as is the effect of experience. Strupp (1955a) has found that psychologists who considered themselves Rogerians at all levels of experience made greater use of non-directive responses in an initial interview than exploratory responses. With increasing experience the Rogerians became diversified in their techniques although they still preferred non-directive responses as opposed to exploratory questions. In comparing the assessments of patients made by Rogerians to those made by analysts consistent differences were also
found. Rogerians were less prone to propose treatment goals, placed less emphasis on the necessity of discussing certain areas and placed less emphasis on the obtaining of a case history. In more recent studies Sundland and Barker (1962) and Wallach and Strupp (1964) have investigated the customary therapeutic practices of experienced and inexperienced therapists on a variety of dimensions. The dimensions investigated have been influenced to the greatest extent by differences in theoretical orientation. Experienced therapists in each theoretical orientation responded more like their inexperienced colleagues than like the experienced therapists in other orientations. The factor producing greatest differences between orientations has been called an analytic-experiential dimension (Sundland and Barker, 1962). Greatest differences have been found between Rogerians and Freudians. Freudians tended to emphasize conceptual activities of the therapist, training of the therapist, planning of therapy, unconscious processes, and a restriction of therapist spontaneity. The Rogerians de-emphasized conceptualizing, stressed the personality of the therapist, stressed an unplanned approach to therapy, de-emphasized unconscious processes, and accepted therapist spontaneity (Sundland and Barker, page 205).

In an earlier well known series of studies, Fiedler (1950a, 1950b) found that differences in theoretical orientation had little effect on therapists' conception or practice of an "ideal therapeutic relationship." In one study Fiedler had psychoanalytically oriented therapists and Rogerians, both groups containing experienced and inexperienced therapists, sort a large series of statements as regards the
therapeutic relationship into a Q-sort. In the second study the quality of the therapeutic relationships of Psychoanalytic, Rogerian, and Adlerian therapy sessions were assessed, by Q-sort methodology, to determine how closely they approached the therapeutic ideal. It was found that the more experienced therapists of the different schools agreed more highly with each other on what constitutes an ideal therapeutic relationship than they agreed with the less well trained therapists within their own schools. Therapeutic relationships created by the more experienced therapists of a given school resembled more closely those created by the more experienced of another school than they resembled relationships created by novices within the same school. Theoretical differences were least apparent in the therapists' ability to communicate, understand, and maintain rapport with a patient. Differences between schools were apparent only in terms of the status which the therapist assumed towards the patient. The Adlerian and some of the analytically oriented therapists placed themselves in a tutorial role while the Rogerians tended toward the opposite direction (Fiedler, 1950).

In the basis of these studies it appears that the unique influences of theoretical orientation upon the behavior and attitudes of therapists vary according to the dimension being investigated. As the different orientations share many views as regards the process of psychotherapy it is to be expected that differences in orientation will not produce differences in therapeutic behavior in all cases. A more careful delineation of these dimensions, as they are affected by
theoretical orientation, must be determined on the basis of further empirical research.

**Patient Variables**

Increasing attention is being paid to the relationship between patient variables, therapist attitudes, and verbal behavior. A major difficulty in this area has been the adequate control of "patient-stimulus" conditions. Recent attempts to control this stimulus variability have involved presenting therapists with trained actors playing specified patient roles (Heller, *et al.*, 1963; Russell and Snyder, 1963), presenting therapists with filmed therapy interviews (Strupp, 1958) and presenting therapists with tape recordings of therapy sessions (Bohn, 1965; Parsons, 1966). The analysis of tape recordings of actual therapy situations although less controlled by the experimenter has been more naturalistic in its approach and has also produced a great deal of useful data as regards the process of psychotherapy (Bandura, *et al.*, 1960; Carcarena, 1965). Although one must be cautious in generalizing from these experimental conditions to actual therapy situations these procedures have the advantage of presenting the same objective stimulus conditions to different therapists.

The patient dimensions of hostility, friendliness, and dependency exert significant influences on therapist behavior. Research indicates that therapists respond differentially to hostile and friendly patient behavior. Bandura, *et al.*, (1960) studied the response tendencies of therapists as it related to the source of hostility of
patients. They found that hostility directed towards a therapist elicited significantly less positive or approach behavior than hostility directed towards a neutral source. Schuldt (1966) using a procedure and method of analysis similar to Bandura, et al. found that therapists tend to approach dependency directed at themselves more than they approached dependency directed at others.

Heller, et al. (1963) utilized client actors who played friendly and hostile roles. Therapists responded in a directive and reassuring manner to dependent clients. Hostile clients were responded to in a significantly less friendly and more hostile manner. Russell and Snyder (1963) found that hostile client behavior led to greater anxiety in therapists than did friendly behavior.

Bohn (1965) found results which suggested that differences in patient types elicited differences in therapist directiveness. While studying naive undergraduate and graduate students in psychology he found that his subjects were more directive towards a dependent than a hostile client. Parsons (1966) found that hostile and dependent clients elicited significantly more directiveness from psychiatrists and undergraduate psychology students than did a neutral client.

There have been a number of attempts to relate a therapist's reactions to hostility and dependency as a function of his level of experience or training.

Russell and Snyder (1963) found that experienced student counselors responded with significantly less anxiety to hostile and friendly actors than did inexperienced counselors. Anxiety was assessed by a
verbal measure, a scale filled out by the actors, and the eye-blink rate of the therapist.

Bohn (1967) found that graduate students showed a significant decrease in the amount of directiveness they expressed towards a hostile client as a function of an intensive course in theory and practice of psychotherapy. No differences were found in response to a dependent client over a similar period. Bohn hypothesized that training might affect therapist responses to hostility differently than to dependency.

Parsons (1966) found that psychiatrists were less directive in their responses to a hostile, neutral, and dependent patient than were a group of undergraduates.

Gamsky and Forwell (1966) investigated the responses of school counselors at three levels of experience to a group of hostile patients. Trained actors played the role of patients. They found that the more experienced counselors showed less avoidance to hostile expressions than did the less experienced counselors. Mills and Abeles (1965) and Carcarena (1965) investigated the relationship between experience and the tendency of therapists to approach dependent statements made by patients. Both studies compared experienced psychologists to interns and practicum students. It was found that the former group approached dependency significantly more than the latter groups.

Carcarena also found that therapists' approach scores, in response to dependent statements, were higher than their avoidance scores.

Parsons (1966) has investigated the reported attitudes of
undergraduate students towards a hostile, neutral, and dependent client. In terms of rating scores on clinical appraisal and attitudinal items for the three clients, the college students rated the dependent client, as opposed to the hostile client, as being less defensive, more emotionally mature, having higher motivation for therapy and having more attractive qualities. They considered their own personalities as being more appropriate for the treatment of a dependent than a hostile patient. The neutral patient was generally ranked between the latter two patients in terms of these traits. The college students also expressed a significantly more positive attitude towards the dependent client than the hostile client. The ratings of the undergraduates in the afore-mentioned areas were similar to that of psychiatrists as regards the three patient types.

Problem

Manpower shortages, the increased emphasis upon the therapeutic use of non-professionally trained individuals and the body of research which has demonstrated that these individuals may render valuable services are vital factors in current thought about mental health. As the vast majority of research on the psychotherapy process has investigated professionally trained individuals there is little controlled research as regards the activities of the non-professional. With few exceptions the research that has been carried out is primarily "outcome" studies which afford little insight into the verbal behavior and attitudes of these individuals. An important aspect of a therapist's behavior is the extent to which he encourages or discourages a patient
from talking about conflictual or disturbing subject matter. Verbal responses of a therapist may approach or avoid patient verbal behavior. The relevance of this dimension for understanding subsequent patient behavior has been demonstrated by a number of studies. It has been found that approach behavior by therapists is correlated with continuing dependent behavior (Schuldt, 1966) and hostile behavior (Bandura, et al., 1960) by patients. Winder, et al. (1962) found that patients whose dependent comments were approached by therapists tended to stay in treatment longer than patients whose dependent statements were avoided by therapists.

This investigation will study the approach-avoidance communications and attitudes of three non-professionally trained groups towards patients with emotional problems. Untrained groups will be compared to a group of professionally trained subjects to examine similarities and differences in the behavior of these groups. Relationships to be investigated will be those between 1) therapist response measures, 2) therapist variables, 3) patient variables.

1. Therapist response measures
   A. Approach-avoidance communications during interviews
   B. Personal attitudes towards patients
   C. Objective clinical appraisal of patients' strengths and weaknesses

2. Therapist variables--professional affiliation, socioeconomic status

3. Patient variables
   A. Neutrality
B. Hostility

C. Friendliness

Although this study is largely exploratory, hypotheses based upon work with professionally trained groups can be proposed.

Subjects' Experience and Theoretical Orientation

It has been shown that inexperienced therapists use a great many evaluative and probing responses (Munger and Johnson, 1960; Demos and Zuwaylif, 1965; Jones, 1963). Persuasion and forcing of the topic are preferred to non-directive responses in undergraduate college students (Bohn, 1965; Parsons, 1966). Inexperienced therapists are rated as being more controlling and more prone to give advice (Grigg, 1961). With increasing experience therapists become more accepting, more understanding, and more permissive (Jones, 1963; Bohn, 1965; Parsons, 1966) and less controlling (Grigg, 1961). It is therefore expected that non-professionally trained groups will show a preference for avoiding the problems and conflictual material discussed by patients. They would be expected to use a variety of means to direct the patient's attention to topics they consider more appropriate. The group of professionally trained subjects would be expected to manifest greater approach towards the conflictual material of patients. The professionally trained subjects would also be expected to differ from non-professionally trained subjects in their attitudes towards patients.

Findings by Strupp (1955), Strupp and Wallach (1964), and Sundland and Bacter (1962) indicate that theoretical differences contribute significant variance to verbal behavior and attitudes towards
towards psychotherapy. Fiedler (1950a, 1950b) has demonstrated that
some dimensions of therapist behavior and attitudes are not influenced
by differences in theoretical orientation for experienced therapists.
It is necessary to determine by controlled research whether the
approach-avoidance behavior and attitudes of non-professionally trained
groups will be correlated with the different social and cultural back-
grounds of these groups. Since the groups to be investigated differ
widely in terms of their experiences and undoubtedly hold different
implicit assumptions about mental illness this suggests that they may
consequently differ in their approach-avoidance behavior and attitudes
towards patients.

Strupp, et al. (1964), Strupp and Wallach (1965), and Parsons
(1966) have demonstrated that a correlation exists between personal
attitudes towards patients and clinical appraisals. Personal attitudes
have been defined as the likability of patients and the desire of therape-
ists to become involved in a helping relationship with a given patient.
This correlation has been demonstrated for trained therapists and col-
lege students. On the basis of this work it would be expected that
similar correlations should exist for both professional and non-profes-
sionally trained groups. It is uncertain as to whether this correlation
is related to differences in patient type. Strupp and Wallach (1965)
have found no relation between the extent of the correlation and dif-
ferences in patient type whereas Parsons has suggested that the
correlation may be greater for a neutral patient than for a hostile
or dependent patient.
It has been shown that those therapists expressing a warm, accepting, and positive attitude towards patients effect more positive outcomes than those expressing negative attitudes (Strupp, et al., 1964; Lorr, 1965; Stoler, 1963; Truax, 1963). Strupp (1960) reports that psychologists who expressed a neutral attitude towards patients accepted the dynamic focus of the latter less than those psychologists who expressed a positive attitude towards patients. Strupp and Wallach (1965) demonstrated a positive correlation between positive attitude and verbal behavior of therapists. It is therefore expected that subjects differing in their attitudes will differ in the types of verbal communications they address to patients. Subjects expressing positive attitudes should approach patients' statements more than subjects expressing a negative attitude towards patients. Carkhoff and Truax (1965a) have found that non-professionals are less congruent in their behavior towards patients than are professionals. Therefore it is also to be expected that the relationship between expressed attitudes and approach behavior will be greater for the professional group than for non-professionals.

Finally, the many differences found in the behavior of experienced and inexperienced therapists in therapy situations suggest that significant differences in attitudes and clinical assessments are to be expected towards patients by these different groups.

**Patient Type**

Experienced therapists manifest greater hostility (Heller, et al., 1963) and anxiety (Russell and Snyder, 1963) in response to a
hostile client than they do to a friendly client. Gamsky and Farwell (1966) found that experienced therapists showed less avoidance to hostile expressions than did inexperienced therapists. Therefore it is to be expected that professionally trained subjects will show less avoidance than the non-professionally trained groups towards a hostile patient. In addition, non-professionally trained subjects should differ more from professionals in relation to a hostile patient than they would for a friendly patient.

Bohn (1965) and Parsons (1966) have found that a hostile and friendly client elicited significantly more directiveness than a neutral client. The latter found that psychiatrists and college students report a more positive attitude and more favorable clinical impressions of a friendly than a hostile patient. A neutral client was rated midway between them on all dimensions. Bandura, et al. (1960), Winder, et al. (1962), Mills (1965), and Carcarena (1965) have demonstrated that a therapist's verbal approach score is related to the dimensions of hostility and dependency. Hostility directed towards a therapist elicits more avoidance behavior than hostility directed at a neutral source (Bandura, et al., 1960). Dependency directed towards a therapist elicits more approach than dependency directed at a neutral source (Winder, et al., 1962). Therapists' approach scores, in response to dependent statements, were higher than their avoidance scores (Carcarena, 1965).

On this basis it is to be expected that non-professional and professional groups will differ in their verbal behavior towards patients to be investigated. The friendly patient should be responded to
with the highest approach score followed by the neutral client. The hostile client should be responded to with the lowest approach score. Reported personal attitudes should be most positive for the dependent patient and least for the hostile client. The neutral patient will be rated in an intermediary position.

Hypotheses

Hypotheses to be investigated are:

1. Approach Avoidance Verbal Behavior as a Function of Subject Group and Patient Type.
   a. Subject groups will differ in their approach scores. Professionally trained subjects will attain the highest score. Non-trained subjects will differ among themselves.
   b. Patient types will elicit different approach scores. The friendly patient will elicit the highest score; the hostile patient will elicit the lowest approach score; the neutral patient will occupy an intermediary position.
   c. Approach scores for each subject group will be related to patient type. The friendly patient will elicit the highest approach score; the hostile patient will elicit the lowest score; the neutral patient will occupy an intermediary position.
   d. There will be a significant interaction between subject group and patient type. A greater difference in approach scores will occur, between trained and non-trained subjects, in relation to the hostile client than for other patient types.
   e. Subject groups will differ in their overall preference for avoidance responses. Non-trained subjects will show an overall preference for avoidance responses. Trained subjects will show an overall preference for approach responses.

2. Approach Avoidance Verbal Behavior as a Function of Subjects' Attitudes
f. There will be a relationship between subjects' attitudes and approach scores. Subjects expressing positive clinical assessments and positive personal attitudes towards patients will have higher approach scores than those expressing negative ones.

g. The relationship between attitude and approach score will be higher for the trained group than for the non-trained groups.

3. Responses on Clinical Assessment and Personal Attitudinal Factors.

h. There will be a correlation between clinical assessment and personal attitudinal factors. This correlation will be unrelated to differences in subject group or patient type.

i. Subject groups will differ in scores attained on clinical assessment and personal attitudinal factors. Trained subjects will differ from other groups. Non-trained subjects will differ among themselves.
CHAPTER II

METHOD

Subjects

Psychiatric Attendants

Thirty subjects were psychiatric attendants employed in a State psychiatric hospital. The group was composed of thirty females. The mean age of the group was forty years with a range from eighteen to sixty-five years. The range of work experience of the group was from two months to fifteen and one-half years, with eight years and eleven months as the mean years of experience.

College Students

Thirty subjects were students enrolled in an undergraduate course in abnormal psychology at Louisiana State University. The group was composed of eighteen females and twelve males. The mean age of the group was twenty-two years and two months with a range from twenty-one to twenty-seven years.

Adult Women

Thirty subjects were adult women belonging to the Junior League of Baton Rouge. All subjects had received college degrees and were currently unemployed. The mean age of the women was thirty-three years with a range from twenty-eight to forty years.

Subjects in the latter two groups had received no formal training or experience in psychotherapy. Psychiatric attendants had received
limited "in service training" as regards patient care in a milieu
therapy program and had had considerable interaction with psychiatric
patients.

**Professionally-Trained Therapists**

Thirty subjects represented the three major mental health profes-
sions. The sample had the following composition: nine social
workers accredited by the Academy of Certified Social Workers, three
psychiatrists, four third-year residents in psychiatry, five clinical
psychologists with Ph.D. degrees, one counseling psychologist with a
Ph.D. degree, and eight advanced graduate students in clinical psy-
chology who had completed a year of internship and were working towards
Ph.D. degrees. The group was composed of twenty-three males and seven
females. The mean age of the group was thirty-three years and nine
months with a range from twenty-five to fifty-seven years. The mean
number of psychotherapeutic interviews of the group was two thousand,
one hundred hours with a range from fifty to ten-thousand hours of
psychotherapeutic interviews.

**Test Stimuli**

**Tape Recordings**

Subjects were asked to listen to tape-recorded psychotherapy
interviews. Content of the interviews was based on actual cases (Bohn,
1965). Interviews were recorded with actors playing the role of coun-
selor and client.

Patients represented three patient prototypes. A neutral
patient, a friendly patient, and a hostile patient.

The neutral patient was a college male seen at a university counseling center. His major complaints centered around difficulties in getting along with his roommate and in relating to girls. He presented no particular difficulties in relating to the therapist. He did not interact with the therapist in any meaningful emotional relationship.

The friendly patient was a depressed male reporting severe states of anxiety and an inability to cope with his responsibilities. His attitude was one of a complete lack of self-assurance. He was extremely deferent towards the therapist and asked for constant reassurance and advice.

The hostile patient was an aggressive agitated young man who was referred to a counseling center because of academic difficulties. He vehemently denied any personal difficulties and directed a great deal of anger towards the university and the therapist.

Transcripts of the complete interviews may be found in Appendix A.

Parsons (1966) obtained Adjective Check List ratings on similar recordings in order to supplement the verbal descriptions of the clients with psychometric descriptions. His judges were fourteen male graduate students and four male counselors. Results generally corroborated the verbal descriptions. The hostile client was described by adjectives like assertive, headstrong, and self-centered while such adjectives as over-controlled, apathetic, submissive and self-effacing
were used to describe the friendly client. The neutral patient ranked between the former two clients on these traits.

Development of Therapy Response Alternatives

A pilot study was conducted in which the experimental recordings were played to undergraduate college students. Subjects were asked to write, in a free response format, what they would say to patients at selected stopping points. Instructions given to students may be found in Appendix B. From a pool of obtained responses items were selected to be presented to subjects at selected stopping points during the subsequent investigation. Selected statements were representative of categories in a system of content analysis developed by Bandura, et al. (1960).

Responses representing four approach and four avoidance categories were selected. The approach categories were the following:

1. **Approval or Support (AS):** expressed approval or agreement with the patient's feelings, attitudes, or behavior.

2. **Exploration (E):** remarks or questions which encouraged a patient to describe or express more fully feelings or actions which he described.

3. **Reflection or Labeling (RL):** repeated or gave a name to a portion of the feelings or attitudes contained in a patient's verbalizations.

4. **Factual Information (FI):** therapist gave information to direct or implied questions by the patient.

The avoidance categories were as follows:
1. **Disapproval (D):** included critical, sarcastic or antagonistic remarks expressing rejection in some manner.

2. **Persuasion (P):** attempts made by the therapist to change a patient's feelings or attitudes by stating he will feel better if he behaves differently.

3. **Topic Transition (TT):** therapist changed or introduced a new topic of discussion not in the immediately preceding patient verbalization.

4. **Mislabeling (M):** attempts made to name attitudes, feelings, or actions not present in the patient's comments.

Approach categories were equally represented in the response choices selected for the hostile and friendly patients. For the neutral patient four reflection or labeling and six factual information choices were selected. Other approach categories were equally represented. Avoidance response categories were equally represented for the hostile and neutral patients. For the friendly patient there were six disapproval responses and four mislabeling responses. At each stopping point there were two approach and two avoidance responses. With the exceptions noted, each specific response category was represented five times for a given interview.

In order to minimize subsequent affects of specific response category combinations, on subject responses, the combinations of response choices were controlled. First, each approach category was paired with every other approach category at least once and not more than two times for each transcript. The same procedure was applied to pairs of avoidance categories.
The pairing of approach response categories with specific avoidance categories was balanced so that each approach response was paired with each avoidance response at least once and not more than four times.

Reliability of Therapy Response Categories

Responses selected by the writer were subsequently presented to five judges in order to evaluate the reliability of the classification system. Judges were asked to listen to the recordings and to classify each of the therapy responses, at stopping points, into an approach or avoidance category. Scoring instructions given to judges may be found in Appendix C. On the basis of the ratings of the first three judges modifications were made in response choices. The final set of responses used in this investigation was selected on the basis of the ratings of the last two judges (Appendix D).

Tetrachoric correlation coefficients were computed between the ratings of the final pair of judges. The following Tetrachoric correlation coefficients were obtained:

- Hostile patient \( r = .914 \)
- Neutral patient \( r = .988 \)
- Friendly patient \( r = .974 \)

Attitude Scale

Development

After listening to each tape-recorded interview subjects were asked to complete a thirty-two item attitude scale regarding their
impressions of the patient. Items were intended to have subjects objectively evaluate the psychological functioning of the patient and to register their personal attitudes towards patients. Clinical concepts used by professional therapists were reworded into behavioral terms which subjects untrained in psychotherapy could be expected to answer. Items measuring attitudes towards patients were modeled after ones used in previous research (Strupp and Wallach, 1964; Parsons, 1966). The attitude scale may be found in Appendix E.

**Factor Analysis.**  

In order to obtain normative data on subjects' attitudes towards the three patient types, a pilot study was undertaken in which a group of undergraduate college students completed a Likert Type attitude scale after listening to each of the three interviews. Instructions given to subjects may be found in Appendix F.

In order to most adequately test the hypotheses in this investigation, three separate Factor Analyses were carried out on the responses to each of the recordings. A principle components and varimax rotation procedure was employed as programmed for computer use by the Biometric Laboratory of the University of Miami. Minimum eigenvalues for which principle components were computed was .8. Those factors with eigenvalues of 1.0 or more were retained for rotation. Axes were rotated to orthogonal simple structure. Squared multiple correlation coefficients were placed in the diagonal of the correlation matrix during rotation. A total of thirteen factors were extracted from the rotation; four for
the hostile patient, four for the neutral patient, and five for the
friendly patient. Subjects' factor scores were used to test hypotheses
concerning relationships between subjects' attitudes and other vari-
ables.

In order to determine whether the orthogonal axes provided the
most accurate solution all combinations of pairs of axes were graphic-
ally plotted for each of the three factor analyses. Oblique rotations
were carried out where it appeared significant differences in factorial
composition might be achieved. However inspection of the results
indicated that the orthogonal rotation was the more adequate solution
and consequently retained for further investigation. Factors derived
from the analysis, characteristics of the sample with the factor load-
ings of items for each of the three interviews, may be found in Appendix
G.

Procedure

Instructions

At the beginning of an experimental session instructions were
read to subjects (Appendix H). Instructions were intended to accom-
plish the following purposes:

1. to request subjects to assume the role of a helping person
   and to respond to the tapes as they normally would in that
   role;

2. to inform subjects about the procedure to be followed in
   selecting therapy response alternatives.
Administration

Subjects were tested in groups. At the beginning of each session subjects were provided with sets of therapy response alternatives and asked to choose, during thirty-second periods of silences, those responses which would be most similar to what they would say to the patient. At each stopping point two approach and two avoidance responses were available. The response alternatives were printed in booklets. Recordings were played for groups and stopping points were identified by announcing a number. After listening to each recording subjects completed the attitude scale. Administration of recordings was randomized, for all groups except the students who were tested in one session. Attendants were tested in four sessions, adult women in five sessions, and the professional group in four sessions.

Scores on Dependent Variables

Subjects' verbal approach scores were determined by counting the number of approach responses selected for each patient type. Subjects' scores on the attitude scale were treated in terms of factor scores derived from the pilot study. A factor score was computed by multiplying a Likert scale value selected by the subject and the factor loading of each item with a value of .30 or higher. Products of this operation were added together to attain a composite factor score for each subject.

Method of Analysis

Two types of Analysis of Variance designs were used. In one
design subject groups formed a between factor with four levels and
client types formed a within factor with three levels (Lindquist, 1956,
p. 267-272). In a second analysis of variance a Simple Randomized
design was used which yielded one main and one between effect (Lind-
quist, 56-58).

A Pearson product moment correlation was used to determine the
relationship between factor scores on the attitude scale and approach
scores. A Chi-Square analysis was used to evaluate the association
between a number of correlations and subject groups. The Binomial
Test was used to assess the relationship between subject group and
emphasis upon approach responses in reacting to the three patients.
CHAPTER III

RESULTS

Approach Avoidance Verbal Behavior as a Function of Subject Group and Patient Type

Hypothesis a: Subject groups will differ in their approach scores. Professionally trained subjects will attain the highest score. Non-trained subjects will differ among themselves.

Means and standard deviations of approach scores as a function of subject group and patient type may be found in Table 1.

Table 2 contains a summary of the analysis of variance of approach scores as a function of subject group and patient type.

The F-ratio for differences between subject groups was significant beyond the .001 level. A multiple range test of significance was carried out in order to test for differences between specific subject group means. Results of this analysis may be found in Table 3. Means are ranked in ascending order with attendants attaining the lowest mean score and trained therapists the highest mean score. (Differences between subject group means are found in the body of the table.) The mean approach score for attendants was significantly lower than approach scores for other groups. No differences were found between other subject groups. Mean scores for adult women, college students, and trained therapists did not differ from each other.

Obtained results partially supported Hypothesis a. Professionally trained subjects achieved higher approach scores than one non-professional group, i.e., attendants. Verbal approach behavior of
### Table 1

**Summary of Means and Standard Deviations of Approach Scores as a Function of Subject Group and Patient Type**

<table>
<thead>
<tr>
<th>Subject Group</th>
<th>Patients</th>
<th>Average for Subject Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>H</td>
</tr>
<tr>
<td>A M</td>
<td></td>
<td>5.43</td>
</tr>
<tr>
<td>S.D.</td>
<td></td>
<td>2.11</td>
</tr>
<tr>
<td>P.T. M.</td>
<td></td>
<td>8.53</td>
</tr>
<tr>
<td>S.D.</td>
<td></td>
<td>1.36</td>
</tr>
<tr>
<td>A.W. M.</td>
<td></td>
<td>7.66</td>
</tr>
<tr>
<td>S.D.</td>
<td></td>
<td>1.35</td>
</tr>
<tr>
<td>C.S. M.</td>
<td></td>
<td>8.87</td>
</tr>
<tr>
<td>S.D.</td>
<td></td>
<td>3.90</td>
</tr>
</tbody>
</table>

**Key**

- A: Psychiatric Attendants
- P.T.: Professionally-trained Therapists
- A.W.: Adult Women
- C.S.: College Students
- H: Hostile Patient
- N: Neutral Patient
- F: Friendly Patient
### Table 2

**Summary of Analysis of Variance of Approach Scores as a Function of Subject Group and Patient Type**

<table>
<thead>
<tr>
<th>Source</th>
<th>d.f.</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>119</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Groups (G)</td>
<td>3</td>
<td>10.54</td>
<td>.001*</td>
</tr>
<tr>
<td>error</td>
<td>116</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within</td>
<td>240</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients (P)</td>
<td>2</td>
<td>15.27</td>
<td>.001*</td>
</tr>
<tr>
<td>G x P</td>
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<td>.01*</td>
</tr>
<tr>
<td>error</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>359</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Significant beyond level indicated.*
TABLE 3

MULTIPLE RANGE TEST APPLIED TO DIFFERENCES BETWEEN
SUBJECT GROUP MEANS

(D.F.=116; Significance Level=.05)

<table>
<thead>
<tr>
<th>Means</th>
<th>A.</th>
<th>A.W.</th>
<th>C.S.</th>
<th>P.T.</th>
<th>Shortest Significant Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.96</td>
<td>7.74</td>
<td>8.39</td>
<td>8.73</td>
<td>P=.05</td>
</tr>
<tr>
<td>A.</td>
<td>5.96</td>
<td>1.78</td>
<td>2.43</td>
<td>2.77</td>
<td>1.42</td>
</tr>
<tr>
<td>A.W.</td>
<td>7.74</td>
<td>.65</td>
<td>.99</td>
<td></td>
<td>1.38</td>
</tr>
<tr>
<td>C.S.</td>
<td>8.39</td>
<td></td>
<td>.35</td>
<td></td>
<td>1.31</td>
</tr>
</tbody>
</table>

Treatment means not underscored by the same line are significantly different from each other.

Treatment means underscored by the same line are not significantly different from each other.
trained subjects did not differ significantly from that of adult women or college students. Non-trained subjects differed among themselves. Adult women and college students achieved significantly higher approach scores than attendants.

**Hypothesis b:** Patient types will elicit different approach scores.

The friendly patient will elicit the highest score; the hostile patient will elicit the lowest score; and the neutral patient will occupy an intermediary position.

Means and standard deviations of approach scores for patient types may be found in Table 4.

The F-ratio for patient type (Table 2) was significant beyond the .001 level. Results of a multiple range test computed for differences between patient means may be found in Table 5. All differences were found to be significant beyond the .01 level. The friendly patient elicited a higher approach score than did the neutral or hostile patient. The hostile patient elicited a significantly higher score than the neutral patient. These results partially support the hypothesis. Differences in patient type were associated with differences in approach behavior of subjects. The friendly patient elicited the highest score. An unexpected finding was that the hostile patient elicited more approach behavior than did the neutral patient.
TABLE 4

MEANS AND STANDARD DEVIATIONS OF APPROACH SCORES AS A FUNCTION OF PATIENT TYPE

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>M</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostile</td>
<td>7.63</td>
<td>2.74</td>
</tr>
<tr>
<td>Neutral</td>
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<td>2.61</td>
</tr>
<tr>
<td>Friendly</td>
<td>8.67</td>
<td>1.43</td>
</tr>
</tbody>
</table>

TABLE 5

MULTIPLE RANGE TEST APPLIED TO DIFFERENCES BETWEEN PATIENT MEAN APPROACH SCORES

(D.F.=357; Significance Level=.01)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Shortest Significant Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Means</td>
<td>6.82(N)</td>
<td>7.63(H)</td>
<td>8.67(F)</td>
<td>P=.01</td>
</tr>
<tr>
<td>6.82</td>
<td>.81</td>
<td>1.85</td>
<td>.53</td>
<td></td>
</tr>
<tr>
<td>7.63</td>
<td></td>
<td>1.04</td>
<td>.50</td>
<td></td>
</tr>
</tbody>
</table>

All treatment means are significantly different from each other.
Prothesis c: There will be a significant interaction between subject group and patient type. There will be a greater difference in approach scores, between trained and non-trained groups, for the hostile patient than for other patient types.

Reference to Table 2 indicates that the interaction effect between subject group and patient type was significant beyond the .01 level. This relationship is graphically represented in Figure 1.

A multiple range test of significance was carried out to assess differences in subject group means as a function of patient type (Table 6). Means used in this test may be found in Table 1.

Results indicated there were no differences between subject group mean scores for the friendly patient. Attendants who had the lowest average mean score did not differ from other groups for this patient. Attendants' mean scores for the hostile and neutral patient were lower than corresponding scores for other subject groups.

Scores for adult women did not differ from college students and trained therapists as regards the friendly patient. With the hostile patient adult women attained a lower approach score than college students but their scores did not differ significantly from those obtained by trained subjects. Adult women attained lower approach scores than trained therapists for the neutral patient. Their scores did not differ from college students for the neutral patient. In brief, adult women's scores did not differ from any group for the friendly patient. They attained higher approach scores than attendants for the hostile patient, but did not differ from
Figure 1. Interaction Effect Between Subject Group and Patient Type with Respect to Approach-Avoidance Verbal Behavior.
### TABLE 6

**MULTIPLE RANGE TEST APPLIED TO DIFFERENCES BETWEEN SUBJECT GROUP MEANS AS A FUNCTION OF PATIENT TYPE**

(D.F 348; Significance level .05)

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>4.19</td>
<td>5.43</td>
<td>7.10</td>
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<td>8.23</td>
<td>8.47</td>
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<td>8.87</td>
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<td>(P=.05)</td>
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<tr>
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<td>1.67</td>
<td>1.97</td>
<td>2.23</td>
<td>2.60</td>
<td>3.06</td>
<td>3.10</td>
<td>3.16</td>
<td>3.44</td>
<td>3.46</td>
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<td></td>
<td></td>
<td></td>
<td>3.41</td>
<td>1.77</td>
<td>1.14</td>
<td>1.38</td>
<td>1.44</td>
<td>1.50</td>
<td>1.70</td>
<td>1.81</td>
<td>1.97</td>
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<td>1.47</td>
<td>0.06</td>
<td>1.04</td>
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<td>0.81</td>
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<td>1.24</td>
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<td>8.23</td>
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<td>0.35</td>
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<td>0.83</td>
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<td>0.41</td>
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<td>0.34</td>
<td>0.37</td>
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<td></td>
<td>0.47</td>
<td>0.30</td>
<td>0.47</td>
<td>0.90</td>
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<td>0.87</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>0.17</td>
<td>0.81</td>
</tr>
</tbody>
</table>

Treatment means not underscored by the same line are significantly different.
Treatment means underscored by the same line are not significantly different.
trained therapists and attained lower scores than college students.

For the neutral patient, adult women achieved higher scores than attendants, but did not differ significantly from college students, and attained lower scores than trained therapists.

College students' approach scores did not differ from those of trained therapists for the hostile and friendly patient. They attained lower scores than trained therapists for the neutral patient. They did not attain lower scores than other non-trained group for any patient.

These results lend partial support to hypothesis c. Groups attained similar scores for the friendly patient. All non-trained groups differed from the trained group for the neutral patient. Only attendants differed from trained therapists for the hostile patient. Non-trained group scores differed among themselves for the neutral and hostile patient.

Hypothesis d: Approach scores for each subject group will be related to patient type. The friendly patient will elicit the highest approach score; the hostile patient will elicit the lowest approach score; the neutral patient will occupy an intermediary position.

Differences in approach score for each subject group, in relation to patient type, are presented in Table 6.

Attendents' approach scores were significantly related to patient type. Attendents achieved highest scores with the friendly patient and lowest scores for the neutral patient. Attendents' scores for the hostile patient occupied an intermediary position.

Adult women and college students obtained higher scores for
the friendly patient than for the neutral patient. Approach scores did not differ between the hostile and friendly patient. Approach scores of trained therapists were not found to be related to patient type. Approach scores for the three patient types did not differ for this group.

These results lend partial support to hypothesis d. It was found that the hostile patient elicited a greater number of approach responses from non-trained groups than did the neutral patient. Attendee's approach scores for the friendly patient were higher than scores for other patient types. Adult women and college students approached the friendly patient more than the neutral patient. Approach behavior of trained therapists was not associated with differences in patient type.

Hypothesis e: Non-professionally trained groups will show an overall preference for avoidance responses. Professionally trained subjects will show an overall preference for approach responses.

Subject groups were dichotomized into individuals who displayed a majority of approach or avoidance responses in their reactions to the three patients. Subjects with approach scores of 16-30 used a greater percentage of approach responses in reaction to the three patients. Subjects with scores of 0-15 used a greater percentage of avoidance responses (Table 7). The Binomial Test was applied to the response distribution of each subject group to evaluate the probability of the obtained distribution arising by chance. The obtained P values are as follows:
TABLE 7

NUMBER OF SUBJECTS EMPHASIZING APPROACH OR AVOIDANCE RESPONSES TO THREE PATIENT TYPES

<table>
<thead>
<tr>
<th></th>
<th>Attendants</th>
<th>Adult</th>
<th>College</th>
<th>Pro.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approach</td>
<td>21</td>
<td>30</td>
<td>29</td>
<td>36</td>
</tr>
<tr>
<td>Avoidance</td>
<td>9</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
1. attendants  
P .02
2. college students and adult women  
P .00003
3. professionally trained therapists  
P .00003

Hypothesis receives only partial support from these results.

Trained therapists emphasized approach responses in reaction to the three patients. The hypothesis that non-trained groups would emphasize avoidance responses is rejected at a high level of confidence. It is noteworthy that attendants, who attained the lowest mean approach score, also emphasized approach responses in their overall approach to patients.

Before examining results related to subjects' attitudes attention will be focused on a description of factors derived from the pilot study described in Chapter II.

Items with factor loadings of .30 or higher were used to identify factorial structure. Factors investigated in this research may be found in Appendix I.

Factors distributed themselves into two general categories:

1. **Objective Clinical Assessment**

Factors 1 (hostile patient), 5 (neutral patient), 10 (friendly patient), and 12 (friendly patient) were composed of items which asked subjects to evaluate the patients psychological functioning. Factor 1 accounted for 35% of the common variance; factor 5 for 36% of the common variance; factor 10 for 15% of the common variance and factor 12 for 15% of the common variance. Factors 1 and
accounted for the largest portion of variance for their respective patients.

Item composition and factor loadings between these factors were markedly consistent. The most obvious difference between these factors was that items defining factors 1 and 5 split into two separate factors (10 and 12) for the friendly patient.

Items comprising these factors asked subjects to evaluate psychological functioning of patients in a variety of areas. Areas assessed were social functioning, ability to deal with stress and responsibility, and the possibility of the patient becoming dangerous to himself or others. A number of items asked subjects to make predictions concerning future adjustments of the patients. The positive pole of these factors reflected adequate psychological adjustment and the negative pole a maladaptive adjustment to the patients' environment. These four factors lent themselves to ready identification as measuring patients' adjustment in a wide variety of areas.

Factors 3 (hostile patient), 8 (neutral patient), and 13 (friendly patient) also asked subjects to objectively assess patients' functioning. These factors, however, were composed of fewer items, accounted for smaller portions of
common variance (13, 10, and 14% respectively), and were more restricted in psychological meaning.

A common theme of these factors was an evaluation of patients' motivation or need for help. Factor 3 loaded heavily on items describing the patients' motivation for therapeutic assistance; factors 8 and 13 loaded heavily on items describing the patients' need for help.

In brief, two sets of factors assessed patients' psychological functioning. A set of factors concerned with broad areas of psychological functioning and a set of factors assessing patients' need for or motivation for help were identified.

2. Personal Attitudes Towards Patients

Factors 2 (hostile patient), 6 (neutral patient), and 5 (friendly patient) were composed of items assessing personal reactions of subjects to patients. Factor 2 accounted for 22% of common variance; factor 6 accounted for 20% of common variance, and factor 9 for 23%.

Items comprising the positive pole of these factors asked subjects to indicate how likable they found patients. Items asked how warmly subjects felt towards patients and how willing they would be to enter into a therapeutic relationship with the patient. The negative pole of the factor asked subjects how angry or impatient this type of person was likely to make them.
Despite a slight variation in item content and factor loadings these factors were consistent across patient types in terms of factorial structure and apparent psychological meaning.

Factors 4 (hostile patient), 7 (neutral patient), and 11 (friendly patient) also assessed subjects' personal reactions towards patients. However, these factors accounted for smaller portions of common variance (10, 14, and 13% respectively) and with the exception of factor 7 were composed of fewer items.

Items comprising factors 4 and 11 asked subjects how readily they could identify or empathize with the patients. Factor 7 was more complex in its meaning as it combined items assessing psychological functioning, personal attitude, and ability to identify with patients.

In brief, there were two types of factors assessing personal reactions towards patients. One set of factors assessed likeability of patients and the other set of factors assessed identifying with patients.

Results for hypotheses f and g will be considered jointly.

Hypothesis f: There will be a relationship between subjects' attitudes and approach scores. Subjects expressing positive clinical assessments and positive personal attitudes towards patients will have
higher approach scores than subjects expressing negative ones.

**Hypothesis g:** The relationship between attitude and approach score will be greater for trained therapists than for non-trained subjects.

Means and standard deviations for subject group scores on clinical assessment and personal attitudinal factors may be found in Table 8.

Pearson product moment correlation coefficients computed between factor scores and approach scores for each subject group may be found in Table 9.

For the four subject groups and three patient types fifty-two (52) correlations were possible between factor scores and approach scores. Of this total number, only five (5) were significant beyond the .10 level for non-trained subjects.

No significant correlations were found between factor and approach scores for any patient type for trained subjects. Of a total of thirteen possible correlations, none surpassed the .10 level of significance for this group.

Hypothesis g thus receives minimal support. Out of a total possibility of fifty-two relationships only five were significant. Of these five correlations, two were significant for attendants, none for trained subjects, two for adult women, and one for college students. Obtained correlations did not appear to be related to differences in factor type or patient type.

A Chi Square Analysis (Appendix j) indicated that subject
TABLE 8
MEANS AND STANDARD DEVIATION OF SUBJECTS ON FACTOR SCORES AS A FUNCTION OF PATIENT TYPE. (A CONSTANT OF 20 WAS ADDED TO THE RAW SCORE OF EACH SUBJECT.)

<table>
<thead>
<tr>
<th>Patient Type</th>
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<th>F.2</th>
<th>F.3</th>
<th>F.4</th>
<th>F.5</th>
<th>F.6</th>
<th>F.7</th>
<th>F.8</th>
<th>F.9</th>
<th>F.10</th>
<th>F.11</th>
<th>F.12</th>
<th>F.13</th>
</tr>
</thead>
<tbody>
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<td>Hostile</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
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<td>19.67</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>3.58</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>P.T. M.</td>
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<td>28.79</td>
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</tr>
<tr>
<td>A.W. M.</td>
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<td>33.12</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Friendly</td>
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<td>A. M.</td>
<td>20.13</td>
<td>22.12</td>
<td>26.27</td>
<td>23.67</td>
<td>33.41</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>SD.</td>
<td>4.92</td>
<td>3.04</td>
<td>2.58</td>
<td>3.59</td>
<td>1.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P.T. M.</td>
<td>19.81</td>
<td>21.89</td>
<td>27.04</td>
<td>24.96</td>
<td>32.61</td>
<td></td>
<td></td>
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<tr>
<td>SD.</td>
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<td>2.66</td>
<td>2.16</td>
<td>2.04</td>
<td>1.55</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A.W. M.</td>
<td>18.15</td>
<td>21.54</td>
<td>26.82</td>
<td>23.47</td>
<td>33.06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD.</td>
<td>4.69</td>
<td>2.95</td>
<td>2.51</td>
<td>1.76</td>
<td>2.68</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.S. M.</td>
<td>21.17</td>
<td>23.32</td>
<td>27.06</td>
<td>24.59</td>
<td>32.81</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>SD.</td>
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<td>2.58</td>
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<td>2.21</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>
### TABLE 9

**SUMMARY OF PEARSON PRODUCT MOMENT CORRELATION COEFFICIENTS BETWEEN FACTOR SCORES AND APPROACH SCORES FOR SUBJECT GROUPS AS A FUNCTION OF PATIENT TYPE**

#### Hostile Patient

<table>
<thead>
<tr>
<th></th>
<th>F.1</th>
<th>F.2</th>
<th>F.3</th>
<th>F.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>-.51***</td>
<td>-.09</td>
<td>-.16</td>
<td>-.25</td>
</tr>
<tr>
<td>P.T.</td>
<td>-.18</td>
<td>.18</td>
<td>.22</td>
<td>-.05</td>
</tr>
<tr>
<td>A.W.</td>
<td>-.02</td>
<td>.19</td>
<td>-.03</td>
<td>.10</td>
</tr>
<tr>
<td>C.S.</td>
<td>.24</td>
<td>.00</td>
<td>.05</td>
<td>.12</td>
</tr>
</tbody>
</table>

***Significant at .01 level

#### Neutral Patient

<table>
<thead>
<tr>
<th></th>
<th>F.5</th>
<th>F.6</th>
<th>F.7</th>
<th>P.T.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>.15</td>
<td>-.05</td>
<td>-.18</td>
<td>-.17</td>
</tr>
<tr>
<td>P.T.</td>
<td>-.03</td>
<td>.16</td>
<td>-.08</td>
<td>.10</td>
</tr>
<tr>
<td>A.W.</td>
<td>-.08</td>
<td>.13</td>
<td>-.24</td>
<td>-.32*</td>
</tr>
<tr>
<td>C.S.</td>
<td>.15</td>
<td>.15</td>
<td>.39**</td>
<td>-.25</td>
</tr>
</tbody>
</table>

*Significant at .10 level

**Significant at .05 level

#### Friendly Patient

<table>
<thead>
<tr>
<th></th>
<th>F.9</th>
<th>F.10</th>
<th>F.11</th>
<th>F.12</th>
<th>F.13</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>.48***</td>
<td>.04</td>
<td>-.11</td>
<td>-.13</td>
<td>.25</td>
</tr>
<tr>
<td>P.T.</td>
<td>.26</td>
<td>-.21</td>
<td>.11</td>
<td>-.11</td>
<td>.21</td>
</tr>
<tr>
<td>A.W.</td>
<td>.45**</td>
<td>.16</td>
<td>.27</td>
<td>-.15</td>
<td>-.07</td>
</tr>
<tr>
<td>C.S.</td>
<td>.03</td>
<td>-.03</td>
<td>-.22</td>
<td>-.13</td>
<td>-.01</td>
</tr>
</tbody>
</table>

*Significant at .05 level

**Significant at .01 level
groups did not differ in the number of obtained significant correlations between attitudes and approach scores. Therefore hypothesis $g$ was rejected. Correlations between attitudes and approach scores were not greater for trained than for non-trained subjects.

**Hypothesis $h$:** There will be a correlation between scores on clinical assessment and scores on personal attitudinal factors. Correlations between factor scores will be unrelated to differences in subject group or patient type.

Pearson product moment correlation coefficients between all possible pairs of clinical assessment and personal attitudinal factors are shown in Tables 10, 11, and 12. For the three patient types and four subject groups fifty-six (56) correlations were possible. Of this total number, sixteen (16) were significant at or beyond the .10 level. Further inspection of these relationships revealed that there were three significant correlations for the hostile patient, nine for the neutral patient, and four for the friendly patient.

A Chi Square Test of Analysis (Appendix k) was computed to determine whether there was a relationship between patient type and number of significant correlations. The obtained Chi Square was significant beyond the .05 level. This indicated that the correlation between scores on clinical assessment factors and scores on personal attitude factors was significantly greater for the neutral patient than for the hostile and friendly patients.

A Chi Square Analysis (Appendix l) to determine if subject groups differed in the number of significant correlations between factors was not significant.
TABLE 10

SUMMARY OF CORRELATION COEFFICIENTS BETWEEN

CLINICAL ASSESSMENT AND PERSONAL
ATTITUDINAL FACTORS

Hostile Patient

<table>
<thead>
<tr>
<th></th>
<th>F. 1, 2</th>
<th>F. 2, 3</th>
<th>F. 1, 4</th>
<th>F. 3, 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>.08</td>
<td>.35*</td>
<td>.11</td>
<td>.11</td>
</tr>
<tr>
<td>P.T.</td>
<td>.30</td>
<td>.09</td>
<td>.44**</td>
<td>-.11</td>
</tr>
<tr>
<td>A.W.</td>
<td>.51***</td>
<td>-.04</td>
<td>.05</td>
<td>-.16</td>
</tr>
<tr>
<td>C.S.</td>
<td>.31</td>
<td>.02</td>
<td>.09</td>
<td>.01</td>
</tr>
</tbody>
</table>

*Significant at .10 level
**Significant at .05 level
***Significant at .01 level
TABLE 11

SUMMARY OF CORRELATION COEFFICIENTS BETWEEN CLINICAL ASSESSMENT AND PERSONAL ATTITUDINAL FACTORS

Neutral Patient

<table>
<thead>
<tr>
<th></th>
<th>F. 5, 6</th>
<th>F. 6, 8</th>
<th>F. 5, 7</th>
<th>F. 7, 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>.30</td>
<td>-.05</td>
<td>.40</td>
<td>.16</td>
</tr>
<tr>
<td>P.T.</td>
<td>.55**</td>
<td>-.74***</td>
<td>.71***</td>
<td>-.58***</td>
</tr>
<tr>
<td>A.W.</td>
<td>.76***</td>
<td>.12</td>
<td>.48**</td>
<td>.15</td>
</tr>
<tr>
<td>C.S.</td>
<td>.53***</td>
<td>-.17</td>
<td>.47***</td>
<td>.10</td>
</tr>
</tbody>
</table>

**Significant at .05 level
*** Significant at .01 level
### TABLE 12

SUMMARY OF CORRELATION COEFFICIENTS BETWEEN CLINICAL ASSESSMENT AND PERSONAL ATTITUDINAL FACTORS

**Friendly Patient**

<table>
<thead>
<tr>
<th></th>
<th>F. 9, 10</th>
<th>F. 9, 12</th>
<th>F. 9, 13</th>
<th>F. 10, 11</th>
<th>F. 11, 12</th>
<th>F. 11, 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>.10</td>
<td>-.02</td>
<td>.16</td>
<td>.18</td>
<td>.00</td>
<td>-.09</td>
</tr>
<tr>
<td>P.T.</td>
<td>.00</td>
<td>-.05</td>
<td>.22</td>
<td>.38**</td>
<td>.43**</td>
<td>-.02</td>
</tr>
<tr>
<td>A.W.</td>
<td>.24</td>
<td>-.15</td>
<td>-.29</td>
<td>.32</td>
<td>.18</td>
<td>-.11</td>
</tr>
<tr>
<td>C.S.</td>
<td>.49***</td>
<td>.35*</td>
<td>.29</td>
<td>.08</td>
<td>.19</td>
<td>-.21</td>
</tr>
</tbody>
</table>

*Significant at .10 level
**Significant at .05 level
***Significant at .01 level
In summary, partial support for hypothesis h was found. A number of significant correlations between scores on clinical assessment and scores on personal attitudinal factors was found. Correlations between these factors were found to be related to differences in patient type. The neutral patient elicited more significant correlations than did the hostile and friendly patient. The number of correlations was not related to differences in subject group.

**Hypothesis i:** Subject groups will differ in scores attained on clinical assessment and personal attitudinal factors. Trained subjects will differ from other groups. Non-trained groups will differ among themselves.

Table 13 contains a summary of the analysis of variance of thirteen factor scores, for the three patient types, as a function of subject group.

Eight of the thirteen factors had F-ratios significant beyond the .10 level. Multiple Range Tests were carried out between subject group means for these factors (Table 14). Findings regarding responses to clinical appraisal and attitudinal factors for the hostile patient may be summarized as follows.

Subject groups did not differ from each other as regards their general clinical assessment of this patient (factor 1). Adult women expressed a less favorable personal attitude towards the patient than other subject groups (factor 2). Adult women rated the patient as being less motivated for help (factor 3) than did college students. Attendants and adult women found the patient less easy to
### TABLE 13

**SUMMARY OF ANALYSIS OF VARIANCE OF SCORES ON ATTITUDE AND CLINICAL ASSESSMENT VARIABLES AS A FUNCTION OF SUBJECT GROUP**

<table>
<thead>
<tr>
<th>Source</th>
<th>d.f.</th>
<th>Between</th>
<th>Within</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor and Patient Type</th>
<th>F.</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. hostile patient</td>
<td>1.37</td>
<td>n.s.</td>
</tr>
<tr>
<td>2. hostile patient</td>
<td>7.28</td>
<td>.010*</td>
</tr>
<tr>
<td>3. hostile patient</td>
<td>2.46</td>
<td>.128</td>
</tr>
<tr>
<td>4. hostile patient</td>
<td>4.08</td>
<td>.128</td>
</tr>
<tr>
<td>5. neutral patient</td>
<td>2.22</td>
<td>.137</td>
</tr>
<tr>
<td>6. neutral patient</td>
<td>2.21</td>
<td>n.s.</td>
</tr>
<tr>
<td>7. neutral patient</td>
<td>.83</td>
<td>n.s.</td>
</tr>
<tr>
<td>8. neutral patient</td>
<td>18.23</td>
<td>.000*</td>
</tr>
<tr>
<td>9. friendly patient</td>
<td>2.42</td>
<td>.127</td>
</tr>
<tr>
<td>10. friendly patient</td>
<td>2.26</td>
<td>.137</td>
</tr>
<tr>
<td>11. friendly patient</td>
<td>.74</td>
<td>n.s.</td>
</tr>
<tr>
<td>12. friendly patient</td>
<td>1.82</td>
<td>n.s.</td>
</tr>
<tr>
<td>13. friendly patient</td>
<td>.88</td>
<td>n.s.</td>
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</table>

*Significant beyond level indicated*
TABLE 14
SUMMARY OF MULTIPLE RANGE TESTS OF DIFFERENCES ON FACTOR SCORES
BETWEEN SUBJECT GROUPS

<table>
<thead>
<tr>
<th>Factor</th>
<th>A vs PT</th>
<th>A vs AW</th>
<th>A vs CS</th>
<th>PT vs AW</th>
<th>PT vs CS</th>
<th>AW vs CS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>D</td>
<td>P</td>
<td>D</td>
<td>P</td>
<td>D</td>
<td>P</td>
</tr>
<tr>
<td>2</td>
<td>.55 ns</td>
<td>4.76 .01</td>
<td>2.18 ns</td>
<td>4.21 .01</td>
<td>1.63 ns</td>
<td>2.58 .05</td>
</tr>
<tr>
<td>3</td>
<td>.52 ns</td>
<td>.53 ns</td>
<td>1.49 ns</td>
<td>1.05 ns</td>
<td>.97 ns</td>
<td>2.02 .05</td>
</tr>
<tr>
<td>4</td>
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<td>.02 ns</td>
<td>1.70 .05</td>
<td>1.67 .05</td>
<td>.91 ns</td>
<td>1.68 .05</td>
</tr>
<tr>
<td>5</td>
<td>5.06 .05</td>
<td>1.75 ns</td>
<td>2.63 ns</td>
<td>3.31 ns</td>
<td>2.43 ns</td>
<td>.88 ns</td>
</tr>
<tr>
<td>6</td>
<td>.83 ns</td>
<td>1.45 na</td>
<td>1.97 ns</td>
<td>2.28 na</td>
<td>2.80 .05</td>
<td>.55 ns</td>
</tr>
<tr>
<td>8</td>
<td>2.76 .01</td>
<td>2.41 .01</td>
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<td>.53 na</td>
</tr>
<tr>
<td>10</td>
<td>.31 ns</td>
<td>1.98 ns</td>
<td>1.06 ns</td>
<td>1.67 na</td>
<td>1.37 na</td>
<td>3.04 .05</td>
</tr>
<tr>
<td>11</td>
<td>.24 ns</td>
<td>.57 ns</td>
<td>1.20 ns</td>
<td>.33 ns</td>
<td>1.44 ns</td>
<td>1.77 .05</td>
</tr>
</tbody>
</table>

D difference
P probability value
identify with than did college students and trained therapists (factor 4). Mean scores of college students and trained therapists did not differ on any factor.

Results for the neutral patient may be summarized as follows. Attendants rated the neutral patient as being more disturbed (factor 5) and in greater need of help (factor 8) than did other groups. College students expressed a more favorable personal attitude (factor 6) towards the neutral patient than did other groups. Other subject groups did not differ in regard to factor scores.

For the friendly patient subject groups differed on two factors. College students had significantly higher mean scores than adult women on both of these variables. Other differences were not significant.

These results lend partial support to hypothesis 1. Selected differences were found in mean factor scores as a function of subject group. Inspection of the data indicated, however, that trained therapists did not differ from other subject groups any more than did the non-trained groups differ from one another.

Selected differences were found among non-trained groups.
CHAPTER IV

DISCUSSION

Approach Avoidance Verbal Behavior as a Function of Subject Group

A purpose of this investigation was to compare approach-avoidance verbal behavior of subjects who lacked formal training in psychotherapy with subjects who have had extensive training.

One non-trained group, attendants, obtained lower mean scores than trained therapists. Adult women, college students, and trained therapists did not differ in mean approach scores.

The difference in approach behavior between attendants and trained subjects was an expected finding on the basis of previous research which had shown that inexperienced therapists use more evaluative (Munger and Johnson, 1960; Demos and Zuwaylif, 1963; Jones, 1963) and persuasive responses (Bohn, 1965; Parsons, 1966) than trained therapists. Inexperienced therapists have also been rated as being more controlling and advice-giving than trained therapists (Grigg, 1961). In this investigation attendants avoided conflictual material of patients, more than trained therapists, by the use of persuasive and disapproving remarks, by changing the topic of conversation, and by mislabelling patients' remarks.

The finding that adult women and college students did not differ from trained therapists in mean approach scores is a significant one. These results disagree with many previous studies of the
psychotherapy process which indicate significant differences in verbal behavior between inexperienced and experienced therapists. This finding, however, is consistent with the ever-growing body of research which has emphasized the psychotherapeutic potential of non-professionally trained groups. Research and ideas expressed by Carl Rogers have consistently indicated that professional training is neither necessary nor a sufficient pre-requisite for effective psychotherapy. Results of this investigation support Rogers' ideas in that selected non-trained groups were found to approach or listen to conflictual material of disturbed individuals as readily as trained therapists. It is also consistent with research which has indicated that interaction with non-trained individuals by psychiatric patients often produces outcome results as favorable as that produced by trained therapists (Rioch, 1963; Beck, 1963; Carkhuff and Truax, 1965; Christmas, 1966; Mendel and Rapport, 1963; Poser, 1966).

A second purpose of this investigation was to compare the approach-avoidance verbal behavior of a number of non-trained groups to each other. It was found that attendants avoided patients' problems more than college students and adult women. This indicated that groups lacking professional training will differ among themselves in their reactions to patients. Differences in socio-cultural variables and implicit assumptions about mental illness between these groups may be associated with obtained differences. Students and adult women were younger, considerably more educated, and undoubtedly raised in different cultural environments than attendants. It is also probable that
the unique contact of attendants with psychiatric patients has created a set towards patients which is different from that of the other subject groups.

Findings of Sundland and Barker (1962), Strupp (1955), and Strupp and Wallach (1964) have indicated that theoretical differences are associated with significant variance in verbal behavior among trained therapists. This relationship may be paralleled by a similar relationship between socio-cultural variables and verbal behavior for non-trained groups. An absence of differences between students and adult women is probably associated with the marked homogenous background of these groups.

**Overall Preference for Approach Responses as a Function of Subject Group**

Previous research indicated that inexperienced therapists were advice-giving, controlling, and relied heavily on persuasive types of arguments in their relationships to patients. It was therefore expected that non-trained groups would emphasize avoidance responses in their overall communications to patients. This hypothesis was rejected at a high level of confidence. It was found that the overwhelming majority of non-trained subjects emphasized approach responses in their reactions to patients. Highly significant was the finding that even the majority of attendants, who received the lowest mean approach score, also emphasized approach responses in their overall communications to patients. This finding has relevance as regards future community mental health programs and volunteer programs in psychiatric hospitals. A fundamental aspect of any therapeutic interaction is that a therapeutic
person approach or accept disturbed patient behavior. Present results suggest that non-trained subjects can be rated high on this dimension of therapeutic behavior.

Approach Avoidance Verbal Behavior as a Function of Patient Type

The relationship between patient type and approach behavior was found to be significant. This indicates that patient type is an important determinant of therapist behavior. It was found that the friendly patient elicited the highest approach score and the neutral patient the lowest approach score. The hostile patient occupied an intermediary position.

The greater approach elicited from subjects by the friendly patient, than by other patient types, is consistent with findings from related studies, which have found that therapists respond most favorably to the former type of patient (Heller, 1963; Russell and Snyder, 1963; Bohn, 1965; Parsons, 1966).

The obtained finding that the neutral patient elicited a lower mean approach score than the hostile patient was an unexpected result. A possible explanation for this finding is that other personality variables, aside from friendliness vs. hostility, are instrumental in determining therapist behavior towards patients. Most studies which have investigated effects of patient type upon therapist behavior have de-emphasized other patient variables which should be accounted for in future research designs. For example, hostile and friendly patients investigated in this research were more anxious and
in greater psychological distress than the neutral patient, who was relatively well integrated. Subjects' approach behavior may be as closely related to psychological distress experienced by patients as it is to the dimension of friendliness-hostility. It is possible that the better integrated and more relaxed patients become (neutral patient) the more prone therapists become to avoid some of the material presented by patients. Inclusion of more complex patient variables in therapy process research seems indicated by results of this investigation.

Relation Between Subject Group and Response to Patient Type

Within each subject group mean approach scores were found to be differentially related to patient type. For attendants variations in patient type were most closely related to variations in approach score. The friendly patient achieved the highest score and the neutral patient the lowest score. The hostile patient occupied an intermediary position. Adult women and college students obtained higher scores for hostile and friendly patients than for the neutral patient. Scores were not different for the former two patients. Scores for trained therapists were not related to differences in patient type. All patient types received similar approach scores for this group.

These results suggest that approach behavior of non-professional groups is more dependent upon patient type than is approach behavior of trained therapists. Professional therapists approached all patient types in a similar manner whereas non-trained subjects approached certain patient types more than others. This suggests that
for trained subjects the tendency to approach patients' verbal statements operates regardless of the type of problems being discussed.

For untrained groups tendencies to approach patient behavior may be more closely related to what a patient is saying and less dependent upon a theoretical frame of reference, which trained therapists are able to utilize. The existence of an explicit theoretical orientation which trained therapists utilize when dealing with patients, as opposed to the absence of such an orientation for untrained groups, may partially account for some of these differences. Future research as regards effects of a lack of theoretical orientation upon the behavior of non-trained subjects may be highly relevant.

Interaction Effect Between Patient Type and Subject Group

Obtained results indicated there was a significant interaction between subject groups and patient type.

No differences between subject groups mean approach scores were found for the friendly patient. This indicates that all subject groups approached the verbal behavior of this patient in a similar manner.

Attendants' scores for the hostile and neutral patient were lower than scores for other subject groups for these patients.

Adult women obtained lower approach scores than college students for the hostile patient but did not differ from trained therapists. Adult women obtained lower scores than trained therapists for the neutral patient, but did not differ from college students. College students achieved lower approach scores than trained therapists for one patient type (neutral patient).
Present results are consistent with ideas presented by Schofield (1964) and Riech (1963) who demonstrated the therapeutic potential of non-professionals with selected patient types. Schofield has argued that many types of emotional problems could just as readily be dealt with by non-trained individuals as by professional therapists. The obtained interaction effect indicates that the variety of subject groups investigated in this study, despite differences on many variables, do not vary in their tendency to approach or listen to conflictual material of certain patient types. If one accepts the importance of "approach behavior" as a crucial therapeutic variable then the present investigation indicates with certain patients non-trained subjects may perform as well as trained therapists. In situations where approach behavior may be instrumental in effecting therapeutic change Schofield's ideas may be extremely relevant. Additional research is necessary in order to determine more fully with what type of problems non-professionals can successfully deal.

The tendency of selected subject groups to approach certain patient types as well as trained therapists is also consistent with the findings of Schulte (1966) and Varble (1964) who found that inexperienced therapists approach dependency and hostility as frequently as experienced therapists. However these results do not agree with findings by Mills and Abeles (1965) and Carcarena (1965) who found that experienced psychologists approached dependency more than graduate students. Reasons for these differences are undoubtedly related to differences in methodological approaches employed by these investigations.
Obtained differences between trained therapists and non-professionals for neutral and hostile patients indicate there are patient types and conflictual material which are approached at a higher rate by trained therapists than by non-trained subjects. A more careful delineation of differences and similarities in the approach tendencies of these subject groups is needed in future research.

To account for the tendency of college students to attain a higher mean approach score for the hostile patient than adult women is difficult as these groups did not differ as regards other patient types. Perhaps the problems of this patient, who complained about his teachers and school in general, were more comprehensible to students involved in similar circumstances than to adult women more removed from this type of situation. Differences and similarities in the behavior of lay populations towards patients should be more fully investigated.

Approach Behavior as a Function of Subject Attitudes

The hypothesis stating there would be a correlation between subjects' attitudes and approach scores received minimal support in this investigation. Subjects expressing favorable clinical assessments and personal attitudes towards patients generally did not obtain higher approach scores than subjects expressing negative attitudes. It was also found that trained therapists did not have a closer relationship between attitudes and approach scores than did non-trained groups.

The hypothesis relating attitudes and approach behavior was suggested by experimental evidence indicating a correlation between therapists' expressed attitudes and verbal behavior in therapy.
situations (Strupp and Wallach, 1965). Studies demonstrating positive
correlations between attitudes and therapy outcome also lent support to
this hypothesis (Strupp, et al., 1964; Lorr, 1965; Stoler, 1963; Truax,
1963).

The hypothesis that trained therapists would obtain a greater
number of significant correlations than non-trained subjects was based
on experimental evidence which indicated that trained therapists were
more congruent in their behavior towards patients than inexperienced
therapists (Carkhoff and Truax, 1965a).

Reasons for the limited number of significant relationships
between attitudes and approach scores are not clear. A possible ex-
planation is that a relation between attitudes and approach behavior as
defined in this investigation is not a measure of congruence as defined
by Rogers.

Rogers defines "congruence" as an expression of genuineness on
the part of a therapist; the overt expression by a therapeutic person
of feelings he entertains towards a patient. However even more funda-
mental for therapeutic encounters is the ability of therapeutic persons
to approach patients' conflictual material regardless of the feelings
he may have towards a patient. Within limits, therapeutic persons will
approach people in distress regardless of their personal attitudes or
clinical assessments. Therefore a relative absence of significant
correlations in this investigation may actually indicate the presence
of a more fundamental therapeutic attitude than congruence for the group
investigated.
Correlation Between Scores on Clinical Assessment Factors and Scores on Personal Attitudinal Factors

Correlation coefficients were computed between all possible combinations of clinical assessment and personal attitudinal factors.

The hypothesized correlation between these variables was partially substantiated. In selected cases, particularly for the neutral patient; favorable clinical assessments were associated with favorable personal reactions towards patients. However a substantial number of correlations for each patient type were not significant.

This is consistent with Parsons' (1966) findings in that a number of scores on clinical and personal attitudinal factors were not correlated with each other.

The extent of the correlation between these variables is thus questionable.

Obtained results agreed with previous findings by Strupp, et al. (1964), Strupp and Wallach (1965), and Parsons (1966) who have found no relationship between level of experience and the extent of the correlation. In this investigation trained therapists did not differ from untrained subjects in the number of obtained significant relationships.

A finding, unrelated to previous research, was that the non-trained groups representing differing socio-cultural environments did not differ from each other as regards the correlation between these variables. This suggests that the relationship between clinical assessment and personal attitudinal variables is not related to clinical training or socio-cultural background.
Despite the presence of significant correlations for all patient types a greater number of correlations were obtained for the neutral patient than for other patient types. This finding is consistent with a trend discerned by Parsons (1966) when investigating similar patient types. A major cause of this difference may be due to the high loadings of an identical group of items on factor 5 (clinical assessment) and factor 7 (ability to identify with patients) for the neutral patient. This suggests that for certain patients (neutral patient in this investigation) subjects' clinical assessments and their ability to identify with patients are more closely related to each other than for other patient types.

Scores on Clinical Assessment and Personal Attitudinal Factors as a Function of Subject Group

Factors investigated represented a composite of items assessing the adequacy of patients' psychological functioning in a variety of areas, patients' need or motivation for help, subjects' liking for patients, and ability of subjects to identify with patients.

It was hypothesized that clinical assessments and personal attitudes of trained therapists would differ from that of non-trained subjects. This hypothesis was based on evidence which indicated that inexperienced therapists were more controlling, probing, advice-giving, less understanding and less interpretive than experienced therapists (Bohn, 1964; Demos and Zuwaylif, 1963; Grigg, 1961; Jones, 1963; Munger and Johnson, 1963). Parsons (1966) found that trained therapists were less extreme in their clinical appraisals than were college
students. It was expected that these differences would be manifested in differing attitudes of trained vs. non-trained subject groups towards patients.

Obtained results lend minimal support to hypothesized differences between clinical assessments of trained vs. non-trained subjects. On the four major clinical assessment factors (factors 1, 5, 10, 12) trained subjects obtained lower scores than attendants on factor 5 and lower scores than college students on factor 10. On factors relating to patients' motivation or need for help (factors 3, 8, 13) trained subjects obtained higher scores than adult women and attendants on factor 3 and lower scores than attendants on factor 5. Other differences on clinical assessment factors were not significant.

On the three factors measuring likeability of patients (factors 2, 6, 9) trained therapists obtained higher scores than adult women on factor 2 and lower scores than college students on factor 6. On factors measuring ability to identify with patients (factors 4, 7, 13) trained therapists obtained higher scores than attendants and college students on factor 4. Inspection of obtained differences indicated that trained therapists did not differ from non-trained groups any more than did the latter groups differ among themselves.

The marked similarities between clinical assessments and personal attitudes of trained vs. non-trained subjects are consistent with other results obtained in this investigation indicating minimal differences in the behavior of these groups. A major reason for obtained similarities in ratings may be due to an absence of technical
clinical concepts on the attitude scale. Subjects' measured attitudes were based upon items assessing behavior of patients. These results suggest that trained therapists do not differ from non-trained groups, in their clinical assessments and personal reactions to patients, when these groups are asked to make judgments using non-technical terms.

Non-trained subjects differed among themselves on factors 5 and 10 (clinical assessment), 3 and 8 (patient motivation), 2 and 6 (personal attitude), and factor 4 (ability to identify with patients). The only consistent trend in these differences was a negative reaction by adult women towards the hostile patient. Adult women expressed a more negative attitude, perceived the patient as being less motivated for help, and were less able to identify with the patient than were college students and trained subjects. Other differences did not fall into any consistent pattern as differences between groups on factor type were dependent upon the patient being evaluated. Further research is necessary to categorize reactions of non-trained subject groups to specific patient types.
CHAPTER V

SUMMARY

The purpose of this investigation was to provide further knowledge of the psychotherapeutic potential of non-professionally trained groups. Current trends in the mental health movement and manpower shortages necessitate a broadening of traditional concepts as to what psychotherapy is and who may engage in its practice.

Responses investigated included subjects' approach-avoidance verbal behavior, during therapeutic interviews, and subjects' clinical assessments and personal attitudes towards patients. These responses were studied in relation to the following:

1. subject variables, i.e., psychotherapy experience, education, age, and socio-cultural background;
2. patient variables, i.e., hostility, neutrality, and friendliness.

Non-trained groups in the experiment were adult women, undergraduate college students, and psychiatric attendants. Responses of these groups were compared to a group of professionally trained therapists representing the three major mental health professions. Assuming the role of therapist, subjects listened to tape recorded psychotherapy interviews with three patients representing hostile, neutral, and friendly characteristics. At pre-selected stopping points in the interview, subjects indicated their choice of responses to the patients. Response choices included both approach and avoidance alternatives.
After listening to each interview subjects rated the patients on an attitude scale comprised of clinical assessment and personal attitudinal factors.

Experimental findings may be summarized as follows:

1. Attendants obtained lower approach scores than did other groups. Average approach scores for adult women and college students did not differ significantly from those of trained therapists.

2. Average approach scores were related to variations in patient type. The friendly patient attained the highest score and the neutral patient the lowest score; the hostile patient occupied an intermediary position.

3. Approach scores for subject groups were differentially related to variations in patient type. Approach scores for trained therapists did not vary as a function of patient type. Approach scores for non-trained groups were related to variations in patient type.

4. There was a significant interaction, upon verbal approach behavior, between subject group and patient type. Mean approach scores for subject groups did not differ for the friendly patient. Approach scores for subject groups differed for other patient types.

5. All subject groups were comprised of individuals who emphasized approach responses in their overall reaction to patients.

6. There was minimal evidence to support the hypothesis stating there would be a correlation between subjects' attitudes and
their approach scores. Trained therapists did not have a greater relationship between attitude and approach scores than did non-trained groups.

7. A correlation between scores on clinical assessment and scores on personal attitudinal factors was found for selected factors. The neutral patient elicited a significantly-greater number of correlations than other patient types.

8. Minimal differences were found between personal attitudes and clinical assessments of trained vs. non-trained subjects. Trained subjects did not differ from non-trained subjects any more than did the latter differ among themselves.
BIBLIOGRAPHY


Umberger, C., Dalsimer, J., Morrison, A., Bregin, P. College Students in a Mental Hospital. N.Y.: Grune and Stratton, 1962.


APPENDICES
APPENDIX A

Transcript of Hostile Patient

Co: It's customary for us to record the interviews here.

Cl: Use a recorder, huh? What are they going to do with the recording?

Co: Well, it's kept entirely confidential.

Cl: Yeah, well, I guess it should be. Well, I'll tell ya. The deal is I was told I was supposed to come over here from the Dean's office. This, uh, this instructor I got, he told me that uh, I better come over, and uh, . . . Kinda help me out, ya know, and uh, the whole deal is that he's—he says he's concerned about my grades. . . . And he said I should come over here. I don't know, I don't know what good it's going to do, really. But uh, he thinks I've got a problem and . . . Actually, I haven't got a problem. It's, uh, if there's anybody that's got a problem, it's him. And, uh, er, he told me to come over here so that's why I'm here.

Stopping Point #1

Co: So really you don't feel that there's a problem.

Cl: Yeah, that's right, in a way. Uh, really, the deal is, uh, it runs like that, you know. These guys out here, uh, students, you know, it's the same deal all the time, you know, and they, uh, . . . If you don't do what everybody else does, you know, then you got a problem.

Co: Mmhmm.

Cl: If you don't want to follow along with everybody else, if you don't want to be a sheep, then you've got a problem. They're always sticking the blame on you 'cause you don't do what everybody else does. And, . . . hell.

Stopping Point #2

Co: You sort of stand out, uh, in your conformation, and uh, . . .

Cl: No, it isn't, it isn't nonconformity, it's just the idea that, uh, that uh, you're a nonconformist. I don't like that, that nonconformity bit. It's just that some guys are, some guys have to stand up for themselves. They're more or less the leaders and then you got these other guys like this one up here, the professors and most of the guys up here. They're not . . . they're no
leaders. They just go on and they'll do whatever . . . Somebody says do somethin' and they'll go ahead and do it. And when, when they do it, then they're all right. But, if they don't do it, then they got a problem, so they think I got a problem. So they told me to come over here, but I haven't got any problem.

Stopping Point #3

Co: What do you think, uh, might be their reason?

Cl: What do you mean, "What's their reason?"

Co: Well, it sounds as though some people think you have a problem.

Cl: Well, the only thing I can see, if uh, . . . I'll get out of this. See, it's this course is actually how this all started. Well, I got, I, well every once in a while, uh, I'll get guys like this. Uh, they, uh, I'm not doing so well in their course, see? And so they think it's my fault, and it's always my fault; it's never the other guy. It's always my fault. And so they think that, well, "Sonny, you got a problem. You're going to flunk my course if you don't do something about it."
I'll get along; I'll get by. I'll pull her out. I always, I always do. And, uh, but being I'm not gettin' the grades I should from some guy, really, ya know. These guys aren't, uh, this guy, especially, and there's other ones, quite a few of them, too, that aren't red-hot teachers to start with and then they expect you to soak up all this crap and, uh, and if you don't, . . . If you don't go gettin' grades and uh, doin' all this stuff, then there's somethin' wrong with you.

Stopping Point #4

Co: And you don't, you don't really go along with this too much, you . . .

Cl: No, . . . uh, well, uh, they uh, I suppose they got a right, you know, they got a . . . I came to school up here and all this. They've got a job to do, too, but it's, it's just, uh, the way they go about it, that uh, isn't quite, uh, . . . Well, I don't think it's quite what it could be.

Co: Mmhum.

Cl: Well, they expect, uh, all of the students and the professors and that to be the same way, and uh, a lot of them are. I mean most of the people around here are this way, but, uh, there's some of them that just, uh, you can't be this way all the time, isn't that right? There's going to be the different ones, too. Isn't that right?
**Stopping Point #5**

**Co:** Not everybody's the same.

**Cl:** Yeah, ya can't do, ya can't do what everybody's always yelling at ya to do, uh, but if you don't, then you're wrong, you're different.

**Co:** I'm not sure I know what you mean.

**Cl:** I mean, I mean I don't like it . . . I don't like it just 'cause I miss a few classes, miss a few papers, . . . Have this guy come up and tell me there's something wrong, like I was sick or something. That maybe I ought to go talk to somebody, talk to somebody about my problems.

**Stopping Point #6**

**Co:** You didn't like to be told that you had problems.

**Cl:** Yeah, I didn't like it. I didn't like that and I didn't like to be told that I ought to go talk to somebody, kinda get things off my chest. "Go over and hash it out with 'em, why don't you go over and do that?" I, I can't see, what's, . . . If somethin' was botherin' me, what's the, I mean what's the good in talking about it, anyway? What's the use in talking about it? That's right. Even, . . . even if I had something wrong, . . . Uh, what business is it of his, that instructor? What business is it of that dean? I mean they're not goin' through the same things I am. They can't see this, see things the way I do. Why should they send me over here? What have you got to do with it? What, uh, . . . business is it of yours?

**Stopping Point #1**

**Co:** Mmmmm.

**Cl:** And I don't see what, uh, . . . what you've got to, uh, to do with it. What your job in this deal is.

**Co:** You don't see any purpose in coming here.

**Cl:** Yeah, I, I know you talk good. You can . . . sit there and pretend you understand everything I say. I tell you how I feel and, . . . and you just look at me, and you . . . You want me to think you don't care what I say, like it doesn't faze you at all, . . . Just as though you understood everything, just as though you had all the answers.
Stopping Point #8

Co: Perhaps you have all the answers.

Cl: I have about all, . . . uh, I know I've had about all the advice and bossing around that I need or want. If this outfit'd leave me alone a little. Let me do it my own way. They think they got to take me by the hand, they got to lead me through this stuff.

Co: They kinda get in your way.

Cl: Just as though I couldn't make it on my own. That's stupid. Sure, I don't look red-hot now. I mean, . . . I mean I'm not in real good shape in school, but that doesn't mean it's all over.

Stopping Point #9

Co: That doesn't mean you won't make it.

Cl: I'll make it and I don't need any help doing it. If they'd just get off my back, let me do things my way, uh, I wouldn't have this problem.

Co: Mmmmm.

Cl: Yeah, I wouldn't have this problem 'cause I don't have a problem. I don't, uh, need anybody, need anybody to tell me how things are goin', and what's goin' to happen. I don't need anybody to tell me to talk things over with you, 'cause I don't have anything I want to talk over.

Stopping Point #10

Transcript of Neutral Patient

Co: First I'll mention that we record the interviews here.

Cl: OK.

Co: Why don't you tell me what brings you to see me.

Cl: Well, my roommate and I just had a very nice discussion about this today. Just before I came we talked about two hours.

Co: You already got your counseling for today.

Cl: Gee . . . gee, I was surprised that . . . he put it very well. Ah, he . . . he has little faults, you know, like, well, he was using
my comb. I... I didn't like it; I think he should use his own, so I got mad at him. And, uh, he used my shaving cream and sprayed some other kid and I didn't like that, so I got mad. And then for little things like this I get mad and I tell him I don't like it, and he... and then after I tell him it's OK again. Ah, so today he came in and he wondered if I was still mad about using his shaving... or using... him using my shaving cream. He did this just the Friday before... yeah, last Friday, and ah, he thought I was still mad and that I... I carry a grudge. And I told him, "No," that there was something else that had happened the last couple days. He got up at 6:30 in the morning, and well, we agreed, earlier in the year, when we should go to bed and what he won't do and I don't like and what I shouldn't do that he doesn't like, you know. And we sort of agreed that we would get up between 7 and 8. And he was getting up at 6:30, and I really got mad, but I didn't say anything, you know. I figured, if he's gonna get up this morning at 6:30, I'm gonna say something. He didn't, so I didn't say a thing.

Co: He escaped your wrath.

Cl: Yeah. So I came in this noon and he says, "I... I think you have a bad attitude. Ah, I put in my application for a single room because I can't study in here." Ah, and so I asked him ah, what was the matter. Uh, he said, uh,... well, he doesn't like the way I get... get mad at these little things. Uh, and... and then I have the attitude that I sort of judge him. And if he doesn't do... or he doesn't do things the way I think they should be done, I put him down for it. Uh, (pause) like he had a cold; he thought that we should close all the windows and uh, he should bundle up. And I told him that I liked to leave the windows open all night. If I have a cold I like to go out and get lots of exercise. And uh, well, I used to... used to be that I would try to tell him to do the same thing. And so the time when he got the cold just a little while ago I left my window open and, well, I don't know why... I like to sleep with my window open and I didn't care if he had a cold or not because it doesn't hurt me when I have a cold, so why should it hurt if he has a cold. Now, he pointed this out, and it's true, I think this way... what's good for me ought to be good for him, but that doesn't work that way. Ah, let me see (pause). And ah, he thinks, like I said if I get mad I... carry it over for a long time. But I keep telling him that... that I get mad and maybe one or two hours afterwards I... I remember it pretty well, and I won't say anything to him or something. But afterwards I forget it. Well, I don't forget it, but I don't hold it against him. Well, you know what I mean.

Co: Mmhmm.
Cl: Ah, he thinks that I do.

**Stopping Point #1**

Co: There is something about your behavior that gives that indication, even though . . .

Cl: Yeah, you see when I come in the room and he's sitting there studying, I don't say anything. I just come in and I sit down and I start studying and reading, whatever I want to do. When I come in at night I . . . I, well, I don't actually come in and greet him with cheers, you know. And I just don't say much, especially in the morning, I don't say anything. Apparently, like he said, he thinks that . . . because of the way I look and act, he thinks that I'm still holding a grudge against him. Now, well, maybe I do, I don't know. I thought that's just the way I am. I don't talk in the morning; I don't feel like it. And I may look bad, I don't . . . I don't smile when I get up in the morning, and maybe (pause) I don't know. But then when we talk things over like this we get along, you know, for a couple of days or a week, maybe. And he'll so something I'll get mad at him again. And that's all right, just the one thing. And pretty soon I get mad at him at many other things. He doesn't open his shade during the day. Well, I don't say anything; I just open them sometimes. But . . . but these things, then, start to make me mad. You know, they get . . . the things get finer and finer at what I get mad at.

Co: Mmmmm.

Cl: It doesn't take such big things anymore, and then we have a nice little discussion and everything's back to normal for a while.

**Stopping Point #2**

Co: And then it starts all over again.

Cl: Yeah.

Co: First big things and then smaller and smaller things.

Cl: Yeah. Well, he mentioned that my attitude is sort of . . . like I say, one of judging. And he wonders who I am to judge. And I thought, well, I told him I didn't think I was judging, I was just . . . I told him that's . . . that's what I don't like in people. I don't like people sharing my things. I mean, uh, we each have half of a medicine cabinet, or whatever you call it. He uses his stuff and then uses mine and I don't like . . . especially him, whom . . . whom I don't even know. I don't want him using my stuff. I don't like that in people. I told him I don't think I was judging him; it's just the way I am. I don't like it.
**Stopping Point #3**

Co: It sounds to me like you're still really two strangers, even though you live together a good part of the day.

Cl: Well, I think we are strangers. Ah, well, I don't know what... what makes two people... friends. We don't share any of the common interests, and, well, we don't even eat together most of the time, and... well, did I say "I don't know him" when I was referring to him using my...

Co: When you were talking about interchanging articles.

Cl: Oh, yeah.

Co: You said, "I don't like this because I don't even know him."

Cl: Yeah, well, like... like... well, the other guy that's down here from back home. I would... well, I think I would still tend to (laugh) dislike it a little if he used it without asking me. But I would... I would tend to feel like, gee, you know, he's sort of dependent on me. I like to have people, my friends, ask me for things, you know, like I want them to. If they don't have a car I want them to ask me if I can take them there, or if they can come over and borrow my basketball. But not with people I don't know, I don't like... well, my roommate, I... I guess maybe it's because my friends, I know what... what they're like. I'll know what they'll do with it; I know they'll take care of my articles. And well, I just don't know my roommate that well.

**Stopping Point #4**

Co: What was the rest of the two-hour discussion you had this afternoon with him?

Cl: Ah, well, it's... it sort... well, one thing I remember right now is that... telling each other that, you know, I dislike you. Like... telling... like I should tell my roommate I dislike him before I tell it to somebody else. Well, about the shaving cream bit, uh, I came up to my room. I saw all the shaving cream all over, so he went down to eat. Guys all gathered around the hall, and I said, "Well, where did he get the shaving cream?" You know. And he walked over to the medicine cabinet and pointed to my uh, can. So, OK, so I was waiting for him to come up from dinner and I asked him if he used it, and he said he did. Well, I... I got mad and he went to class and...
Cl: Well, my tone of voice...

Co: Well, I'll tell you, instead of doing it in general, tell me how you did it this time, specifically.

Cl: I said, uh, . . . I think I said, uh, "Whose shaving cream did you use to, uh, spray all over the door?" and uh, I really can't . . . can't show you my expressions the way I had them then because I just don't feel it now. But he said, uh, "Well, I used mine and a little of yours." And . . . and I said, uh, (soft laugh) "Why in the hell don't you get out of here? Why in the hell don't you go to class?" You know, well, I raised my voice a little, but I didn't yell at him. I said, "Why in the hell don't you get out of here? Where were you born, in a barn?" So, with that he walked out and I went down to eat dinner, and that's it. I was really mad. I guess the guys could tell it and they said, "What's the matter with you?" You know. I said, "Oh, my damn roommate was using . . . was goofing around with shaving cream and he's using my shaving cream." And well, they were sort of razzing me about, "Ahh, you have all the money, anyhow." I just took a little while and I was back to normal. But today he said, "I hear, uh, I hear you called me a thief." And, uh, (pause) I told him I didn't call him a thief. I said, "I was mad at you because you used my shaving cream." And . . . this is what brought on the discussion about uh, telling each other before we spread it around.

Stopping Point #5

Co: When you told him, "Why don't you get out of here?" , were you menacing at all in a physical way?

Cl: No, no, I'm not really . . .

Co: "You'd better get out of here?"

Cl: No, no (laughing) he'd beat me to a pulp. I just sort of . . . well, I just used words, I guess. Compensation, I just looked at him real derogatorily, I guess. I imagine my face was flushed or something. So he just walked out. No, I didn't threaten him or raise my arms at him or anything. I just stood there and asked him. He couldn't look me in the eye and he said he did feel about yea high, but he thought I was carrying a grudge over and I told him I wasn't. But apparently my actions . . . convey that . . . that I do. And I think, uh, it is this attitude or these actions that calls for a split in relationships.

Stopping Point #6

Co: Did these ever happen with the girls at home, too? Did you ever, uh, have the same attitude and actions come out?
Cl: Well, they must. (pause) Except, well, with girls I usually
don't . . . don't get mad. I don't . . . well, I may get mad, but
I don't . . . don't say anything. I must . . . I must do something
else when I get away from them to release my anger. But I don't
say anything to them. But I think my . . . general attitude must
. . . must still be the same.

Co: But something gets conveyed to them.

Cl: Yeah, that . . . uh. (pause) Oh, a few people have told me that,
uh, "You should stop trying to be perfect, uh, stop trying to
achieve perfection." I think I . . . maybe I expect it from other
people, I expect them to really think and do things the same way
I do. And if they don't it sort of bothers me.

**Stopping Point #7**

Co: Even though you don't get mad with girls, do you ever say something
like, uh, "Gee, your hair looks terrible today?"

Cl: Th, . . . no. (pause) In fact, I, uh, (pause) I think it must be
very . . . very uninteresting, because I don't . . . I don't
compliment them an awful lot. And yet I don't . . . well, I joke
around with them a little. Like uh, (pause) you know, like uh,
very ambiguously we talk about parentage and yet sort of jokingly
with some girls. (pause) I'm just trying to think, (pause) well,
it must have been last summer or sometime during the year . . .
we started discussing religion. And, uh, I guess I let her talk
on what she thinks but then after she was done I sort of put my
questions to her in a way that . . . "Gee, don't you think my way
is better?" Well, I expected her to . . . to sort of say, "Gee,
that's . . . that's a good way of thinking." You know, I sort of
. . . a lot of things she said I contradicted. That's something
I've noticed, uh, when people say something, sometimes I just feel
like contradicting them for no other reason than because of that.
I just, uh, I just want to be opposite or something. I don't know
why. It's just . . . when some people say something, I just . . .
just want to say . . .

**Stopping Point #8**

Co: Want to get in there and do battle.

Cl: Yeah. I guess that's it.

Co: Would these be people who talk with you otherwise?

Cl: Th, yeah. I think it's more true of, uh, people who I know better.
 Uh, some of my better friends. Uh, not the best ones, but . . .
but ones a little more distant whom I don't care as much about as
the closer ones, but yet enough that I want to hang onto them.

**Stopping Point #9**

Co: Sounds like you might be a little ambivalent towards these... this intermediate group of people.

Cl: Yeah, uh, sometimes... I may have mentioned this before... that sometimes I... I want to be with them, and other times I don't want them around me... these are the most distant friends. But the close group I want to be around all the time. And so between the distant friends and... and me I guess there's bound to be some bad feelings because, you know, I'm the good guy one time and the bad guy the other time. (pause)

Co: Are these people who, uh, do say, "Well, gee, your ideas are pretty good."?

Cl: No, these people are... well, with the friends that are real close I can do anything. All right, some of the close friends don't play basketball, well, these distant friends are good guys... When we go to a movie (pause) I... I don't like these distant friends for movie companions. Uh, I want these close friends.

**Stopping Point #10**

Transcript of Friendly Patient

Co: Good afternoon, Mr. Saunders. Won't you tell me a little about yourself?

Cl: Well, my trouble was... lately... how I got the address of the clinic was I went out to the state hospital and I saw the psychiatrist out there and he said that all they take in there are mental patients and there's nothing wrong with me mentally, he said, and all I need is to see a psychiatrist or a psychologist or maybe somebody to try and straighten me out, so he recommended the clinic and I came down here and made an appointment. It's taken almost about six weeks now.

Co: Mmhm.

Cl: So I don't know.

Co: Mmhm.

Cl: My trouble is with people and getting out... I, I can't... Well, I'm introverted, inhibited and... and it extends itself
into my social life and in my work. It's like a mental block.
(pause) Well, because of it, I ... I'm just not very happy.

Co: This bothers you a great deal.

Cl: Well, I, I don't know. If I ... if I thought I was this way naturally then I don't think it would bother me so much, do you? I mean there's some extraverts and some introverts and society needs them both ... and I scored extraverted on different tests and so forth, so I think I am an extravert by nature or something, but ... I can't take a walk with a girl ... I feel ... gee, I go all into myself and I blush easily. Maybe it's emotional immaturity, I don't know. And I read a lot. I did a lot of reading on this stuff, perhaps I shouldn't have ... I don't suppose it's done me any good, actually. But you know, I read a lot of psychiatric books and in trying to find out ... I mean, well, I'm not happy because I'm not natural the way I am. I mean it seems to be a block and it affects everything I do, whether it be in the line of work or in the social ring. It's just ... well, it's like something's holding me and I can't release myself. I feel so nervous and tense all the time. You know it's ... well, I don't know ... it's just ... any adjective you could use to describe me ... it probably be right. And my confidence ... there just isn't any ... I ... I mean ...

Stopping Point #1

Co: You feel inadequate as compared to other people.

Cl: Well, I think I could be able to do things as well as anyone else, but there ... there seems to be ... I don't know ... it's my confidence. I left school because of it. I felt odd and out of place ... and the same way with jobs. I was in the service for four years and I got out last year ... since then I've had almost 12 different jobs now. I'm not the dumbest person in the world, but I don't know what I want. I can try as I may, but ... of course, I don't think that's too unusual because there are a lot of people today, young people who don't know what they want. (pause) The way I skip, you know, insecurity and, irresponsibility and, and boom ... a different job every month and so on and so forth down the line. And it seems to be some ... something keeping me from enjoying myself ... some ... I don't know what it is or ... why it is ... but if I thought I was the way I should be, I wouldn't be here. I wouldn't be seeking any kind of help. (Clears throat.) But to put my finger on it ... I can't, well, I don't know ... I just never feel relaxed and loose within myself ... and I'm constantly worrying ... the world's worst worrier.

Co: How long have you felt this way?
C1: Well I suppose I have felt this way since . . . oh, maybe since I was in high school. Of course I felt the same way in the service. I was unhappy, too . . . well, insecure and nervous and quite sensitive. And my confidence, I . . . I had no reasonable confidence of my own . . . just the same as now. I . . . I can see . . . where it's gotten worse now . . . It manifests itself now more than ever.

Co: It goes back quite a ways.

C1: Well, I wouldn't say it's all come about five or six months or so . . . I would say it goes back five or six years ago. Well, is this common? I mean, do you ever have a neurosis of this type?

Stopping Point #2

Co: Well, I think this is . . . uh . . . not too unusual. I think this is something that we can help you with if we work on trying to understand why you feel this way.

C1: Yeah, but . . . how I got this way . . . I don't know. I . . . I can't describe to you the way I feel now, or the way I usually do. I can't picture the way you feel but I don't think if you felt . . . that you were like me, I don't think you would be very contented.

Co: You feel that you're different from other people.

C1: Just where it is, or why it is, or how come it is, or where the change is . . . I don't know . . . it's just stifled everything I've done. I mean the different jobs that I've had where I felt I, I can't do it or I couldn't do it. I felt . . . well, I don't know . . . I felt uncomfortable. I . . . I quit school because of it. Oh, I liked school in itself, but I felt uncomfortable in a classroom. I . . . I felt like I should be somewhere else, or something . . . and I'm always looking for that somewhere else and I never seem to find it. Maybe it's because I'm emotionally immature. Do you think that might be it?

Stopping Point #3

Co: An adult shouldn't feel this way?

C1: No, I don't think he should, actually. I . . . I mean, if he's emotionally and mentally and intellectually grown up I don't think he should. But he should be able to come to the situation and face it. Well, like . . . you and millions of other people do. It . . . it's everyday situations and there are crises in every people's . . . in everyone's lives. And . . . and if you can't seem to manage them or make decisions one way or . . . or another
I hope I have described to you in some little . . . partially what I'm talking about so that you might understand.

Stopping Point #4

Co: Mm hmm.

Cl: Well, I'd like to know whether I . . . what I feel . . . if it's real or . . . or imaginary, or . . . or whether it's . . . or if I have somewhat of a controverted view the way in which I look at the world or something. Well, is this unusual? I mean is this what you might call a neurosis.

Co: Would calling it a neurosis help?

Cl: Well, it . . . is it common? Is it a common ailment among people . . . or among people who seek out some kind of help. I don't know. Is this something you run into very often? (pause) Well, am I unusual . . . as far as the run of the mill goes . . . or is it, or not generally here, but in your experience with the psychiatrist, is this case uncommon or is it something you don't run into very often? Is this something that happens to quite a few people?

Stopping Point #5

Co: I would say that it's not uncommon.

Cl: It's not unique then.

Co: It bothers you that you may be different from other people.

Cl: Well, yes, I suppose it does actually, I don't know. I'm so defeated all the time and it's defeatism with me all the time actually. It just seems to automatically and without my . . . well, it seems to have got hold of my subconscious or something and it's . . . each day is just . . . well, I don't know . . . there is just no interest . . . can't get any interest anywhere. Well, and everything you do turns out screwy . . . and yet before I think of it, it will anyway . . . and maybe that's what's wrong with me . . . that I, I think it will turn out bad before I even begin on something. I don't have any competitive spirit to . . . to at least try. I feel I, I lost again or something.

(pause) Do you want me to keep talking?

Stopping Point #6

Co: Just say anything that occurs to you.

Cl: Well, I sure wish I . . . I could beat this because, well, I don't
I don't know. Well, it's not natural, or normal for me to feel this way . . . to go on thinking the way I do and . . . and yet I am not my feeling. I am my own free will, and if I'm not, I don't know why I'm not. Maybe I'm not exercising it enough or something. Well, I don't know. I . . . I'm not the way I feel actually, is that . . . is that right? I am a product of my own free action.

Co: And you want to get hold of yourself.

Cl: Why should I be different from other people. I don't know. I guess I have a something that . . . that keeps me from enjoying myself. I . . . I guess it's easy for a person to adopt certain attitudes toward himself and say, "well, I'll change. I'll do it this way or do it that way." But I'm not able to do that. I just can't make decisions. I can't do it. I'm always thinking: "Should I have done it this way or perhaps this, or I don't know what to do." And it's . . . it's hell.

Stopping Point #7

Co: Mmmmm.

Cl: I don't know what happens somewhere along the line . . . if it stems from my family or . . . or . . . or what. It may have been . . . well, I don't know where it comes about. What makes a person take on attitudes towards himself like this?

Co: What do you think?

Cl: Well, I don't know. Maybe I want some kind of attention. But why am I . . . why do I think the way I do? I don't know. Why can't I be the way I feel I should be?

Co: Why can't you do something about it?

Cl: That's right. To at least try. I feel like my emotions run away with me . . . and it makes it quite difficult. I just don't know what to do. Well, how does this strike you? Is there any hope for me?

Stopping Point #8

Co: What do you mean?

Cl: Well, I . . . I just seem to be in a bind and I can't get out. I don't know. It just makes life not very worthwhile, that's all. If . . . if I thought I had to go through another 50 years or so of this . . . Well, I'd rather die tomorrow . . . really I would . . . because it's not living, it's existence . . . Yet a lot of
people have handicaps and they succeed in spite of them, but it doesn't seem I'm able to do this... Whether my problems are too great or I have blown them up... well, I don't know. It, it gets me all...

Co: Really incapacitating.

Cl: But other people succeed in spite of their handicaps. I... I guess they think in a normal frame of mind or something, I don't know. (voice cracks)

Stopping Point #9

Cl: Is it wrong for a person to take on an attitude like this... to... to feel like an underdog? to feel thwarted and inferior? inhibited? Do most people feel this way? Maybe some of the time, but they don't feel this way all of the time. It doesn't occupy... it doesn't become dominant in their makeup, does it? They can't feel this way. I don't see how they could. Do most people feel this way? They can't. It just seems... to dominate your thoughts and to occupy your time. You're always within yourself. I... I can hardly forget myself. I can't get my mind out of... outside of myself and on to something else. Well, I guess if you keep on with this attitude that it will develop into some kind of neurosis or symptom, but I just can't seem to get my mind off of myself. Maybe if I could find some kind of outside interest it would be a good outlet... a means to a solution or something.

Stopping Point #10
You are about to hear three tape recordings in which actors are portraying individuals who have applied to an agency for professional help with their emotional problems. Although the individuals on tape are actors the material is based on actual cases.

In the recordings a patient is talking with a counselor. Try to place yourself in the role of the counselor to whom the client is talking.

Ten times during each interview the recording will be stopped. At these times you are to write on a piece of paper what you would say to the patient.

Respond in the way which you think would be most helpful to the person. Since there are many ways of responding what you say will probably be different from what the counselor on the tape actually says. What the counselor does say is not necessarily the best response that could be given.

Each stopping point will be thirty seconds long.

Are there any questions?
Categories of Therapist Response

Therapist responses to each patient statement are divided into two mutually exclusive classes, approach and avoidance responses.

A. Approach Responses: An approach response is any verbalization by the therapist which seems designed to elicit from the patient further expressions or elaborations of the feelings, attitudes, or actions described in the patient's immediately preceding statement.

1. Approval or Support: expresses approval or agreement with the patient's feelings, attitudes, or behaviors.

   Examples:
   a. P: May I just be quiet for a moment?
      T: Certainly.
   b. P: I hate to ask favors from people.
      T: I can understand that would be difficult for you.

2. Exploration: includes remarks or questions that encourage the patient to describe or express his feelings, actions, or attitudes further; asks for further clarification or descriptive information or calls for examples.

   Example:
   P: I can't understand his behavior.
   T: What is it about his behavior that you can't understand?

3. Reflection or Labeling: repeats or restates a portion of the patient's verbalization of feeling, attitude, or action;
gives a name to the feeling, attitude or action contained in the patient's verbalization.

Examples:

a. P: I wanted to spend the entire day with him.
   T: You wanted to be together.

b. P: I just don't want to talk about that anymore.
   T: What I said annoyed you.

4. Factual Information: gives information to direct implied questions.

Example:

P: What's counseling all about?
T: It's a chance for a person to talk about what is on his mind.

B. Avoidance Responses: An avoidance response is any verbalization by the therapist which seems designed to inhibit, discourage, or divert further expression of patient behavior. The therapist attempts to inhibit the feelings, attitudes, or behavior described in the immediately preceding patient statement.

1. Disapproval: includes critical, sarcastic, or antagonistic remarks by the therapist toward a patient or his statements, expressing rejection in some way.

Examples:

a. P: Why don't you make a statement? Don't ask another question.
   T: It seems that you came here for a reason.

b. P: I'm mad at him. That's how I feel.
   T: You aren't thinking of how he may feel.

2. Persuasion: includes attempts by the therapist to change
patient's feelings or attitudes by stating he will be better off if he behaves differently.

Example:

P: I'm so nervous I don't know what I'm doing.
T: Talking that way is just going to make you feel worse.

3. **Topic Transition**: includes attempts by the therapist to change or introduce a new topic of discussion not in the immediately preceding patient verbalization. Usually fails to acknowledge even a minor portion of the statement.

Example:

P: My mother never seemed interested in me.
T: What does your father do for a living?

4. **Mislabeled**: includes attempts by the therapist to name attitudes, feelings, or actions which are not present in the actual verbalization preceding the response.

Example:

P: I just felt crushed when she said that.
T: That really made you angry.
APPENDIX D

THERAPY RESPONSE ALTERNATIVES FOR THE HOSTILE PATIENT

I. 1. How have you been getting along with your family? (TT)
   2. This is annoying for you. (EL)
   3. Tell me more about this. (E)
   4. Everyone has problems. (D)

II. 1. You may have a persecution complex. (M)
   2. Tell me more about what they want you to do. (E)
   3. I can understand how you feel. (AS)
   4. You should try to understand the other students a little more. (D)

III. 1. There is no need to raise your voice. (D)
   2. You are right. Some people are leaders and some are followers. (FL)
   3. You feel very angry. (EL)
   4. If you looked at things more carefully you would realize that you might have a problem. (E)

IV. 1. Hollering and raising your voice will probably make things worse for you. (E)
   2. How do you get along with friends? (TT)
   3. I don't think there is anything seriously wrong. (AS)
   4. This is upsetting for you. (EL)

V. 1. Yes. People are different. (FL)
2. You are probably treating me just like you treat your teachers. (M)

3. Tell me more about this. (E)

4. If you calmed down you would probably understand this situation better. (P)

VI. 1. I can understand why this upset you. (AS)

2. You probably didn't understand your teacher. (D)

3. People often feel like this. Like you, they don't like to be told they have problems. (FL)

4. Tell me about some of the things you do well. (TT)

VII. 1. I think I can help you by talking or listening to you. (FL)

2. You would do better if you didn't get so excited. (P)

3. To feel this is none of my business. (RL)

4. Have you always had a bad temper? (TT)

VIII. 1. I don't have all the answers but sometimes I can help. (FL)

2. I understand how you feel. (AS)

3. Hollering at me will not help you. Let's talk this over calmly. (P)

4. Tell me why you came here. (TT)

IX. 1. What do you want to do when you finish school? (TT)

2. You must have had a bad relationship with your family. (M)

3. Of course it's not all over. You can still do it. (AS)

4. Tell me more about this. (E)

X. 1. You probably make many of your own problems. (D)

2. There is nothing you want to talk over. (RL)
3. Tell me more about these feelings. (E)

4. Deep down inside you probably do want to talk. (M)

THERAPY RESPONSE ALTERNATIVES FOR THE
NEUTRAL PATIENT

I. 1. Aren't you being inconsiderate in some cases? (D)

2. Tell me how you are doing in school. (TT)

3. Tell me more about this situation. (E)

4. I can understand how you feel. (AS)

II. 1. You would probably feel better if you overlooked some of these little things. (P)

2. I would imagine that other people in your family have bad tempers. (M)

3. This is upsetting for you. (RL)

4. This kind of thing happens frequently in tense situations. (FI)

III. 1. It makes you angry when he uses your things. (RL)

2. If you kept your things in separate places that should solve the problem. (P)

3. How do you get along with girls? (TT)

4. You are right in not wanting your roommate to borrow your things. (AS)

IV. 1. Tell me more about your roommate. (E)

2. You should get to know your roommate better. (D)

3. You feel uncomfortable with your roommate. (RL)

4. You are probably afraid to get to know your roommate. (M)

V. 1. Was the dormitory supervisor told about this? (TT)
2. Tell me more about how you felt. (E)
3. Hollering probably covers up your feelings of inferiority. (M)
4. I don't blame you for your attitude here. (AS)

VI. 1. The type of situation that you describe often produces a split in relationships. (FI)
2. If you cannot adjust you should get another room. This is the sensible thing to do. (P)
3. Are you sure that you don't have a bigger problem than your roommate? (D)
4. Has this attitude caused you problems with other people? (E)

VII. 1. This is a common attitude. (FI)
2. You should realize people are different. (D)
3. Tell me about your family. (TT)
4. This is disturbing to you. (RL)

VIII. 1. You probably fought a great deal as a child. (M)
2. You might feel better if you thought more of your roommate's feelings. (P)
3. Why do you think you feel this way? (E)
4. This is a common problem. (FI)

IX. 1. This sounds reasonable. (FI)
2. Sometimes you must see things the way others do. This will help you. (P)
3. Tell me more about your roommate. (TT)
4. I see. (AS)

X. 1. I think we can help you with this problem. (AS)
2. You like your close friends better because you are probably afraid to make new friends. (M)

3. You shouldn't think about yourself so much. (D)

4. People usually feel most comfortable with close friends. (FI)

THERAPY RESPONSE ALTERNATIVES FOR THE FRIENDLY PATIENT

I. 1. You must not let this get you down. Try to relax. (P)

2. Tell me more about these feelings. (E)

3. Have you had a medical examination lately? (TT)

4. You feel unsure of yourself. (RL)

II. 1. Yes. Some people do have a difficulty like this. (FI)

2. Whatever the problem is I think you can be helped. (AS)

3. I wonder whether you may have sexual problems. (M)

4. You worry too much. (D)

III. 1. Tell me more about your good points. (TT)

2. Sometimes emotional immaturity does make people unhappy. (FI)

3. What do you mean by emotional immaturity? (E)

4. You probably had a bad experience as a child. (M)

IV. 1. You are doing very well. (AS)

2. You want me to take responsibility for you. (D)

3. Yes, I understand you. (FI)

4. You would feel better if you didn't worry so much. (P)

V. 1. I actually think you don't like people. (M)

2. You wonder whether you are different from others. (RL)

3. You are asking so many questions. No one could possibly answer them but yourself. (D)
4. Tell me more about these feelings. (E)

VI. 1. You are doing fine. (AS)
2. Tell me about your family. (TT)
3. You feel lost and confused now. (RL)
4. If you thought more of others and less of yourself you would probably feel better. (P)

VII. 1. Are you saying that making decisions always bothered you? (E)
2. It's all right. Many people feel this way. (FI)
3. If you weren't so frightened of everything you could make decisions. (P)
4. You probably disliked your parents. (M)

VIII. 1. You are too much inside of yourself. (D)
2. What will you do in the future? (TT)
3. Yes. There is hope for you. (FI)
4. You feel lost and inside of yourself now. (RL)

IX. 1. Before we can work on this you must pull yourself together. (P)
2. We can help you with this problem. (AS)
3. You are unhappy and confused. (RL)
4. You become upset too easily. (D)

X. 1. Tell me more about this. (E)
2. You are right. People are happier if they have outside interests. (FI)
3. Do you do anything well? (D)
4. Do you ever become angry? (TT)
APPENDIX E

Answer each question in the following manner. Do not omit any items.

+1 I agree a little
+2 I agree mildly
+3 I agree very much
-1 I disagree a little
-2 I disagree mildly
-3 I disagree very much

_1. The patient worries about what other people think of him.
_2. The patient should receive a careful examination by a psychologist or a psychiatrist.
_3. The patient may become harmful to himself or others.
_4. The patient is emotionally disturbed.
_5. The patient will be a good father.
_6. The patient is self-confident.
_7. The patient is angry.
_8. The patient will be a good husband.
_9. The patient is nervous.
_10. The patient gets along with other people.
_11. The patient should be in a mental hospital.
_12. The patient's opinions are easily swayed.
_13. The patient is emotionally mature.
_14. The patient will be able to deal with his problems if he does not receive outside help.
_15. The patient wants help in dealing with his problem.
_16. The patient is friendly.
_17. The patient is presently able to deal with difficult situations.
_18. The patient has been successful in the past in dealing with his problems.
19. The patient may be able to accept normal adult responsibilities.
20. I can put myself in this person's shoes.
21. I find this person likeable.
22. I feel that this person has few positive qualities.
23. I feel sorry for this person.
24. I am likely to avoid this type of person.
25. I believe I could help this person in some way by listening or talking to him.
26. I feel warmly towards this person.
27. I have felt like this person at times.
28. This kind of person is likely to make me nervous.
29. I believe that this person has the same kinds of problems as many people his age.
30. This kind of person is likely to make me angry.
31. I feel this person would be happier if he receives help.
32. This kind of person is likely to make me impatient.
APPENDIX F

You are about to hear two tape recordings in which actors are portraying individuals who have applied to an agency for professional help with their emotional problems. Although the individuals on tape are actors the material is based on actual cases.

In the recordings a patient is talking with a counselor. Try to place yourself in the role of the counselor to whom the client is talking. Probably none of you have had specialized training in this type of situation; however I am interested in finding out how people like yourself respond in these situations.

After listening to each person you will be asked to fill out a brief questionnaire. The questionnaire will ask you to evaluate the client and to describe some of your personal reactions to him which are based on the recordings you have heard. Be sure to answer every item.

Are there any questions?
1. One-hundred forty-nine subjects completed the attitude scale after hearing the hostile patient. One-hundred were females and forty-nine were males. The median age of the sample was twenty years, three months. The range was from eighteen to forty-three years.

2. One-hundred fifty-two subjects completed the attitude scale after hearing the neutral patient. One-hundred two were females and fifty were males. The median age of the sample was twenty years, eight months. The range was from seventeen to forty-nine years.

3. One-hundred fifty-eight subjects completed the attitude scale after hearing the friendly patient. One-hundred twenty were females and thirty-eight were males. The median age of the sample was twenty years, six months. The range was from seventeen to forty-nine years.

Each subject responded to two interviews. Administration of the recordings was randomized.
HOSTILE PATIENT

Varimax Rotation

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</table>

Percent of Common Variance

34.818 22.414 12.814 9.971 = h²

Rotated Factor Loadings
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<td>0.274</td>
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<td>0.020</td>
<td>0.0010</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
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<tr>
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<td>0.020</td>
<td>0.0010</td>
<td>0.0000</td>
<td>0.0000</td>
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</tr>
<tr>
<td>43</td>
<td>0.020</td>
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<td>0.0000</td>
<td>0.0000</td>
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<td>39</td>
<td>0.020</td>
<td>0.0010</td>
<td>0.0000</td>
<td>0.0000</td>
<td>0.0000</td>
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</table>

Recent Precipitation

Percent of Common Variance

Verbal Interpretation

Statistical Analysis

123
APPENDIX H

INSTRUCTIONS

You are about to hear three tape recorded interviews in which actors are portraying individuals who have applied to an agency in order to obtain help with their emotional problems. Although the individuals on the recordings are actors the material is based on actual cases.

In the interviews a patient is talking with a counselor. Try to imagine you are the counselor to whom the patient is talking. During each interview I will stop the recording ten times for a period of 30 seconds. At the beginning of each 30 second period of silence I will call out a number. The first time the recording is stopped I will say "Number 1." The second time it is stopped I will say "Number 2." The tenth time I will say "Number 10."

When I stop the tape open your booklet to that number and circle one of the four choices written next to the number. Circle the choice which is most similar to what you would say to the patient at that moment. None of the choices is what the counselor on the tape actually says, so there are no right or wrong answers.

After circling your choice put the colored marker on the top of the page on which you have just marked and then close the book so that you can listen to the tape. When the next number is announced open the book to the marker, check to see that you have the right number
and then circle your response. Do not look backward to choices already completed or forward to future choices.

Remember to respond in the manner you believe would be most helpful to the patient.

Are there any questions?
### APPENDIX I

**FACTORS DERIVED FROM FACTOR ANALYSIS OF ATTITUDES**

**FOR HOSTILE PATIENT**

**Factor 1.** (bipolar factor)

<table>
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<tr>
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<th>Item</th>
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<td>-.68</td>
<td>2. The patient should receive a careful examination by a psychologist or a psychiatrist.</td>
</tr>
<tr>
<td>-.39</td>
<td>3. The patient may become harmful to himself or others.</td>
</tr>
<tr>
<td>-.60</td>
<td>4. The patient is emotionally disturbed.</td>
</tr>
<tr>
<td>.79</td>
<td>5. The patient will be a good father.</td>
</tr>
<tr>
<td>.73</td>
<td>8. The patient will be a good husband.</td>
</tr>
<tr>
<td>.57</td>
<td>10. The patient gets along with other people.</td>
</tr>
<tr>
<td>.55</td>
<td>13. The patient is emotionally mature.</td>
</tr>
<tr>
<td>.68</td>
<td>14. The patient will be able to deal with his problems if he does not receive outside help.</td>
</tr>
<tr>
<td>.55</td>
<td>16. The patient is friendly.</td>
</tr>
<tr>
<td>.51</td>
<td>17. The patient is presently able to deal with difficult situations.</td>
</tr>
<tr>
<td>.43</td>
<td>18. The patient has been successful in the past in dealing with his problems.</td>
</tr>
<tr>
<td>.58</td>
<td>19. The patient may be able to accept normal adult responsibilities.</td>
</tr>
<tr>
<td>.41</td>
<td>21. I find this person likable.</td>
</tr>
<tr>
<td>-.40</td>
<td>23. I feel sorry for this person.</td>
</tr>
<tr>
<td>-.54</td>
<td>31. I feel this person would be happier if he receives help.</td>
</tr>
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</table>
**Factor 2. (bipolar factor)**

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<th>Item</th>
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<td>.43</td>
<td>21. I find this person likeable.</td>
</tr>
<tr>
<td>-.65</td>
<td>24. I am likely to avoid this type of person.</td>
</tr>
<tr>
<td>.58</td>
<td>25. I believe I could help this person in some way by listening or talking to him.</td>
</tr>
<tr>
<td>.71</td>
<td>26. I feel warmly towards this person.</td>
</tr>
<tr>
<td>-.67</td>
<td>28. This kind of person is likely to make me nervous.</td>
</tr>
<tr>
<td>-.74</td>
<td>30. This kind of person is likely to make me angry.</td>
</tr>
<tr>
<td>-.76</td>
<td>32. This kind of person is likely to make me impatient.</td>
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</tbody>
</table>

**Factor 3.**

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</tr>
<tr>
<td>-.52</td>
<td>6. The patient is self-confident.</td>
</tr>
<tr>
<td>.38</td>
<td>9. The patient is nervous.</td>
</tr>
<tr>
<td>.36</td>
<td>12. The patient's opinions are easily swayed.</td>
</tr>
<tr>
<td>.56</td>
<td>15. The patient wants help in dealing with his problem.</td>
</tr>
<tr>
<td>.41</td>
<td>31. I feel this person would be happier if he receives help.</td>
</tr>
</tbody>
</table>

**Factor 4.**

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<td>20. I can put myself in this person's shoes.</td>
</tr>
<tr>
<td>-.31</td>
<td>23. I feel sorry for this person.</td>
</tr>
<tr>
<td>.69</td>
<td>27. I have felt like this person at times.</td>
</tr>
<tr>
<td>.44</td>
<td>29. I believe that this person has the same kinds of problems as many people his age.</td>
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**FACTORS DERIVED FROM FACTOR ANALYSIS OF ATTITUDES FOR NEUTRAL PATIENT**

**Factor 5. (bipolar factor)**

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<tr>
<td>-.35</td>
<td>3. The patient may become harmful to himself or others.</td>
</tr>
<tr>
<td>-.71</td>
<td>4. The patient is emotionally disturbed.</td>
</tr>
<tr>
<td>.63</td>
<td>5. The patient will be a good father.</td>
</tr>
<tr>
<td>.44</td>
<td>6. The patient is self-confident.</td>
</tr>
<tr>
<td>.54</td>
<td>8. The patient will be a good husband.</td>
</tr>
<tr>
<td>.68</td>
<td>10. The patient gets along with other people.</td>
</tr>
<tr>
<td>.68</td>
<td>13. The patient is emotionally mature.</td>
</tr>
<tr>
<td>.68</td>
<td>14. The patient will be able to deal with his problems if he does not receive outside help.</td>
</tr>
<tr>
<td>.36</td>
<td>16. The patient is friendly.</td>
</tr>
<tr>
<td>.77</td>
<td>17. The patient is presently able to deal with difficult situations.</td>
</tr>
<tr>
<td>.70</td>
<td>18. The patient has been successful in the past in dealing with his problems.</td>
</tr>
<tr>
<td>.53</td>
<td>19. The patient may be able to accept normal adult responsibilities.</td>
</tr>
<tr>
<td>.35</td>
<td>20. I can put myself in this person's shoes.</td>
</tr>
<tr>
<td>.49</td>
<td>21. I find this person likeable.</td>
</tr>
<tr>
<td>-.53</td>
<td>23. I feel sorry for this person.</td>
</tr>
<tr>
<td>-.33</td>
<td>24. I am likely to avoid this type of person.</td>
</tr>
<tr>
<td>-.52</td>
<td>31. I feel this person would be happier if he receives help.</td>
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Factor 6. (bipolar factor)

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<td>16. The patient is friendly.</td>
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<tr>
<td>.49</td>
<td>21. I find this person likeable.</td>
</tr>
<tr>
<td>-.62</td>
<td>24. I am likely to avoid this type of person.</td>
</tr>
<tr>
<td>.40</td>
<td>25. I believe I could help this person in some way by listening or talking to him.</td>
</tr>
<tr>
<td>.52</td>
<td>26. I feel warmly towards this person.</td>
</tr>
<tr>
<td>-.68</td>
<td>28. This kind of person is likely to make me nervous.</td>
</tr>
<tr>
<td>-.74</td>
<td>30. This kind of person is likely to make me angry.</td>
</tr>
<tr>
<td>-.72</td>
<td>32. This kind of person is likely to make me impatient.</td>
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Factor 7.

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<td>.47</td>
<td>5. The patient will be a good father.</td>
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<tr>
<td>.49</td>
<td>8. The patient will be a good husband.</td>
</tr>
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<td>.34</td>
<td>13. The patient is emotionally mature.</td>
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<tr>
<td>.63</td>
<td>20. I can put myself in this person's shoes.</td>
</tr>
<tr>
<td>.36</td>
<td>21. I find this person likeable.</td>
</tr>
<tr>
<td>.45</td>
<td>25. I believe I could help this person in some way by listening or talking to him.</td>
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<td>26. I feel warmly towards this person.</td>
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<td>27. I have felt like this person at times.</td>
</tr>
<tr>
<td>.44</td>
<td>29. I believe that this person has the same kinds of problems as many people his age.</td>
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**Factor 8.**

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<td>.30</td>
<td>2. The patient should receive a careful examination by a psychologist or a psychiatrist.</td>
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<tr>
<td>.40</td>
<td>3. The patient may become harmful to himself or others.</td>
</tr>
<tr>
<td>.31</td>
<td>6. The patient is self-confident.</td>
</tr>
<tr>
<td>.44</td>
<td>7. The patient is angry.</td>
</tr>
<tr>
<td>.49</td>
<td>11. The patient should be in a mental hospital.</td>
</tr>
<tr>
<td>-.37</td>
<td>15. The patient wants help in dealing with his problems.</td>
</tr>
<tr>
<td>-.42</td>
<td>16. The patient is friendly.</td>
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**FACTORs DERIVED FROM FACTOR ANALYSIS OF ATTITUDES**

FOR FRIENDLY PATIENT

**Factor 9.** (bipolar factor)

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<tr>
<td>.36</td>
<td>22. I feel that this person has few positive qualities.</td>
</tr>
<tr>
<td>-.33</td>
<td>23. I feel sorry for this person.</td>
</tr>
<tr>
<td>-.69</td>
<td>24. I am likely to avoid this type of person.</td>
</tr>
<tr>
<td>.45</td>
<td>25. I believe I could help this person in some way by listening or talking to him.</td>
</tr>
<tr>
<td>.61</td>
<td>26. I feel warmly towards this person.</td>
</tr>
<tr>
<td>-.66</td>
<td>28. This kind of person is likely to make me nervous.</td>
</tr>
<tr>
<td>-.70</td>
<td>30. This kind of person is likely to make me angry.</td>
</tr>
<tr>
<td>-.67</td>
<td>32. This kind of person is likely to make me impatient.</td>
</tr>
</tbody>
</table>
**Factor 10. (bipolar factor)**

<table>
<thead>
<tr>
<th>Loading</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>-.49</td>
<td>3. The patient may become harmful to himself or others.</td>
</tr>
<tr>
<td>-.45</td>
<td>4. The patient is emotionally disturbed.</td>
</tr>
<tr>
<td>.44</td>
<td>10. The patient gets along with other people.</td>
</tr>
<tr>
<td>-.40</td>
<td>11. The patient should be in a mental hospital.</td>
</tr>
<tr>
<td>.40</td>
<td>13. The patient is emotionally mature.</td>
</tr>
<tr>
<td>.40</td>
<td>16. The patient is friendly.</td>
</tr>
<tr>
<td>.39</td>
<td>17. The patient is presently able to deal with difficult situations.</td>
</tr>
<tr>
<td>.30</td>
<td>18. The patient has been successful in the past in dealing with his problems.</td>
</tr>
<tr>
<td>.45</td>
<td>19. The patient may be able to accept normal adult responsibilities.</td>
</tr>
<tr>
<td>.46</td>
<td>21. I find this person likeable.</td>
</tr>
</tbody>
</table>

**Factor 11.**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>.73</td>
<td>20. I can put myself in this person's shoes.</td>
</tr>
<tr>
<td>.75</td>
<td>27. I have felt like this person at times.</td>
</tr>
<tr>
<td>.46</td>
<td>29. I believe that this person has the same kinds of problems as many people his age.</td>
</tr>
</tbody>
</table>

**Factor 12.**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>.71</td>
<td>5. The patient will be a good father.</td>
</tr>
<tr>
<td>.77</td>
<td>8. The patient will be a good husband.</td>
</tr>
<tr>
<td>.39</td>
<td>17. The patient is presently able to deal with difficult situations.</td>
</tr>
<tr>
<td>.40</td>
<td>18. The patient has been successful in the past in dealing with his problems.</td>
</tr>
</tbody>
</table>
**Factor 13.**

<table>
<thead>
<tr>
<th>Loading</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>.55</td>
<td>2. The patient should receive a careful examination by a psychologist or a psychiatrist.</td>
</tr>
<tr>
<td>.34</td>
<td>4. The patient is emotionally disturbed.</td>
</tr>
<tr>
<td>-.47</td>
<td>14. The patient will be able to deal with his problems if he does not receive outside help.</td>
</tr>
<tr>
<td>.57</td>
<td>15. The patient wants help in dealing with his problems.</td>
</tr>
<tr>
<td>.70</td>
<td>31. I feel this person would be happier if he receives help.</td>
</tr>
<tr>
<td>.37</td>
<td>23. I feel sorry for this person.</td>
</tr>
</tbody>
</table>
APPENDIX J

SUMMARY OF CHI SQUARE TEST OF ASSOCIATION BETWEEN NUMBER OF SIGNIFICANT CORRELATIONS, BETWEEN FACTOR AND APPROACH SCORES FOR SUBJECT GROUPS

<table>
<thead>
<tr>
<th></th>
<th>A.</th>
<th>P.T.</th>
<th>A.W.</th>
<th>C.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>13</td>
<td>13</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>13</td>
<td>13</td>
<td>52</td>
</tr>
</tbody>
</table>

Chi Square = .68 (d.f. = 2)  P = 7.70
(Yates Correction Applied)
**APPENDIX K**

**SUMMARY OF CHI SQUARE ANALYSIS FOR TEST OF ASSOCIATION**

**BETWEEN NUMBER OF SIGNIFICANT CORRELATIONS BETWEEN**

**CLINICAL ASSESSMENT AND PERSON ATTITUDBINAL**

**FACTORS AS A FUNCTION OF PATIENT TYPE**

<table>
<thead>
<tr>
<th>Hostile and Friendly</th>
<th>Neutral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7</td>
</tr>
<tr>
<td>No</td>
<td>33</td>
</tr>
</tbody>
</table>

Chi Square = 6.50 (1 d.f.)

\[ P = .05 \]
APPENDIX L

SUMMARY OF CHI SQUARE ANALYSIS FOR TEST OF ASSOCIATION

BETWEEN NUMBER OF SIGNIFICANT CORRELATIONS AND
SUBJECT GROUP

<table>
<thead>
<tr>
<th></th>
<th>A.</th>
<th>P.T.</th>
<th>A.W.</th>
<th>C.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2</td>
<td>7</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>54</td>
<td>49</td>
<td>53</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>56</td>
</tr>
</tbody>
</table>

Chi Square = 2.38

P  .50

Yates Correction Applied
VITA

Robert Lovitt was born in New York City on July 3, 1939. He entered public schools in the Bronx, New York and graduated from James Monroe High School in 1957. He received the Bachelor of Arts degree from City College of New York in 1961 and a Master of Arts degree in Psychology from Temple University in 1963.

Robert Lovitt began his training for the Ph.D. degree in clinical psychology at Louisiana State University in 1963. From 1965 to 1966 he was involved in his clinical internship at Southwestern Medical School in Dallas, Texas. He has accepted a clinical position at the Dallas Child Guidance Clinic, Dallas, Texas.

Robert Lovitt is a candidate for the Ph.D. degree at the Spring 1968 commencement.
EXAMINATION AND THESIS REPORT

Candidate: Robert Lovitt

Major Field: Psychology

Title of Thesis: A Comparison of the Approach-avoidance Verbal Behavior and Attitudes of Professionally and Non-professionally Trained Subjects in a Quasi-therapy Situation

Approved:

Joseph D. Dawson
Major Professor and Chairman

Dean of the Graduate School

EXAMINING COMMITTEE:

John D. Dwyer
John R. Fite
A.O. Cunningham
William E. Haag

Date of Examination:

28 February 1968