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Authoritarianism & Preference for Directive or Non-Directive Therapy

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Henry,

Philip W.

1978

AUTHORITARIANISM AND PREFERENCE
FOR DIRECTIVE OR NON-DIRECTIVE THERAPY

A Thesis
Presented to
the Faculty of the Department of Psychology
Western Kentucky University
Bowling Green, Kentucky

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

Philip W. Henry
August 1978

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AUTHORITARIANISM AND PREFERENCE
FOR DIRECTIVE OR NON-DIRECTIVE THERAPY

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AUTHORITARIANISM AND PREFERENCE
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70 Pages

Directed by: Samuel G. McFarland, C. Clinton Layne,
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The California F Scale differentiated groups of low-, moderate-, and high-authoritarian undergraduate students who participated in a study of subject preference for either a directive or non-directive therapy. The subjects read specially prepared descriptions of Rational Emotive Therapy (directive) and Client-centered Therapy (non-directive) and were asked their preference for a therapy. They also gave their perceptions on and consideration for 14 dimensions of therapist behavior and style and therapy assumptions about human motivation. All three groups chose client-centered therapy. A factor analysis of the 14 perception scores yielded two factors: a halo "good-guy"-similarity - competent factor and a directive-evaluative factor. These two factors were not correlated for the high and moderate authoritarian groups. For the low-F group, the factors were negatively correlated. Additional analysis showed that the perception factors were unrelated to therapy preference for the high-F subjects. For the low- and moderate-F groups

Factor 1 was significantly related to preference. Factor 2 contributed only a marginally small amount of variance to the low authoritarians. A factor analysis of the 14 consideration scores revealed two factors: therapist capability - similarity - attraction and therapy assumption - problem causation. There were no significant differences across the three groups in the consideration they gave these factors. The discussion focussed on a comparison with Kraus' study, the implications for further research and the limitations of this investigation. The sole use of authoritarianism as a matching criterion was questioned.

Introduction

In recent years, a controversy has surfaced regarding the purported benefits of matching clients and therapists on some criterion variable in order to enhance the therapeutic process. Part of this debate has involved the very nature of basic research in psychotherapy. Goldstein (1971) believes that therapy research should investigate the "efficiency reducing...procedures and conceptualizations embedded in clinical lore which are largely or totally irrelevant to patient change" (p.1). As examples of this "clinical lore," Kiesler (1966) refuted three myths evident in past research: the client uniformity myth, the therapist uniformity myth, and the spontaneous remission myth. The latter stated that people with severe emotional problems might show considerable improvement or even recovery without the aid of systematic psychotherapy. However, Kiesler's cogent attack on the uniformity assumption myths was most relevant to this present study. The client uniformity assumption myth stated that all individuals who came for psychotherapy were homogeneous because they sought treatment. Kiesler suggested that an examination of demographic data showed significant interclient differences. Consequently, he concluded that any therapy research that failed to control for subject differences was methodologically flawed. He

also questioned the companion notion that therapists chosen to participate in research were similar and "that whatever they do with their patients may be called psychotherapy" (p. 112). According to Kiesler, the theoretical notion that each type of therapy could be applied to all clients perpetuated this therapist similarity myth. Interestingly, Kiesler noted that different therapeutic formulations, although touted as ideal for all, were derived from work with different populations, e.g., Carl Rogers with college students or Freud with hysterics. To avoid the detrimental effects of these methodological and theoretical defects, it is crucial that critical client and therapy variables be isolated and controlled in future studies.

Goldstein (1971) recognized the multifaceted nature of therapy research and proposed two approaches to confront this issue. The first suggestion emphasized the search for effective differences between psychotherapies. This general format subsumed such topics as the matching of treatments and clients on some measure of personality, the recognition of the uniformity myths, and the relevancy of clinical diagnosis to therapy. The second salient recommendation was for research to focus on commonalities across both the myriad of therapeutic techniques as well as non-therapeutic change methods.

This current study examined Goldstein's recommendation regarding personality similarity and its effects on

therapeutic outcomes. In particular, a person's level of authoritarianism and a preference for a directive or non-directive therapy were investigated. By means of a regression analysis, this study tried to delineate the factors which entered into the selection decision by those who differ in their level of authoritarianism.

Personality Similarity and Therapy Success

Tuma and Gustad (1957) hypothesized that the amount of learning about self by clients in a counseling situation was related to the degree of similarity between clients and counselors on selected personality characteristics. The authors administered the Taylor Manifest Anxiety Scale, the California F Scale, and the Tolerance, Flexibility, Dominance, Social Participation, Social Presence, Impulsivity, Self-Acceptance, and Good Impression Scales of the California Personality Inventory to college undergraduates who sought vocational counseling and to their counselors. The students also completed the Self-Knowledge Inventory both before and after counseling sessions as an indicator of learning. The results showed that all the counselors were high on the Dominance, Social Presence, and Social Participation personality scales and that students who were also high on these scales demonstrated the most improvement in self-knowledge. The authors concluded that counselors who used essentially the same methods with similar clients produced different effects on the criterion performance of their

clients and that a close resemblance between clients and counselors on selected personality variables was associated with relatively better criterion performance by clients. However, the authors assumed that the counselors behaved uniformly during the counseling sessions because they were associated with the same school of counseling. In the discussion, the researchers did recognize the need to study the systematic differences between types of counseling. Another serious deficiency involved the premise that specific, comparable behavioral patterns can be derived from an analysis of personality scale measures. In this case, although some of the students and counselors had similar high level personality profiles, there was no attempt to ascertain the specific behaviors being exhibited in the counseling situation by these individuals. In their discussion, the authors recommended that future studies control for sex differences and examine the outcomes of therapeutic interactions between clients and therapists with similar lower personality profiles on the California Personality Inventory.

Carson and Heine (1962) reasoned that the relationship between client-therapist similarity and therapeutic success was curvilinear. They conjectured that with very high similarity, therapists would be unable to maintain their objectivity and that with a very high level of dissimilarity, the therapist's ability to empathize with the client's plight would be impaired. In other words, as

client-therapist personalities increased in congruence, therapeutic success should increase up to a certain unspecified point. Beyond that point, success should decrease as similarity increased. To test this hypothesis, 60 senior medical students and 60 hospitalized psychiatric patients were matched, based on their scores on the Minnesota Multiphasic Personality Inventory. The subsequent dyads were evaluated by a supervising psychiatrist who completed a questionnaire. The curvilinear relationship was supported, but with reservations. The inexperience of the therapists and the necessary time constraints interfered with the development of the relationships.

Mendelsohn (1966) criticized previous conflicting client-therapist similarity studies because of their diverse definitions of similarity, the differing client samples, and the various statistical methods used to determine the "similarity score." Using a methodology basic to previous research, i.e., the administration of personality measures to both client and therapist and correlating the results, he investigated the relationship between commitment to therapy and the ability of the client and therapist to communicate with each other. He defined commitment as the number of completed therapy sessions and communicative ability as a by-product of client-therapist personality similarity as measured by the Myers-Brigg Type Indicator. The author found that high similarity was associated with a wide range in the duration of therapy, but a low similarity resulted in

short durations.

In summary, these studies showed the possible advantages of matching similar clients and therapists. Moreover, it is apparent, based on these citations "that one must get beyond gross dimensions of similarity or dissimilarity and make quite specific differential predictions such that similarity on some dimensions, but dissimilarity on others will be attraction-enhancing" (Goldstein, 1971, p. 135).

Authoritarianism and Therapeutic Success

In conjunction with Goldstein's recommendations, several investigators have looked at the relationship between client and therapist authoritarianism regarding a preference for psychotherapist. Vogel (1961) investigated the hypotheses that client and therapist authoritarianism would affect attitudes toward psychotherapy and behavior while in therapy and that client-therapist similarity on an authoritarianism-equalitarianism trait dimension would facilitate therapy. To test these ideas, the author administered prior to therapy the California F Scale and the Authoritarian-Equalitarian Therapy Sort (developed for this study) to 62 clients and 49 therapists representing two different clinical populations. The instruments measured authoritarianism and preference for authoritarian vs. equalitarian therapy. Thirty-two psychiatric inpatients seen by 32 senior medical students comprised Group A and Group B had 30 university counseling center clients treated

by 17 experienced therapists. The degree of correlation between the responses by the clients and their assigned therapists on these two measures was an indication of similarity. The author gathered data regarding attitudes toward therapy and behavior while in therapy by using a Therapist Rating Scale and an Observer Rating Scale. All of the therapists used the former to gauge their perceptions of the quality of the therapeutic relationship and their estimates of the clients' feelings about the affiliation. Based on the assumption that the initial interview was the most crucial in determining the quality of any subsequent relationship, two judges the author and a psychology graduate student competent in therapy used the Observer Rating Scale to assess the quality of the relationship and the client's satisfaction with the process from audio recordings. Also, they evaluated five categories of therapist behavior (aggressive-submissive, directive-nondirective, high-low anxiety, domination-equalitarian, rigid-flexible) and five dimensions of client behavior (aggressive-submissive, dependent-self-sufficient, high-low anxiety, conventional-individualistic, rigid-flexible). The sum of these ratings made by the judges had a low but significant interjudge reliability coefficient of .38. The results from this scale were incomplete because it was used only with Group A interviews. The correlation of F scale scores and the Observer Rating Scale responses, showed that high-F therapists were rated as significantly more authoritarian and rigid;

and were often viewed as more aggressive, directive, anxious, and dominating than low scorers, but not significantly so. There were no significant behavioral differences between high- and low-F scoring clients, although high scoring clients demonstrated a non-significant tendency to be rated as more aggressive than low scorers. Vogel also analyzed the correlation between the client's authoritarianism and both the therapists' and judges' estimates of the quality of the relationship and client satisfaction. The results showed that equalitarian clients in Group A (psychiatric inpatients) were rated as having significantly better therapeutic relationships than authoritarian clients. However, the estimates of client satisfaction were only slightly higher for the equalitarians. In Group B (counseling center clients) there were no significant differences between equalitarians and authoritarians. The author also found that a similarity in therapy style preferences, as measured by the Authoritarian-Equalitarian Therapy Sort, resulted in higher rated relationships. This suggested that an advantageous therapeutic fit could be made by matching client-therapist preferences regarding therapy.

Vogel explained his ambiguous findings in several ways. He felt that the "very authoritative tone" of the F scale may have inhibited some respondents who were wary of absolute statements which contained the words "always" or "never ." Also, he believed the use of a gross high-low F scale divisions probably hid the more important

characteristics of those people not in those extreme groups. He also cited the differences between the F scale and the Authoritarian-Egalitarian Therapy Sort. While the former measured a more basic trait, the latter may have contained items important to therapy but not related to authoritarianism. Other methodological limitations included the lack of experience of some therapists which probably affected the actual quality of the relationships.

Wallach (1962) reasoned that college students preferred therapists who encouraged self-determination and the use of rational processes. Also, he hypothesized that students who preferred therapists who gave direct assistance or served as role models to be imitated would tend to be more authoritarian. Two-hundred and sixteen undergraduates expressed their preference for a type of therapist by ranking the descriptions of three such therapists. The students imagined that they were contemplating entering therapy and that all three therapists were equally available. Although the therapists had equivalent amounts of experience, they differed in certain ways. One labeled "Nurturant" was noted for his understanding, warmth, acceptance, giving of praise, giving of assistance, and problem-solving. Another called "Critic" was described as a critical thinker, thoughtful, able to phrase things well, able to see things in their proper perspective, generally aware of alternatives, and allowing clients to reach their own conclusions and decisions. The third imaginary therapist, "Model," was

pictured as being highly respected, able to feel, to think, able to act appropriately, the possessor of many fine qualities, and as being a model person. Along with their preference for a therapist, the students indicated on a rating scale how much difficulty they had making their choice. Also, each student completed a nine item true-false survey that assessed feelings about obtaining psychiatric help. The responses to the California F Scale were available for all students. Wallach found that 82% of this sample expressed a preference for the "Critic" therapist and had mean F scale scores significantly higher than those who selected either of the other therapists ($p < .001$).

Kraus (1975), in his analysis of Wallach's study, stressed the ambiguity of the results. He pointed out that the descriptive paragraphs of the therapists apparently were not discriminating enough because both high and low authoritarian groups selected a non-directive therapist. However, "if one assumes that 'Nurturant' (giving of assistance) represents a directive style of therapy and 'Critic' (allows clients to arrive at their own decisions) subsumes a non-directive orientation, then Wallach's findings are consistent with leadership studies that suggest authoritarians prefer high-status leaders who exhibit strong authority and direction (Secord and Bachman, 1964)" (Kraus, 1975, p. 5).

Other design weaknesses flawed the Wallach study. The author assumed that students would be able to behave as

though they truly needed psychiatric assistance. He also failed to verify if his descriptions actually portrayed both directive and non-directive therapeutic styles.

Kowitt (Note 1), in an unpublished doctoral dissertation, used a multivariate approach to ascertain the relationship between a variety of demographic and personality variables and a preference for directive or non-directive psychotherapy. First, he constructed a 20-item Directiveness Preference Questionnaire (DPQ). The final form yielded a three week test-retest reliability of .82. A factor analysis of the responses of a sample of college students yielded two orthogonal factors. The first factor described the extent of an individual's desire for a therapist to take the responsibility for causing change within the individual during therapy. The latter indicated a preference for a critical, behavior-shaping, here-and-now-oriented therapist (teacher) versus a passive, sympathetic-listener type (analyst). These factors were cross-validated on a second sample of 300 college students.

In the second phase of the study, 300 college undergraduates completed the DPQ, the California Personality Inventory, the California F Scale, a locus of control scale, and a brief measure of socio-economic status. A separate analysis of all dependent variables was done on high and low scorers on the total DPQ, DPQ factor 1 and DPQ factor 2. The results suggested that males who scored high on the total DPQ were described as less flexible, less independent

thinking, more authoritarian, lower in socio-economic status, and tending to prefer more technical professions. Only two significant characteristics identified high DPQ females: a tendency to be less independent in thinking and more authoritarian. No significant associations with DPQ Factor 1 were found. On DPQ Factor 2, males who liked a "therapist as a teacher" were more assertive and self-confident than males who wanted a "therapist as an analyst." Among females, those with lower levels of socio-economic status preferred the "therapist as a teacher". Kowitt concluded that these findings pointed to the existence of "clear personality and demographic profiles which are related to preferences for therapy directiveness." Also, he declared that the DPQ was efficacious for research and general clinical use. The external validity of this study may be questioned because only the responses of college students were used in the original reliability work-up and the subsequent factor analysis cross-validation.

In a related area, Kerlinger and Rokeach (1966) reported a range of correlations of .54 to .77 between the Rokeach Dogmatism Scale and the California F Scale, suggesting that these instruments measured similar though not identical traits. Tosi (Note 2) examined the effects of different levels of client-therapist dogmatism on the clients' perceptions of the dyad following the initial interview. Twelve male counselors and 69 clients responded to the Rokeach Dogmatism Scale. They were subsequently

divided into high, medium, and low dogmatism score groupings. Following the first session, the clients completed the Barrett-Lennard Relationship Inventory to relate their impressions of the first meeting. Tosi concluded that the best relationships occurred between low dogmatic counselors and either low or medium dogmatic clients. Conversely, the worst dyads resulted from the pairing of high dogmatic counselors with medium or high dogmatic clients.

In a parallel study, Helweg (Note 3) proposed that people who favored a directive therapeutic approach would be more anxious, externalized, and dogmatic than those who preferred a non-directive approach. Seventy-seven college undergraduates and 77 hospitalized psychiatric patients answered the Rokeach Dogmatism Scale (Form E), Rotter's I-E Scale, the Taylor Manifest Anxiety Scale, and Gordon's Survey of Interpersonal Values. Following the administration of the questionnaires, the subjects viewed movies of Albert Ellis and Carl Rogers conducting an initial interview typical of their respective directive (Rational Emotive Therapy) and non-directive (Client-Centered Therapy) approaches. The author then administered the Barrett-Lennard Relationship Scale. The subjects also stated a preference for one of the therapeutic methods. In the author's only significant findings, high dogmatic subjects having an external locus of control favored the directive approach (Ellis) and, from Gordon's survey, subjects who valued independence as a basis for relating to others liked the Rogerian method.

Since some of the previous authoritarianism studies relied on the subjects' ability to imagine the characteristics and behavior of hypothetical therapists, Fernbach (1973) tried to eliminate results confounded by the subjects' varying conceptions of the imaginary clinician. In a pilot study, the author showed the film, Three Approaches to Psychotherapy (published by Psychological Films, Santa Ana, California, 1965) to 147 college students. The film had Carl Rogers, Albert Ellis, and Frederick Perls interviewing the same client. The students rated each therapist on the dimension of directiveness-nondirectiveness and the degree of liking they felt for the therapist. Ellis was rated as the most directive and Rogers the least directive. With this data as a guide, the author randomly selected 30 hi-F (authoritarian) and 30 low-F (non-authoritarian) students from a pool of 300 to view the films of Rogers and Ellis. After the showing, the students rated the therapists only on the degree of liking they felt for each. An analysis of variance revealed a significant Film X Authoritarianism interaction: the authoritarians preferred Ellis and the non-authoritarians liked Rogers ($p < .01$). The author acknowledged the confounding of therapist and dimension of directiveness and questioned whether the students were reacting to the therapeutic technique or some unknown quality of personality or bearing.

Kraus (1975), as an elaboration and replication of Fernbach's study, investigated specific therapist

characteristics which might have affected a subject's choice of a directive or non-directive therapist. Kraus also wished to create more emotional involvement on the part of the subjects to elicit their full cooperation and attention. One hundred and thirty-five adult college students (school teachers and police officers) completed the California F Scale. The author then read standard instructions that emphasized the value of knowing about psychotherapy and its practitioners in order to foster greater student participation. After viewing segments of the film, Three Approaches to Psychotherapy, the students completed the Therapist Rating Scale (developed from an earlier form by Boulware and Holmes, 1970) which assessed their choice of therapist, their perceptions of each therapist (based on 12 dimensions of therapist behavior) and the consideration they gave each dimension in making their decision. For the comparative analysis, the author randomly drew three groups of 18 students each that scored in either the high (one standard deviation above the mean) or the moderate (closest to the mean) or the low (one standard deviation below the mean) F scale category. Results showed that high authoritarian students favored Ellis and the low authoritarians liked Rogers. These findings were consistent with Fernback. A factor analysis of the 12 dimensions of therapist behavior yielded two factors: a general good-guy, halo-effect factor and a directive-evaluative factor. There was minimal relationship between the two factors in

the moderate group. They were positively correlated for the high authoritarians, $r = .54$, and negatively correlated for the low authoritarians, $r = -.68$. Apparently, both factors were important for the extreme groups when making the selection, since his regression analyses revealed that both factors contributed significant variance when regressed on therapist selection for both high and low authoritarians. An analysis of variance on the perception factor scores revealed that the students did not differ in determining which therapist was directive and which was non-directive. However, they differed significantly in their perception of which therapist was the "good guy." The higher the F score the greater the likelihood that the student viewed Ellis as the "good guy." From the analysis of the 12 consideration items, three factors emerged: affective-competence, similarity-attraction, and directive-evaluativeness. None of the consideration factors related significantly to therapist preference. Kraus concluded that "better-than-chance" client-therapist rapport might be obtained by using client authoritarianism as a criterion in case assignment decisions in a mental health facility. The researcher also recognized two major limitations to the study: the artificiality of the laboratory method and the lack of evidence that greater therapeutic progress would result from assignments based on authoritarianism.

The interaction effects of the client's sex and age and the therapist's sex and age as perceived by the subjects

were unexamined. In as much as age and sex are important determinants of attraction to therapists (Boulware and Holmes, 1970), it is conceivable that subjects may have responded in some unknown fashion to the stereotypical relationship present in the film. More importantly, the author seemed to believe that the subjects held similar attitudes and understandings about the therapeutic process as evidenced by the lack of control of the variable. Also, there was a tacit belief held by Kraus, Fernbach, and Kowitt that a therapist and the therapy utilized were synonymous. One must question whether the subjects in the aforementioned studies were responding to a particular therapist personality or to a type of therapy. Other observations must be considered at this point. A casual review of the bestseller lists, book clubs, and book store shelves shows a plethora of psychological self-help books and consumer guides to psychotherapy. Perhaps this indicates that people more frequently develop opinions about therapy from written descriptions and explanations rather than by observing movies. Another ignored factor has been the subject's concept of human nature. Since every therapy has a philosophy, either stated or implied, describing basic human motivations, it seems logical to investigate this issue as it applies to a client's selection of therapy.

This current study was an extension of the research done by Fernbach and Kraus. Its intention was to investigate the issues raised in the preceding paragraph: control for

the interaction of age and sex, subjects' general understanding of therapy, the assumed synonymy of therapist and therapy, the source of information about therapy, and the relationship between subjects' beliefs about human motivation and therapy preference. Since this was an exploratory study that utilized procedures different from previous research, no predictions were made regarding the relationship between a subject's level of authoritarianism and a preference for either Albert Ellis's Rational Emotive Therapy or Carl Rogers' Client-Centered Therapy. This study not only examined a straight forward indication of preference for a particular therapy; it also tried to delineate the specific characteristics about therapy that different groups of people valued and it tried to determine the degree to which these factors were considered in making selections.

Method

Subjects

Two hundred and eighteen undergraduates who attended classes during a regularly scheduled three week session at Western Kentucky University served as subjects in the initial phase of this experiment. In the second part, 59 students from the original pool of 218 (24 males and 35 females) volunteered to participate. Three subjects were later dropped from the final analysis because of missing data.

Procedure

Professors in each class administered the California F Scale (Adorno, Frenkel-Brunswick, Levinson and Sanford, 1950) to their students on the first day of the term. Prior to its administration the instructor read standard instructions that explained the purpose of the survey, the need for student participation and the confidentiality of the results (Appendix A).

The California F Scale (Appendix B) was used to discriminate among high-, moderate-, and low-authoritarian subjects. Each question on the F scale was scored +1, +2, +3 for the high, medium, and low degrees of agreement and +4, +5, +6 for the low, medium, and high degrees of disagreement. Since the scale contains 30 items, the F scores had a possible range from +30 to +180. This scoring

format was altered from the usual F scale scoring system, (i.e., -1, -2, -3, and +1, +2, +3) in order to accommodate the use of computer scored answer sheets. Those who scored one standard deviation or more above the mean of the present sample were considered low authoritarians; scores within one-half standard deviation of the mean constituted the moderate-F group; and high authoritarians scored one standard deviation or less below the mean. This instrument had been standardized on such diverse populations as university students, prison inmates, military personnel, and psychiatric patients with a range of reliability coefficients from .81 to .97 with an average reliability of .90 (Adorno, et al., 1950).

Approximately 3 to 7 days after the completion of the F scale, the experimenter personally contacted subjects, on a class by class basis, who were rated either low-, moderate-, or high-authoritarian and requested their participation in a research project. They were provided standard general information about the nature of the study and the amount of time required (Appendix C). The experimenter met with groups of volunteers at prearranged times and locations.

Following the experimenter's reading of standard instructions which emphasized their need to know about psychotherapy and its practitioners and provided a definition of therapy derived from Hinsie and Campbell (1977; Appendix D), the subjects read descriptions of Albert Ellis's Rational Emotive Therapy and Carl Rogers' Client-Centered Therapy

(Appendices E and F). The descriptions, written especially for the present study, were based on Kopp's (Note 4) dissertation which compared the theories and techniques of Rational-Emotive Therapy and Client-Centered Therapy; the explanations of their therapies provided by both Ellis and Rogers in their segment of the movie, Three Approaches to Psychotherapy, and the textbook writings of Morse and Watson (1977) and Davison and Neale (1974). In order to maintain a reading level consistent with that of college undergraduates and to verify the adequacy and accuracy of content, three psychologists who were knowledgeable about the therapies and who taught undergraduates read the therapy descriptions and concurred on their sufficiency. The descriptions were matched as closely as possible, on basic format and length. Each was approximately 600 words long. The labeling and presentation of the descriptions were counterbalanced so that half of the subjects read about Rational Emotive Therapy first and half read about Client-Centered Therapy first. The subjects were encouraged to take their time while reading and to refer to the descriptions as often as necessary while answering the questionnaire. When the subjects completed reading the descriptions, they responded to the Therapy Rating Scale (TRS; Appendix G), an adaptation of Kraus's (1975) Therapist Rating Scale. This instrument was designed to assess the subjects' choice of therapy, their perceptions of the behavior of therapists using the particular therapy, their perceptions about each therapy's

position regarding human motivation and behavior and the consideration they gave to each perception in making their choice of therapy. The subjects expressed their preference for a therapy by circling points on four nine-point Likert items with the end points labeled "Strongly prefer Type A" and "Strongly prefer Type B." These items were checked for internal consistency and were summed for a single measure of therapist preference. The coefficient alpha was .88 for all 56 subjects. Using techniques suggested by The American Psychological Association (1977), e.g., pluralization and neutral terms, sexist language was eliminated from the descriptions and questionnaire to avoid confounding due to sexual bias.

To ascertain the subjects' relative perceptions of the two therapies, they responded to 14 dimensions describing the individual therapist style and the therapy's conception of human motivation. These items were modeled after the therapist expectancy scale developed by Boulware and Holmes (1970). For example, the subjects responded to the statements "I believe that a therapist using Type A therapy would understand my personal problems and feelings" or "I believe that the way people are described in Type A therapy is the same as I view other people" by circling a number on a nine point continuum labeled at the end points "strongly agree" or "strongly disagree ." The same 14 statements addressed the same issue in conjunction with Type B Therapy. A single score on each of the 14 dimensions was calculated by

subtracting each subject's rating of Type A therapy minus his evaluation of Type B therapy. For instance, if a subject assigned a value of 9 to Type A therapy and a rating of 1 to Type B therapy, the difference of +8 would represent the degree to which the subject perceived Type A therapy as higher than Type B therapy on that dimension.

Consideration scores were derived in a similar fashion. The subjects responded to a second nine-point continuum on each perception item for each therapy labeled at the end points "Not considered in making my choice" and "Considered very much in making my choice". The two consideration scores on each dimension were summed for a single measure of how that impression was considered by the subject in making his choice. The consideration scores assigned to each therapy on each item for all 56 subjects were highly correlated on all 14 dimensions ($p < .001$). The correlations ranged from .37 to .80 with a median of .65. At the end of the instrument, space was provided for the subjects to note any previously unmentioned factors which might have influenced their choice.

Data Analysis

A 2 (sex) X 3 (levels of authoritarianism) analysis of variance was employed to investigate the relationship between authoritarianism and choice of therapy with the three levels of authoritarianism serving as the independent variable and subjects' preference scores as the dependent variable. To determine if one therapy was chosen over the

other at a rate significantly different from chance, chi-square analyses within each level of authoritarianism was used.

The 14 perception scores pertaining to therapist style and behavior and the therapy's conception of human nature were analyzed by a principal components analysis with a forced two-factor solution because of the limited number of subjects. The factor scores for the subjects at each level of authoritarianism were placed in separate stepwise multiple regression equations to determine which factors were most highly related to therapy preference within the three groups. To ascertain if the subjects at different levels of authoritarianism varied in their impressions of a therapist who used each therapy, the factor scores associated with each derived factor were analyzed by separate one-way analyses of variance. The consideration scores assigned to each therapy were analyzed by the same method as the perception scores.

Results

The mean of the California F Scale for the sample was 107.1 with a standard deviation of 20.9. Subjects included in the low-F group had scores of 118 and above; the moderate-F group was comprized of subjects who scored between 98 and 117; the high-F subjects scored 96 and below.

The 56 subjects (24 males and 32 females) who were used in the final analysis had a mean age of 22 years with a range of 17 to 46 years. Twelve subjects indicated having had prior professional counseling or therapy. Prior exposure to psychotherapy was not related to the subjects' level of authoritarianism, $\chi^2 = .79$, ns.

According to the analyses of variance, therapy preferences did not vary as a function of sex, $F(1,50) = .054$, ns, level of authoritarianism, $F(2,50) = 1.49$, ns, or their interactions $F(2,50) = 1.49$, ns. In both the high and low authoritarian groups, chi square analyses showed that these subjects' choice of one therapy over the other was significant. For these tests, therapy preference scores were dichotomized at the neutral point. In the high-F group, 14 of 19 subjects preferred Client-Centered Therapy over Rational Emotive Therapy, $\chi^2 = 4.266$, $p < .05$, two-tailed; while 13 of 18 low authoritarians liked Client-Centered Therapy, $\chi^2 = 3.55$, $p < .05$ one-tailed. The moderate-F group

had a nonsignificant tendency towards a preference for Client-Centered Therapy, $\chi^2 = .89$, ns, with 11 of 18 choosing Client-Centered Therapy; one subject was completely neutral.

The principal components analysis of the 14 perception scores yielded two factors. Table 1 is the factor matrix after varimax rotation of the item loadings with Factors 1 and 2. Factor 1 seems to be a halo "good-guy"-similarity-competent factor. Such items as the mutual attraction between the subject and therapist (items 4, 5, 10); the similarity of attitudes and experiences (items 8, 9) and the competence of the therapist (item 3) defined this factor. Factor 1 accounted for 76.6% of the explained variance. Defined as the directive-evaluative factor, Factor 2 pertained to the therapist's willingness to take charge of the discussion and offer specific advice to a client (items 2, 7). These derived perception factors were paralleled to those obtained in the Kraus study.

Although there was a near significant overall correlation between the Factors 1 and 2, $r = -.21$, $p < .06$, this condition did not exist in either the high- or moderate-F groups, $r = -.04$, ns and $r = -.26$, ns respectively. However, within the low authoritarian group there was significant negative correlation, $r = -.43$, $p < .05$. This suggests that the degree to which low authoritarians perceived the therapist as a "good-guy" they also say him an non-directive and non-evaluative.

The multiple R, degrees of freedom, and F values for

Table 1
 Varimax Rotated Factor Loadings
 of the TRS Perception Scores

Item No.	Factor 1	Factor 2
1	.34	.36
2	.25	-.61
3	.67	.06
4	.57	.29
5	.52	.29
6	-.40	-.56
7	.03	-.62
8	.69	.08
9	.80	-.12
10	.56	.29
11	.55	.58
12	.43	.56
13	.37	.52
14	.34	.44

Factor	Eigenvalue	% of Variance	Cumulative %
1	4.69	76.6	76.6
2	1.43	23.4	100.0

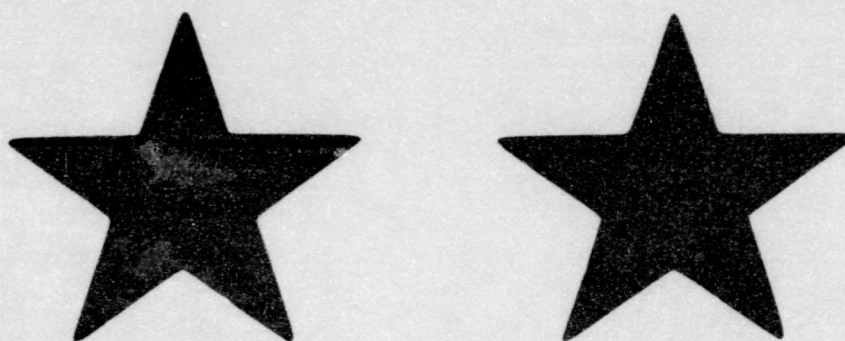
the three levels of authoritarianism are presented in Table 2. For both the low- and moderate-F groups, Factor 1 was significantly related to a subject's choice of therapy, $F = 20.10$, $p < .10$, and $F = 4.49$, $p < .05$. The addition of Factor 2 contributed only a marginally significant amount of variance, $F(1,15) = 3.352$, $p < .10$, to the low authoritarians. Neither factor related to the therapy selections made by high authoritarians. These findings suggest that the degree to which subjects in the low- and moderate-F groups perceived a therapist as a "good-guy" they chose that therapy. However, high authoritarians chose their therapy on grounds not related to the present perception items.

The subjects did not differ on either perception Factor 1 or Factor 2 as a function of sex, authoritarianism or their interaction according to the analysis of variance of the perception scores. All F 's were less than 1.0 except for the main effect of authoritarianism in Factor 1. These findings were inconsistent with the Kraus study which showed high authoritarians perceiving Ellis as a "good-guy."

The factor analysis of the 14 consideration items is presented in Table 3. Two factors emerged from these items and are labelled Factor A, therapist capability-similarity-attraction (items, 3, 4, 5, 8, 9) and Factor B, therapy assumptions-problem causation (items 11, 12, 13, 14). Factor A accounts for 76.1% of the explained variance.

Regression to the subjects' preference scores on the

CORRECTION



***PRECEDING IMAGE HAS BEEN
REFILMED
TO ASSURE LEGIBILITY OR TO
CORRECT A POSSIBLE ERROR***

Table 2
Stepwise Multiple Regression of Preference Scores on Factors 1 and 2

	Low-F Group	Moderate-F Group Step 1	High-F Group
Multiple R	.75 (Factor 1)	.46 (Factor 1)	.25 (Factor 2)
df	1/16	1/17	1/17
F value	20.10**	4.49**	1.18 <u>ns</u>
		Step 2	
Multiple R	.80 (1 and 2)	.47 (1 and 2)	***
df	1/15	2/16	***
F value	3.352*	2.30 <u>ns</u>	***

* $p < .10$

** $p < .05$

*** F level too low for computation for Factor 1

Table 3
 Varimax Rotated Factor Loadings
 of the TRS Consideration Scores

Item No.	Factor A	Factor B
1	.29	.19
2	.23	.34
3	.70	.05
4	.62	-.01
5	.72	.34
6	.50	.35
7	.55	.38
8	.72	.05
9	.60	.31
10	.46	.34
11	.18	.76
12	.11	.70
13	.19	.85
14	.08	.61

Factor	Eigenvalue	% of Variance	Cumulative %
A	4.71	76.1	76.1
B	1.48	23.9	100.0

two consideration factor scores was employed. Table 4 depicts the Multiple R, degrees of freedom and F values for the consideration factors. None of the obtained F values were significant in relationship to therapist preference. Thus, preference for therapy was unrelated to the consideration of therapist qualities or abstract qualities of the therapy. The subjects did not differ in the consideration given to each factor in their choice of therapist as a function of authoritarianism.

Table 4

Stepwise Multiple Regression of Consideration Scores on Factors A and B

	Low-F Group	Moderate-F Group Step 1	High-F Group
Multiple R	.22 (Factor A)	.09 (Factor B)	.18 (Factor B)
df	1/16	1/17	1/17
F value	.83*	.15*	.57*
		Step 2	
Multiple R	.24 (A and B)	.15 (B and A)	.19 (B and A)
df	2/15	2/16	2/16
F value	.47*	.19*	.31*

*non-significant

Discussion

The failure of authoritarianism to serve as a predictor of therapy preference in this study contradicts the Kraus findings. In the current study when low-, moderate-, and high-authoritarians analyzed the abstract qualities of the therapies, they chose the client-centered approach. The Kraus preference results showed that as authoritarianism increased so did the preference for directive therapy. However, despite different preference patterns, the subjects from both studies perceived similar characteristics of therapist style and behavior: a "good-guy"-competent impression and a directive-evaluative quality. This suggested that the written descriptions of therapy provided information equivalent to that contained in the movie depictions about the directive and non-directive therapists.

To reconcile these different findings, certain elements must be examined. As previously stated, the results from Kraus' research may have been an artifact of an unexpected variable: some unknown personal trait of either Ellis or Rogers. Similarly, the data from this study may have resulted from an inequality of the written descriptions. Although parallel in format and length, the descriptions did use different examples with which the subjects may have identified. This identification may have served as an unmeasured

consideration factor in the selection process. As one subject stated (on the page provided for comments), " I seem to be pulled more toward Therapy Type B [Client-Centered Therapy] when I was younger, my parents did criticize me quite a bit and even now I think I've hung on to some of those feelings."

An important difference between the studies was the age of the subjects. Kraus surveyed older and presumably more secure graduate students; whereas this study used undergraduates. Perhaps the younger students were attracted to the seemingly more friendly, supportive, less confrontive, non-directive therapist because of their own needs for affiliation, validation, and support during this period in their lives. This theme was evident in comments made by some of the subjects: "usually people respond better when they are at ease with the therapist" or "many times people need someone to listen."

Another significant dissimilarity involved the circumstances under which the subjects processed the information. In this investigation, the subjects were encouraged to read at their own pace and to reread the descriptions as often as desired while answering the questionnaire. However, in the Kraus study subjects could not review the films. Instead they had to rely on their memory when responding to the questionnaire.

The regression analysis of the consideration scores showed that among all groups neither consideration factor related to therapy selection. The absence of a relationship

may be due to the fact that subjects expressed only the degree of consideration they attributed to each characteristic as they made their decisions. The scores did not designate a preference. The emergence of the two consideration factors (therapist competence-similarity and therapy assumptions) from the factor analysis demonstrated that individuals could differentiate between the abstract qualities of the therapy and the behavioral traits of the therapist. Also, within each level of authoritarianism the consideration factors were differently correlated. For low authoritarians the factors were not significantly related, $r = .18$, ns; for the moderate- and high-F groups they were significantly correlated, $r = .54$, $p < .02$. This indicated that although subjects with different levels of authoritarianism made the same therapy selection, their decision-making patterns were unique. Moderate- and high-F subjects did not distinguish between a therapy and its practitioner, while low-F's separated the concepts. In summary, the differences between these investigations reflect the importance of age and information processing more so than a simple measure of authoritarianism in the prediction of therapy preference.

These findings have implications for both clinical and therapeutic research applications. Since clinicians today are required in most instances to acquire "informed consent" from their clients before engaging in therapy, it is in their best interests to have some understanding of the

influence different methods of conveying information can have on client decisions. Future research should examine the differential effects of video, written and oral presentations of therapy descriptions on therapy success. Subjects should be controlled for sex, age, and presenting problems and then matched with a therapist. Success could be defined as the number of completed sessions. These data would assist in the formulation of more enlightened policies in this area at the community mental health center level.

If age is an important determinant of therapy selection, perhaps the special problems that coincide with the transitional periods in life require different therapeutic approaches, e.g., a client-centered technique might be best for people experiencing the uncertainty of life changes around the age of 30. Consequently, the omnipotent claims of various therapeutic positions need to be examined more vigorously through the use of program evaluation. Specifically, clients with similar age crisis problems could be assigned to either a Rational Emotive or Client-Centered approach. Therapeutic success could be assessed later by a questionnaire that gauged client satisfaction and feelings of improvement.

The link between authoritarianism and decision-making strategy needs to be examined more closely. First, the more salient qualities of therapies must be delineated and checked for their importance to people as they struggle with the selection of a therapy. These qualities could be

grouped and then correlated with the individual's levels of authoritarianism. These results could then be used in subsequent therapy preference and matching research. In previous matching and preference research, the person who was actually experiencing emotional stress and in need of selecting a therapy was not investigated. Since stress can distort normal patterns of information processing (Janis and Mann, 1977), it is crucial that people who are in the initial stages of acquiring psychological assistance be surveyed in order to get a more accurate understanding of the nature of therapy selection. Reduced fees could be offered as an incentive for participation in the study.

The results of this investigation conceivably were affected by certain flaws. The subjects may have had difficulty with the required task: comprehending, integrating and analyzing a large quantity of abstract information. The performance of this task may have been influenced by the subjects' varying levels of concentration due to their participation in the experiment either before or after a three hour class.

In conclusion, the effectiveness of the sole use of authoritarianism as a predictor of therapy preference is severely limited. The inclusion of other important factors, e.g., the age of the clients and the method of conveying information, might enhance its predictive ability. However, a more fruitful avenue of investigation involves information processing and its relationship to therapy selection. The

issue of matching clients and therapist grows more complex with each new study. Nonetheless, research must continue in this area until therapeutic success becomes less a product of happenstance.

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Appendix A

INSTRUCTIONS:

This is a questionnaire to find out how certain important events affect different people. The statements have been collected from different groups of people and represent a variety of opinions. There are no right or wrong answers to the questionnaire. For every statement there are large numbers of people who agree and disagree. Please indicate whether you agree or disagree with the statement as follows:

Blacken space 1 if you STRONGLY AGREE

Blacken space 2 if you AGREE

Blacken space 3 if you SLIGHTLY AGREE

Blacken space 4 if you SLIGHTLY DISAGREE

Blacken space 5 if you DISAGREE

Blacken space 6 if you STRONGLY DISAGREE

Please read each item carefully and be sure to indicate the response which most clearly corresponds to the way you feel. Print your name, phone number, course title, and instructor's name on the top of your answer sheet. Your responses will be kept confidential; no one will see your responses except the graduate researchers. Your name is needed only for the purpose of contacting you to request your participation in further research. Please answer the

questionnaire as honestly as possible. Thank you for your cooperation.

Appendix B
California F Scale
FORMS 45 AND 40

- ___ 1. Obedience and respect for authority are the most important virtues children should learn.
- ___ 2. A person who has bad manners, habits, and breeding can hardly expect to get along with decent people.
- ___ 3. If people would talk less and work more, everybody would be better off.
- ___ 4. The business man and the manufacturer are much more important to society than the artist and the professor.
- ___ 5. Science has its place, but there are many important things that can never possible be understood by the human mind.
- ___ 6. Every person should have complete faith in some supernatural power whose decisions he obeys without question.
- ___ 7. Young people sometimes get rebellious ideas, but as they grow up they ought to get over them and settle down.
- ___ 8. What this country needs most, more than laws and political programs is a few courageous, tireless, devoted leaders in whom the people can put their faith.

- ___ 9. No sane, normal decent person could ever think of hurting a close friend or relative.
- ___ 10. Nobody ever learned anything really important except through suffering.
- ___ 11. What the youth needs most is strict discipline, rugged determination and the will to work and fight for family and country.
- ___ 12. An insult to our honor should always be punished.
- ___ 13. Sex crimes, such as rape and attacks on children, deserve more than mere imprisonment---such criminals ought to be publicly whipped, or worse.
- ___ 14. There is hardly anything lower than a person who does not feel a great love, gratitude, and respect for his parents.
- ___ 15. Most of our social problems would be solved if we could somehow get rid of the immoral, crooked, and feeble-minded people.
- ___ 16. Homosexuals are hardly better than criminals and ought to be severely punished.
- ___ 17. When a person has a problem or worry, it is best for him not to think about it, but to keep busy with more cheerful things.
- ___ 18. Nowadays more and more people are prying into matters that should remain personal and private.
- ___ 19. Some people are born with an urge to jump from high places.

- ___ 20. People can be divided into two distinct classes:
the weak and the strong.
- ___ 21. Some day it will probably be shown that astrology
can explain a lot of things.
- ___ 22. Wars and social trouble may someday be ended by an
earthquake or flood that will destroy the whole
world.
- ___ 23. No weakness or difficulty can hold us back if we
have enough willpower.
- ___ 24. Most people don't realize how much our lives are
controlled by plots hatched in secret places.
- ___ 25. Human nature being what it is, there will always
be war and conflict.
- ___ 26. Familiarity breeds contempt.
- ___ 27. Nowadays when so many different kinds of people
move around and mix together so much, a person has
to protect himself especially carefully against
catching an infection or disease from them.
- ___ 28. The wild sex life of the old Greeks and Romans was
tame compared to some of the goings-on in this
country, even in places where people might least
expect it.
- ___ 29. The true American way of life is disappearing so
fast that force may be necessary to preserve it.
- ___ 30. The trouble with letting everybody have a say in
running the government is that so many people are
just naturally stupid or full of wild ideas.

Appendix C

My name is Phil Henry and I am a graduate student in clinical psychology at Western. I got your name and phone number from a questionnaire you filled out in Dr. _____ class. I wonder if you would be interested in being in an experiment I am conducting? Let me tell you something about it before you decide. All that you would have to do would be to read some information that I would provide you and then respond to a questionnaire based on what you read. The whole process should not take any longer than 20 to 30 minutes. We would meet in room _____, which is just down the hall from your classroom, right after class on _____.

Can I count on you?

Appendix D

General Instructions

Recent statistics in mental health research indicate that one out of three people in our society today will require therapy at some time in their lives either for personal problems, marital difficulties or family counseling. It is in your best interests to know something about the nature of therapy and its practitioners. To help you in this matter, you are asked to read descriptions of two types of therapy. We are interested in your reactions to these descriptions so please read them carefully. For your information, therapy is defined as a process in which relationships are established between clients and therapists for the specific purpose of assisting the clients in making changes in their behavior so they can be more effective in coping with life situations.

After reading the descriptions you will be asked to complete a questionnaire. There is no time limit. You can refer back to the descriptions as often as you like while answering the questionnaire. All of your answers will be kept in strictest confidence. Only you and the researchers will know how you responded on the questionnaire. You will be asked to sign your name in order to properly identify your answers later. You may begin reading the attached descriptions.

Appendix E

Rational Emotive Therapy

Therapists who use this therapy believe that people are thinking creatures who have many basic ideas of living that are not necessarily based on objective reality. Because these ideas are not based on reality, they are considered irrational, illogical or nonsensical. People use these ideas to analyze personal experiences. Then, based on this irrational thinking, people create negative unwanted emotions for themselves. For example, many people have picked up the belief that it is necessary to be loved and approved by everyone. So, if people who hold this attitude are rejected by others, they follow these steps in their thinking:

- (A) they sense that others do not want to have relationships with them.
- (B) they then evaluate the experience by thinking "this is absolutely terrible, everyone should like me. I must be a worthless, no-good person because they do not."
- (C) then based on this irrational, self-defeating thinking, they cause themselves to feel depressed because they believe they are worthless and no-good.

There are many other nonsensical ideas that are used to evaluate experiences which lead to frustration, anger, pain, self-pity, and various other unwanted feelings. Furthermore, therapists who use this therapy are convinced that people are generally prone to continually practice making themselves emotionally disturbed. Also, people continue this unhealthy process until they are taught to change their self-defeating feelings by changing the irrational thoughts that underlie these emotions. In essence, these therapists believe that people's feelings are based on how they think. If persons use irrational illogical thoughts to evaluate situations, they experience negative unwanted emotions. However, if they think and analyze events more objectively, they can avoid many of these unwanted feelings.

In helping clients come to grip with themselves and their problems, the therapist assumes that the clients have practiced their irrational illogical thinking for so long that they are unable to change without help. Consequently, after listening to the initial descriptions of the problems, the therapist begins teaching immediately. He points out time and again the irrational thoughts that underlie the clients' emotional problems. He shows them concretely that their current emotional problems do not arise from past events or from situations beyond their control, but rather from their present irrational attitudes toward or fears about the particular troublesome situation. The therapist teaches the clients that they can control their thinking and thus

their emotions by learning to identify their own irrational beliefs and by understanding how these beliefs cause and maintain their self-defeating emotions. Once the therapist is satisfied that the clients understand that their anger, depression etc., is caused by their mistaken beliefs; he assists the clients to develop a more rational approach to life. The therapist teaches clients how to analyze situations and the accompanying emotions more objectively. He then teaches the clients how to replace the old emotions with healthier rational ones. As part of the learning process, the therapist insists that the clients practice behaviors that oppose the nonsense in which they originally believed. For example, if clients believe that they should feel depressed because others reject them, the therapist would have them recite this phrase when they begin to feel depressed--"It was unfortunate that I was rejected, but feeling depressed does not change the facts. I will analyze this situation to understand how I behaved and thought. This event has no logical affect on meetings with others in the future." Eventually, as the clients demonstrate the ability to challenge negative unwanted feelings and successfully replace them with rational thoughts and behavior, they can go on to take greater charge of their lives.

Appendix F

Client-Centered Therapy

Therapists who use this therapy have a deep faith that people naturally move towards emotional health and personal growth. In other words, unless something interferes, people normally do not become emotionally disturbed. As people grow they unconsciously judge their actions to make certain that their behaviors are contributing to their personal growth and emotional health. And because people naturally sense what is best for themselves, they are the best judges of their behavior. However, people can have learning experiences which interfere with their normal healthy development. People can learn to accept the inaccurate evaluations of their actions made by others rather than trusting their own judgment. For example, adolescents may regard themselves as inadequate human beings after being criticized by their parents. If the adolescents accept the parents' criticisms and do not pay attention to their own naturally good feelings about themselves, they will acquire persistent negative opinions about themselves. When people do pay closer attention to the evaluations of their behavior made by others rather than relying on their personal judgment, they experience a real internal conflict. This conflict arises when people compare the "ideal self"

that they sense they can be with the "self" they learn to accept which is based on the negative evaluations made by others. This internal conflict can operate below their level of awareness. People then can experience anxiety and feelings of unhappiness and not know why. In essence, these therapists believe that people are naturally capable of behaving in ways that are emotionally healthy. However, these therapists also believe that people can unintentionally create anxiety and emotional pain for themselves by learning to accept the evaluations of themselves made by others and ignoring their natural good judgment.

In helping clients come to grip with themselves and their problems, the therapist assumes that the clients have the capability and personal resources to solve their own problems. The therapist primarily tries to foster an atmosphere of trust and security in which the clients can return to their natural tendency to grow and make good use of their resources. The therapist tries to convey to the clients the feeling that he genuinely prizes them and accepts them totally regardless of their backgrounds, values, or past behavior. The therapist is eager for clients to express whatever feelings or thoughts that are going through them during the session--fear, confusion, pain, pride, anger, hatred or love. The therapist responds to the clients in an open honest but nonjudgmental way as he tries very hard to understand and sense their emotions as if they were his. During the therapy sessions, the therapist does not tell the

clients what to think or how to solve their problems. Instead, because the clients may not be fully aware of the exact nature of their conflicts, the therapist clarifies and makes more understandable for them their concerns and feelings. The therapist is confident that the clients will provide their own best solutions for their problems as they become more responsive to their inner thoughts and feelings. Consequently, the clients lead the discussions and suggest alternative solutions which are explored with the therapist. If the therapist successfully conveys to the clients that he is not a phoney and that he fully supports and accepts them, the clients can learn to trust their own different impulses, thoughts and feelings. They can then begin to make independent decisions. As clients continue to increase their sense of self-confidence and personal responsibility, they decide to end the relationship and go on to take greater charge of their lives.

Appendix G

Therapy Rating Questionnaire

Name: _____ Age: _____ Sex: _____

Please place a check mark to indicate your most recent grade point average:

0 - 1.00 _____

1.1 - 2.00 _____

2.1 - 3.00 _____

3.1 - 4.00 _____

have no grade point average _____

Please indicate if you have ever had professional help (counseling or therapy) for any personal problems. Yes _____
No _____

Directions for Part 1

In the first part of this booklet is a series of statements that pertain to your specific choice of therapy. Read each sentence carefully and decide which type of therapy is best suited for the question. Answer the question by circling from 1 to 9 that number which best represents your true feelings. For instance, you may decide that Type A Therapy is your choice, in which case you would circle a 1, 2, 3 or 4 depending on how strong your preference is; or you may decide that Type B Therapy is your choice, in which case you would circle a 6, 7, 8 or 9 depending on how strong your

preference is. Remember that the scale goes from 1 to 9, with 1 being a strong preference for Type A Therapy and a 9 being a strong preference for Type B Therapy, and the other numbers falling between the two. Answer the questions as honestly as possible. Please do not discuss your choices with anyone until everyone has finished this questionnaire.

Part I

1. If I had personal problems and wanted to talk to someone about them, I would choose a therapist who uses this type of therapy:

Strongly prefer Type A	Mildly prefer Type A	I have no preference	Mildly prefer Type B	Strongly prefer Type B
1	2	3	4	5
				6
				7
				8
				9

2. If my best friends were in need of therapy, I would tell them to choose a therapist who uses this type of therapy:

Strongly prefer Type A	Mildly prefer Type A	I have no preference	Mildly prefer Type B	Strongly prefer Type B
1	2	3	4	5
				6
				7
				8
				9

3. If strangers asked me to help them with a choice of therapy, I would advise them to see as their therapist someone who uses this type of therapy:

Strongly prefer Type A	Mildly prefer Type A	I have no preference	Mildly prefer Type B	Strongly prefer Type B
1	2	3	4	5
				6
				7
				8
				9

4. In my opinion, people with problems would get the best help if they choose as their therapist someone who uses this type of therapy:

- b. I believe that a therapist using Type B therapy would understand my personal problems and feelings.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- 2a. I believe that a therapist using Type A therapy would give me specific advice and tell me how to solve my problems.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- b. I believe that a therapist using Type B therapy would give me specific advice and tell me how to solve problems.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- 3a. I believe that therapists using Type A therapy would be very capable in the handling of their own personal problems.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- b. I believe that therapists using Type B therapy would be very capable in the handling of their own personal problems.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- 4a. I believe that a therapist using Type A therapy would like me as a person.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- b. I believe that a therapist using Type B therapy would like me as a person.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- 5a. I believe that I would like as a person a therapist who uses Type A therapy.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- b. I believe that I would like as a person a therapist who uses Type B therapy.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- 6a. I believe that a therapist using Type A therapy would take charge of the discussion and decide what I would talk about.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- b. I believe that a therapist using Type B therapy would take charge of the discussion and decide what I would talk about.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

7a. I believe that a therapist using Type A therapy would make a moral evaluation of my behavior.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

b. I believe that a therapist using Type B therapy would make a moral evaluation of my behavior.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

8a. I believe that a therapist using Type A therapy would have interests and attitudes like my own interests and attitudes.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

b. I believe that a therapist using Type B therapy would have interests and attitudes like my own interests and attitudes.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

9a. I believe that a therapist using Type A therapy would have experienced the same problems that I have experienced.

while answering the questions.

- 11a. I believe that the way people are described in Type A therapy is the same as I view other people.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- b. I believe that the way people are described in Type B therapy is the same as I view other people.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- 12a. I believe that the way people are described in Type A therapy is the same as I view myself.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- b. I believe that the way people are described in Type B therapy is the same as I view myself.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- 13a. I believe that people develop emotional problems the way it is described in Type A therapy.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

Not considered in making my choice 1 2 3 4 5 6 7 8 9 Considered very much in making my choice

- b. I believe that people develop emotional problems the way it is described in Type B therapy.

Strongly Disagree 1 2 3 4 5 6 7 8 9 Strongly Agree

