SOCIAL INFLUENCE THEORY

AND CLIENT-THERAPIST MATCHING

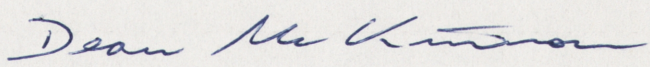
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for the degree of Doctor of Philosophy of
the Australian National University

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ORIGINALITY OF THESIS

I hereby declare that the work embodied in this thesis is the result of my original research, that no part of it has been submitted for any degree or diploma to any other University or Institution and that to the best of my knowledge no material previously published or written by another person has been included, except where due acknowledgement has been indicated.



Dean G D McKinnon

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ABSTRACT

Although Strong's (1968) model of social influence in therapy has been extensively examined in terms of what persuades clients to perceive therapists as attractive, expert, or trustworthy agents of influence, the contribution of client characteristics to such perceptions has generally been ignored. Compounding this omission, most investigations in the area have been analogue in design, with little ecological validity. The present series of studies sought to elucidate the model described through the utilization of genuine therapy settings, genuine clients and genuine therapists and through the inclusion of both client and therapist characteristics in the generation of explanatory variables.

Two areas of research not before accurately examined in the light of social influence theory are those relating to client-therapist need compatibility and client-therapist sex-role orientations. As evidence in the literature had indicated that each of these variables might be potentially consequential in the determination of adjudged therapeutic outcome, the power of these variables to influence client and/or therapist evaluations of therapy was explored.

To resolve whether genuine clients considered sex-role orientation an important therapist attribute, a first study replicated analogue research which had shown that female students (acting as clients) rated feminine sex-role

oriented therapist descriptions the most favourably. Contrary to this finding, the current study found that nonuniversity male and female clients rated masculine- and androgynous-oriented therapist descriptions the most favourably and feminine-oriented male therapist descriptions the least favourably.

In order to determine the degree of correspondence between client-preferred therapist sex-role orientations and therapists' *actual* orientations, a second study explored the orientations of a large group of experienced and practising psychologists and social workers throughout Australia. American research had demonstrated that more social workers evidenced an androgynous orientation than any other orientation. Similarly, in the present case the androgynous orientation was the single orientation most commonly held by therapists, although, the majority of practitioners were found to hold non-androgynous orientations.

A third and final study examined the individual and combined effects of client-therapist need compatibility, sex-role orientation and demographic and related data on client and therapist appraisals of aspects of therapy. Previous researchers had established that female clients in compatible client-therapist pairs rated the outcome of therapy most favourably. Further, client-therapist pairs in which at least one member held an androgynous sex-role orientation rated the outcome of therapy more favourably than when neither member held such an orientation. Findings

from the current study indicated that: (1) favourable ratings of therapy were significantly associated with client-therapist need compatibility, regardless of either client or therapist gender; and (2) the most favourable client and therapist therapy evaluations occurred when *both* participants held an androgynous sex-role orientation. Client and therapist groups were found to estimate therapy similarly and estimations were significantly influenced by several demographic and related variables.

Findings were discussed in terms of social prejudice, conformity pressures, external validity, social influence theory, need theory, the complementarity/similarity constructs, sex-role orientation theory, methodological limitations and the need for standard inclusion of demographic and related data in the development of predictive models of therapy. Potentially profitable research directions were delineated and discussion of the theoretical and practical implications of the work was included throughout.

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CHAPTER 1

SOCIAL INFLUENCE THEORY AND THE CONSTRUCTS OF NEED AND ANDROGYNY

OVERVIEW AND DEVELOPMENT

In any interpersonal interaction there are at least three sets of variables operating that serve to influence the outcome of the event and the participants' evaluation of it. These pertain to the communicator, the receiver of the communication and the nature of the communication delivered. In a therapeutic interaction, for example, these may be considered as: (1) the characteristics of the therapist (including the therapeutic setting), (2) the characteristics of the client and (3) the characteristics of the messages transmitted between them. In an examination of studies designed to investigate the effects of these variables in relation to Strong's (1968) interpersonal influence model of therapy, Heppner and Dixon (1981) and Heppner and Heesacker (1983) noted that the majority of research has dealt only with the manner in which clients perceive therapists and all but ignored the contribution of client needs to the model. More generally, the authors

stated that in therapy research virtually no attention has been paid to the effects of recipient characteristics (e.g., expectation of and involvement in therapy, degree of cognitive complexity) or message variables (e.g., incongruous, two-sided, opinionated and forewarning messages). Although there exists a wealth of research and comment on the communication process in therapy (e.g., Bateson, 1972; Dean, Austin & Watts, 1971; Dutton, 1973; Jones & Brehm, 1970; Krasner, 1963; McCroskey, 1969; Mehrley & McCroskey, 1970; Miller & Baseheart, 1969; Petty & Cacioppo, 1977; Strong, 1964; Strong & Claiborn, 1982; Watzlawick, 1978; Watzlawick, Beavin & Jackson, 1967; Watzlawick & Weakland, 1977; Watzlawick, Weakland & Fisch, 1974), one review reported that of 70 studies designed to examine therapy as a social influence process, only 6 employed client characteristics as independent variables and that in half of these, subject sex appeared as the only such characteristic (Corrigan, Dell, Lewis & Schmidt, 1980).

The difficulties involved in the evaluation of therapy are well appreciated and variables to be considered include: client characteristics, therapist characteristics, the nature of presenting problems, the therapy techniques employed, duration of therapy, goal definition, methods of

assessment, influences external to the therapy process, spontaneous remission, the long-term effects of therapy and the use of control groups (Wolcott, 1984; cf., also Gelso, 1979, and Gurman, Knudson & Kniskern, 1978). It seems, however, that some aspects of the therapy process have been considered to the apparent neglect of others. For example, although a majority of clients have indicated they believe one of the most desirable therapist traits is the therapist's ability to "make a good impression" (Hartlage & Sperr, 1980, p.289) and whereas clients' reactions to therapy have been researched in many diverse contexts, including the effects on such reactions of: source authoritarianism (Harvey & Hays, 1972), locus of control (Ritchie & Phares, 1969; Rosen & Osmo, 1984), environmental manipulations (Amira & Abramowitz, 1979; Dinges & Oetting, 1972; Haase, 1970; Haase & DiMattia, 1970, 1976; Mehrabian, 1968), expectations (Doster, 1975; Ford, 1978; Grosz, 1968; Hardin, Subich & Holvey, 1988; Heine & Trosman, 1960; Hoehn-Saric, Frank, Imber, Nash, Stone & Battle, 1964; Karzmark, Greenfield & Cross, 1983; Lennard & Bernstein, 1960; Lindsay, Martin & Sterne, 1977; Martin, Sterne, Moore & Friedmeyer, 1976; Richert, 1976; Tinsley, Brown, de St.Aubin & Lucek, 1984), information giving (Greenberg, 1969), pre-therapy training (Heitler, 1976; Luther, 1982; Rivera, 1982; Strupp & Bloxom, 1973), client-therapist

diagnostic agreement (Hurst, Weigel, Thatcher & Nyman, 1969), client age (Robiner & Storandt, 1983), client involvement (Kolb, 1982) and client reluctance (Paradise & Wilder, 1979), investigations of the social influence process in therapy (discussed in detail in the next section) have focussed almost exclusively on the effects on therapeutic outcome of therapists being perceived as *attractive* (Barak, Patkin & Dell, 1982; Carter, 1978; Cash & Kehr, 1978; Fretz, Corn, Tuemmler & Bellet, 1979; Hackman & Claiborn, 1982; Schmidt & Strong, 1971; Strong, 1971a; Tessler, 1975), *trustworthy* (Claiborn, 1979; Roll, Schmidt & Kaul, 1972; Rothmeier & Dixon, 1980; Ruppel & Kaul, 1982; Strong & Schmidt, 1970a), or *expert* (Angle & Goodyear, 1984; Atkinson & Carskaddon, 1975; Dell, 1973; Gelso & Kahl, 1974; Heppner & Pew, 1977; Joseph, 1983; Schmidt & Strong, 1970; Siegel & Sell, 1978; Strong & Dixon, 1971; Strong & Schmidt, 1970b) agents of influence. The study of all three dimensions in concert has also been undertaken (Heppner & Heesacker, 1982, 1983; Kerr & Dell, 1976).

Whereas the above situation has led some researchers to recommend specific training for therapists in expert, attractive and trustworthy persuasions (Kerr, Claiborn & Dixon, 1982), other researchers have commented that investigation of social influence in therapy has been

underscored by a "paradigm fixation," whereby most studies have employed analogue designs in laboratory settings. In addition to therapy research paradigms, "our sampling of clients, counselors and counseling situations needs to be 'unfixed'" (Zamostny, Corrigan & Eggert, 1981, p.488).

Given the paucity of research devoted to exploring the interpersonal influence process within a therapeutic context and the narrowness of the approaches adopted, observations made some 20 years ago by Krumboltz (1966) still seem particularly relevant: "What we need to know is which procedures and techniques, when used to accomplish what kinds of behavior change, are most effective with what kinds of clients when applied by what kind of counselor" (p.22). More recently, Gelso (1979) was moved to comment "We still know very little about the factors influencing the outcomes of counseling" (p.9). More recently still and appertaining directly to the present endeavour, Dorn (1984a) added:

> Research on the [interpersonal influence] model is still in the infancy stages ... even though a great deal of internal validity exists for the model, there is little that can be said for [its] external validity because research on "in the field" populations has been limited ... it is paramount that counseling researchers focus more attention on those factors that clients bring to counseling ... For far too long, counseling researchers have failed to consider those client variables that enhance as well as mediate the counselor's efforts ... it is the client who specifically holds the key to unlocking the counselor's social power. (pp.344-5)

In line with Dorn's unequivocal message (also Dorn, 1984b, 1984c), the intention of the present work was to contribute to the social influence paradigm by examining in genuine therapy settings the effects of client-therapist characteristics on client-therapist evaluations of therapy. Within the framework of social influence theory then, explanatory models of therapy appraisal were developed, utilizing random assignment of clients to therapists and drawing on the complementarity/similarity hypotheses, client matching research and the constructs of need and androgyny. Each of the foregoing permitted specific predictions in respect of the likely effects on therapy evaluations of certain client-therapist combinations and it was the explication and evaluation of some of these predictions that was undertaken here. Specifically, whether client and/or therapist ratings of aspects of therapy could be influenced by clients and/or therapists possessing particular sex-role orientations, or particular need structures, or particular combinations of each, were examined, as were the effects on evaluations of various client-therapist combinations on these same dimensions. To this end, this chapter gives selective consideration to social influence theory, pertinent experimental design issues in therapy research, client-therapist matching and models of need, the need complementarity/similarity

hypotheses and the androgyny construct. Drawing on the areas described, a set of research questions was developed and these conclude the chapter.

Therapy As Social Influence

Counselling has been defined as:

> the promotion of well-being through the medium of personalized interaction processes ... The relationship should be characterized by: (1) a willingness and collaboration between both counsellor and client; (2) a nonjudgmental and empathic attitude on the part of the counsellor towards the client; (3) a commitment to normative standards of ethical behaviour on the part of the counsellor; and (4) confidentiality. (Tiffen, 1984, p.2)

Krumboltz's (1965) definition was more straightforward:

> Counseling consists of whatever ethical activities a counselor undertakes in an effort to help the client engage in those types of behavior which will lead to resolution of the client's problems. (p.384)

On the distinction between the terms *counselling* and *psychotherapy*, Ard (1975) expressed the view that:

> A fine-line distinction between [the terms] counseling and psychotherapy is admittedly difficult if not impossible to draw ... the two terms overlap and therefore, rather than trying to maintain distinctions which will not hold up under logical analysis, let the reader allow the two terms to be used interchangeably. (p.xv)

In accord with and extending this view, the terms *counselling*, *therapy*, and *psychotherapy* are used interchangeably in the present work and Tiffen's and Krumboltz's definitions are accepted in concert. Additionally, for the purpose of parsimony, the description *demographic and related variables* is used to incorporate such background information as, for example, client and therapist age, client and therapist gender, therapist profession and client referral source.

Strong's reassertion and refinement of Frank's (1961) theory of an interpersonal influence process in counselling was published in 1968. Both Frank's and Strong's work continue to be given considerable attention in therapy research and are widely regarded as milestone contributions. Essentially, the theory postulates a two-phase model of therapy which draws heavily on cognitive dissonance theory. The first phase involves increasing the therapist's power by enhancing client-perceived expertness, trustworthiness and attractiveness. The second phase concerns increasing client persuasibility by enhancing client involvement in the therapy process. Strong (1968) concluded: "As a result of these processes and techniques, the probability of the client's use of other avenues of reducing aroused dissonance is minimized ... in the second phase the counselor does whatever is necessary to enable

the client to achieve his goals" (p.223). The following mathematical representation was offered:

$$P = f(R \approx N)$$

Where:

P = therapist power
R = perception of the therapist as a helpful resource
≈ = the degree of correspondence between
N = the client's perceived need

Strong and Matross, in their 1973 elucidation of the model, postulated that a therapist's ability to influence a client was a function of the correspondence between client need and the client's perception of the therapist as a helpful resource. The authors denoted five *power bases* from which a therapist may *operate* to influence a client, namely, *expert, referent, legitimate, informational* and *ecological* power. Following Strong and Matross (and Goodyear & Robyak, 1981, and Strong, 1978), each of these bases, respectively, is now briefly described. (1) Therapist expert resources refer to knowledge and skills (as perceived by the client) that can reduce the client's costs in achieving goals, such as knowledge of psychological processes, interpersonal relations, vocational choice, career patterns and psychological tests, all of which reflect the therapist's training and experience. (2) People have need for consistency (in their perception) between their behaviours

and values. Individuals seek out other individuals with whom to assess their consistency. Depending on the similarity of basic values and attitudes, therapists can act as referents or "sounding boards" through whom clients can increase their psychological consistency. Such reference can be described as interpersonal attraction. (3) Therapists have legitimate cultural and institutional roles as help givers in personal, vocational and interpersonal relations spheres. By heightening the client's perception of commitment to change and the voluntary nature of therapy, resistance to therapist suggestions becomes inconsistent with voluntary commitment. (4) Clients need information on how to attain their goals. Such information can come from the therapist's remarks or from books, articles, movies, or other communicators. Clients consider such information because the expert attests to its credibility and utility. (5) Ecological power refers to the ability of a person to take some action which modifies another person's social or physical environment, on the assumption that the new environment will subsequently bring about the desired changes in the other person. Therapists operate from a number of these bases at any one time - each with varying strengths - and the therapist's *total power* is a function of the combination of these bases.

Strong and Matross (1973) offered the following mathematical representation of their theory:

$$B = P + (O + R)$$

where:

B = the client's response to the therapist
P = the therapist's social power
O = the client's opposition
R = the client's resistance

A power base was defined as

$$PB_i = (N_i \approx R_i)$$

where:

PB_i = the power base
N_i = the clients's perceived need
$\approx$ = the degree of correspondence between
R_i = perception of the therapist as a helpful resource

Some years later, Merluzzi, Merluzzi and Kaul (1977) argued for the inclusion of both client and therapist characteristics in the social influence model and presented this revision to Strong and Matross' (1973) conception:

$$\Delta B = P(X) + N(Y) + (O + R)$$

where:

Δ B = behaviour change
P = the therapist's social power base
X = the therapist's characteristics
N = the client's need
Y = the client's characteristics
O = the client's opposition
R = the client's resistance

In the present case it is contended that this latter formulation, because of its inclusion of client characteristics, is more able to accommodate examination of the concerns raised by Corrigan et al. (1980) and Dorn (1984a) regarding the paucity of research devoted to investigating such characteristics.

Experimental Design Issues in Therapy Research

As noted by Dorn (1984a), many studies investigating aspects of the social influence model have been analogue in design and have attempted to approximate aspects of therapy in nontherapy settings using nonclients and nontherapists. However, little work has been completed in-the-field to determine the validity of these findings in genuine settings. Initial examinations of the comparability of analogue and more applied research have resulted in considerable debate (e.g., Beavin, 1984; Gurman, 1984) and

inconsistent conclusions (e.g., Elliott, 1979; Helms, 1976, 1978; Kushner, 1978). Strong (1971b) denoted five conditions of therapy which should be considered when applying laboratory research results to therapy: (1) therapy is a conversation between or among persons, (2) status differences between or among interactants constrain the conversation, (3) the duration of contact between interactants in therapy varies and at times is extended, (4) many clients are motivated to change (presumably this also means that some are not) and (5) many clients are psychologically distressed and heavily invested in the behaviours they seek to change. Of 51 studies reviewed by Heppner and Dixon (1981), no study was found to meet all 5 conditions and 29 did not meet any of the conditions. Some of the reasons researchers avoid in-the-field research designs are believed to include issues of confidentiality and difficulties relating to the use of control groups (Gelso, 1979).

Gelso (1979) commented that the employment of any research design involves a trade-off, and that the act of choosing one design over another inevitably confronts the *bubble hypothesis*. This hypothesis likens the conduct of science to the placement of a sticker on a car windshield, as follows.

> During the placement, a bubble would appear. The owner presses the bubble in an attempt to eliminate it, but it reappears elsewhere. No matter how hard the person tries to eliminate the bubble, it always appears in another place. The only way to get rid of it is to eliminate the entire sticker ... the bubble hypothesis underscores the fact that all experiments are highly imperfect. (p.12)

Following this, in a major critique and evaluation of methodologies employed in therapy research, Gelso distinguished and described four types of research design: (1) the experimental analogue, in which the researcher has full, or nearly full control over the scheduling of experimental stimuli and determines who gets exposure to which stimuli and when; (2) the correlational analogue, in which the researcher does not maintain control over who is exposed to levels of stimuli and does not randomly, or nearly so, assign subjects to two or more treatments; (3) the field experiment, in which the researcher not only maintains control over who is exposed to the stimuli and when, but also randomly assigns subjects to two or more groups. Field experiments are usually constituted as outcome studies and process studies are most often correlational; and (4) the correlational field study, in which the researcher does not maintain control over who is exposed to stimuli, or when, and does not randomly assign subjects to treatments.

Several studies have supported the utility of matching clients and therapists on the basis of demographic variables (e.g., Cartwright & Lerner, 1963; Howard, Orlinsky & Hill, 1970; Olesker & Balter, 1972; Orlinsky & Howard, 1976), but a number of studies have provided alternative evidence (e.g., Breisenger, 1976; Cotler, 1970; Jones, 1978; Scher, 1975). The present research provides data towards this issue, for, although the model of social influence has barely been examined in respect of client variables, following Heppner and Dixon's (1981) and Dorn's (1984a) exhortations, it is towards this deficit that the current work is directed. The research design employed in all studies to be reported was closest to the field experiment, whereby all the necessary conditions of therapy denoted by Strong (1971b) and detailed above could be satisfied.

Client-Therapist Matching and Models of Need

Client-therapist matching refers to the notion that certain combinations of clients and therapists are preferable to certain other combinations. Writers and researchers concerned with therapy as a social influence process have seemingly ignored the potential contributions to theory and practice of exploits in the literature

pertaining to client-therapist matching. Just as investigation of the social influence model centers around the determination of which particular set of client and therapist characteristics will influence a particular outcome, so does investigation of client-therapist matching, with a particular emphasis on combinational effects, such that:

> It is clear that the accountability of the therapeutic professions would be enhanced by the development of systematic guidelines for pairing patients with therapists and techniques so as to increase the probability of favourable outcomes. (Berzins, 1977, p.223)

It would seem, therefore, that a clear elucidation of the component of client need as denoted by Strong and Matross (1973) in their conceptualization of therapist power may be achieved through the consideration of need in a client-therapist matching framework. In a more general way, it has been asserted that consideration needs to be given to the client-therapist matching that has, or has not taken place:

> The point is that counseling (and psychotherapy) involve two people who both interact and make independent contributions to the process. This truism, however, rarely finds its way into the design of research on the clinical relationship. Until it does, the literature is apt to remain inconclusive. (Mendelsohn & Geller, 1967, p.214)

In a major review of the client-therapist matching literature, Berzins (1977) argued that a concern with client-therapist matching can be justified on the same grounds that a concern with psychotherapy can: on scholarly, ethical, or curative premises. Examples given included a scholarly researcher who proceeds from a concern with interpersonal compatibility in a dyadic influence situation; the ethical researcher concerned with the avoidance of a psychonoxious mismatch between client and therapist; and the curatively-oriented researcher concerned with instrumental consequences, such as better outcomes than those afforded by prior or adventitious procedures. Berzins concluded that the goals implicit in theories and research concerned with optimizing outcome through optimizing client-therapist matchings "seem unimpeachable" (p.222). This same author, in a discussion of the difficulties likely to be encountered by any researcher of client-therapist matching made the following observation:

> It is a sad but fair observation that the serious student of therapist-patient matching must proceed relatively unencumbered by theoretical propositions regarding how to conceptualize dyadic therapeutic interactions, let alone how to conduct research that could improve clinical practice. (p.223)

Of the theories relevant to client-therapist matching that Berzins discussed, it is Schutz's (1958) theory of

interpersonal compatibility that seems to hold promise for the explication of need as encouraged by Heppner and Dixon (1981) and endorsed by Mendelsohn and Rankin (1969): "It is surprising that [Schutz's Scale] has been so little used in clinical research, for it is virtually unique in providing a direct operational measure of interpersonal compatibility; the test is specifically designed for use in studies of dyadic and group behavior" (p.157) and, from Berzins himself, "Schutz's formulations in principle afforded psychotherapy researchers propositions that could have received extensive empirical examination" (p.227).

Schutz (1958) described every individual as having three interpersonal needs, defined as the needs for *Inclusion, Control* and *Affection*. These areas were understood as constituting a sufficient set of areas of interpersonal behaviour for the prediction and explanation of interpersonal phenomena. The need for Inclusion was defined as the need to establish and maintain a satisfactory relation with people with respect to interaction and association, Control as the need to establish and maintain a satisfactory control and power relation with people and Affection as the formation and maintenance of satisfactory relations with others with respect to love and affection. Schutz identified three types of compatibility related to the three need areas.

Interchange Compatibility refers to dyadic similarity along the dimension of desire for exchange relevant to each of the need areas. For example, two people will be more compatible in the area of affection if both want to initiate and receive it than if one wants to initiate, but the other does not want to receive. *Originator Compatibility* refers to dyadic complementarity along a dimension from only wanting to initiate to only wanting to receive, across the three need areas. For example, compatibility will exist between the person who only wants to initiate affection and the person who only wants to receive it. The third type of compatibility, *Reciprocal Compatibility*, refers to a matching between one person's Expressed Behaviour and another person's Wanted Behaviour. For example, when one member of a dyad has the need to express affection and the other member expresses the need to receive affection, and vice versa, the dyad is said to be reciprocally compatible.

Any discussion of dyad matching or dyad compatibility should include reference to the need complementarity/ similarity hypotheses, as these relate directly to the study of interpersonal satisfaction or satisfaction with outcome of interpersonal interaction, an example of which is the therapeutic interaction.

The Need Complementarity/Similarity Constructs

Winch (1955a, 1958) proposed the theory of complementary needs based on the premise that an individual will seek out a marriage partner who it is believed will provide maximum need gratification. Couple complementarity describes the extent to which two people's differing needs come together in an interlocking fashion. Winch identified two types of complementarity: (1) the mutual gratification of identical needs between the two partners; and (2) the mutual gratification of differing, but related needs (for example, one partner may be high in the need to dominate and the other high in the need to submit). The latter type may be described by the proverb *opposites attract* (Antill, 1983). The need similarity hypothesis is less well delineated in the literature, but essentially it proposes that individuals seek out persons similar in important (to the individual) need areas (this shares much in common with Schutz's notion of Interchange Compatibility). The proverb *birds of a feather flock together* characterizes the hypothesis (Antill, 1983). The research evidence pertaining to couple complementarity/ similarity is divided between support for the theory of complementarity (and/or lack of support for the similarity hypothesis; e.g., Kerckhoff & Davis, 1962; Moss, 1974; Winch, 1955b; Winch, Ktsanes & Ktsanes, 1954, 1955) and

support for the similarity hypothesis (and/or lack of support for the theory of complementarity; e.g., Beutler, Jobe & Elkins, 1974; Blazer, 1963; Hlasny & McCarrey, 1980; Katz, Glucksberg & Krauss, 1960; Levinger, Senn & Jorgensen, 1970; Meyer & Pepper, 1977; Murstein & Beck, 1972). Other research has demonstrated that the importance of couple similarity or complementarity varies, depending on the stage of the relationship. Similarity - on the Myers-Briggs Type Indicator (MBTI) and on measures of positive and negative components of conscience and ego ideal - has been shown to be a major determinant of couple satisfaction during the *initial* phase of attraction, while complementarity contributes to relationship *maintenance* (Vinacke, Shannon, Palazzo, Balsavage & Cooney, 1988).

The balance between supporting evidence for the similarity and complementarity hypotheses is not equal, however, to the extent that White and Hatcher (1984) commented:

> Sociologists and social psychologists have researched need patterns to a fair extent in nonclinical populations. Generally this line of inquiry fails to support complementarity as an important determinant of mate selection, let alone the relationship of complementary needs to marital or dyadic satisfaction. Evidence for need similarity between mates is stronger, especially among well-adjusted couples. (p.16)

Bearing on the need complementarity/similarity debate, but rarely applied to it, is evidence from client-therapist matching research. The empirical investigation of client-therapist personality similarity and the resultant influence on therapeutic outcome has a short history of some 30 years. However, prior to this time, some related research had been conducted. Cohen (1956), for example, investigated changes in dyad members' assessment of their interaction as a consequence of members being paired on the basis of differing personality defences. Of interest in the present context was the finding that similarity or dissimilarity of defence did not affect the perception of the interpersonal interaction. More directly pertinent to the current endeavour were the results of Sapolsky's (1960) study in which it was hypothesised (in part) that subjects (students) matched with experimenters (also students) for compatibility as indicated by Schutz's Fundamental Interpersonal Relations Orientation - Behavior scale (FIRO-B), should produce stronger verbal conditioning responses than incompatibly matched pairs. This hypothesis was supported. Subjects in the compatible group enhanced the reinforcing value of the experimenter's comments and demonstrated significantly better learning on the task than subjects in the incompatible group. Sapolsky concluded by noting the potential for application of the findings to

clinical practice and added that they supported the possibility that "resistive or negativistic patients" (p.246) may not express the influence experienced during therapy until after termination of the therapeutic relationship. This observation adds weight to the advisability of conducting follow-up investigation of clients who are subjects in therapy research.

In an attempt to relate the similarity of clients' (psychiatry clinic patients) and therapists' (medical students) personality profiles with therapeutic success (supervisors' ratings), Carson and Heine (1962) had clients and therapists complete the Minnesota Multiphasic Personality Inventory (MMPI) immediately prior to therapy and matched them, utilizing all scales, on the basis of a rank-order correlation of the two sets of "*T* scores" (p.39). Therapeutic success was shown to vary significantly with similarity and the form of the relationship was curvilinear: Judged success initially increased as dissimilarity did, but at an optimal point of dissimilarity, rated success decreased dramatically. Interestingly, White and Hatcher (1984) contemplated the possibility of a curvilinear relationship between needs and marital adjustment as a way of explaining many of the negative research findings in respect of the theory of

complementarity. Perhaps in a marital relationship, as in a therapeutic relationship, there exists an optimal degree of complementarity/similarity above or below which satisfaction will be judged to be less. White and Hatcher noted that this proposition had not been tested. Unfortunately, however, neither Carson and Llewellyn (1966) nor Lichtenstein (1966) were able to replicate Carson and Heine's (1962) findings using the MMPI. Carson and Llewellyn concluded that the curvilinear finding of the latter authors represented "a rather ephemeral phenomenon" (p.458) and agreed with Lichtenstein's estimation that the personality and evaluation instruments employed by Carson and Heine were too crude to measure the dimensions in which they were interested. Not considered was the possibility that differences between the studies simply reflected variability between students. Also to be considered is the degree to which findings based on the utilization of medical students as therapists can be generalized to genuine therapy situations.

Mendelsohn (1966) and Mendelsohn and Geller (1963) found that clients' and therapists' similarity, based on the MBTI, was significantly related to an increased number of therapy sessions and that such dyads were more variable in their number of sessions than were less similar dyads.

These results were interpreted as pointing to the ability and willingness of similar pairs to work either efficiently and directly or more slowly and methodically, depending on the nature of the client's problem(s). On the other hand, Mendelsohn and Geller (1965) reported a bewildering array of findings in relation to the investigation of client-therapist similarity and the outcome of therapy. Clients and therapists were assessed on the MBTI prior to therapy and evaluation questionnaires were forwarded to clients between 3 and 12 months post-therapy. The effect of similarity was found to vary depending on the criterion employed to assess outcome: It was curvilinear with client-evaluation of therapy (middle similarity produced the highest evaluation scores), unrelated to client-judged therapist competence and, depending on the sample (freshmen or nonfreshmen), both linear (for freshmen, high similarity was associated with high levels of reported comfort-rapport) and curvilinear (for nonfreshmen). The design of the studies may have contributed to some of the results obtained. For example, in the first of the two studies reported, therapist MBTI scores were not collected at the same time as client scores, thereby calling into question the assumption of concurrent client-therapist similarity.

Further research by Sapolsky, reported in 1965, investigated the relationship between patient and psychiatric resident need compatibility (as measured by the FIRO-B) and the outcome of treatment. Patients were hospitalized females with functional psychiatric disorders. Results showed that highly compatible patients evidenced significantly greater effects of their psychiatrist's influence than did low compatibility patients and that the former patients also sensed a similarity between themselves and their psychiatrists and felt more understood by them. However, in analysing the data, Sapolsky utilized *K*, the measure of *Total Compatibility* proposed by Schutz (1958). (*K* can be calculated by combining the values that result from scoring the three compatibility domains represented in the FIRO-B and described earlier). Mendelsohn and Rankin (1969), Berzins (1977), Malloy (1980a, 1980b) and Malloy and Copeland (1980) have all pointed out that the use of the *K* index in the form originally advocated by Schutz is inappropriate, since whereas Reciprocal and Interchange Compatibility can take only positive values, scores for Originator Compatibility can have both positive and negative values. The net result of this artifact is that as one form of incompatibility increases, so does overall compatibility. The problem can be remedied, however, by computing Originator Compatibility as an absolute value. (A

worked example illustrating the anomaly is presented in Appendix 1.)

Mendelsohn and Rankin's 1969 study took account of the scoring artifact just noted and employed instead an ad hoc multiple regression composite. (Several suggestions for altering the scoring procedure of the FIRO-B have appeared in the literature and these are considered in detail in Chapter 3.) The authors sought to further elucidate the relationship between client-therapist compatibility and the outcome of therapy via the assessment of students presenting at a university counselling service. Male and female clients and therapists were administered the FIRO-B prior to therapy and evaluation questionnaires were forwarded to clients three months after the last recorded interview. Findings demonstrated that compatibility scores were important independent predictors of outcome for female, but not for male clients. What effect the time difference between therapy termination and eventual evaluations of therapy may have had on these results is unknown, as is the relationship between immediate (if it had occurred) and long-term evaluations. The authors concluded that comparable data from other clinical settings was required to substantiate the results obtained and commented: "Effective matching alone can hardly guarantee

success, but the results of this study and of Sapolsky's [1965] strongly suggest that it is a feasible and practicable way to facilitate favorable outcomes" (p.163).

The first empirical exploration of the effects of client perceived need on therapist power was reported by Heppner and Dixon in 1978. Subjects were requested to rate their need for problem-solving skills. Differential subject need as measured by a Problem-Solving Skills Inventory was not found to lead to differential influence effects. The authors concluded that further research was required to examine different populations and more intense levels of subject need. In another therapy analogue study, designed in part to investigate the social influence paradigm, Dixon and Claiborn (1981) found that social power was more a function of therapist controlled procedures designed to enhance client commitment to change (e.g., giving clients homework), than it was of clients' perceived needs. Although not indicating that the observed effects needed replication in real-life therapy situations, the authors, as they had assessed need by asking recruited subjects to indicate on a six-point scale how much they "needed help at this time deciding on a career" (p.412), did concede that "Perhaps a different method of measuring perceived need" (p.415) could be employed in future.

Sex of the therapist was included as an independent variable in Malloy's (1981) investigation of the connection between client-therapist compatibility and therapy outcome. Clients were female students presenting at a university psychology department for individual therapy. Therapists were male and female graduate students enrolled in a university psychotherapy practicum and inexperienced in the practice of psychotherapy. The FIRO-B was administered to clients and therapists prior to therapy beginning. The Mooney Problem Checklist and the Tennessee Self Concept Scale served as criterion measures of therapy outcome and were administered at the beginning and at the termination of therapy. It was found that the sex of the therapist did not have a significant differential effect on the outcome of therapy nor on the compatibility of client-therapist dyads. Compatibility was found, however, to be significantly related to outcome, with results suggesting that moderate to high levels of compatibility may result in an optimum therapeutic outcome. Malloy made two observations that are especially relevant to the present work. Firstly, that research which cannot be carried out over long periods of time should include process variables, such as satisfaction with therapy and the therapist, rather than outcome measures requiring major personal/ psychological change (for example, modification of a

diminished self-concept); and secondly, that perhaps the sex of the therapist contributes less to therapeutic outcome than "the degree to which the therapist holds traditional sex-role stereotypes and wittingly or unwittingly introduces them into therapy" (p.320). Berzins (1977) was more direct:

> It is (also) a significant fact that the sex-role orientations of therapists and patients, which, after all, are not necessarily predictable from a knowledge of gender, have been almost totally excluded from the matrix of variables thought to have a bearing on the processes and outcomes of therapy. (p.240)

In response to these observations, of interest in the current context is the possibility that therapists and clients possess certain sex-role personality characteristics which, in particular combinations more than others, might influence their evaluations of therapy. The possibility that different Inclusion, Control and Affection need structures might be evidenced by persons with different sex-role orientations (together with the singular and combined effects of each of these on therapy appraisals) and the contribution of gender to any such relation, also are of interest.

Masculinity, Femininity and Androgyny

Androgyny is a concept with a short history, dating back only to the mid-1970s. The term did not even appear as a separate listing in *Psychological Abstracts* until 1982, prior to which it was included under the heading *Masculinity*: A significant point, given the tenets of the concept. Movement and impetus for the notion arguably grew from an increased concern for the status of women generated by the women's liberation movement of the 1960s (Whitley, 1979). The benefits of a nonsex-typed orientation have been appreciated for some time: "The cause of mental health may be better served if both men and women are encouraged toward maximum realization of individual potential, rather than to an adjustment to existing restrictive sex roles" (Broverman, Broverman, Clarkson, Rosenkrantz & Vogel, 1970, p.7); however, the writers and researchers who pioneered the concept of androgyny - or, more accurately, who pioneered conception of the construct in a manner enabling its rigorous measurement - were three women: Anne Constantinople (1973), Sandra Bem (1974) and Janet Spence (with Robert Helmreich and Joy Stapp, 1974, 1975). The traditional hypothesis that healthy functioning implies masculinity for men and femininity for women came under attack and the surge thus begun has shown no sign of

abating. (For example, within five years of Constantinople's 1973 paper there had been developed at least five measures purporting to tap *psychological androgyny*, those proposed by: Bem, 1974; Spence, Helmreich and Stapp, 1974, 1975; Baucom, 1976; Heilbrun, 1976; and Berzins, Welling and Wetter, 1978. In addition, Janet Spence is one of the most referenced authors to appear in the Social Science Citation Index.) There exists a voluminous literature in this relatively new field and a selective review of work pertinent to the current project follows.

The challenge to the traditional views of masculinity and femininity began with intense scrutiny of the notions that the possession of masculine traits was necessarily accompanied by a concomitant lack of feminine traits and that the possession of feminine traits was necessarily accompanied by a concomitant lack of masculine traits. Constantinople (1973) questioned whether masculinity and femininity were opposite poles of a single continuum and whether these dimensions were satisfactorily represented by a unidimensional construct quantified by a single score. (Some 14 years later, the concern remained: "Most often, the general concepts of masculinity and femininity are viewed in terms of opposition, with the presence of one set of characteristics implying the absence of the other" and

hence use of the term *the opposite sex* [Deaux, 1987, p.292].) Bem (1974) submitted her paper for publication in the same year as Constantinople - 1973 - and had pondered the same possibility: Masculinity and femininity may not be bipolar opposites on a single continuum. Bem, however, went further by suggesting that:

> Many individuals might be "androgynous"; that is, they might be *both* masculine and feminine, *both* assertive and yielding, *both* instrumental and expressive - depending on the situational appropriateness of these various behaviors; and conversely, that strongly sex-typed individuals might be seriously limited in the range of behaviors available to them as they move from situation to situation. (p.155)

In this way, Bem introduced the notion of androgyny, according it eminent and uncommon status. (The word itself derives from the Greek words *andro* meaning man and *gyne* meaning woman.) Bem thus understood androgyny as a *balance* or mix of masculine and feminine "self-concepts" which "might allow an individual to freely engage in both "masculine" and "feminine" behaviors" (p.155). The balance model of androgyny therefore predicts only a masculinity *by* femininity interaction (Hall & Taylor, 1985). In the same 1974 paper, Bem introduced the Bem Sex-Role Inventory (BSRI) which treats masculinity and femininity as independent dimensions and allows for the calculation of an androgyny score based on the difference between an

individual's endorsement of masculine or feminine personality traits. The BSRI consists of 60 items: 20 masculine, 20 feminine and 20 neutral. Items were selected for the Masculinity and Femininity scales on the basis of whether they were judged by students to be desirable in American society for one sex more than the other.

The first empirical investigation of androgyny was undertaken by Bem in 1975. Bem argued that a nonandrogynous sex-role orientation could seriously impede an individual's behaviour across changing situations. Subjects were exposed to a "masculine" condition (social pressure to conform) and a "feminine" condition (an opportunity to play with a kitten). Findings confirmed that, as the situation demanded, androgynous subjects were more able to engage in masculine independence (from social pressure) and feminine playfulness, than were nonandrogynous subjects. (Similar findings were reported in a replication of this study by Bem, Martyna & Watson, 1976; additionally, Bem & Lenney, 1976, found that androgynous individuals exhibited a greater willingness to undertake other-sex type tasks than did traditional sex-typed individuals.) Furthermore, Bem commented, "feminine females ... seem to have the most serious behavioral deficit" (p.642).

The same year as this investigation was reported, Spence et al. (1975) challenged Bem's definition of androgyny. These researchers administered their Extended Personal Attributes Questionnaire (EPAQ) together with the Attitudes Toward Women Scale and the Texas Social Behaviour Inventory to a group of male and female university students in a bid to determine the relationships between the latter measures and ratings on the male-valued, female-valued and sex-specific subscales of the EPAQ (described below). Results led the authors to conclude:

> The most desirable state of affairs is *androgyny*, defined, in contrast to Bem's [1974] conception of balance, as possession of a *high* degree of both [masculine and feminine] characteristics. Conversely, a low degree of both is least desirable. (p.38)

This became known as the *additive* or *main effects* hypothesis of androgyny. Masculinity and femininity were conceived as constituting a dualism: "Each a separate, socially desirable component present in both sexes, though typically in different degrees" (p.38). (This conception has much in common with Bakan's, 1966, and Block's, 1973, notion of agency and communion and with Parsons and Bales', 1955, instrumental and expressive orientations.) Spence et al. (1975) added two categories to the two already postulated by Bem (1974), namely, cross-sexed (i.e., males with high feminine and low masculine traits and the inverse for

females) and undifferentiated (persons possessing few traits of either gender). Bem herself adopted this four-category scheme in subsequent writings (e.g., Bem, 1977; Bem, Martyna & Watson, 1976).

Spence et al.'s (1975) EPAQ consists of 55 bipolar attributes drawn from Rosenkrantz, Vogel, Bee, Broverman and Broverman's (1968) 130-item Sex Role Stereotype Questionnaire. In the initial item selection process for the EPAQ, college students were asked to rate "typical" characteristics representative of each gender: 55 items significantly differentiated typical males and females. The "ideal" male and female was then rated by different judges on each of the 55 items. Of these, 18 items were regarded as ideally occurring in males and females, but believed more typical of females, and 23 items were regarded as ideally occurring in both sexes, but believed more typical of males. These constituted the ***Masculinity*** and ***Femininity*** scales respectively. Each of the remaining items (except for one, which could not be classified) was judged socially desirable for only one sex and together these constituted the ***Masculinity-Femininity*** scale. A short form of the EPAQ, the Personal Attributes Questionnaire (PAQ), was developed by Spence and Helmreich (1978) and is composed of 24 bipolar items divided equally among the Masculinity, Femininity and

Masculinity-Femininity scales. Six Masculinity-Femininity items are female-valued and two are male-valued. (Several suggestions for altering the procedures used to score androgyny measures have appeared in the literature and these are considered in detail in Chapter 3.)

As measured by the PAQ, notions of masculinity and femininity refer to a "limited set of socially desirable instrumental and expressive personality traits" (Spence & Helmreich, 1979a, p.1045) and the term "androgyny" to the possession of "relatively high degrees" (p.1035) of these traits. It is not uncommon in the androgyny literature to find the term *sex-role* employed where *sex-role orientation* is the intended meaning. Throughout this thesis however, the term sex-role orientation has been used to connote a person's expressive and/or instrumental trait orientation or leaning and the term sex-role has not been used as a substitute for this meaning. It is held that the latter term refers directly to a group of *behaviours* which might be regarded as characteristic of gender, as opposed to *personality traits*. Research evidence has supported the utility of this distinction. For example, although it has been shown that the PAQ - and instruments like it - do in fact measure instrumental and expressive personality traits (Helmreich, Spence & Holahan, 1979) and that such personality traits

have implications for the exhibition of instrumental and/or expressive behaviours, it has been noted that "The content of gender stereotypes is not limited to trait adjectives" (Deaux, 1987, p.290). Further, when distinguishing males from females, individuals have been shown to utilize not only source personality trait information, but also information relating separately to the source's sex-role behaviour, physical presentation and occupational status (Deaux & Lewis, 1984).

By the late 1970s and into the 1980s debate surrounding the concept of androgyny had intensified. Indicative of this was the provocatively entitled paper by Locksley and Colten published in 1979: "Psychological androgyny: A case of mistaken identity?." Spence and Helmreich's (1979a) retort: "The many faces of androgyny. A reply to Locksley and Colten." Locksley and Colten took the androgyny researchers to task on several counts, including: (1) acceptance of the assumption that androgynous persons are better adjusted than sex-typed individuals, (2) criticism of the usefulness of the notions of masculinity and femininity and (3) concern with the inappropriateness of an instrumental-expressive distinction. Spence and Helmreich countered by stating that Locksley and Colten's critique possessed an underlying "pervasive theme" suggestive of a

belief in "a single androgyny theory to which ... the BSRI and the PAQ ... are firmly tied" (p.1033) and that "invidious effects, endemic in the sex-role literature" (p.1040) and evident in Locksley and Colten's paper, resulted from a failure to distinguish between personality traits and sex-role behaviours. At the same time, Pedhazur and Tetenbaum (1979) delivered their critique on the BSRI and Bem (1979) responded to this and to Locksley and Colten's paper.

The year 1983 saw a proliferation of comment relating to the concept of androgyny. Nicholls, Licht and Pearl (1982) began the series by commenting that often construct validity was attended to in the development of personality tests to the neglect of face validity and went on to discuss the BSRI and the PAQ in this light. Spence and Helmreich (1983) answered this by noting that the PAQ did not measure the global concepts of masculinity or femininity, but rather "what their manifest content indicates" and, that this conclusion was not reached by consideration of "anything as uncomplicated as face validity" (p.182). Friedman (1983) joined in with a paper which reasserted "the primacy of convergent and discriminant validity in construct validation" (p.185). Nicholls, Pearl and Licht (1983) came back, stating that

Spence and Helmreich and Friedman had misinterpreted the intent of their earlier paper, which was to draw attention to the possible invalidity "of inferences researchers make about the constructs they claim their scales measure - specifically, inferences about relations between different constructs and between constructs and nontest behavior" (p.188).

Lubinski, Tellegen and Butcher (1983) conducted a study to investigate (among other things) the equivalence of the BSRI and the PAQ. Results supported the two measures being empirically interchangeable, but did not support androgyny as an indicator of psychological well-being. Spence (1983) retorted stating that the claim androgyny could legitimately be employed only as an interactive concept was false and that data collected with the PAQ "have revealed essentially additive relations" (p.443). Spence also moved further away from the notions of masculinity and femininity - admitting a change of opinion since 1975 - and advocated instead nongender-related terms such as instrumental and expressive, or self-assertiveness and nurturance/ interpersonal concern. This movement seems an over-reaction by Spence. Given the research and comment, it remains clear that the BSRI and PAQ measure certain traits commonly associated with notions of masculinity and femininity.

Spence and her associates never claimed the PAQ measured global constructs of these dimensions. There seems no need, therefore, for a shift from the original stance, providing the limitations of the measures continue to be acknowledged:

> Indeed, given the salience of the gender dichotomy in human experience, it would be remarkable if this dichotomy were not reflected in the personality characteristics differentially attributed to the sexes and lodged in the self concept of individuals. (Farnill & Ball, 1985, p.212.)

Tellegen and Lubinski (1983) replied to Spence's comments stating that they agreed the labels masculinity and femininity refer to multidimensional domains and, further, that reliance on patterns related to these labels and their subsequent treatment purely as nominal categories might obscure simple and complex relations which may be present. The authors urged application of an interactive model to the study of androgyny and encouraged the use of multivariate methods of analysis; they also noted that their observations concerning the desirability of testing interactions empirically through the application of regression methods "without recourse to rather crude and arbitrary typologies" (p.453) applied equally to any classification, including, for example, personality disorders and MMPI profile types:

> Each of these [profile classes] may capture important interaction effects and may be descriptively and predictively useful for that reason. They may also reflect certain variations in underlying personality structure. Yet these features are in themselves no evidence that the profile classes in question represent discontinuities indicative of real types. They could instead be arbitrary divisions of a multidimensional space in which covariational changes do occur, and motivate the creation of profile types ... but are continuous. (p.453)

Spence (1983) remarked on this conclusion noting that androgyny understood as an interactive concept has no theoretical basis:

> One does not promote a pair of uncorrelated variables to a novel emergent concept merely because it has been demonstrated that the variables combine nonadditively to determine an occasional type of criterion measure ... the fact that an investigator develops a hypothesis about a specific type of criterion measure that leads to the explicit prediction of a significant Masculinity x Femininity interaction in regression or two-way analysis of variance does not qualify that hypothesis as a theoretical model in which androgyny appears as an interactive concept. (p.445)

As is clear in the following sections, evidence for the additive hypothesis of androgyny is substantial and, as Spence has outlined, independent of an interactive conception of masculinity and femininity. For the purposes of the present work, the additive hypothesis was regarded as most accurately reflecting the original belief of the androgyny pioneers, namely, that benefits accrue from the simultaneous holding of masculine and feminine or

instrumental and expressive traits that do not accrue from the adoption of sex-typed stances.

Indications for a relationship between mental health/ adjustment/well-being and sex-role orientation (as operationalized by instruments such as the BSRI and PAQ) will now be considered.

Androgyny as a Mental Health Indicator

In an incisive critique of results from a selected sample of more than 100 articles, Taylor and Hall (1982) investigated the evidence for and against the balance model of androgyny proposed by Bem (1974) and the main effects or additive hypothesis advocated by Spence et al. (1975). Criterion measures of health utilized by researchers and employed as categories by Taylor and Hall included (amongst others): self-esteem, adjustment (e.g., depression, state anxiety, insecurity), ego development, dogmatism, locus of control, self-control and social poise. The authors concluded there was a lack of support for either of the androgyny hypotheses, stating: "Masculinity is seen to show considerably stronger relationships to the dependent variables than does femininity" (p.357) and (concerning the balance hypothesis), "The cumulative findings certainly cannot be said to offer support for this idea. On key

variables, our tables show that interaction effects are as likely to favour the sex typed as the balanced ... The empirical verdict on the main effects hypothesis is equally clear" (p.359). As indicated below, this conclusion, at least as it pertains to Spence et al.'s main effects hypothesis, seems precipitous and over-stated. Taylor and Hall continued: "The main effects hypothesis predicts that masculinity and femininity will each show substantial positive relationships with measures of psychological health" (p.357) and, "Indicators of healthy psychological functioning showed relatively large and consistently positive masculinity effects and less consistently positive and almost always much smaller femininity effects" (p.359). The authors go on to note that their accumulated findings from the literature indicate that masculinity related to dependent measures of health 91% of the time and femininity 79% of the time. Presumably Spence and Helmreich (1979a) would have gained great satisfaction from this conclusion, particularly as they pre-empted it three years earlier: "Since M is more strongly correlated with the indices of adjustment than F, men and women classified as Masculine (high M, low F) receive scores that are only slightly different from those classified as Androgynous (high M, high F)" (p.1044).

Some findings relating androgyny to mental health and not included in Taylor and Hall's (1982) analysis include those by Hinrichsen, Follansbee and Ganellan (1981). The latter authors found that androgynous subjects manifested more positive self-concepts and psychological health than did sex-typed subjects. In a study designed to investigate the "optimally integrated person," Neulinger, Stein, Schillinger and Welkowitz (1970) asked therapists to rate 20 paragraphs, each one illustrating one of Murray's manifest needs. The major finding relating to therapists was that female therapists placed "need for achievement" significantly higher than male therapists. Although stating that they were not able to satisfactorily interpret this finding, the authors did comment that in studies of the optimally integrated person, sex of the therapist should be included as a predictor variable. In a study of the relationship between "sex-roles" (by which the authors are believed to mean *sex-role orientations*) and marital adjustment, Murstein and Williams (1983) found that husbands' androgyny scores were the major factor in differentiating their own and their wives' marital adjustment scores from the lower marital adjustment scores of sex-typed couples. In a study of sex-role orientations and adjustment in new mothers, Bassoff (1984) found significant main effects for masculinity only. Tentative support was gained, however,

for the notion that androgynous new mothers were less hostile than sex-typed or undifferentiated mothers.

Moore and Rosenthal (1984) established a positive relationship between the main effects hypothesis of androgyny and measures of adjustment. The researchers found an association between androgyny and adjustment for Anglo- and Italian-Australian adolescents, but not for Greek-Australian adolescents. It was suggested that the nature of adjustment for Greek subjects might be different and/or that: "The nature of stereotypically masculine and feminine personality dimensions within Greek culture is different from that represented by adjectives of the questionnaire [PAQ]" (p.830). This evidence points to the need for consideration of subjects' ethnic backgrounds when assessing androgyny using sex-role orientation inventories. Patterson and McCubbin (1984) studied the relationship between sex-role orientation and the coping responses of women separated from their naval husbands who were absent on sea duty. Results indicated that in response to the separation androgynous women mitigated their distress by altering their coping behaviours to a greater extent than did nonandrogynous women. In a study of leadership roles, Porter, Geis, Cooper and Newman (1985) found androgynous men and women shared leadership more and sex-typed partners

less when reminded of their gender role beliefs prior to discussion involvement. Androgynous- and feminine-oriented persons also have been found to be both more dependable and more communicative (Holleran, Staszkiewicz & Lopez, 1983). Harrington and Andersen (1981) found both masculinity and androgyny to be significantly related to measures of creativity and provided some support for the "multiplicative" (p.753) - or balance - model of androgyny. Finally, Feather (1984) investigated the connection between value structures and sex-role orientation, but found no support for either the balance or additive hypotheses of androgyny. Feather concluded that to completely describe the value structure of masculinity, femininity and sex-role characteristics, other dimensions of variation would have to be considered, such as the overlap in value priorities that the sexes could be expected to exhibit.

A great deal of investigation has been undertaken examining therapists' perceptions of clients (see, for example, the review by Wills, 1978). One particularly interesting line of research has involved asking mental health professionals to rate, usually on the BSRI, the mentally healthy female, male and adult person (sex unspecified). Results, however, have been equivocal. The professionals polled in the three studies to be discussed

included psychologists, psychiatric nurses, social workers and psychiatrists. The "healthiest" male was rated as either masculine (Kravetz & Jones, 1981; Marwit, 1981) or androgynous (Swenson & Ragucci, 1984); the healthiest female as undifferentiated (Marwit; Swenson & Ragucci) or androgynous (Kravetz & Jones); and the healthiest person as masculine (Swenson & Ragucci), undifferentiated (Marwit) or androgynous (Kravetz and Jones). Comparing results across the three studies, highest mental health ratings were given to the masculine male (Marwit); the androgynous male (Swenson & Ragucci); and the androgynous person, sex unspecified (Kravetz & Jones). Kravetz and Jones concluded that many mental health professionals are moving away from the traditional assumption that it is only the sex-typed person who represents "model" mental health. Marwit commented that professionals seem to hold a "double standard" (p.597) of mental health whereby masculinity is favoured over femininity and regarded as the overall standard of mental health. Swenson and Ragucci expressed similar sentiments based on their own findings and added that it would be of interest in future research to ascertain the association between therapists' own sex-role orientations and their ratings of the mentally healthy person.

Rationale for the Present Investigations

The question of which therapist sex-role orientation subjects (students) rate more favourably and whether these ratings are related to subjects' own sex-role orientations has been investigated by Highlen and Russell (1980). Subjects were female university students who were asked to rate their preference (as if they were seeking therapy) for seeing a feminine, masculine, or androgynous therapist. Therapist sex-role was manipulated via pictures of full frontal head views of (independently rated) attractive males and females and appropriate (independently rated) written descriptions. The three therapist descriptions were randomly paired with either the three male or three female pictures. Therapist sex and subject sex-role orientation did not influence the way a therapist was rated, but therapist sex-role orientation did, with feminine and androgynous therapists rated more highly than masculine therapists. The authors concluded by recommending that these variables be examined within a therapeutic context. It is this examination which comprises the first study reported in Chapter 4 of the current work.

Although the utility of investigating the sex-role orientations of mental health professionals has been

expressed (Swenson & Ragucci, 1984), no such examination has been conducted in Australia. The equivocal nature of evidence gleaned from asking professionals which sex-role orientation they believe reflects mental health allows for no conclusion in this regard (Kravetz & Jones, 1981; Marwit, 1981; Swenson & Ragucci, 1984). Nevertheless, research findings support androgyny as the desirable sex-role orientation relating to mental health (Bem, 1974; Glazer & Dusek, 1985; Hinrichsen et al., 1981; Murstein & Williams, 1983; Pyke, 1985; Spence et al., 1975). Consequently, if it is assumed that mental health professionals score highly on indicators of mental health, one could reasonably predict that the androgynous orientation will be the one most likely held by mental health professionals. Further, as both instrumental and expressive traits may be regarded as contributing to the interpersonal flexibility required of therapists called on to respond to clients with diverse concerns in situations where therapeutic demands change rapidly (Highlen & Russell, 1980), therapists might be expected to exhibit high levels of such traits. The investigation of this expectation is detailed in the second study of the present series and is reported in Chapter 5.

Previous sections have illustrated the need for elucidation of the components of Strong and Matross' (1973) model of therapy as a social influence process. In particular, the salience of client variables in the model and the nature and outcome of the interactive process between these and therapist variables require examination (Dorn, 1984a, 1984b; Heppner & Dixon, 1978, 1981). Specifically, it still is not known what relationships exist between immediate post-therapy evaluations and pre-therapy client-therapist need compatibility. In the one study which attempted to address this issue (Gassner, 1970), the compatibility measure employed to match subjects was Schutz's (1958) *K* index and, as mentioned earlier, use of this index in its original form has been criticized as inaccurate. Gassner's subjects consisted of three sex-balanced groups of (predominantly psychotic) inpatients and theological students in training for pastoral counselling. Setting aside measurement issues, Gassner found that compatibly paired patients rated the therapy relationship more positively than incompatibly paired patients. Differences in attraction to therapists were found to correspond to differential compatibility on the Reciprocal and Interchange components of the Total Compatibility measure *K*. No mention was made, however, of any sex effect (either patient or therapist mediated) on

the results obtained. As mentioned earlier, however, Mendelsohn and Rankin (1969) found FIRO-B compatibility scores to be important independent predictors of outcome for female, but not for male clients. Other research devoted to investigating patterns of interpersonal relating in marriage has offered much in support of an affiliation between need similarity and dyad satisfaction (e.g., Blazer, 1963; Katz et al., 1960; Levinger et al., 1970; Meyer & Pepper, 1977; Murstein & Beck, 1972; White & Hatcher, 1984). The relationship between client-therapist therapy evaluations and client-therapist need compatibility is explored in the third study reported in Chapter 6 of this thesis.

Whether clients change their sex-role orientations from pre-therapy to post-therapy, or some time following the termination of therapy, is a question of some import which has not yet received research attention. (Mendelsohn & Geller, 1965, and Mendelsohn & Rankin, 1969, did not utilize any end-of-therapy evaluation measures, but did employ three month post-therapy follow-up evaluations.) As androgyny is regarded by many researchers as an ideal psychological state (Lubinski, Tellegen & Butcher's, 1983, observation), and given that some clients may not manifest an androgynous orientation upon entering therapy, it

appears reasonable to expect that by the termination of therapy, or some short time later, these clients should have modified their orientation towards the perceived ideal. Indeed, some writers have argued that therapeutic goals should specifically include the movement of clients towards this end, that is, towards an androgynous sex-role orientation (Cook 1985; Gilbert, 1981; Kaplan, 1976; Sturdevant, 1980) and that "gender-role analysis" be included as a standard feature of the psychological assessment process (Brown, 1986). Yet others have urged determination of the nonstereotypic characteristics which accompany an androgynous sex-role orientation and which play a part in yielding healthy psychological functioning (Vogel, 1979). In part, the third study reported in this thesis also describes the investigation of clients' sex-role orientation changes from pre-therapy, to post-therapy, to follow-up.

Again, little research relating therapy evaluations to client-therapist pre-therapy similarity/dissimilarity on measures of sex-role orientation was located, despite several writers alluding to the need for such investigation (Berzins, 1977; Malloy, 1981). Antill (1983) wrote that the general conclusion from laboratory studies "is that androgynous individuals ... increase the likelihood of

harmony in interpersonal encounters" (p.146). Antill's own 1983 research, in the field of marriage, provided support for the existence of an association between sex-role similarity and partner satisfaction. More directly pertinent, research by Petry and Thomas (1986) investigated the relationship between client and therapist sex-role orientations and adjudged quality of the therapeutic relationship. Data were analysed using analysis of variance and multiple regression procedures. Findings indicated that clients gave more positive ratings when seen by an androgynous, than by a nonandrogynous therapist. Neither client nor therapist gender nor client sex-role orientations were found to significantly affect ratings. The authors interpreted their results as providing verification that androgynous therapists are unique in dealing with problem-solving and interpersonal situations and added that their findings confirmed other findings which had established associations between the androgynous orientation and: (1) an assertive yet supportive stance; (2) a greater array of behaviour and emotionality; and (3) an open, naturalistic and direct interviewing style. It also was concluded that the findings may be generalizable to perceptions of better therapeutic outcomes and that further research utilizing more experienced therapists in nonuniversity settings could profitably be undertaken. The

latter suggestion was taken-up and the investigation comprises part of the third study to be reported.

It is not known what relationships obtain between the appraisal of therapy and clients' and therapists' needs and sex-role orientations, but there does exist some related evidence from research in other areas of interpersonal interaction. For example, Ickes and Barnes (1978) studied males and females with androgynous, masculine and feminine sex-role orientations interacting in mixed-sex dyads. It was concluded that significantly greater interpersonal compatibility and reduced stress existed in dyads in which one or both members were androgynous than in dyads comprising a masculine sex-typed male and a feminine sex-typed female. Antill (1983) investigated the relation between happiness and sex-role complementarity/similarity in married couples. The happiness of the wife was found to be positively related to the husband's femininity and the husband's happiness to the wife's femininity. Antill commented: "The complementarity hypothesis was convincingly refuted in terms of both pairing with a partner and in terms of happiness. Indeed, similarity of both masculinity and femininity was found to be associated with happiness" (pp.152-3). Although these and findings like them permit speculation regarding the likely effects of various

client-therapist sex-role orientation combinations on satisfaction with therapy, no evidence has been located pertaining to the probable combined impact of client-therapist needs and sex-role orientations on evaluations of therapeutic outcome, or the likely contribution of such findings to the social influence model as delineated by Strong (1968) and modified by writers such as Merluzzi, Merluzzi and Kaul (1977). The third study in this thesis also encompasses examination of these questions.

From the preceding discussion, specific aims and associated hypotheses were generated and these are now presented. As noted earlier, as several areas were being investigated for the first time, it was not possible to generate specific hypotheses relating to each aim. Consequently, the aims presented below describe the general research questions and guided the general direction of the work, while hypotheses based on previous findings allowed for more specific examinations.

Aims

(A) To determine which therapist sex-role orientation(s) clients rate more favourably.

(B) To determine the sex-role orientation(s) of a group of psychologists and social workers.

(C) To investigate the relationship of short- and long-term client-therapist ratings of therapy to client-therapist pre-therapy need compatibility as measured by Schutz's (1958) Fundamental Interpersonal Relations - Orientation (FIRO-B) measure.

(D) To investigate the relationship of short- and long-term client-therapist ratings of therapy to client-therapist similar versus dissimilar pre-therapy sex-role orientations as measured by Spence and Helmreich's (1978) Personal Attributes Questionnaire (PAQ).

(E) To investigate the relationship of short- and long-term client-therapist ratings of therapy to clients or therapists holding androgynous or nonandrogynous pre-therapy sex-role orientations.

(F) To compare clients' and therapists' post-therapy ratings of therapy and clients' post-therapy and follow-up ratings of therapy.

(G) To establish whether any changes occur in clients' sex-role orientations from before therapy to: (1) immedia-

tely following therapy termination, (2) three months post-therapy, or (3) eight months post-therapy.

(H) To establish the relationships between client and therapist needs, client and therapist sex-role orientations and client and therapist short- and long-term evaluations of therapy.

Hypotheses

1. Clients will rate therapists with androgynous or feminine sex-role orientations more favourably than they will therapists with a masculine sex-role orientation.

2. Social workers are more likely to manifest an androgynous sex-role orientation than any other sex-role orientation.

3. As measured by Schutz's (1958) Fundamental Interpersonal Relations - Orientation (FIRO-B) measure, there will be a positive relationship between the Control area pre-therapy need compatibility of (male and female) therapists and female clients, and their favourable ratings of therapy.

4. When either member of a client-therapist dyad manifests an androgynous pre-therapy sex-role orientation

as measured by Spence and Helmreich's (1978) Personal Attributes Questionnaire (PAQ), clients and therapists will rate therapy more favourably.

5. Clients not possessing an androgynous sex-role orientation before therapy will have modified their position towards such an orientation upon the termination of therapy, or by three months or eight months later.

CHAPTER 2

THE FAMILY COURT OF AUSTRALIA

A DESCRIPTION

As the research reported in this thesis involved clients and counsellors of the Family Court of Australia, this chapter briefly details the purposes and functions of the Court and, in particular, the counselling operations. In so doing, the chapter draws on the text *A Guide to Family Law*, edited by the former Chief Judge of the Court, Justice Elizabeth Evatt (1986) and on a number of papers written by Court Counsellors and others.

Every year in Australia approximately 40,000 couples are divorced, affecting some 50,000 children under the age of 18 years (Evatt, 1986). Recognition of the many costs which attach to such figures are well appreciated (e.g., Parkinson, 1983). In part to address the spiralling divorce rate of the 1970s, radical legislation was introduced in Australia to streamline divorce procedures. The *Family Law Act 1975* was assented to on the 12th of June, 1975, proclaimed on the 28th of August, 1975 and came into operation on the 5th of January, 1975 (*Family Law Act 1975*, 1983). The most

immediate consequence from introduction of the Act was the repealing of the *Matrimonial Causes Act 1959* and the establishment of a "no-fault" divorce scheme which dictated 12 months separation from one's spouse as the only ground on which divorce could be pursued or granted. Such a separation was regarded as constituting an irretrievable breakdown of the relationship. As the ground for divorce was decreased to one related only to time, a further consequence of the Act was a dramatic reduction in the number of contested divorce cases appearing before the Courts.

The Act covered married persons, their children, their property, maintenance and related matters. To administer the Act, the Family Court of Australia was established and given Federal jurisdiction. The primary functions of the Court were to provide a counselling service for the resolution of disputes; to decide guardianship, custody, access, property and maintenance issues; and to grant divorces and other orders pertaining to family law matters. In short, all family law, as it related to married persons, became vested in the Family Court. Although some matters of law concerning married couples and their children and property could still be dealt with by the State Courts, these cases were usually referred to the Family Court. Law relating to families constituted outside of marriage (e.g.,

those based on de facto relationships) remained vested in the States. Very recent amendments to the Act, however, have extended the jurisdiction of the Family Court to now include ex-nuptual children and their parents.

The Australian Family Court was certainly not the first to incorporate a counselling arm in its operations. The Conciliation Court of the Superior Court of Los Angeles County was established in 1939, but did not employ professionally qualified counsellors until 1955 (Elkin, 1962, 1973) and the Conciliation Service of the Santa Clara County (California) Superior Court was established in 1972 (Weiss & Collada, 1977). Arguably, however, following the no-fault divorce clause, the most important component of the Australian Act was the mandate that the Family Court be serviced by an integral Counselling Service.

Although the Act and its various amendments have fallen short of offering a definition of counselling, they have provided commentary as to what should be included under the term "marriage counselling." The latter was stated to include the counselling of persons: entering a marriage, reconciling to a marriage, dissolving or annulling a marriage, or adjusting to the dissolution or annulment of a marriage. Further, "marriage counsellors" were defined as

including counsellors of the Family Court (*Family Law Act 1975*, 1983, Section 4, Part 1, 82,104). All Court Counsellors are professionally qualified psychologists or social workers and clients utilizing their services are not charged fees. There are two streams of counselling offered by the Service: confidential and nonconfidential. Confidential counselling is as implied by the name, but, as described below, the level of confidentiality in effect during such counselling extends beyond that which usually applies in therapy settings.

All Court Counsellors are sworn to oath - and sign a witnessed document to the effect - that nothing said in a confidential counselling session conducted under the auspices of the Family Court will ever be communicated to any person, or any Court, whether that Court exercises Federal jurisdiction or not. *Non*confidential counselling, on the other hand, is such that *anything* said in a session may appear in a report subsequently handed to the Court. The latter reports are prepared by the counsellor by order of the Court and for use by the Court in protracted cases of disagreement between the parties on issues pertaining to guardianship, custody, access and the like. Obviously, therapists inform clients of the type of counselling they are involved in prior to counselling beginning. In any

event, because of an obvious eventual conflict of interest were it to occur, a counsellor having seen a client for confidential counselling is not permitted, by law, to ever interview that client nonconfidentially or to ever write a report on that client for the Court (or anyone else). It is permissible, however, for clients to move from nonconfidential to confidential counselling with the same counsellor. This being said, the vast majority of clients are involved in voluntary, confidential counselling.

The work conducted by the Family Court Counselling Service has been much lauded, by those involved with its formation (Report of Joint Select Committee on the Family Law Act, 1980), concerned with its continuance (Family Court Liaison Committee, 1981) and serviced by its counsellors (Beecher, 1983). By focusing unequivocally on clients' needs and the needs of their children, Court Counsellors are regarded as having a clinical, therapeutic and nonadversarial role in assisting clients with the emotional concomitants of relationship breakdown (Madison, 1982; Marshall, 1980; McIsaac, 1984) and are urged not to curtail their therapeutic endeavours because of Court rules or procedures or because they work in an atmosphere of litigation (Twigg, 1982). In the Court system, then, counsellors deal primarily with clients' relationship

issues (which sometimes include property and maintenance issues); the judiciary with hearing evidence and making orders; senior public servants with administrative issues; and registrars with administration, property and maintenance matters. Registrars have proved a regular referral source for the Counselling Service, as have judges, solicitors and other helping agencies.
Self-referrals also form a large part of the counselling practice. Though judges often make orders for clients to attend confidential counselling, there are no consequences outlined in the Act for noncompliance with such orders and, clients not wanting to remain in counselling, regardless of their source of referral, simply leave (as some occasionally do). "Reluctance is in fact rare and usually transient and ... not necessarily due to resistance to court-ordered [counselling]" (Burrett, 1981, p.581). All clients attending confidential Court counselling, then, from whatever referral source, do so voluntarily.

Counselling section procedures are the same as those adopted in most other therapy centres: Clients make appointments through a secretary; they are interviewed in separate offices, sometimes separately, sometimes together, sometimes with or without the children, sometimes away from the centre altogether, depending on the counsellor's

decision; if clients wish, they may at any time request another counsellor; clients may attend information groups with other clients before beginning their individual sessions; some attend counselling for a single session, others attend many sessions over a prolonged period, again, depending on the judgment of the counsellor; and finally, counsellors use whatever techniques and skills they believe appropriate and co-counsell if they believe it advantageous to do so.

The following chapter outlines the measures employed in the research reported in this thesis. The first study in the series, which involved clients presenting at the Counselling Service of a large Family Court Registry, is detailed in Chapter 4.

CHAPTER 3

EVALUATING NEED, ANDROGYNY AND THERAPY

This chapter presents a detailed discussion of the measures utilized in the current research and, in particular, the measurement considerations undertaken in their application. In so doing, the chapter also details reasons for not employing some of the more commonly used measures.

The Measurement of Need

Although the utilization of need measures has advanced to the stage where a continuum of therapy process goals has been developed based on a needs hierarchy (Bruce, 1984), very few measures have been developed for the purpose of studying need per se. One of them, based on Murray's (1938) need theory, has received considerable research attention and will be discussed first. This will be followed by reference to Maslow (1954), Trainer (1982) and Schutz (1958).

Murray's (1938) theory of need, as developed by a number of writers (including Atkinson, 1958, and McClelland,

Atkinson, Clark & Lowell, 1953) proposed that motivation operates as a function of the power of various needs at any given time. The theory focussed on task performance needs (i.e., the need for achievement) and interpersonal needs. Included in the latter were the need for independence, termed *Autonomy;* the need for friendship, termed *Affiliation;* the need for control, termed *Dominance;* and the need for success, termed *Achievement*. The work of Steers and Braunstein (1976) was designed to provide a "reasonably valid, reliable - and brief - instrument to measure four specific needs following the need theory of Murray (1938)" (p.251). To this end, the authors developed the Manifest Needs Questionnaire (MNQ) as a behaviourally-based measure of the needs categories identified by Murray (1938) and referred to above. The result was a questionnaire containing 20 statements, each of which described activities people engaged in or might engage in while working. (Other authors have noted the connection between need satisfaction and effective job completion, e.g., Harvey & France, 1982; Herzberg, Mausner & Snyderman, 1959.) Each item is rated on a seven-point scale with response categories ranging from *always* to *never*. Steers and Braunstein (1976) undertook both laboratory and field research employing the MNQ and concluded that their questionnaire exhibited "acceptable levels of convergent,

discriminant, and predictive validity, as well as reasonably high test-retest reliability and internal consistency" (p.251).

The reliability of the MNQ scales has been called into question, however, to the extent that the "doubtful reliability of the scales could be the cost which has to be paid in attempting to measure four needs with only 20 items" (Williams & Woodward, 1980, p.221). In addition, work by Joiner (1982) indicated that none of the MNQ need scales exhibited acceptable internal reliability and the suggestion was made that a measure containing a larger number of items should be utilized in research on needs. Furthermore, after examining the results from eight published studies, Dreher and Mai-Dalton (1983) determined that the need for dominance scale was the only one that could be said to exhibit a minimally useful degree of internal consistency. Given these findings in respect of the MNQ, it was regarded as unsuitable for application in the current case.

Lester, Hvezda, Sullivan and Plourde (1983) conducted questionnaire-based research designed to investigate the relationship between the satisfaction of needs as reported by Maslow (1954; i.e., physiological, safety, belonging-

ness, esteem and self-actualization needs) and indicators of psychological health (inventory measures of neuroticism and belief in an external locus of control). Results suggested that the higher the level of needs satisfaction, the higher the level of psychological health. However, as only one of the five basic needs described by Maslow pertained directly to interpersonal relating (belonging), the model was believed inadequate for the present purposes. Given that the current undertaking was concerned in particular with aspects of interpersonal need fulfilment, Schutz's model, specifically developed to assess such needs, was the one judged best able to accommodate these concerns.

Schutz's FIRO Theory

A brief outline of Schutz's (1958) theory of interpersonal behaviour was proffered in Chapter 1. A select, though more detailed consideration will now be presented with a view to demonstrating the utility of Schutz's measures for the present investigation.

Whereas some theory development has taken place in the area of needs-oriented methods of therapy (Trainer, 1982), little has occurred in the way of therapy outcome prediction since Schutz first proposed his model of

interpersonal relations. The Fundamental Interpersonal Relations Orientation - Behavior measure (FIRO-B; Appendix 3A) was first introduced by William Schutz in 1958 in his book entitled *FIRO: A Three Dimensional Theory of Interpersonal Behavior*. The book was retitled in 1966 *The Interpersonal Underworld* and the theory expanded in later books such as *Joy* (1967a), *Here Comes Everybody* (1971), *Elements of Encounter* (1973) and *Leaders of Schools: FIRO Theory Applied to Administrators* (1977). Schutz's manuals, *The FIRO Scales* (1967b), *FIRO Scales Manual* (1967c) and *FIRO Awareness Scales Manual* (1978), complemented the texts.

Schutz (1958) defined *interpersonal* as "relations that occur between people" and an *interpersonal situation* as one "involving two or more persons, in which these individuals take account of each other for some purpose, or decision ... It is also specified as existing during a stated time interval" (p.14). *Need* was defined as "a situation or condition of an individual the nonrealization of which leads to undesirable consequences" and an *interpersonal need* as one "that may be satisfied only through the attainment of a satisfactory relation with other people" (p.15). *Compatibility* was defined as "a property of a relation between two or more persons, between an individual and a role, or between an individual and a task situation, that leads to mutual satisfaction of interpersonal needs, and harmonious

coexistence" (p.192). In outlining FIRO theory, Schutz offered four postulates, as follows (after Schutz, 1958):

1. *The Postulate of Interpersonal Needs.*
   a. Every individual has three interpersonal needs: Inclusion, Control, and Affection.
   b. Inclusion, Control, and Affection constitute a sufficient set of areas of interpersonal behaviour for the prediction and explanation of interpersonal phenomena.

2. *The Postulate of Relational Continuity.*
   - An individual's Expressed interpersonal behaviour will be similar to the behaviour he experienced in his earliest interpersonal relations, usually with his parents.

3. *The Postulate of Compatibility.*
   a. If the compatibility of one group, h, is greater than that of another group, m, then the goal achievement of h will exceed that of m.
   b. If the compatibility of one dyad, y_1, is greater than the compatibility of another dyad, y_2, then the members of y_1 are more likely to prefer each other for continued personal exchange.
   c. If the compatibility of one group, h, is greater than the compatibility of another group, m, then the productivity goal achievement of h will exceed that of m.
   d. If the compatibility of one group, h, is greater than the compatibility of another group, m, then h will be more cohesive than m.

4. *The Postulate of Group Development.*
   - The formation and development of two or more people into an interpersonal relation (that is, a group) always proceed in the same sequence, beginning with Inclusion, followed by Control, and finally by Affection.

Four behaviour types were identified as being associated with each of the Inclusion, Control and Affection dimensions, namely: (1) *deficient* - indicating that the person is not trying directly to satisfy the need, (2) *excessive* - indicating that the person is constantly trying to satisfy the need, (3) *ideal* - indicating satisfaction of the need and (4) *pathological*. The types relating to each dimension, respectively, are as follows:

1. *Inclusion Types*
    a. The Undersocial.
    b. The Oversocial.
    c. The Social.
    d. A close relation between disturbance in the Inclusion area and psychosis.

2. *Control Types*
    a. The Abdicrat (a person who tends toward submission and abdication of responsibility in interpersonal relationships).
    b. The Autocrat.
    c. The Democrat.
    d. A close relation between disturbance in the Control area and psychopathy.

3. *Affection Types*
    a. The Underpersonal.
    b. The Overpersonal.
    c. The Personal.
    d. A close relation between disturbance in the Affection area and neurosis.

Additional terms used to describe FIRO-B need measurements are as follows.

- *Sum Inclusion* results from addition of the *Expressed* and *Wanted* scores on the Inclusion scale and relates to the desire for contact with people.
- *Sum Control* results from addition of the *Expressed* and *Wanted* scores on the Control scale and relates to the desire for giving and taking orders.
- *Sum Affection* results from addition of the *Expressed* and *Wanted* scores on the Affection scale and relates to the desire for exchange of warmth and affection.
- *Total Sum* results from adding the above three values, or from adding the summed *Expressed* and *Wanted* values across the three need dimensions, and relates to the degree of preference for interaction with others, in all need areas. This sum indicates an individual's characteristic total amount of interaction.
- *Difference Inclusion* results from subtraction of the *Wanted* from the *Expressed* scores on the Inclusion scale and relates the degree of preference for initiating Inclusion behaviour rather than receiving it.
- *Difference Control* results from subtraction of the *Wanted* from the *Expressed* scores on the Control scale and relates the degree of preference for giving orders rather than taking them.
- *Difference Affection* results from subtraction of the *Wanted* from the *Expressed* scores on the Affection scale and relates the degree of preference for initiating rather than receiving affection.
- *Total Difference* results from adding the above three difference values and relates to the degree of preference for interaction with others, in all need areas. This difference score indicates an individual's preference for taking the initiative in relating, regardless of the need area.

The following description of the calculations involved in measuring compatibility is based on the work of Schutz (1958) in conjunction with the revisions proposed by

Mendelsohn and Rankin (1969), Malloy (1980a, 1980b) and Malloy and Copeland (1980) and described in Chapter 1. Compatibility is assessed by using the client's and therapist's six FIRO-B sub-scale scores to derive three measures each of Reciprocal, Originator and Interchange Compatibility, namely, Reciprocal: Inclusion (*RKinc*), Control (*RKcon*) and Affection (*RKaff*); Originator: Inclusion (*OKinc*), Control (*OKcon*) and Affection (*OKaff*); and Interchange: Inclusion (*XKinc*), Control (*XKcon*) and Affection (*XKaff*). These values are summed to provide the Total Compatibility measure, *K*. Mathematically, relations between compatibility measures may be described thus:

$$
\begin{aligned}
RKinc &= |(Einc_i - Winc_j)| + |(Einc_j - Winc_i)| \\
RKcon &= |(Econ_i - Wcon_j)| + |(Econ_j - Wcon_i)| \\
RKaff &= |(Eaff_i - Waff_j)| + |(Eaff_j - Waff_i)| \\
OKinc &= |(Einc_i - Winc_i) + (Einc_j - Winc_j)| \\
OKcon &= |(Econ_i - Wcon_i) + (Econ_j - Wcon_j)| \\
OKaff &= |(Eaff_i - Waff_i) + (Eaff_j - Waff_j)| \\
XKinc &= |(Einc_i + Winc_i) - (Einc_j + Winc_j)| \\
XKcon &= |(Econ_i + Wcon_i) - (Econ_j + Wcon_j)| \\
XKaff &= |(Eaff_i + Waff_i) - (Eaff_j + Waff_j)| \\
RK &= RKinc + RKcon + RKaff \\
OK &= OKinc + OKcon + OKaff \\
XK &= XKinc + XKcon + XKaff \\
Kinc &= RKinc + OKinc + XKinc \\
Kcon &= RKcon + OKcon + XKcon \\
Kaff &= RKaff + OKaff + XKaff \\
K &= Kinc + Kcon + Kaff \text{ or,} \\
K &= RK + OK + XK
\end{aligned}
$$

Where E=Expressed Behaviour, W=Wanted Behaviour, $_{i,j}$=Subjects

Although much research and comment has been devoted to exploring *group* performance and composition (e.g., Altman & Haythorn, 1967; Lundgren 1975; Lundgren & Knight, 1977; Schutz, 1955, 1961), it seems likely that much of this work can profitably be applied to examination of dyadic composition as well. Indeed, in describing FIRO theory, Schutz (1958) commented that "Every time people form themselves into groups, *including two-person groups*, the same three interpersonal problem areas are dealt with" (p.172; *italics* added). It does not seem unreasonable, therefore, to suppose that the compatibility construct as suggested by Schutz (1958) might operate in a therapy situation as it does in any other two-person, or larger group.

The FIRO model in general has been applied to a number of research areas, including a novel application to family therapy. Doherty and Colangelo (1984) proposed a model for organizing family issues around the Inclusion, Control, and Affection dimensions postulated by Schutz and a framework for attaching theories of family therapy based on these same domains. The authors concluded that each theory specialized in one such domain and that, based on whether the identified family problem could be understood as representing an Inclusion, Control, or Affection issue, so could the appropriate therapeutic techniques accompanying

the relevant theory be utilized. In other words, the model provided a way of employing therapeutic techniques appropriate to the FIRO stage at which the family was stuck or floundering.

Schutz's Measure of Interpersonal Needs

The Fundamental Interpersonal Relations Orientation - Behavior measure (FIRO-B) was developed as a self-administered questionnaire to assess how an individual acts in interpersonal situations and to predict how specific characteristics of people might be combined in particular ways in order that relations between them might be anticipated. An individual will have *Expressed* and *Wanted* needs in each of the Inclusion, Control and Affection dimensions, resulting in six sub-scale measurement values. These values are calculated from summing respondents' ratings to each sub-scale item. Ratings are made on six-point Likert-type scales, ranging in description, for example, from *usually* to *never*. Nine items comprise each dimension. Respondents accept or reject an item by rating it at a point already determined by the distribution of responses. Accepting an item results in a score of 1, rejecting an item in a score of 0. A high score in any need area corresponds to a high need in that area. Each

sub-scale score, then, ranges from 0 to 9 and respondents have their scale score results expressed as six single-digit numbers. The scale was originally developed on "about 150" students and Air Force personnel (Schutz, 1958, p.60) and cross-validated on "approximately 1,500" students from several schools and colleges (Schutz, 1958, p.61). In 1978 Schutz presented FIRO-B need data gathered from more than 5,000 subjects, including data from psychology majors, teachers, architects, salesmen, nurses and educational administrators. While acknowledging the nonindependence of some of its component scales, Schutz (1958, 1978) described the reliability and validity of the FIRO-B as satisfactory. Other investigators have both agreed (e.g., Gard & Bendig, 1964; Gluck, 1979, 1983; Kramer, 1967; Ullman, Krasner & Troffer, 1964; Vraa, 1971) and disagreed (e.g., Froehle, 1970; Ryan, Maguire & Ryan, 1970) with this conclusion. Some of this evidence will now be considered.

The FIRO-B was developed and refined on the basis of several investigations which validated the scale in terms of: content, concurrent, predictive and construct validity; internal consistency; and test-retest reliability (Schutz, 1958). The coefficient of internal consistency was found to be acceptably high for all scale dimensions (*mean*=.94, *n*=1,543), as was the test-retest reliability for all scales

(*mean*=.76). Sub-scale intercorrelations ranged from a low of r=0 to a high of r=.62 (n=108). Twenty years later, Schutz (1978) reported sub-scale intercorrelations ranging from a low of r=.06 to a high of r=.49 (n=1,340).

Kramer (1967) established significant relationships between subjects' estimated and actual need scores on each of the six sub-scale dimensions comprising the FIRO-B. In an attempted replication, Froehle (1970) was only able to establish a significant relationship between scores on the Expressed Control dimension. Froehle discussed the failure to reproduce Kramer's findings in terms of possible differences in the degree of relevance that subjects had accorded each dimension. However, as Froehle had given subjects written information regarding the FIRO-B prior to their completing it, only a partial replication of Kramer's study was achieved. Gluck (1979), however, by more closely approximating the original methodology, was able to reproduce Kramer's findings.

The assumptions underlying the choice of samples selected by Ryan, Maguire and Ryan (1970) may have been partly responsible for those researchers failing to confirm the construct validity of the FIRO-B. Subjects were selected on the basis that they had not received any college training.

The first sample was composed of 48 male traffic patrol officers who were expected to score highly on the Expressed Control dimension, the second sample of 48 male life insurance sellers was expected to score highly on the Inclusion dimension and the third group of 24 male and 24 female registrants at a volunteer service organization was expected to score highly on the Affection dimension. Although the findings did not support all these expectations, volunteers rated the two Affection dimensions higher than any other two dimensions; of the three occupation groups, insurance sellers reported the highest Inclusion scores; and on five of the six dimensions, traffic patrol officers recorded the lowest ratings.

An issue not addressed by the investigators was the possibility that, for example, volunteer workers might declare the need for Inclusion as much as the need for Affection. In other words, in the absence of supporting evidence, the use of occupation as a criterion by which to gauge needs may have resulted in the investigation itself having little validity. Employment in a particular occupation does not *necessarily* relate to the holding of a particular need structure and the possibility that it might invites empirical substantiation. Schutz (1958) commented: "Beyond speculative interest, interpretation [of the

connection between occupation and need] is risky ... interpretation is complicated by the fact that it is difficult to distinguish whether certain personality types are attracted to certain occupations or whether practicing the occupation determines the orientation. This problem could yield to empirical investigation" (p.73).

The decision to use the FIRO-B in the present case gained additional support from Gluck's (1983) conclusion that although the measure's predictive, concurrent, content and construct validity had been demonstrated in a large number of investigations, additional studies were needed "to extend our knowledge of the situations in which the FIRO-B will be useful" (p.28).

An issue of significant import in the current context was the method employed to analyse FIRO-B response data. Following Schutz (1958), the compatibility measure *K*, discussed in Chapter 1, is calculated from the addition of score totals across each of the three compatibility dimensions, that is, across the *Reciprocal*, *Originator* and *Interchange* spheres. Table 3.01 presents the relations between the various compatibility scales.

The continuous compatibility scale *K* can range from a score of 0 (maximum compatibility) to a score of 108

Table 3.01

Relationships between Schutz's FIRO-B Need Compatibility Measures

Areas of Compatibility		Types of Compatibility: Reciprocal (R)	Originator (O)	Interchange (X)	Column Sums
Inclusion (inc)	Expressed / Wanted	inc RK	inc OK	inc XK	inc K
Control (con)	Expressed / Wanted	con RK	con OK	con XK	con K
Affection (aff)	Expressed / Wanted	aff RK	aff OK	aff XK	aff K
Row Sums		RK	OK	XK	*K*

(maximum incompatibility). Worked examples illustrating the calculation of these particular scores are presented in Appendix 3B. Later in this thesis, although regression

coefficients appear in tables accompanied by their accurate arithmetical signs, to maintain the logical sense of the *K* scale and to enable the presentation of data in terms of compatibility rather than *in*compatibility, the signs have been reversed when interpreting results in the text.

In the first test of the FIRO-B reported by Schutz in the 1958 manuscript, subjects were divided into "three approximately equal groups, and assigned the names 'high,' 'middle,' and 'low'" (p.79). In the same text, using another FIRO measure, the FIRO-5B3, Schutz divided subjects on the basis of a median-split technique, whereby those above the median compatibility score were regarded as compatible and those below it incompatible. "A lower score indicates greater compatibility; hence for each member the other members are divided in half and considered 'compatible' or 'incompatible' for each measure" (p.122). Referring to the issue of defining score levels in the 1978 manual, Schutz offered the following comments:

> A score is considered *high* or *low* by various criteria:
>
> 1. *Absolute:* 7,8,9 is high; 0,1,2 is low; 3,4,5,6 is medium.
>
> 2. *Relative:* Divide your population into three equal parts based on scale scores. Highest third is designated *high*, lowest third is designated *low*, middle third is designated *medium*.

> 3. *Normative:* Scores of your population are compared with norms of other groups presented in the appropriate tables within this manual... ***High*** means a certain designated amount above that norm, perhaps two points or perhaps one or two standard deviations.
>
> Which of these you choose depends on your purpose. If you are doing work within your own group, as with compatibility, the relative method would be most appropriate. If your interest is with comparisons to other groups, the normative approach is best. The absolute technique gives the best estimate of a person's score, compared to the largest and most varied population. (p.6)

Another method for analysing FIRO-B need data seemingly over-looked, or at least not referred to by Schutz (1958, 1978), (or Ryan, 1977, or Musselwhite & Schlageter, 1985, in their discussions of scoring procedures), was that of using compatibility scores in a multiple regression modelling procedure. This method of analysis would ensure there was not the loss of information entailed in the procedures suggested and adopted by Schutz. Such loss of information occurs when several scores hover around the median, such that one point more or less has the effect of placing an individual in a different category. Such loss of data represents an unwelcome feature of categorizing continuous data that can be circumvented by the application of analysis of variance or regression procedures (Blackman, 1982). Malloy (1980a, 1981) recommended using standard deviation units as a way of defining degrees of

compatibility to "foster a more uniform use of this [FIRO-B] construct and permit stronger comparisons across studies employing this methodology" (p.121). It should be pointed out, however, that *not* utilizing a system of score categorization (such as when using, for example, regression procedures), does *not* preclude comparisons between findings from different studies. For example, *means*, *standard deviations*, score distributions and each of Schutz's (1958) 10 scale score and total score measures can all be utilized for this purpose. The method adopted in the present case was to employ FIRO-B compatibility scores as predictor variables - together with various other variables of interest - and model therapy evaluation data with them. In this way, findings could be compared with those of Schutz and others without the need to define *high* (as suggested by Schutz and detailed above under the heading *Normative*) and without recourse to data categorization.

The Measurement of Androgyny

Presented in this section are measurement considerations relating to Bem's (1974) Sex-Role Inventory; Antill, Cunningham, Russell and Thompson's (1981) Personal Description Questionnaire; and Spence and Helmreich's (1978) Personal Attributes Questionnaire.

The Bem Sex-Role Inventory

As described in Chapter 1, Bem first presented the Bem Sex-Role Inventory (BSRI) in 1974. It consists of 20 masculine, 20 feminine and 20 neutral items, each presented on a seven-point scale ranging from 1 (*Never or almost never true*) to 7 (*Always or almost always true*). Originally, Bem (1974) used a *t* ratio to determine androgynous individuals, but by 1977 had changed this procedure to accommodate the median-split method advocated by Spence, Helmreich and Stapp in 1975. Although recent factor-analytical evidence has supported the two-dimensional nature of the short forms of Bem's BSRI Masculinity and Femininity scales (Martin & Ramanaiah, 1988), for two reasons unrelated to this evidence the measure was considered inappropriate for the current purpose. (The decision not to use the measure was made in 1985.) First, research findings had suggested that for use with an Australian population, the measure would require development, in that seven items on the scale had been found to contain words that were not understood - or were found difficult to understand - by a criterion number of Australian respondents (Antill, Cunningham, Russell & Thompson, 1981). As a consequence, reworking the scale for the current sample of clients and therapists would have been a large, cumbersome and time-consuming venture.

Second, for busy therapists and often distressed clients, because of the large number of items contained in the scale, it was believed that the BSRI's completion time would have been excessive. Additional support for the decision not to employ the instrument was provided by Briere, Ward and Hartsough (1983) who concluded that assessing androgyny using the BSRI remained, at best, equivocal.

The Personal Description Questionnaire

The Personal Description Questionnaire was developed by Antill, Cunningham, Russell and Thompson and reported in 1981. A sample primarily comprised of students was asked to rate adjectives in terms of their self-applicability, their desirability in the sexes and the degree to which they were expected in the sexes. The resultant scale consisted of 50 items: 10 masculine positive and 10 masculine negative items, 10 feminine positive and 10 feminine negative items and 10 social desirability items. Findings by the authors and by Russell and Antill (1984) revealed reliability problems with the feminine negative scale comprising Form B, while Hong, Kavanagh and Tippett (1983) found reliability problems with the social desirability sub-scales of both Form A and Form B. Although offering

support for the sub-scale design of the measure, Farnill and Ball (1985) commented that because of the low correlation between the feminine sub-scales, it may not be advisable to sum them to provide an overall femininity score. Other research employing the Antill et al. measure established that males from the community at large were as likely as females to score highly on feminine-valued items and that females were as likely as males to score highly on masculine-valued items (Ray & Lovejoy, 1984).

In the present case, consideration was given to the fact that although Antill et al.'s measure had 10 items fewer than the BSRI, it contained more than twice the number of items as Spence and Helmreich's (1978) sex-role orientation measure. It did not, therefore, satisfy the requirement for brevity as outlined above.

In sum then, for use with Australian clients and therapists, the present author would have preferred to use a measure developed on an Australian sample; however, at the time the present research was implemented (1985), Antill et al.'s measure was still in the process of refinement and validation. Issues pertaining to reliability, validity and other psychometric qualities were regarded as having greater import than the issue of scale

origin, particularly as the Personal Attributes Questionnaire had been shown to be suitable for use with an Australian sample, as described below.

The Personal Attributes Questionnaire

Prior to the current studies and in contrast to the measure developed by Antill et al. (1981) and just described, Spence and Helmreich's (1978) Personal Attributes Questionnaire (PAQ; Appendix 3C) had been used extensively in androgyny research and had received considerable research attention (e.g., Antill & Cunningham, 1982; Gaa, Liberman & Edwards, 1979; Helmreich, Spence & Holahan, 1979; Helmreich, Spence & Wilhelm, 1981; Pearson, 1980; Spence, 1979; Spence & Helmreich, 1978, 1979b). The instrument was regarded as one of the best measures of psychological androgyny available. Cook (1985) had observed that test-retest reliabilities for the PAQ scales had "generally been acceptably high" (p.51). In addition, it had been demonstrated that whereas 7 items on the BSRI and 13 from the Adjective Check List (Heilbrun, 1976) would have to be discarded for use with Australian subjects (because at least 10% of an Australian sample exposed to them did not understand some of the words they employed), all PAQ items could be retained (Antill, et al., 1981).

As discussed in Chapter 1, the PAQ was reported by Janet Spence and Robert Helmreich in 1978. as a shorter form of Spence et al.'s (1975) Extended Personal Attributes Questionnaire. The PAQ was developed using college students and designed to assess, on five-point Likert-type scales, acceptance or rejection of eight Masculinity items (Appendix 3C, item numbers 2, 6, 10, 16, 17, 19, 20 and 24), eight Femininity items (item numbers 3, 7, 8, 9, 12, 15, 21 and 22) and eight Masculinity-Femininity items (item numbers 1, 4, 5, 11, 13, 14, 18 and 23), each defining a characteristic previously identified by college student raters as socially desirable. Items are scored from zero to four and, of the total number of items, six require reverse scoring (item numbers 5, 13, 14, 16, 18 and 23). Item content was used by Spence and Helmreich to cull the extended version to the shorter version such that Masculinity scale items were identified as referring primarily to instrumental traits, Femininity scale items primarily to expressive traits and Masculinity-Femininity scale items to instrumental, or expressive, or some combination of instrumental and expressive traits.

Although items on the BSRI (Wiggins & Holzmuller, 1981) and on the PAQ (Antill & Cunningham, 1982) have been found to generalize to sex-role stereotype classifications on

dimensions in addition to those comprising notions of masculinity and femininity - including those of Social Distance, Emotionality, Laziness and Coldness - Helmreich, Spence and Wilhelm (1981) reported that the Masculinity and Femininity scales of the shortened form of the PAQ could be reproduced factor analytically, that the factor structure was highly consistent in both sexes and that the internal consistency of weighted scales reflecting those dimensions was satisfactory (p.1106-7). Further, in both males and females, the Masculinity and Femininity scales, respectively, have been shown to reliably tap the instrumental and expressive traits they purport to (Holmbeck & Bale, 1988).

For the above-stated reasons, Spence and Helmreich's (1978) PAQ was the measure employed to assess sex-role orientations in the present work.

Androgyny Measurement Methods

Regarding the measurement of PAQ scale scores, Spence and Helmreich (1978) commented:

> In instances in which more than one of the individual scales on the PAQ are found to be correlated with other variables, a method of combining scale scores is necessary if the nature of the conjoint relationship is to be determined. The approach we have adopted for purposes of both description and prediction is first to

> determine for a total sample (females and males combined) or a normative group the median scores on the M and F scales. Then the individuals are classified by means of a 2 by 2 table according to their position above or below the median on the two scales. (p.35)

It will be argued in the following sections that, without reference to categories, there is a more precise way of measuring the conjoint relationship of scales found to correlate with other variables.

Bem's (1974) *t* score method allowed for defining sex-typed persons, but failed to discriminate between those having high masculine and high feminine ratings and those having low ratings on these dimensions (Briere et al., 1983). Consequently, the androgynous person could be either high or low on both dimensions, the only proviso being a ***balance*** between the scores. Spence, et al.'s (1975) median-split method described the androgynous individual as one who gave high masculine and high feminine ratings, the masculine person as one who gave high masculine and low feminine ratings, the feminine person as one who gave high feminine and low masculine ratings and the undifferentiated person as one who gave both low masculine and low feminine ratings.

Following these initial formulations, there has been quite a deal written concerning appropriate and

inappropriate techniques for the measurement of androgyny. Although some researchers have not stated their rationale for employing more than one measurement method (e.g., Williams, Leak & Millard, 1984), others have been more systematic. Orlofsky, Aslin and Ginsburg (1977), for example, suggested that an androgynous person should satisfy the demands of both the *t* score ***and*** the median-split methods. Downing (1979), on the other hand, in attempting to "bridge the gap" (p.291) between the latter two measurements, suggested defining androgynous individuals through the use of a masculinity minus femininity difference score in the range -.43 to +.43. Several other suggestions have been put forward for scoring androgyny as a unidimensional continuous variable, including Kalin's (1979) proposition:

$$\text{Androgyny} = [(M+F)-|(M-F)|] \,/\, 2$$

Heilbrun and Pitman (1979) offered:

$$\text{Androgyny} = [(M+F)-|M-F|]$$

Bryan, Coleman and Ganong (1981) suggested the geometric mean:

$$\text{Androgyny} = \text{the square root of } MF$$

Whereas Bobko and Schwartz (1984) recommended:

$$\text{Androgyny} = [6-|M-F|]\times[(M+F)/2]$$

Blackman (1982) noted that measures similar to those described above avoid the loss of information inherent in categorical systems of data description, but that because of their unidimensionality they do not reflect either Bem's or Spence et al.'s two-dimensional androgyny theories. Heilbrun (1983) took Blackman to task on this issue, commenting that when the *combined* effects of Masculinity and Femininity scores are of interest, then unidimensional indices should be used, although why this should be the case was not explained. The point needed elaboration, especially given the fact that combined Masculinity and Femininity effects can be studied via a Masculinity x Femininity multiplicative term (Anderson, 1986; Taylor & Hall, 1982). Heilbrun (1983) concluded that valuable information could be gleaned from an exploration of data based on both unidimensional and bidimensional constructs.

Several authors have used or recommended the use of analysis of variance or regression analysis procedures in the measurement of sex-role orientation data (e.g.,

Anderson, 1986; Antill, et al., 1981; Bem, 1977; Hall & Taylor, 1985; Helmreich, Spence & Holahan, 1979; Kelly, Furman & Young, 1978; Kelly & Worell, 1977; Lubinski, Tellegen & Butcher, 1981, 1983; Strahan, 1975, 1981, 1984; Taylor, 1983; Taylor & Hall, 1982). In an extension of the earlier work comparing androgyny scoring methods, Blackman (1985) found that "The correlations between ... continuous measures and the median-split method of measuring androgyny are similar and are statistically significant. The continuous methods generally related closely to one another" (p.153).

The loss of information inherent in the use of a median-split method of categorization referred to by Blackman (1982) was certainly appreciated by Spence and Helmreich (1978) and prompted their following observations: "the median split technique provides data subject to some statistical distortion" (p.38), "When accuracy of prediction (as opposed to descriptive clarity) is a goal, a multiple *r* to determine whether the variance accounted for can be increased, relative to any PAQ scale taken singly, should routinely be calculated" (p.36) and, "we have therefore chosen to employ the simplest meaningful classification system in describing the combination of PAQ scale scores" (p.37).

One year later, Spence and Helmreich (1979b) seemed to change their 1978 stance, such that in closing a paper discussing the assessment of androgyny, researchers were cautioned not to use regression techniques "to discover post hoc relationships between masculinity and femininity and other measures ... unless prepared to undertake detailed analysis of the model and the pattern of residuals" (p.737). In a paper published in the same year, however, Helmreich, Spence and Holahan (1979) reported using multiple regression techniques to discover relationships between Masculinity, Femininity, the multiplicative term Masculinity x Femininity and other variables of interest, without reference to the pattern of residuals. Examination of residuals may have been undertaken, but the results were not included in the report. It is possible, of course, that the phrase employed by Spence and Helmreich (1979b) "to discover post hoc relationships between masculinity and femininity and other measures" meant 'to analyse post hoc hypotheses concerning relationships between masculinity and femininity and other measures', which is clearly a different point. An endeavour based on the former meaning could involve, for example, analysis of all the possible combinations in a data set in the hope of arriving at an interesting model. An undertaking based on the latter meaning, however, would

have to be predicated on an hypothesis, which in turn would presumably have been derived from theory or expectation. The more general point to be made here is that although it has been argued that categorical procedures allow for consideration of the *joint* contribution of Masculinity and Femininity and the consideration of *levels* of androgyny (e.g., Heilbrun, 1983; Spence, Helmreich & Holahan, 1979), so do regression procedures. It has already been stated that the Masculinity x Femininity multiplicative term can be used to examine the joint contribution of Masculinity and Femininity (if indeed there is one), while examination of estimates can provide information concerning levels of significant Masculinity and/or Femininity main effects in any model.

None of the research cited above was found to include demographic or related data as predictor variables (except for gender). The view is taken here that if, for example, gender, age and marital status serve as the only significant predictor variables in a model which also initially contained androgyny, locus of control and intelligence scores, then it is worth knowing that the latter variables are inferior predictors so that time can be more usefully spent on delimiting the demographic data as a method of further exploring the questions of interest.

Regarding androgyny research, it seems that answers to quite simple questions might not yet have been provided before more complicated questions have been put. Empirical support for the need to include demographic information when studying client-therapist matching was evidenced in research conducted by Howard, Orlinsky and Hill (1970) and is reported later in this section.

The procedure adopted for the purpose of analysing PAQ sex-role orientation data followed that for analysing FIRO-B need data described earlier. Namely, together with various other variables of interest, PAQ sex-role orientation scores were employed as predictor variables in a multiple regression format and modelled with therapy evaluation data, thereby avoiding the need for arbitrary divisions. For the purposes of comparison, the data also were categorized according to Spence et al.'s suggestions.

Therapy Evaluation Measures

For effective use in the present investigation, any therapy evaluation instrument had to meet a number of important criteria. First, it had to accommodate not only client assessment of the therapist, but also an overall client assessment of therapy; second, it had to be capable

of tapping both the client's *and* therapist's perception of what had taken place in and resulted from therapy; third, it had to comprise a number of versions for application pre-therapy, post-therapy and follow-up, over a relatively short time period; and fourth, it had to be brief enough to accommodate the needs of distressed clients and hard-pressed therapists. Only one instrument was found to satisfy these conditions. However, a number of the most commonly employed evaluation measures were considered before the latter was decided upon, and the reasons one of these was not used will be addressed briefly.

The most extensively used therapist rating instrument, the Counselor Rating Form (CRF; Barak & LaCrosse, 1975; LaCrosse & Barak, 1976), was developed as a 36-item client rating scale to tap the three therapist dimensions of expertness, attractiveness and trustworthiness proposed by Strong (1968). As such, it did not provide for therapist ratings of therapy. Some evidence has been gathered supporting the validity of the CRF (LaCrosse, 1980), but other findings have been less than encouraging. For example, Epperson and Pecnik (1985) observed that up to 80% of persons completing the CRF used the digits *5, 6,* or *7* to record their response on the seven-point scale, thereby calling into question the utility of the form of scaling

used, given the items employed. In addition, investigation of the factor structure of the CRF have pointed to difficulties (e.g., Zamostny, Corrigan & Eggert, 1981), leading Corrigan & Schmidt (1983) to conclude that "Factor analyses of the CRF since Barak and LaCrosse (1975) have not replicated their 3-factor orthogonal structure" (p.65). The Counselor Rating Form - Short version (CRF-S; Corrigan & Schmidt, 1983) represents a collapsing of the original version into the 12 items with the highest factor weights. However, Epperson and Pecnik (1985) pointed out that when compared to the longer version, the CRF-S might be measuring a different set of constructs, while Tracey, Glidden and Kokotovic (1988) showed that the shorter instrument contains two levels of factors.

Of the rating scales examined (Atkinson & Wampold's, 1982, Counselor Effectiveness Rating Scale; Barrett-Lennard's, 1962, Barrett-Lennard Relationship Inventory; Friedlander's, 1982, Satisfaction Questionnaires; Ivey's, 1971, Counselor Effectiveness Scale; and Workman & Williams', 1979, Counselor Effectiveness Inventory), all except Friedlander's emphasized evaluation of the *therapist*, to the neglect of evaluation of *therapy*, rendering them, for the present purposes, inadequate. (Although Tinsley, Workman and Kass' 1980 Expectations About Counseling

instrument does include measures of process, even the Short Form contains 59 items [Tinsley, Brown, de St.Aubin & Lucek, 1984]. Consequently, because of its length, it was considered inappropriate for use in the current research.) In 1957 Grigg and Goodstein (cited in Ponterotto & Furlong, 1985) wrote that:

> some appraisal of the client's reaction to the counselor *and to counseling* should be obtained before we can say we have any comprehensive understanding of who makes a good counselor and what constitutes successful counseling techniques. (p.597) (*italics* added)

Ponterotto and Furlong (1985) went on to comment that "Since that time [1957], the evaluation of counselor effectiveness has been a crucial issue in counseling practice and research" (p.597). It is significant that the same could not be said in relation to the evaluation of therapy as urged by the quoted authors over 30 years ago. It is contended here that the measurement of social influence would be more accurately and profitably served by inclusion, not only of specific client reactions to and perceptions of the therapist, but also by inclusion of more general reactions to the therapeutic process per se. Therapist power may be considered as having application beyond the immediate effects of perceived therapist expertness, attractiveness and/or trustworthiness, to the more general effects of the therapeutic process. These

general effects, though often mediated by the therapist, have components that go beyond those brought to bear by the therapist's persona. Put another way, profitable measurement of therapist and/or therapeutic effectiveness demands more than measurement of clients' perceptions of their therapists. There is no requirement to consider the therapist, or the client, or other intervening variables in isolation. Indeed, in their description of therapist power, Strong and Matross (1973) stressed the importance of the *joint* contribution of such influences. Although not explicitly formulated to do so, the evaluation measures proposed by Friedlander (1982) accommodate many of these observations.

Friedlander's Measures - The Foundations

In their review of therapist effectiveness rating scales appearing in published reports during the period 1974 to 1984, Ponterotto and Furlong (1985) stated that they did not include for consideration measures that had been used "just once or twice, as in the case of a scale developed for a dissertation study" (p.598). It is regrettable this was the case, as one of the scales thus omitted was developed by Friedlander (1982) for a dissertation study and formulated specifically to address not only

satisfaction with the therapist, but also to examine, implied as necessary in the quotation offered earlier, broader process and outcome issues related to therapy. Friedlander conducted research based on a model of dynamic interaction in therapy adapted from Patton, Fuhriman and Bieber (1977) and questionnaires modified from work by Howard et al. (1970).

The latter researchers formulated 13 "Patient Satisfaction Items" (p.131) in part to examine the role of client and therapist personality characteristics in influencing client reports of satisfaction with therapy. Female clients of the Katharine Wright Mental Health Clinic in Chicago acted as subjects and completed questionnaires following each of a series of psychotherapy sessions with an experienced therapist. Therapists at the Clinic were assigned clients in a nonrandom fashion and, for the purposes of the study, clients and therapists were matched post hoc, based on age, marital status, parental status and therapist sex. Factor analysis of ratings revealed a four-factor solution. The factors were defined as *Catharsis, Mastery-Insight, Encouragement* and *Nothing.* (For the purpose of comparison with Friedlander's 1982 scales, items comprising these factors are presented in Appendix 3D.) Results demonstrated that patients appear to have a rewarding experience in psychotherapy if:

- their therapists embody a successful life adaptation in a situation that is similar to the patients' ...
- the therapy relationship holds a potential for satisfying the patients' current life needs ...
- their therapists maintain a personal detachment from the patients' problems, and are likely to have a frustrating experience if their therapists are faced with similar problems in their own personal situations ...
- their current life status is one that their therapists have personal reasons to respect or admire ... (Howard et al., 1970, p.134)

These findings led the authors to conclude that:

> the personal characteristics of the patient and the therapist who are paired together definitely and differentially influence the experienced satisfactions of the patient. In some cases, patients found most satisfaction with therapists whose personal characteristics were similar to theirs, while in other cases, they found least satisfaction with similar therapists. A comparison of these cases might yield fruitful hypotheses concerning the sources of satisfaction and therapeutic benefit. (p.133)

As noted earlier, the present work included demographic and related data as independent variables.

Friedlander's Measures - Development and Research

As described in detail below, Friedlander (1982) developed four therapy evaluation measures with the intention of examining the relations between perceptions and behaviour in a therapy context. The present author revised these

measures, and also presented below is a description of this revision. The revised measures were not renamed and are: the Client Expectancy Questionnaire (CEQ), Client Perception Questionnaire (CPQ1; Appendix 3E), Counselor Perception Questionnaire (CPQ2; Appendix 3F) and Client Satisfaction Questionnaire (CSQ; Appendix 3G). Except for the instructions accompanying each instrument, the random ordering of items, and the syntax used, the four evaluation measures are identical. Each of the original questionnaires contains 14 items and each item is scored on a Likert-type scale which ranges from a low of 1 (*Disagree*) to a high of 6 (*Agree*).

The model of dynamic interaction employed by Friedlander is diagrammatically presented in Figure 3.01. Referring to the figure and, following Friedlander (1982, p.402), *Perception* refers to "the individual's symbolic representation of past transactions with the environment (including other people) and of the self." The interaction of these perceptions produce *Expectancies* (defined as "subjective probabilities of the occurrence of events or behavior") and *Preferences* (defined as "affective states of liking or disliking objects, events, or people"). Expectancies and preferences interact to produce *Intentions* (defined as "an individual's plans to influence events in a

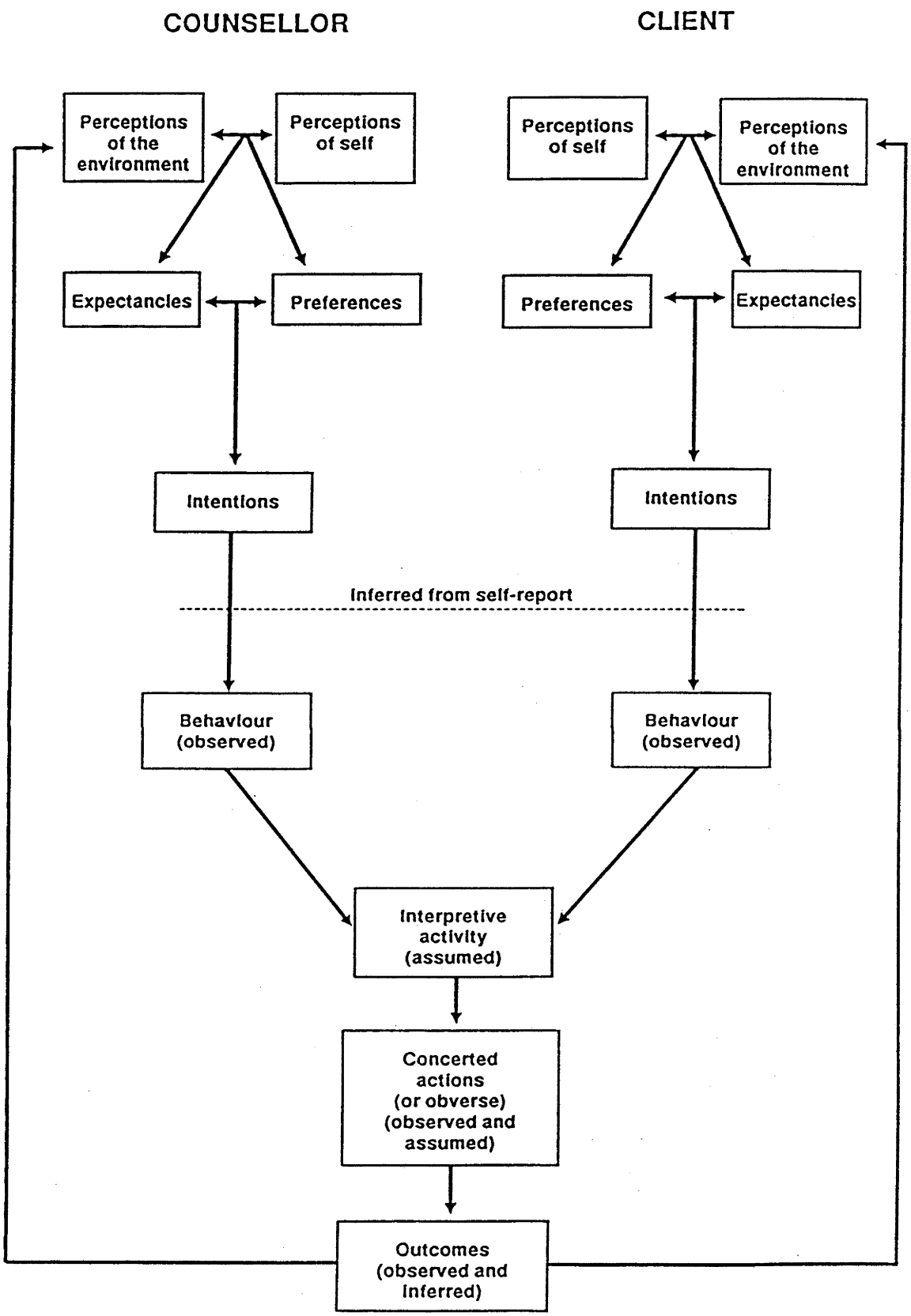


Figure 3.01. Model of dynamic interaction in therapy (after Friedlander, 1982)

desirable manner"). The *Interpretive Activity* through which verbal and nonverbal behaviours are assigned meaning remains assumptive. *Concerted Action* refers to coordinated speech and observable interaction, but concerted action involving *Mutual Understanding* remains assumptive. Finally, *Outcomes* can occur during therapy or at some stage during its course, allowing for new or modified perceptions. "Thus, the model is continually re-created throughout the duration of the relationship" (p.402).

Friedlander's (1982) research focussed on: (1) relationships between expectancies and perceptions and, in particular, the degree of change from pre- (Expectancy stage), to during- (Perception stage), to post-therapy (Satisfaction stage); and (2) the relationship between perceptions and behaviour. Friedlander asked all students in a Psychology of Personal Effectiveness course to complete the pre-therapy expectancy questionnaire (CEQ). Those students from the course who later requested therapy at a student consultation centre were asked to participate in the study. Doctoral candidates on practicum at the centre served as therapists. Following the initial interview, clients completed a first evaluation questionnaire (CPQ1) and upon the termination of therapy

completed a second evaluation measure (CSQ). Therapists completed their evaluation questionnaire (the CPQ2) after the second interview. The number of therapy sessions ranged from two to eight, with an average of five sessions.

Analysis of clients' pre-therapy responses resulted in three-factors which Friedlander termed *Affective Process* ("containing items reflective of the client's and counselor's emotional investment in the relationship"), *Mastery-Outcome* ("insight and skills that might be achieved in counseling") and *Counselor Activity* ("behaviors such as giving hope, reassurance and encouragement" p.404). Six items reached a criterion value of .39 in Factor One, six in Factor Two and three in Factor Three (one item loaded on two factors). Each of these items was accorded a value of 1, such that scores on Factors One and Two could range from 6 (6 items X a rating of 1 for each item) to 36 (6 items X a rating of 6 for each item) and on Factor Three from 3 (3 items X a rating of 1 for each item) to 18 (3 items X a rating of 6 for each item). Audio tape recording segments also were analysed to determine a client Verbal Activity Ratio, a client/therapist Verbal Activity Level and a Role System Ratio.

Results showed that because clients participating in the study had higher Affective Process expectancies than clients of the therapy centre not participating in the study, the sample studied was probably nonrepresentative of the centre's client population. Factor dimensions of client scores were found to be highly correlated with the corresponding dimensions of therapist scores ($r \geq .87$, $p<.0001$, in each case). As there were large differences observed between clients' pre- and post-therapy evaluation responses, change scores were calculated and found to be significantly related to therapists' evaluation responses. It also was established that before therapy, clients focussed more on the client/therapist relationship than on expected outcome. Clients with educational-vocational problems were found to have higher affective process expectations than those with personal-social concerns. This was interpreted as perhaps indicative of a cautious pose towards expecting emotional investment, due either to the nature of the problem(s) expressed, or characteristic wariness in interpersonal relations. Finally, the assumption in the model that concerted action leads to perceptions of positive results was supported.

Implications for the Present Work

Together with the measurement techniques applied to the scales developed, there are a number of features associated with Friedlander's research (two of which Friedlander, 1982, noted) deserving of further comment. First, students were solicited and as a result may not have been representative of genuine therapy clients; second, as the therapists were not described as being experienced in the practice of therapy, it may be assumed they were not; third, given the aims of the project, the sample of clients was small (n=17); fourth, no client or therapist demographic or related variable was included in any reported analysis; and fifth, clients were debriefed before the conclusion of the study (after the second therapy session and before completing the CSQ final evaluation measure).

Another source of concern related to the questionnaire items Friedlander employed. Each measure contained only one negative item (item 21 on the revised CPQ1 client evaluation questionnaire presented in Appendix 3E), thereby rendering it prone to acquiescent response bias (Ray, 1984). In the present case, in an effort to balance the scale, 6 negative items were added to the measure (items 2,

5, 9, 11, 15 and 20 on the revised CPQ1 client evaluation questionnaire presented in Appendix 3E), resulting in a total of 21 items: 14 positive and 7 negative. In developing the additional items, the present author produced an original pool of 14 items which were rated by a group of psychologists for suitability as negative items relating to aspects of therapy. The item pool was culled until raters agreed on which six statements most accurately reflected the intended meaning.

A further issue related to the questionnaire measurement technique employed by Friedlander: Assigning equal values (1) to items exhibiting very different factor loadings may have been ill-advised. For example, an item included in the Counselor Activity factor with a loading of .39 was given the same value as an item included in the Mastery-Outcome factor with a loading of .87, and an item included in the Affective Process factor with a loading of .41 was assigned the same value as another item included in the same factor with a loading of .87. Items not reaching an arbitrary cut-off loading of .39 were excluded from consideration in the scale measurement and, although there were no item loadings hovering very close to the cut-off point, a number of items with loadings between .20 and .24 obviously were contributing to scale performance, albeit relatively less.

The latter highlights a common dilemma: Whether to opt for a measurement technique that takes account of all available information in a data set at the expense of some scale portability (in the sense that a scale may be applied in different settings), or whether to opt for a procedure which allows for more portability, but which, as a result, loses or fails to take into account some information. The argument declared so far in this thesis has been that the application of rigour in an effort to minimize information loss while endeavouring to achieve maximum generalizability represents a superior enterprise to the development of portability alone. In a forced choice dilemma, it might be argued that the former should take precedence. The utility of a single-score scale is obvious, as is a three-factor scale comprising three composite scores. That utility is undermined by imprecision is equally clear. Consequently, in the current project, *all* item loadings resulting from factor analysis were utilized.

In addition to those already detailed, and to remedy some of the perceived design flaws in Friedlander's research referred to earlier, other corrective features were implemented in the third study to be reported. Namely, client and therapist demographic and related variables were systematically collected for routine inclusion in the

estimation of predictive models and neither clients nor therapists were debriefed until the study had been concluded.

Although several problems have been highlighted in the manner in which the Friedlander (1982) research was conducted, the measure developed for it - more than any other examined - satisfied the current requirements as outlined earlier in this section. Therefore, Friedlander's therapy evaluation measures were those employed in the third study of the present series, although the timing of their application was changed. Rather than being applied after the second therapy session (as in Friedlander's study), the first client evaluation form (CPQ1) was given at the termination of therapy, as was the therapist evaluation form (CPQ2). This enabled presentation of the second client evaluation form (CSQ) at follow-up. The therapist form of the questionnaire requests the therapist to answer questions in respect of the client just interviewed and, given that all forms of the questionnaire are identical, thus provides the opportunity for direct comparison between client and therapist evaluations. (As it was not the intention to examine the effects of client and/or therapist *expectancy sets* on therapy appraisal, Friedlander's [CEQ] expectancy measure was not utilized.)

The next chapter reports the first study in this series and details the therapist sex-role orientation preferences of a sample of genuine therapy clients.

CHAPTER 4

CLIENT-PREFERRED THERAPIST SEX-ROLE ORIENTATIONS

INTRODUCTION

Before examining the effects of joint client and therapist sex-role orientations on the assessment of therapy and given so many unknowns in the area of sex-role orientation as it relates to therapy, clients' and therapists' sex-role orientations were considered independently in the first two studies to be reported. It was considered imperative to determine firstly the valence (if any) that clients might accord different therapist orientations. If clients rated all therapist orientations similarly, pursuit of the variable as potentially significant in the social influence formula would seem unwarranted, or at least the strength of the argument purporting its significance would appear weakened.

Research regarding the therapist gender preferred by clients has yielded ambiguous data and shown, for example, that clients prefer male therapists (Fuller, 1963) and female therapists (Howard, Orlinsky & Hill, 1970). Part of

the reason for this lack of congruity may result from the fact that subjects are typically undergraduate students receiving course credit for their involvement. It is possible that what is being assessed in these studies, rather than therapist preference, is student sample variability which may or may not be present in the same way in samples of actual clients. Further, students may be motivated by the promise of financial or other rewards to "repay" researchers with what they think researchers want to see and/or hear.

In this connection, Gelso (1979) discussed three conditions necessary to maintain the external validity of analogue therapy research. These were (1) to approximate as closely as possible the therapy situation; (2) to examine questions which either have been raised in-the-field by practitioners, or which cannot be examined in-the-field (perhaps for ethical reasons); and (3) to gain confirmation of laboratory findings through in-the-field research replication. To the extent that these guidelines have often been ignored in analogue therapy research, so is the generalizability and utility of findings based on this approach reduced.

An area of therapy research that has attracted both analogue and in-the-field investigation is that concerned with the therapist sex-role orientations most preferred by clients. As reported in the introduction to this thesis, Highlen and Russell (1980) conducted such an investigation using a therapy analogue approach. The researchers based their study on the belief that both instrumental and expressive traits comprise the interpersonal flexibility required of a therapist called on to respond to clients with diverse concerns in situations where therapeutic demands change rapidly. Individuals who possess high levels of both instrumental and expressive traits are said to hold an androgynous sex-role orientation (Spence & Helmreich, 1978; Spence, Helmreich & Stapp, 1975). Highlen and Russell's findings indicated that first year Psychology undergraduate female students (acting as clients) preferred feminine-oriented or androgynous therapist descriptions to masculine-oriented therapist descriptions. Neither student nor therapist gender nor student sex-role orientation was found to affect students' ratings. The authors concluded by recommending that these variables be examined within an actual therapeutic context.

Blier, Atkinson and Geer (1987) also used the therapist sex-role orientation descriptions developed by Highlen and

Russell to explore clients' preferences for therapists with different sex-role orientations. Clients were 47 male and 60 female students presenting for therapy at a university counselling centre. Upon arrival at the centre, clients were given a written list of 23 typical client concerns and asked to rate their willingness to see a particular therapist in response to each concern. There were both similarities and discrepancies between Blier et al's. findings and those reported by Highlen and Russell. The feminine therapist sex-role orientation description was rated higher than the masculine description for listed concerns of a personal nature; the converse held when concerns related to assertiveness; and for academic concerns, both the androgynous and masculine orientations were rated higher than the feminine orientation. Neither client nor therapist gender nor client sex-role orientation significantly affected the ratings given. Whether these or Highlen and Russell's findings would generalize to a nonstudent client sample in a nonuniversity setting was unknown. To ascertain this, and in spite of the difficulties involved in conducting research with genuine clients, Gelso's (1979) third condition described above was invoked in the present case and an in-the-field replication of Highlen and Russell's research was undertaken.

Insofar as genuine clients in the current study were more likely to be seeking therapy for personal concerns, both Highlen and Russell's and Blier et al.'s findings pointed to the likelihood of feminine sex-role oriented therapists being rated more positively than masculine sex-role oriented therapists. It also was expected that neither client nor therapist gender would significantly influence ratings. In order to minimize clients' involvement time and counselling section disruption and because neither Highlen and Russell nor Blier et al. had found the variable to be a significant determinant of ratings of therapist descriptions, client sex-role orientations were not assessed in the present case.

To reiterate the hypothesis associated with this study (from Chapter 1):

- Clients will rate therapists with androgynous or feminine sex-role orientations more favourably than they will therapists with a masculine sex-role orientation.

METHOD

Description of the Sample

The project continued for a period of two months, in which time 210 clients agreed to be involved and 30 clients (12%) declined. Inevitably, some clients were not asked to be involved. Reasons included: because it was not remembered to ask them, because they could not understand English, or because they arrived late for their appointment. Participating clients ranged in age from 16 to 64 years (total *M*=34.99, *SD*=6.54; females: *M*=33.72, *SD*=6.36; males: *M*=36.26, *SD*=6.49). Of the 30 persons who declined to be involved in the study, 14 were female and 16 male (total *mean* age=34.37 years, *SD*=6.99; females: *M*=35.19, *SD*=6.18; males: *M*=33.54, *SD*=6.33).

Means, frequencies and percentages relating to the various demographic and other data collected from each participating client are presented in Table 4.01. Unfortunately, the level of client educational attainment was recorded for only a few clients. There were insufficient data, therefore, for meaningful analysis. This only became known at the time of data analysis. Although

secretaries were requested to collect this information, this typically did not occur. The reasons for this are unclear, but may reflect a reluctance based on self-consciousness. In other words, secretaries may have felt that questioning clients regarding their level of educational attainment was overly intrusive. However, such a belief was not communicated to the author.

Procedure

The study was conducted in one of the largest Family Court Counselling Sections in New South Wales, Australia. The Section (Registry A) serviced a general population

Table 4.01

Demographic and Related Data Pertaining to Clients

Variable	Sex	Frequency
Number of, and Sex of Clients	f	106
	m	104

(n = 210)

(*table continues*)

Table 4.01 (Contd.)

Demographic and Related Data Pertaining to Clients

Variable	Sex	Frequency	Percent of Total
Number of Couples[a]	-	62	-
Number of Individuals[a]	-	86	-
Country of Origin			
Americas	-	2	0.9
Asia	-	2	0.9
Australia	-	111	52.9
Europe	-	40	19.0
Oceania	-	7	3.3
Occupation			
Armed Services / Corrective Services Personnel	m	3	1.4
	f	3	1.4
Home Duties	m	0	0
	f	29	13.8
Managerial Position / Self-Employed	m	14	6.7
	f	1	0.5
Manual Worker / Unskilled Labourer	m	21	10.0
	f	4	1.9
Office Worker / Customer Services Personnel	m	15	7.1
	f	20	9.5
Professional	m	5	2.4
	f	8	3.8
Tradesperson	m	22	10.5
	f	3	1.4
Unemployed	m	18	8.6
	f	31	14.8

(n = 210)

Note. Due to missing data, some sections do not total 100%

[a] Refers to whether both members of a couple attended for therapy, or only one member

(table continues)

Table 4.01 (Contd.)

Demographic and Related Data Pertaining to Clients

Variable	*M* (*SD*)	Sex	Frequency	Percent of Total
Years of Age	34.98 (6.60)	-	-	-
Number of Years Married	9.86 (5.90)	-	-	-
Number of Children	2.26 (1.10)	-	-	-
Total Number of Children	-	m	240	51.9
Total Number of Children	-	f	222	48.1
Clients Having[a]				
All of the Children		m	17	8.1
in Their Care	-	f	24	11.4
Some of the Children		m	8	3.8
in Their Care	-	f	8	3.8
None of the Children		m	35	16.7
in Their Care	-	f	10	4.8
Clients' Children				
Less than 1 Year Old	-	-	10	2.2
1 to 5 Years Old	-	-	110	23.8
5 to 9 Years Old	-	-	128	27.7
9 to 13 Years Old	-	-	120	26.0
13 to 18 Years Old	-	-	72	15.6

(n = 210)

Note. Due to missing data, some sections do not total 100%

[a] Calculated for couples only

(*table continues*)

Table 4.01 (Contd.)

Demographic and Related Data Pertaining to Clients

Variable	Percent of Total
Clients Married	
Once	70.2
Twice	28.3
Thrice	1.5
Clients Living Apart	88.8
Separate in Same House	2.9
Together in Same House	8.3
Source of Referral	
Court (Judge)	56.1
Court (Registrar)	12.2
Helping Agency	4.4
Self	15.6
Solicitor	11.7
Clients Having Had Previous Court Counselling	30.2
In Ongoing Court Counselling	20.5
Clients Having Seen a Solicitor	80.5

(n = 210)

Note. Due to missing data, some sections do not total 100%

numbering approximately two million and was staffed by a total of 11 Family Court Counsellors. It was chosen for the study on the basis of a large client turnover and, it was envisaged, minimal service disruption, two features which would enable quick and effective completion of the initial stage of research.

After securing approval from Principal Registry for the running of the study - contingent upon agreement at the local level - a meeting was arranged with the Section's Director of Counselling. The Director discussed the particular difficulties experienced in the Registry, but also expressed interest in the research and requested that it be outlined to counsellors and secretaries for final approval. A meeting was convened for this purpose, which all counsellors and secretaries attended. Although several important issues were aired during the meeting, including a focus on client confidentiality, the net result was that all agreed the project should be implemented. No-one in the Section was informed how many clients were to be involved in the study, only that there would be several hundred. In recognition of the fact that secretaries would have the pivotal role in ensuring the success of the study, several meetings were held with them to clarify their role and to ensure the smooth running of the research with minimal

disruption to the primary function of the Section. Furthermore, the author was in the Registry throughout the study to deal with any issues arising as a result of the project's implementation.

All clients presenting at the counselling section were asked by the secretary to participate, voluntarily, in a project designed to investigate "What helps to make counselling effective." Clients were self-selected, the only condition being that each one had an appointment for therapy. Secretaries were requested to make client appointments 15 minutes earlier than the actual appointment time to allow time for completion of the questionnaires. Upon arrival at the Section, client demographic and related details were taken by secretaries as usual, or clients completed such details themselves, after which the client was asked to take away the written request to be involved in the study (Appendix 4A). Appended to the request were the therapist descriptions outlined below. The sheets were fastened to a clipboard with a biro attached. The client was asked to take the clipboard and attached sheets with the request: "Would you please read this and return it to me when you have finished. Thank you." Large boxes were provided for the collection of completed forms. Demographic details of clients who refused to be involved in the study also were kept.

To allay the possibility that they might unwittingly set-up client expectations and to keep them from having to engage with clients in prolonged discussions concerning the study, secretaries were instructed to deflect any client questions regarding the research with the statement "All the information concerning the research is contained in this first sheet" (Appendix 4A). Instructions to secretaries also were provided in written form. It was imperative to set-up the study in such a way that secretarial time devoted to it could be kept to an absolute minimum. If this had not been done and the research had started to impinge on the functioning of the Section, support for the project would have been withdrawn. It also was desirable that the study could proceed unhindered on those occasions when one of the secretaries was not in attendance for whatever reason.

Although neither secretaries nor therapists complained about the project during its period of implementation, it nevertheless clearly represented an additional strain on an already overly-committed service. This, of course, was exacerbated by clients who arrived late for their appointment. This particular event was short-circuited by telling the secretaries not to give the questionnaire to clients who arrived for their appointment more than 10

minutes late. However, often by the time this sort of issue had been brought to light, a certain amount of disruption had already taken place. The point to be made here is that the mere introduction of relatively minor changes to procedure necessitated by a research project can often induce a disproportionate disruption, which, if not quickly and decisively dealt with has the potential also to disrupt the research in progress.

The Therapist Sex-Role Orientation Descriptions

From questionnaires, clients were asked to rate their willingness to see and disclose to an androgynous, masculine and feminine therapist sex-role orientation description. The descriptions used were the same as those developed by Highlen and Russell (1980) and based on adjectives from Bem's Sex-Role Inventory (BSRI), the Personality Research Form, the Jackson Personality Inventory and from loading on the Masculine and Feminine factors of the BSRI. Undergraduate female student raters employed by Highlen and Russell had agreed unanimously that each description matched its respective sex-role orientation definition. Held constant across the three descriptions were variables that had been shown to produce significant differences in therapist preference, namely,

age, expertise and marital status. Therapist gender descriptions were manipulated such that they referred to either a male or a female therapist. The instructions preceding the first description and the three descriptions presented to each client were as follows:

> Imagine that you have decided to go to see a counselling psychologist. Based on the descriptions given below, please answer the questions that follow each.
>
> [The Androgynous Therapist Description] This counselling psychologist is single, 31 years old, and has been in practice for five years. At present, s/he is leading assertiveness-training classes part-time while working full days in private practice. This abundance of energy is also reflected in the fact that s/he entertains her/his many friends frequently, sometimes after a long working day. Her/his independence was learned early because her/his parents gave her/him a lot of responsibility. With her/his clients, s/he is compassionate and supportive.
>
> [The Masculine Therapist Description] This 31 year old counselling psychologist obtained her/his degree 5 years ago. An excellent, analytic chess player, s/he enjoys the competitive nature of the game. S/he is a spokesperson for a local social action group as s/he is not afraid to speak her/his mind. The fact that s/he has chosen to remain single, for the meantime, reflects her/his freedom and independence. Although it seems as if there are too few hours in the day for her/his limitless energy in work and play, s/he does use what time s/he has efficiently. S/he is poised in dealing with clients and remains objective when faced with a problem situation.
>
> [The Feminine Therapist Description] This counselling psychologist is 31 years old and is not yet married. S/he has been practicing for the last 5 years in a local agency. Her/his compassionate nature is reflected in her/his involvement as a volunteer with a summer camp for handicapped children. S/he is tactful and gentle with her/his many friends in whom s/he has no difficulty in confiding. S/he is currently involved in several community projects for the rehabilitation of ex-

> psychiatric patients. With her/his clients, s/he is both sympathetic and supportive.

Ratings were made on seven-point scales ranging from a low of 1 *(Extremely Unwilling)*, to a high of 7 *(Extremely Willing)* in response to each of two questions appended to each description, as follows:

> How willing would you be to see the counsellor described here for counselling?
>
> How willing would you be to discuss anything you wished to in your interview with this counsellor?

In order to guard against ordering effects, 35 copies of each of the six possible description combinations were utilized, the description combinations being: (1) the androgynous description followed by the masculine description followed by the feminine description; (2) androgynous, feminine and masculine descriptions; (3) masculine, androgynous and feminine descriptions; (4) masculine, feminine and androgynous descriptions; (5) feminine, androgynous and masculine descriptions; and (6) feminine, masculine and androgynous descriptions. Therapist gender descriptions were manipulated such that 17 copies in each of the first three description questionnaires referred to a male therapist and 18 to a female therapist; 18 copies in each of the latter three

description questionnaires referred to a male therapist and 17 to a female therapist. Description questionnaires were randomly assigned to clients and each client received one questionnaire. In this way, by rating all therapist sex-role orientation descriptions, clients served as their own controls.

Procedures Adopted for Determining Ethnicity and Occupation

The procedures adopted for determining clients' ethnic and employment categories were as follows. Clients were separated into ethnic groupings on the basis of their country of birth using the five divisions employed by the Australian Bureau of Statistics (1985). However, as there were no Africans in the present sample, that category was omitted and, as there were many Australians and other Oceanians, persons from each of these areas were grouped separately. This procedure resulted in the following broad categories:

1. The Americas
2. Asia
3. Australia
4. Europe
5. Oceania

The short (six-point) version of the Australian National University occupation scale was employed to determine the status of clients. The scale was selected primarily because of its extensive development on local samples (Broom, Duncan-Jones, Jones & McDonnell, 1977a, 1977b; Broom & Jones, 1977) and has been described as offering "a broad distinction between Professional, Managerial, White-Collar, Skilled Manual, Semi-Skilled Manual, and Unskilled Manual jobs" (Jones & Jones, 1972, p.76). It was anticipated that a sufficiently large number of people in the current sample might fall outside the groups included in the original version of the scale to warrant the addition of extra categories. Consequently, the categories "Home Duties" and "Unemployed" were added to the scale.

(Throughout this thesis, the term *City*, indicating the city in which a Registry was located, is used interchangeably with the term *Registry*.)

RESULTS

The findings detailed throughout this thesis are based on the .05 decision rule. Only .05 and .01 critical levels have been reported.

Using *t* and χ^2 tests, the group of males and females who declined to be involved in the study were not found to differ significantly from each other on any of the demographic or related variables detailed in Table 4.01. The demographic and related data for the refusing group of clients were compared, via *t* or χ^2 tests, to data from the 210 subjects who agreed to be involved. The only significant result from these analyses concerned the proportion of *Couples/Individuals* in each of the groups. There was a significantly greater proportion of Individuals in the refusing group (χ^2=15.71, p<.01). That is, a client arriving at the Counselling Section with a (ex)spouse was more likely to agree to be involved in the study than was a person arriving alone.

Using analysis of variance, demographic and related variables were analysed to determine their possible influence on ratings of therapist gender and sex-role orientation. Ratings were not found to be significantly related to any such variable.

Within the sample, males and females differed from each other only in respect of occupation (χ^2=71.48, p<.01), with large differences evident in the Home Duties, Managerial, Manual Worker/Unskilled labourer and Trades categories.

A full table of correlations between clients' ratings and demographic and related data is presented in Appendix 4B. In this thesis, for the purposes of comparison, Pearson *r* correlations between demographic and related data and the continuous variables of interest have been included throughout (usually in an appendix). Pearson *r* is equal to a point-biserial correlation (r_{pb}) where one variable is dichotomous (for example, where a dummy variable might be employed) and the other is approximately continuous and normal in array (Howell, 1982). That the distinction between relationships and differences should not be considered clear-cut is demonstrated, for example, by the fact that r_{pb}^2 is a direct function of *t* (Howell, 1982).

Pearson correlation coefficients were calculated to analyse differences between responses to the two questions appended to each of the three therapist descriptions. That is, between the questions "How willing would you be to see this counsellor for counselling?" and "How willing would you be to discuss anything you wanted to with this

counsellor?". Correlations of .86, .87 and .87, all significant at the $p<.01$ level, were found between responses to the questions appended to the androgynous, masculine and feminine descriptions, respectively. As a result, in subsequent analyses responses to each of the two questions were not analysed separately, but were combined for each sex-role orientation description.

To analyse the differences between ratings of therapist sex-role orientations and the differences between ratings of therapist gender within each orientation, a 2 x 3 repeated measures multivariate analysis of variance procedure was adopted. Using the *SAS General Linear Models* programme for repeated measures, MANOVA test criteria could be obtained for each of the gender contrasts in each orientation. Results from this analysis are presented in Table 4.02. As can be seen in the top half of Table 4.02, there was a significant overall sex-role orientation effect, indicating differential client ratings of androgynous, feminine and masculine therapist descriptions.

The bottom half of Table 4.02 reports the results from testing whether therapist gender had any effect on the way clients rated each of the therapist sex-role orientation descriptions. A significant effect was found between

Table 4.02

Results from Repeated Measures Multivariate Analysis of Variance on Ratings of Therapist Sex-Role Orientations and Gender Descriptions

Effect	Wilk's Criterion	*df*	*F*
Therapist Sex-Role Orientation	0.9545	2, 197	4.70**
Therapist Gender			
Sex of Androgynous Description	0.9860	2, 197	1.40
Sex of Masculine Description	0.9677	2, 197	3.29*
Sex of Feminine Description	0.9973	2, 197	0.27

*$p<.05$ **$p<.01$

therapist gender and the masculine sex-role orientation description. Clients rated masculine males significantly more positively than masculine females. Gender was not regarded as an important feature for the androgynous- or feminine-oriented therapist.

To explore further the differences between ratings of therapist sex-role orientations (already noted in the top half of Table 4.02) and to ascertain the degree to which

one orientation was rated more favourably than another, using a 3-way repeated measures analysis of variance procedure, the masculine therapist description was contrasted with the feminine description and the androgynous with the masculine and feminine descriptions. Results of these contrasts are presented in Table 4.03.

Table 4.03

Results from Repeated Measures Analysis of Variance between Ratings of Three Therapist Sex-Role Orientation Descriptions

Source	*df*	*SS*	*F*
Androgynous v. Masculine	1	0.02	0.01
Error	198	491.49	
Androgynous v. Feminine	1	18.42	7.50**
Error	198	486.23	
Masculine v. Feminine	1	19.65	6.90**
Error	198	563.46	

**$p<.01$

As may be seen from Table 4.03, both the androgynous and masculine therapist descriptions were rated significantly more favourably than the feminine description and no significant difference was found between ratings of the androgynous and masculine descriptions.

Relative to each of the two questions appended to each therapist description, means and standard deviations corresponding to the categories presented in Tables 4.02 and 4.03 are presented in Table 4.04.

Table 4.04

Means and Standard Deviations for Ratings of Therapist Preference and Willingness to Disclose by Therapist Sex-Role Orientation and Gender Description

Independent Variable	Therapist Preference (Question1)		Willingness to Disclose (Question2)	
	M	*SD*	*M*	*SD*
Therapist Sex-Role Orientation:				
Androgynous	3.52	1.77	3.49	1.84
Masculine	3.55	1.84	3.46	1.88
Feminine	3.22	1.74	3.18	1.79
Therapist Gender:				
Androgynous Description				
Male	3.66	1.71	3.56	1.85
Female	3.38	1.82	3.43	1.85
Masculine Description				
Male	3.78	1.77	3.68	1.87
Female	3.30	1.88	3.23	1.87
Feminine Description				
Male	3.17	1.64	3.19	1.71
Female	3.26	1.83	3.18	1.89

(n = 210)

DISCUSSION

This study sought to determine the therapist sex-role orientations preferred by genuine clients presenting for therapy. Clients, 210 in number, attending a large Family Court Counselling centre were asked to rate written descriptions of male and female androgynous, masculine and feminine therapists on the basis of their willingness to see and disclose to each one. Clients indicated their preference for the masculine and the androgynous therapist over the feminine therapist and the masculine male over the masculine female. The only significant gender effect was related to this latter finding. Feminine males received the lowest ratings and masculine males the highest ratings. Highlen and Russell employed only females for the purposes of rating therapist descriptions; however, as there were no client sex differences in the way ratings were made in the present study, it seems reasonable to compare findings from the two studies. The present findings do not confirm those reported by Highlen and Russell in that those authors related that feminine therapists were accorded the highest ratings.

Highlen and Russell postulated that as more detailed therapist information was made available to clients asked

to rate therapists, discrepant research findings would abate, particularly those relating to therapist gender. The current results, however, do not support this line of reasoning. Precisely the same amount of information was given clients in this study as was given subjects in the Highlen and Russell study, yet the findings are, for all practical purposes, diametrically opposite. Although some of these differences may be understood as being culturally mediated, a more parsimonious explanation is that the gender, age, status, motivation and environment differences between the two studies renders any comparison between them potentially misleading. Highlen and Russell employed female students with a mean age of 22 years. The current sample was comprised of male and female therapy clients with a mean age of 35 years. Students arriving to participate in an analogue experiment may be considered to have a different motivation for their involvement from clients arriving for therapy in personal distress with significant concerns. Similar noncomparability of the studies can be detected in the therapy and nontherapy settings utilized. The present findings plainly vindicate Gelso's (1979) admonition that analogue findings be confirmed in-the-field.

Similar important age, status and motivation differences can be identified between the present client sample and that of Blier, Atkinson and Geer (1987). The mean age of the latter sample was 22 years, all were students, and probably none were seeking assistance for the purpose of dealing with the extreme personal distress that accompanies the sort of conflictual tension and acrimony generated by arguing about one's children and property.

Blier et al. asked students presenting for counselling at a university counselling centre to rate their preference for therapist sex-role orientations in response to each of 23 written concerns. Preference for a feminine sex-role oriented therapist was rated more highly than preference for a masculine-oriented therapist when the listed concerns were of a personal nature. The only client preference profile similar to that demonstrated by clients in the present case were those made by clients in response to academic concerns. It is unlikely that clients in the present case presented for counselling with concerns of an academic nature. It is more likely they presented with personal concerns related to their dealings with their (ex)spouse. The current findings indicate that Family Court clients preferred an androgynous- and masculine-oriented therapist to a feminine-oriented therapist. Perhaps clients

in the present case felt pressured by the severity of their conflict to favour a more direct intervention in their situation (for example, support for a custody, access, or restraint application) than they perceived a feminine-oriented therapist might provide. Students, on the other hand, may not routinely present with such agitated desperation and be more prepared to accept a less directive stance. The strength of this argument is somewhat weakened, however, by Blier et al.'s comment that their clients presented for counselling because of personal concerns, which in turn may have contaminated clients' ratings of therapists when ratings were made in response to academic or assertiveness concerns.

The present findings suggest that not only problem type, but also the level of severity of concern may be important in influencing the way clients rate their preferences for therapist sex-role orientations. It would be of interest to know whether clients in extremely conflictual relationships who present for assistance at other agencies (for example, at marriage guidance centres) demonstrate similar preference patterns as clients in the present case. If such clients gain more from directive interventions than otherwise, there are implications for the training and practice of therapists. There is no suggestion here,

however, of a necessary link between clients' preferences and ultimately beneficial therapeutic options.

Contrary to the Highlen and Russell and Blier et al. findings, then, present results indicate that clients *were* differentially influenced by therapist gender description and, in the manner in which they were portrayed in the therapist descriptions offered, valued both instrumental *and* expressive traits. In addition, as client preferences were not found to be client-sex dependent, the results confirm some findings (e.g., Scher, 1975) and disconfirm others (e.g., Geer & Hurst, 1976). Findings also clearly speak to the advisability of including therapist gender as an independent variable in models seeking to ascertain the determinants of client satisfaction with therapy or clients' preferences for therapists and support similar suggestions in the literature (e.g., Berzins, 1977). These and other findings from the study attract additional scrutiny and discussion in the chapter concluding this thesis.

Having established client preferences for particular therapist sex-role orientation descriptions, it was desirable next to establish the sex-role orientations actually held by therapists. Although some overseas

research had been completed in this regard, the next chapter documents the first investigation of the sex-role orientations held by experienced and practicing Australian psychologists and social workers.

CHAPTER 5

AUSTRALIAN THERAPISTS' EXPRESSED SEX-ROLE ORIENTATIONS

INTRODUCTION

Dailey (1983) suggested that part of the reason equivocal findings have resulted from investigations of positive and negative therapist bias in response to client gender has to do with the possibility that researchers have been "looking at the wrong variables" (p.20), in that sex-role orientation or "psychological sex" (p.20) might be a more relevant explanatory variable of bias than biological sex has proven to be. In response to these observations, Dailey conducted research to assess the sex-role orientations of American social workers. Mailed questionnaires were utilized to determine whether therapists' identified sex-role orientations could be tied to their clinical judgments of written client case histories and whether differential ratings would be accorded clients described as holding different sex-role orientations. Of 765 therapists polled, 43 percent (n=328) returned completed questionnaires.

Findings based on Bem's (1974) Sex-Role Inventory indicated that: More therapists held an androgynous orientation than any other orientation, therapists' sex-role orientations did not affect the way in which they judged clients' written case histories and androgynous client descriptions evoked more positive therapist responses than did other client sex-role orientation descriptions. In sum, client, but not therapist sex-role orientation was found to affect therapists' clinical judgments. It was concluded that therapist sex-role orientation did not influence a systematic bias in clinical judgment, but that there may be emerging "a new sex bias" (p.20) favouring the androgynous individual, which, Dailey asserted, "may be no less harmful to clinical judgment activities or to the helping process" (p.24) than any other gender based bias. That therapists were more likely to hold an androgynous orientation and that clients with an androgynous orientation were judged most favourably, offers support to opinion which regards the androgynous orientation as the one most closely linked to notions of mental health and well-being (Murstein & Williams, 1983; Patterson & McCubbin, 1984) and perhaps the one that therapists should be inclined to influence clients toward (Gilbert, 1981; Sturdevant, 1980).

Dailey's (1983) stated intention was "to move on" (p.20) from examination of biological sex to consideration of sex-role orientation as a more significant variable in the determination of therapist bias in response to client gender; however, the possible effect(s) of biological sex on the results obtained were not considered, or at least were not reported. This, then, renders it impossible to compare the relative power of the variables to explain the data. In order to demonstrate the superior (or inferior) power of prediction of one variable over another in any hypothesized model, it would appear as given that both variables appear in the model, or at least that they each enter the equation at some point. The net result of Dailey not including biological sex in the model tested is that it still is not known whether biological sex or sex-role orientation is the better predictor of therapists' clinical judgments. So, while information was added to the field, more could have been gleaned from the study had all variables of interest been included in the analyses conducted.

The current study was designed to examine therapists' sex-role orientations in an Australian context. Based on Dailey's American findings, more Australian social workers were expected to demonstrate an androgynous orientation

than any other orientation. In addition, as noted in Chapter 1, if it is supposed that mental health professionals might score highly on indicators of mental health, then research and opinion which supports androgyny as the desirable sex-role orientation relating to mental health might predict that this orientation is the one most likely held by mental health professionals. This prediction gains additional support from the contention that both instrumental and expressive traits are important in contributing to the interpersonal flexibility required of therapists called on to respond to clients with diverse concerns in situations where therapeutic demands change rapidly (Highlen & Russell, 1980). The current study, then, was designed to explore this prediction and to determine whether the sex-role orientations held by a sample of Australian therapists matched the androgynous and masculine orientations most favoured by a sample of Australian clients (reported in Chapter 4). The study also provided the opportunity for cross-cultural validation of Dailey's (1983) American findings.

To reiterate the hypothesis associated with this study (from Chapter 1):

- Social workers are more likely to manifest an androgynous sex-role orientation than any other sex-role orientation.

METHOD

Description of the Sample

The Personal Attributes Questionnaire (PAQ; Chapters 1 and 3 and Appendix 3C) was posted-out to 76 therapists in Family Court counselling centres throughout Australia. Of these, 60 completed questionnaires were returned, resulting in each of the six Australian States and two Territories being represented by a total of 60 mailed returns from 11 Registries. Only three small Registries provided nil returns.

Of the 39 therapists personally approached by the author, all agreed to be involved in the study and all completed the PAQ in the author's presence.

The therapist pool, then, consisted of 99 therapists from 15 Family Court Registries throughout Australia. Table 5.01 presents the information collected from each therapist.

As can be seen from Table 5.01, females outnumbered males in the ratio of nearly two-to-one and therapists ranged in age from 26 to 62 years (total M=40.82, SD=8.47; females:

Table 5.01

Demographic and Related Data Pertaining to Therapists

	N	*M* (Years)	*SD* (Years)
Males	36	-	-
Females	60	-	-
Psychologists	48	-	-
Social Workers	50	-	-
Age	99	41.0	8.5
Full-Time Post-Graduate Training in Therapy	37	2.2	1.4
Part-Time Post-Graduate Training in Therapy	25	2.8	1.4
Full-Time Post-Basic-Degree Practice of Therapy	99	10.0	6.2
Part-Time Post-Basic-Degree Practice of Therapy	15	5.6	2.5
Full-Time Practice of Family Court Counselling	99	4.6	3.3

(n = 99)

Note. Due to missing data not all sections total 100%

M=40.00, *SD*=9.37; males: *M*=41.65, *SD*=6.78). The therapists constituted a group very experienced both in the general practice of therapy (*M*=10.00 years, *SD*=6.24 years) and in the practice of Court Counselling (*M*=4.60 years, *SD*=3.33 years). The mean number of years spent in post-graduate training in therapy was 2.5 years (*SD*=1.40). 37 therapists (37%) reported not having had any formal post-graduate training in therapy. However, although Australian education courses now lean toward more formal graduate clinical training, especially in psychology, in the past it has not been unusual for social workers to complete only a professional undergraduate degree.

Scale Considerations

An issue of some import concerns the degree of comparability of findings based on Bem's (1974) Sex-Role Inventory (BSRI) and Spence and Helmreich's (1978) PAQ. Spence and Helmreich (1978) described correlations between the instruments of .75 for males and .73 for females on the Masculinity scale and .57 for males and .59 for females on the Femininity scale. The authors commented that one reason for these lowered correlations might be related to the fact that while the BSRI employs unipolar scaling (e.g., how characteristic of you is the trait description

"independent"), the PAQ utilizes bipolar scaling (e.g., indicate the point most descriptive of yourself on this scale ranging from "independent-dependent"). It was suggested that such scaling differences "could conceivably lower the correlations between ... measures" (Spence & Helmreich, 1978, p.24). Cunningham and Antill (1980) compared results from five different sex-role orientation measures and reported that results from the PAQ and BSRI were the most similar. Nevertheless, the researchers recommended that caution be exercised in generalizing results from one androgyny measure to another. From their study of the results from 26 investigations of androgyny, however, Bassoff and Glass (1982) concluded that the average correlations between mental health indices and masculinity-femininity scales were similar, regardless of the androgyny measure being employed. Cook (1985, 1987), meanwhile, noted that the scales from different androgyny measures that assessed similar dimensions were positively correlated, though not as highly as one might hope for. It seems, then, that although results from different androgyny measures might reasonably be compared, equivalence of the measures should be not be assumed.

Procedure

In order to determine the sex-role orientations of a group of mental health professionals, a large sample of practicing psychologists and social workers was sought. Probably the majority of therapists in professional practice in Australia belong to one of these professions. To this end, therapists of the Family Court of Australia were polled, Australia-wide. All such therapists are either psychologists or social workers. As in the previous study reported, approval to conduct the research was solicited from the Principal Registry of the Family Court. Approval was granted, subject to therapist agreement.

In addition to the 39 counsellors personally approached by the author, each of the 76 Family Court Counsellors on duty in Australia at the time of the study was posted a copy of Spence and Helmreich's (1978) Personal Attributes Questionnaire, together with a request that it be anonymously completed and returned in the pre-paid envelope supplied. Information was given that the research was broadly concerned with therapist and client variables and the relationship these maintain with therapy outcomes (Appendix 5A). Confidentiality was guaranteed, and several motivating comments were included in the hope of encourag-

ing a high return rate. No comment concerning the questionnaire was made, save to point out that in order to avoid setting up expectations, little could be said about it.

Given the sample and the distinct possibility that a large number of the therapists may have been very familiar with the measure, three additional questions were appended to it, as follows:

1. Did you recognize this measure?
2. Have you previously completed this, or a similar measure?
3. If so, how long ago?

Answers to these questions would enable comparisons between those who were and those who were not familiar with the instrument, to determine the significance of any scale score differences that might be noted between them.

In addition to those therapists who were sent a mailed questionnaire, the 39 therapists from the four large Registries identified in the previous chapter were personally approached by the author and requested to complete the measure. The information given these therapists was the same as that supplied to therapists in the mail-out. Questions from therapists were deflected with the standard reply that discussion of the questionnaire could only take place after its completion.

RESULTS

Of the 99 therapists who completed the Personal Attributes Questionnaire (PAQ), 9 indicated they had recognized and had previously completed it (an average of 3 years ago, SD=1.8 years). Using t tests, the scores of these therapists were not found to be significantly different from the scores of therapists who reported they had not recognized, or previously completed the measure.

T tests were conducted to ascertain whether the 39 therapists who were personally interviewed by the author were influenced to respond to the PAQ differently from those therapists who returned mailed questionnaires. The 9 male therapists who were interviewed personally by the author scored significantly higher on the Masculinity-Femininity scale than the 27 male therapists who returned completed mailed questionnaires (t=2.05, df=34, p<.05). In addition, in the sample of therapists personally approached by the author, there were significantly fewer males (9/39 versus 27/57: χ^2=6.28, df=1, p<.01) and significantly more reported years of full-time therapy practice (t=2.01, df=95, p<.05).

The *means* and *standard deviations* of therapists' PAQ sex-role orientation scale scores, by sex, are presented in Table 5.02. Although a total of 99 therapists completed the measure, 3 did not record their gender and therefore do not appear in some of the tables that follow. Analysis of variance indicated that sex-role orientation scores were not significantly influenced by any demographic or related variable and scores by males and females were not found to be significantly different. A full table of correlations between scale scores and demographic and related variables is presented in Appendix 5B.

Table 5.03 shows that therapists' median Masculinity and Femininity scores were somewhat higher than those reported by Spence and Helmreich (1978), although the Masculinity-Femininity scale scores were identical.

For the purpose of comparison with Spence and Helmreich's (1978) descriptions, the groups' median scores were used to divide responses into four sex-role orientation categories. Cross-sexed individuals were those in the masculine-female and feminine-male categories. As can be seen from Table 5.04, more male and female therapists held an androgynous sex-role orientation than any other orientation, although the χ^2 statistic indicated there were no significant differences between the groups.

Table 5.02

Means and Standard Deviations of

Therapists' Sex-Role Orientation Scores by Sex

	Scale[a]					
	M		F		M-F	
Sex	*M*	*SD*	*M*	*SD*	*M*	*SD*
Males (*n*=36)	22.3	4.1	24.3	2.7	15.4	3.7
Females (*n*=60)	22.1	3.5	24.0	2.7	14.6	3.4
Total (*n*=96)	22.2	3.8	24.2	2.7	15.0	3.6

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

Table 5.05 displays the correlations between PAQ scales. Spence and Helmreich's (1978) androgyny construct predicts

Table 5.03

Therapists' Median Sex-Role Orientation Scores on Each of the Three Scales of the Personal Attributes Questionnaire

Scale[a]		
M	F	M-F
23	24	15
(21)	(23)	(15)

(n = 99)

Note. Spence & Helmreich's (1978) findings are in parentheses

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

that the Masculinity and Femininity scales should be independent, that the Masculinity scale should be positively correlated with the Masculinity-Femininity scale, that the Femininity scale should be negatively correlated with the Masculinity-Femininity scale and that males should score higher on the Masculinity scale and

Table 5.04

Frequency and Percent of Male and Female Therapists in Each of Four Sex-Role Orientation Categories

SRO	Males	Females
Androgynous	12	18
	(33%)	(30%)
Masculine	10	14
	(28%)	(23%)
Feminine	7	12
	(19%)	(20%)
Undifferentiated	7	16
	(19%)	(27%)
Total	36	60
	(100%)	(100%)

females higher on the Femininity scale. These features were evident in the therapist data, except that the Masculinity and Femininity scales were significantly correlated ($p<.05$)

Table 5.05

Product-Moment Correlations among Therapist Sex-Role Orientation Scores on Each of the Three Scales of the Personal Attributes Questionnaire

Scale[a]	M	F	M-F
M	-	.24	.39
F		-	-.12
M-F			-

(n = 99)

Note. Where n = 99, $r_{.05}$ = .20

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

and males scored more highly on the Femininity scale than did females (by 0.3 of a scale point). Given the relatively small size and selected nature of the present sample, especially when compared to Spence and Helmreich's (1978) college student samples, these differences were not unexpected.

DISCUSSION

Although more psychologists and social workers in the present study were found to hold an androgynous sex-role orientation than any other single orientation, most of the sample held nonandrogynous orientations. The sex-role orientation scores of male and female therapists were not found to be significantly different. The finding that therapists' median scores were higher on both the Masculinity and Femininity scales of the Personal Attributes Questionnaire (PAQ) than those reported by Spence and Helmreich (1978) for student samples was not unexpected. For, as the logic of Chapter 1 and the introduction to this study intimated, if mental health workers score highly on indicators of mental health and if an androgynous orientation is related to such indicators, then mental health workers should score highly on measures of androgyny. While acknowledging the scale differences alluded to in the Method section, the finding in respect of social workers verifies Dailey's (1983) conclusion. Further, if the above assumption is accepted, the finding also adds weight to evidence suggesting that the androgynous orientation is the one most linked to aspects of mental health (Bassoff, 1984; Hinrichsen, Follansbee & Ganellan, 1981).

Direct comparisons can be made between findings from the present investigation and Spence and Helmreich's (1978) findings. The latter authors reported the PAQ sex-role orientation scores of individuals from many different groups, including high school students, college students, parents of college students, homosexuals, athletes and scientists. Although it could be argued that therapist scores should most closely resemble those of the scientist group, student norms (Spence & Helmreich, 1978, p.36) are the ones most often utilized by researchers. As noted in the Results section, when compared to students, therapists scored more highly on both Masculinity and Femininity scales, but equally on the Masculinity-Femininity scale. Further, compared to Spence and Helmreich's scientist group, therapists scored equally on the Masculinity scale, higher on the Femininity scale and lower on the Masculinity-Femininity scale. The findings in respect of the higher therapist Femininity scale scores provide some confirmation of the view that a therapist's possession of expressive traits may be profitable in the context of a therapeutic intervention (Farson, 1954).

Apart from gender, Dailey did not report any therapist demographic or related information, either because it was not considered necessary to do so, or because it was not

collected. Based on such indices, therefore, comparisons could not be conducted between Dailey's and the present study. It is possible, however, to compare the two studies' therapist return rates in response to the mailed questionnaires (excluding, in the present case, those questionnaires that were hand delivered). Dailey reported a 43 percent return rate compared to the present 79 percent return. (Other mail survey research designed to examine aspects of psychotherapy research and practice was conducted in which 10 percent of members of the American Psychological Association's Division of Psychotherapy were polled [Morrow-Bradley & Elliott, 1986]. The survey achieved a return rate of 73 percent.)

In the current endeavour, male therapists personally approached by the author (n=9) had significantly higher scores on the Masculinity-Femininity scale than did male therapists who received mailed-out questionnaires (n=27). As described in Chapter 1, traits comprising the Masculinity-Femininity scale are regarded as socially desirable in one sex, but not the other. The scale contains more items of an expressive or communal type (six female-valued items) than of an instrumental or agentic type (two male-valued items). Given this, it might be expected in the present case that therapists personally

approached by the author also would exhibit higher Femininity scores than those who received mailed questionnaires. This was not the case. When compared with the latter group of therapists, therapists approached personally had (nonsignificantly) higher scores on the Masculinity scale and equal scores on the Femininity scale. The reasons for these differences are unclear, in part because of the uncertainty attached to interpreting scores on the Masculinity-Femininity scale (Taylor & Hall, 1982). Also to be considered is the fact that the number of male therapists personally approached by the author was small. Consequently, generalizations from findings based on the latter sample must remain guarded.

The extent to which the motivating comments included in the mailed request to therapists might have played a part in influencing the response rate in the present case is not known, but the most obvious and perhaps most likely explanation for the difference between it and Dailey's (1983) rate lies in the fact that all therapists in the present case were employed by the same employer, The Family Court. The author received considerable research support from the latter, which, in turn, became known to therapists (through explicit reference to such support in the letter requesting therapist involvement in the project [cf.,

Appendix 5A] and through the use of official Court stationery). These features may have served to encourage more therapists to involve themselves in the project than otherwise might have, if only because they were informed (again, through the letter of request) that, of their colleagues approached, all had agreed to be involved. Other possible explanations, for example, that important background variable differences existed, or that Australian therapists might be more responsive than American therapists to requests to be involved in therapy research, although not discounted, are regarded here as less patent explanations for the result observed. As with the findings from the first study in the series, the findings from this study will be elaborated in the discussion chapter concluding this thesis.

Given that it was now known that Australian clients preferred the description of an androgynous and a masculine sex-role oriented therapist compared to a feminine-oriented therapist and that more Australian therapists held an androgynous sex-role orientation than any other orientation, the next question of interest was: 'Are these preferences carried over into the actual therapeutic arena and, if so, what are the consequences of such preferences on any client-therapist appraisals of therapy and its

outcome.' The next phase of research, reported in the following chapter, was directed towards these questions and included analysing the contribution of similar versus dissimilar client-therapist needs and sex-role orientations. Unlike the study conducted by Dailey (1983) - discussed in the introduction to the present study - in order to determine the *relative* strength of sex-role orientation as a potential predictor of client and therapist assessments of therapy and its outcome, *all* variables of interest were included in the models tested. It was in this way that, for example, the relative predictive power of biological sex and sex-role orientation could be examined directly.

CHAPTER 6

NEED EXPRESSION, SEX-ROLE ORIENTATION AND APPRAISAL OF THERAPY

INTRODUCTION

As described in Chapter 1 of this thesis, criticisms have been levelled at the manner in which examinations of therapy as a social influence process (Strong, 1968, and Strong & Matross, 1973) have focussed almost exclusively on the impact of therapist variables, to the virtual exclusion of client variables (e.g., Heppner & Dixon, 1981). A more rounded contemplation of the utility of the model would involve estimation of the relative import of ***both*** sets of variables to the phenomenon under consideration. One of the consequences of such neglect has been a paucity of reliable data pertaining to quite simple questions relating client characteristics to the evaluation of therapy. There has been a scarcity, not only of research including client background data in model development, but also of research examining the social influence process within actual therapy settings. Much of the research has been analogue in design and most subjects engaged as clients have not, in

fact, been clients. As a result, many investigations in the area have little of what might be described as "ecological validity" (Holman, 1988).[1] This situation has led at least one writer to comment that there exists a dearth of knowledge concerning the factors which influence therapeutic outcome (Gelso, 1979) while others have questioned whether therapy analogue research has any relevance at all to what actually takes place during therapy (Parloff, Waskow & Wolfe, 1978).

Although not previously adapted to incorporate the conditions outlined above in actual therapy arenas, the research areas of need expression (Dorn, 1984a) and sex-role orientation (Berzins, 1977) promised to contribute substantially to a fuller understanding of client and therapist variables important in the social influence paradigm. As indicated in Chapter 1, research efforts based on Schutz's (1958) need theory and conducted to examine the effects of client and therapist need compatibility on estimations of therapy have usually employed Schutz's *K* compatibility index (Gassner, 1970; Mendelsohn & Rankin, 1969); however, this index has been criticized as an inaccurate representation of the measurement intended

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[1]Jacqueline Holman, Department of Psychology, The Australian National University. Personal communication.

(Malloy & Copeland, 1980). Sex-role orientation, also, has been regarded as worthy of exploration within a therapy framework, yet research examining its influence has been either analogue in design (e.g., Highlen & Russell, 1980), or involved therapists largely inexperienced in the practice of therapy (e.g., Petry & Thomas, 1986).

As noted in Chapter 1, Petry and Thomas (1986) sought to determine whether clients counselled by androgynous-oriented therapists would rate the therapeutic relationship more favourably than those counselled by nonandrogynous therapists. The possibility of such an effect was considered on the basis that a therapist's ability to utilize traditional gender behaviour in conjunction with cross-gender behaviour, as androgynous individuals do, may facilitate more favourable outcomes. The researchers requested university student clients and their practicum therapists to complete a revised version of the Bem Sex Role Inventory (BSRI-R) following the third therapy session. Clients, but not therapists, were requested to estimate the quality of the therapeutic relationship by completing a relationship inventory. The reasons the BSRI-R was timed for presentation following the third session were not reported, but, given the possibility that sex-role orientation may be directly influenced by therapy (this

possibility will be scrutinized in the current study and is discussed below in more detail), this timing may have influenced the data obtained in ways the researchers did not intend. Findings indicated that clients gave more favourable ratings when seen by an androgynous than by a nonandrogynous therapist.

When compared to most of their clients beginning therapy, it can be argued that therapists possess a higher sense of well-being. If this premise is accepted (and this seems reasonable), it might also be asserted that certain therapist traits can be regarded as useful in the maintenance of this sense of well-being and that, further, therapists may share with the client, knowingly or unknowingly, the advantages such traits confer. Should the client perceive the therapist as a kind of "mental health model," the client may actively seek to emulate what are appreciated as the important components comprising the model, for example, particular attitudes, behaviours, traits and so on that the therapist is observed to engage in or perceived to hold. These considerations, then, when coupled with findings that an androgynous sex-role orientation seems linked to aspects of mental health (e.g., Dailey, 1983; Hinrichsen, Follansbee & Ganellan, 1981), suggest an interesting possibility. Namely, whether client

or therapist mediated, clients might change their pre-therapy sex-role orientation to a more androgynous one as a result of exposure to the therapeutic process. This possibility was tested in the present study by comparing clients' pre-therapy sex-role orientations with both their short- and long-term post-therapy orientations.

The broad aim of the current study, as detailed in Chapter 1, was to explore the associations between client-therapist therapy appraisals and client-therapist need expression and sex-role orientation. As research had indicated that when at least one member of a dyad holds an androgynous orientation the pair are likely to assess their interaction more favourably than if neither member holds such an orientation (Ickes & Barnes, 1978), part of the present study was designed to examine whether a similar effect operates to influence client and therapist assessments of their therapeutic interaction.

To reiterate the hypotheses associated with this study (from Chapter 1):

1. As measured by Schutz's (1958) Fundamental Interpersonal Relations - Orientation (FIRO-B) measure, there will be a positive relationship between the Control area pre-therapy need compatibility of (male and female) therapists and female clients, and their favourable ratings of therapy.

2. When either member of a client-therapist dyad manifests an androgynous pre-therapy sex-role orientation as measured by Spence and Helmreich's (1978) Personal Attributes Questionnaire (PAQ), clients and therapists will rate therapy more favourably.
3. Clients not possessing an androgynous sex-role orientation before therapy will have modified their position towards such an orientation upon the termination of therapy, or by three months or eight months later.

METHOD

This investigation involved the application of client and therapist pre- and post-therapy measures and short- (three months) or long-term (eight months) client follow-up measures. The Fundamental Interpersonal Relations Orientation - Behavior need measure (FIRO-B; Schutz, 1958, and Chapter 3 and Appendix 3A) and the Personal Attributes Questionnaire sex-role orientation instrument (PAQ; Spence & Helmreich, 1978, and Chapter 3 and Appendix 3C) were administered to clients and therapists before therapy. The PAQ was administered to clients again at the conclusion of therapy and at follow-up. Evaluation questionnaires (Friedlander, 1982) were completed by clients (the Client Perception Questionnaire, or CPQ1; Chapter 3 and Appendix 3E) and therapists (the Counselor Perception Questionnaire, or CPQ2; Chapter 3 and Appendix 3G) upon the termination of therapy and again by clients (the Client Satisfaction Questionnaire, or CSQ; Chapter 3 and Appendix 3F) at follow-up. Table 6.01 presents this information diagrammatically.

Table 6.01

Outline of Clients' and Therapists' Completion of the PAQ, FIRO-B, CPQ1, CPQ2 and CSQ Measures[a]

	PAQ	FIRO-B	CPQ1	CPQ2	CSQ
Clients					
Pre-Therapy	*	*			
Post-Therapy	*		*		
3 Months, or 8 Months Follow-Up	*				*
Therapists					
Pre-Therapy	*	*			
Post-Therapy	*			*	

* Questionnaire completed

[a] PAQ = Personal Attributes Questionnaire
FIRO-B = Fundamental Interpersonal Relations Orientation - Behavior Scale
CPQ1 = Client End-of-Therapy Evaluation Questionnaire
CPQ2 = Therapist End-of-Therapy Evaluation Questionnaire
CSQ = Client Follow-Up Evaluation Questionnaire

Description of the Client Sample

Preceding therapy, a total of 714 clients completed the FIRO-B need measure and the PAQ sex-role orientation instrument. *Means*, frequencies and percentages relating to various data collected from each client are presented in Table 6.02. The procedures adopted to determine ethnicity and employment were the same as those used in the first study in this series (reported in Chapter 4). Also in common with the first study, meaningful analyses employing clients' levels of educational attainment could not be conducted; although the item appeared on clients' information cards and secretaries were requested to

Table 6.02

Demographic and Related Data Pertaining to Clients

Variable	Sex	Frequency
Number of and Sex of Clients	f	362
	m	352

(n = 714)

(table continues)

Table 6.02 (Contd.)

Demographic and Related Data Pertaining to Clients

Variable	Sex	Frequency	Percent of Total
Number of Couples[a]	-	232	-
Number of Individuals[a]	-	250	-
Country of Origin			
Americas	-	7	1.0
Asia	-	13	1.8
Australia	-	457	64.0
Europe	-	105	14.7
Oceania	-	17	2.4
Occupation			
Armed Services / Corrective Services Personnel	m	49	6.9
	f	53	7.4
Home Duties	m	1	0.1
	f	105	14.7
Managerial Position / Self-Employed	m	32	4.5
	f	5	0.7
Manual Worker / Unskilled Labourer	m	48	6.7
	f	18	2.5
Office Worker / Customer Services Personnel	m	24	3.4
	f	25	3.5
Professional	m	28	3.9
	f	27	3.8
Tradesperson	m	84	11.8
	f	11	1.5
Unemployed	m	33	4.6
	f	63	8.8

(n = 714)

Note. Due to missing data, some sections do not total 100%

[a] Refers to whether both members of a couple attended for therapy, or only one member

(*table continues*)

Table 6.02 (Contd.)

Demographic and Related Data Pertaining to Clients

Variable	*M* (*SD*)	Sex	Frequency	Percent of Total
Years-of-Age	34.00 (7.40)	-	-	-
Number of Years Married	9.01 (5.72)	-	-	-
Number of Children	1.95 (1.01)	-	-	-
Total Number of Children	-	m	707	53.7
Total Number of Children	-	f	610	46.3
Clients Having[a]				
No Children	-	m	6	0.8
	-	f	6	0.8
All of the Children	-	m	47	6.6
in Their Care	-	f	123	17.2
Some of the Children	-	m	14	2.0
in Their Care	-	f	14	2.0
None of the Children	-	m	120	16.8
in Their Care	-	f	39	5.5
Clients' Children				
Less than 1 Year Old	-	-	78	5.9
1 to 5 Years Old	-	-	393	29.8
5 to 9 Years Old	-	-	344	26.1
9 to 13 Years Old	-	-	304	23.1
13 to 18 Years Old	-	-	39	3.0

(n = 714)

Note. Due to missing data, some sections do not total 100%

[a] Calculated for couples only

(*table continues*)

Table 6.02 (Contd.)

Demographic and Related Data Pertaining to Clients

Variable	Percent of Total
Clients Married	
Once	80.0
Twice	18.6
Thrice	1.4
Clients Living Apart	91.0
Separate in Same House	6.0
Together in Same House	3.0
Source of Referral	
Court (Judge)	23.9
Court (Registrar)	20.6
Helping Agency	3.9
Self	23.2
Solicitor	13.2
Clients Having had Previous Court Counselling	20.0
Clients Having Seen a Solicitor	71.9

(n = 714)

Note. Due to missing data, some sections do not total 100%

complete it, insufficient data were recorded. This did not become apparent until data had been collated. In hindsight it would appear that such information would best be obtained by self reports.

Clients' ages ranged from 16 to 66 years (total *M*=34.00, *SD*=7.35; females: *M*=32.62, *SD*=7.08; males: *M*=35.45, *SD*=7.36). The range of therapy sessions was 1 to 9 (*M*=2.02, *SD*=1.35) and the number of clients seen by each therapist ranged from 1 to 45 (*M*=6.92, *SD*=7.63). Of the 61 persons who declined to be involved in the study, 26 were female and 35 male (total *mean* age=35.10 years, *SD*=6.63; females: *M*=33.05, *SD*=7.26; males: *M*=36.80, *SD*=5.64).

Table 6.03 presents a breakdown, by City, of the number of clients and therapists who completed the pre- and post-therapy questionnaires and clients who: (1) declined to be involved, (2) changed address and could not be contacted, (3) completed the follow-up questionnaires and (4) responded to the reminders to return the follow-up questionnaires.

Table 6.03

Information Pertaining to Clients' and Therapists' Questionnaire Completions

Group/ Measures	Number of Clients/Therapists City A	B	C	D	Total
Client Pre-Therapy Questionnaires (PAQ & FIRO-B)	86	137	234	257 =	714
Therapist Pre-Therapy Questionnaires (PAQ & FIRO-B)	11	5	6	17 =	39
Client Post-Therapy Questionnaires (CPQ1)	49	35	124	110 =	318
Therapist Post-Therapy Questionnaires (CPQ2)	48	37	134	121 =	340
3 Months Follow-Up Questionnaires (CSQ)	38	32/68	120	113 =	303
8 Months Follow-Up Questionnaires (CSQ)	-	30/69	-	- =	30
Replies Received/ Reminders Sent	5/48	12/75	15/114	21/144 =	53
Clients Having Changed Address	1	9	8	17 =	35
Client Refusers	21	3	17	20 =	61

Description of the Therapist Sample

A total of 39 therapists from four Cities were involved in the research and information collected from therapists is presented in Table 6.04. (As only 1 of the 39 therapists reported having completed any part-time practice of therapy, this variable was excluded from all analyses.) Therapists' ages ranged from 27 to 65 years (total *mean*=42.33, *SD*=9.71; females: *M*=42.33, *SD*=10.53; males: *M*=42.33. *SD*=6.76).

Procedure

Pre-Implementation Strategies

Registry Involvement

The project was planned to be instituted in three of the four large Australian Capital Territory and New South Wales Family Court Registries identified in Chapter 2. These Registries will be referred to as Cities B, C and D and correspond to the cities in which they were located. (As City A had already contributed to the initial phase of research, reported in Chapter 4, staff requested that they not be involved in the current phase.) Data were collected

Table 6.04

Demographic and Related Data Pertaining to Therapists

	N	*M* (Years)	*SD* (Years)
Males	9	-	-
Females	30	-	-
Psychologists	21	-	-
Social Workers	18	-	-
Age	39	42.3	9.7
Full-Time Post-Graduate Training in Therapy	19	2.1	1.4
Part-Time Post-Graduate Training in Therapy	6	3.4	1.2
Full-Time Post-Basic-Degree Practice in Therapy	39	10.6	5.6
Part-Time Post-Basic-Degree Practice in Therapy	1	6.0	-
Full-Time Practice in Family Court Counselling	39	4.3	3.3

(n = 39)

over a total period of some 14 months. As was the case in the previous studies, the first step in planning implementation of the research was to gain approval from

the Principal Registry of the Court. This was secured, again, subject to local Registry agreement and cooperation. Meetings were organized with the Directors of Counselling in each Registry to secure support for the project. All of the Directors concerned agreed to have the research conducted in their section. Meetings also were held with each Registrar (a Principal Legal Officer and administrative head of the Registry) for the purpose of introduction and to outline the proposed project. All Registrars' reactions also were favourable.

After securing local agreement, a general meeting was organized in each Registry - to which all personnel were invited - at which the author outlined the general objectives of the research. Care was taken, however, to ensure that the specific aims of the study were not addressed. All therapists and counselling section secretaries in each Registry attended these meetings, but no other Registry personnel did (the single exception being in City C, where the Registrar also attended). Questions were deflected with general answers regarding the desirability of ascertaining which types of client-therapist traits might be important in determining particular types of therapy outcomes. Questions concerning "What kinds of traits?" were dealt with by stating that

answering such questions directly would jeopardize the findings by possibly setting-up expectations. All were assured that upon completion of data analyses the author would return to present the aims and findings of the research undertaken. Therapists and others seemed satisfied with these explanations and assurances and all therapists in the three Registries agreed to be involved in the project. Appointments were then made with each therapist.

Therapist Involvement

At individual meetings with each of the therapists, the specific required therapist commitments to the project were discussed at length, together with the overall plan of research. Therapists understood that they would be required: (1) to complete an initial questionnaire in respect of themselves; (2) to complete a questionnaire upon the termination of therapy in respect of how well they believed the outcome of therapy had been for the client with whom they had just finished therapy, providing, of course, that this was a client who had agreed to be involved in the research; and (3) to request each agreeing client to complete their own evaluation questionnaire while still in the therapy room. To allay possible client concern that their evaluation responses might be studied by their

therapist as soon as they left the therapy room, therapists were requested to advise clients (before giving them the questionnaire) to place their completed questionnaires in the box provided for this purpose at the secretary's desk. Therapists also were asked to remind clients, at the conclusion of the final interview, that they would receive a posted-out follow-up questionnaire approximately three months later. Therapists would recognize those clients involved in the research because secretaries would have stamped the word *questionnaire* in red upper case letters across the front of the client information card handed to the therapist before the beginning of each new therapy session. Red ink pads and rubber stamps with the word engraved were supplied to secretaries for this purpose. The word itself would serve to remind therapists to complete the questionnaire in respect of the client they were finishing therapy with as well as to remind them to distribute questionnaires to clients.

The 28 therapists staffing the three Registries involved in the present study had already completed Spence and Helmreich's (1978) PAQ sex-role orientation instrument as one of the requirements for involvement in the second study reported in Chapter 4. The next stage in the present endeavour was to request each therapist to complete

Schutz's (1958) FIRO-B need measure. The author waited while each therapist did this. Questions from therapists during their completion of the measure were discouraged, but common. Most centered around the meaning of particular wordings - or the scale used - and quite often the comment was made that "Questions are asking the same thing." In any event, all queries were answered with the standard reply: "Just put whatever you think." Although the actual questionnaire completion time was relatively minimal, the time taken to get appointments with therapists and to move between Registries was long. Registries involved in the research were some 50, 300 and 500 kilometres apart.

The opportunity also was taken at the meetings with individual therapists to discuss the project and to invite questions and provide clarification. Therapists understood that some clients would take longer than others to complete the questionnaires and that as a result some disruption to the timing of appointments could be expected. It was agreed that providing the session was not more than about 10 minutes late in starting, significant problems would not arise. This necessitated clients being advised their appointment times were approximately 15 minutes earlier than their therapist's actual available appointment time. Some concern was expressed over the likely consequences of

one member of a couple agreeing to complete the questionnaire and the other member not agreeing. If one agreeing member and one disagreeing member of a couple arrived for an appointment at, say, 8.45am and the agreeing member completed their questionnaire at, say, 9.10am, the nonagreeing member would have been waiting for 25 minutes past what they believed the appointment time to be.

It was suggested that clients could be told of the project in their confirmation of appointment letter and, based on this information, make a decision whether to arrive early to complete the questionnaires, or not. However, if this scheme had been adopted, a large number of potential subjects might have ben lost due simply to their forgetting to arrive early for their appointment. There was no way to resolve this particular dilemma effectively. The possible, relatively minimal inconvenience was regarded as secondary to the potential benefits from having the research conducted. In addition, there were some positive counter-balancing features in the arrangement decided upon. First, couples neither of whom agreed to complete the questionnaire would be seen at the appointment time they were advised, that is, 15 minutes earlier than their therapist's usual appointment time; second, couples both of whom completed the questionnaires quickly would also be

seen earlier than their therapist's usual appointment time; and third, clients might be more willing to participate in the study if they were actually in the counselling section being asked than if they were merely reading a request from someone they had never met. The author also pointed out that almost inevitably a cost attaches to having any kind of research conducted. Whether that cost is measured in terms of a pedestrian's time spent answering survey questions, or someone's discomfort while sitting in a laboratory with electrodes attached, or a client's waiting extra time for a therapy appointment, all entail some inconvenience, some outlay.

Secretary Involvement

Several meetings were held with secretaries to discuss the project and the part they would play in it. Again, it was recognized that their cooperative involvement was crucial to the successful running and completion of the study. It also was recognised that, after the author, secretaries would be involved the most intimately with the project, would be devoting the most time to it and would be the first contact clients would have with it. To gain their support was imperative. The author invested a lot of time motivating and encouraging secretaries as a gesture of

recognition of the energy and commitment that would be required to engage in the sustained effort necessary to bring the research to effective conclusion. As a result, it was hoped that the research might be less easily dismissed or disregarded and, given what would be the author's frequent presence in the Sections, less easily neglected. It was made clear that the author was available at all times to deal with any issue that might arise as a result of the project's implementation.

The details concerning secretary requests to clients and distribution of written material worked so effectively in the first study reported in this thesis (in Chapter 4), that it was decided to replicate them in the present case. What follows then, for the next two paragraphs, repeats some of the procedures adopted and detailed in the first study. Secretaries were requested to make client appointments 15 minutes earlier than the actual appointment time to allow time for completion of the questionnaires. Upon arrival at the Section, client demographic and related details were taken by secretaries as usual, or clients completed such details themselves, after which the client was asked to take away the written request to be involved in the study (Appendix 6A). Appended to the request were the FIRO-B and PAQ questionnaires. The sheets were fastened

to a clipboard with a biro attached. The client was requested to take the clipboard and attached sheets with the request: "Would you please read this and return it to me when you have finished. Thank you." Large boxes were provided for the collection of completed forms. Demographic and related details of clients who refused to be involved in the study also were kept.

To allay the possibility that they might unwittingly set-up clients' expectations and to keep them from having to engage with clients in prolonged discussions concerning the study, secretaries were requested to deflect any client questions regarding the research with the statement "All the information concerning the research is contained in this first sheet" (Appendix 6A). Instructions to secretaries also were provided in written form, as was the list of client groups suitable for involvement in the project (described below). Secretaries were requested to stamp clients' information cards with the red *questionnaire* stamp provided, as a means of alerting the therapist to which clients would require an evaluation questionnaire upon the termination of therapy, as well as indicating which clients would require therapist evaluation. It was imperative to set-up the study in such a way that secretarial time devoted to it could be kept to an absolute

minimum. If this had not been done and the research had started to impinge on the functioning of the Section, support for the project would have been withdrawn. It also was desirable that the study could proceed unhindered on those occasions when one of the secretaries was not in attendance for whatever reason.

Following the experience gained in the first study concerning the disruptive effects on Section functioning of clients arriving late for their appointments and being given questionnaires to complete, secretaries were requested not to give questionnaires to clients arriving more than 10 minutes late. Again, being present during most of the time the study was instituted in the Sections ensured that disruptions could be kept to a minimum.

Client Involvement

Clients presenting for confidential counselling at each Registry's Counselling Section were asked to participate, voluntarily, in a project designed to investigate "What helps to make counselling effective." Clients were presented with written information outlining the auspices under whom the investigation was being undertaken, a guarantee of confidentiality and a description of the research as constituting three parts, as follows:

1. The attached before-counselling questions (which take about 20 minutes to complete)
2. Questions after the final counselling interview (about 15 minutes to complete), and
3. Questions posted-out to you three months after the final counselling interview (about 15 minutes to complete)

Although client confidentiality was guaranteed, given that each client agreeing to be involved in the project would eventually receive a posted-out follow-up questionnaire and because written and telephone reminders would be made in the event of nonreturns, it was impossible to maintain client anonymity. Clients were requested to record their names on all forms completed as a means by which to collate responses. It was clear from the top of the first questionnaire instruction page that anonymity would not be provided, as it was at this point that to become involved in the research, clients were requested to write their names.

Clients were not given direct information concerning the nature or purpose of the questionnaires, save to point out that the project in general was designed to investigate the provision of counselling services within the Family Court. As in the previous studies reported, such noncommittal and vague information was presented to therapists and clients

alike in the hope of avoiding data contaminated by expectancy-sets.

On a number of grounds, certain groups of clients were excluded from involvement in the research. Clients already in Family Court counselling were excluded, because the research involved the application of pre-beginning-therapy measures. However, clients were included who had previously attended Family Court Counselling, but had terminated it more than three months before the beginning of the study. The latter criterion was based on the work of Mendelsohn (1966). It was considered inappropriate to involve persons who were the subject of Court Reports, given the nonconfidential nature of their therapy contract: Anything said in such therapy sessions can later appear in a Report tendered to the Court as evidence. The latter arrangements were not considered representative of those usually agreed to by clients and therapists. The final excluded group of clients were those who presented at a Section under the requirement of the Family Law Act that persons married for less than two years attend therapy before a *decree nisi* be granted. Such clients typically attend therapy to satisfy the requirement of law rather than out of any personal commitment or desire for change and, as a consequence, such therapy is usually a single session of short duration

(about 10 minutes). All other clients attending confidential therapy from any referral source whatsoever were invited to participate in the research. These included self-referrals and referrals from judges, other agencies, registrars and solicitors.

Implementation

The project was first implemented in City B. After establishing the research there for some six weeks the investigation was quickly instituted in the second and third Registries. The same implementation procedures were adopted in all Registries. That is, several weeks advance warning of the impending start of the project was given to all therapists and secretaries, all written materials were provided each Section weeks before they would be needed and staff meetings in each Section were attended by the author in the time leading-up to implementation so that reminders could be given, clarifications offered and questions answered. As it was important that each Section could cope independently with the running of the project, the author: (1) spent the first few days of implementation in each Section stationed near the secretary's desk to furnish support when required; (2) spent at least the first three weeks of implementation in attendance at each Section to

monitor and ensure the smooth functioning of the project; and (3) later in the study, at any one time, spent at least three days in each Section visited. This protocol enabled each Section to be visited at least once every three weeks for the duration of the research.

Post-Implementation Strategies

By the time the first tally was made on how many therapists in City B had completed evaluation questionnaires in respect of clients involved in the research, a large number of clients had already finished therapy. It was established that not only had very few clients had evaluations completed in their regard (12%), but very few had been given their own end-of-therapy evaluation questionnaire to complete (ascertained from the number of completed questionnaires and the number of blank questionnaires remaining). It was clear at this point that without the completed questionnaires, conclusions in respect of immediate end-of-therapy effects of client-therapist matching could not be drawn. It was decided to confront the therapists with the few questionnaires that were being completed/distributed. A meeting was convened, which all therapists attended, and meetings with individual therapists were again organized to

ascertain whether there was a specific reason for the observed lack of response. The therapists stated that it was simply a matter of forgetfulness on their part and agreed to make a renewed effort.

Monitoring was then conducted over a period of several weeks to determine the effect of these assurances. No change was detected. Clients by the score were agreeing to involvement in the project only to conclude their therapy without having had a therapist questionnaire completed in their regard or being offered their own questionnaire for completion. Being, by now, nearly three months since the research had been introduced into the Section, it was decided that if therapists could not be persuaded or enticed to complete and distribute the questionnaires, the study there would have to be brought to a halt. It was decided to make one last attempt to involve the therapists. As so much time had already been spent, the attempt was specifically designed to force a result one way or the other. A memo (Appendix 6B) was distributed to all therapists detailing how many project clients each (anonymous) therapist had interviewed, coupled with how many therapist evaluation questionnaires had been completed. It was pointed out that to offer clients something (an end-of-therapy questionnaire) and then not to

deliver it, did nothing for the credibility of the Service. The item concluded with a plea that the questionnaires be completed.

The memo did in fact secure a result, although not the one that would have been preferred at the time. The author was advised that the therapists had had a meeting at which they resolved to cease involvement with the project. However, that problems experienced in the Section were not attributable to the project was supported by the fact that therapists also resolved to involve themselves in the project again, albeit on a more limited basis, "in about three months time." Reasons given for the temporary withdrawal from the research centred on complicated administrative issues involving local and central authorities, the net result of which was that Section staff felt they already had too much to cope with, without the extra burden of a research project. It was agreed by all concerned that three months later the research could again be undertaken with a guarantee that questionnaires would be completed and distributed as requested until 50 more clients had been included.

Following this agreement, a number of therapists sought-out the author to "clear up" part of what they

perceived to be "the problem" with implementing the project. The therapists reported that their Director had been questioning the bona fides and intentions of the author. Consequently, although appreciating the utility of the research, therapists initially found themselves in a conflict situation. The therapists stated, however, that the Director would be vacating the position "sometime within the next three months" and, hence their suggested time-frame for re-implementation of the project. Towards the author the Director concerned had been nothing but supportive and encouraging of the research, as all Directors had been. It seems, then, that a number of factors may have contributed to the difficulties experienced in the Registry.

If the research were to be brought to conclusion within a reasonable amount of time and other involved Registries were not to be over-loaded, in order to replace the client numbers lost by City B's premature withdrawal, it became necessary to seek the involvement of another Registry. Staff from City A were again approached, that is, those staff involved in the first study (cf., Chapter 4). Again, the Director's support was sought and gained and joint and individual meetings with therapists and secretaries convened and interest solicited. All therapists agreed to

be involved, but only on a limited basis, because, it was stated, the Section had already recently experienced a certain degree of disruption due to the first study being instituted there. Staff agreed to remain involved until the Section had contributed 80 clients to the project. Therapists had already completed the PAQ sex-role orientation instrument for the purpose of the second study (reported in Chapter 5). Therefore, meetings were arranged with each therapist in order for the FIRO-B need measure to be completed and, as with all other therapists, the opportunity also was taken to discuss the project at length and provide any clarifications required. Using the same procedures as those employed in all other Registries then, the study was established in the Section.

Another issue which arose soon after the study commenced concerned therapist unwillingness, in certain circumstances, to request clients to complete their questionnaires in the therapist's room once therapy had terminated. Such circumstances arose when either the client or therapist was running late for another commitment, or when the therapy had been brought to a close strategically, such that further time in the therapist's room might undermine what had been set in motion. The solution was put forward (to all therapists in all Sections) that in such

circumstances it was quite appropriate for the evaluation questionnaire to be posted-out the same day to the client(s) concerned, together with a stamped Section-addressed return envelope. This resolved the matter to the satisfaction of the therapists concerned.

Written reminders delineating the research in general and the part therapists had to play in particular were given to therapists in each Section throughout the course of the project. In each Section one or two therapists volunteered to act as source persons for other therapists to contact regarding any issues that might arise in the author's absence. Each therapist in each Section was advised in writing who this local contact therapist was. Contact therapists at Registries other than the one the author was currently visiting were telephoned each week to discuss any such issues.

In spite of the rigour employed in encouraging therapists to complete and distribute the end-of-therapy questionnaires, therapists in every Registry frequently failed to do so. A seemingly endless string of joint and individual meetings with therapists, informal liaison with the secretaries and therapists responsible for making appointments, attendance at staff meetings to highlight the

problem, written reminders and meetings with management, all seemed powerless to prevent large numbers of clients from not being given their evaluation questionnaires. Although the problem in other Registries did not grow to the proportion that it had in City B, it was nevertheless cause for concern. What the rate of completion/distribution might have been without the just-described efforts, of course, is not known. Presumably, it would have been markedly lower.

A number of reasons can be discerned for the high failure rate just described. First, secretaries often neglected to use the stamp supplied to indicate on clients' information cards who was involved in the study, resulting in the therapist not being signalled of a client's involvement. Second, it may well have been the case that therapists, either consciously or sub-consciously, were not at ease with clients making assessments of their therapy, perhaps fearing negative consequences or repercussions of some kind. All therapists were assured at the outset, however, that they would not be identified in the eventual results and that all data collected during the investigation would be presented in a collected or group format, making identification of individuals, either client or therapist, impossible and, further, that the author would be the only

person with access to the original data and codings, the latter being redundant after data compilation. Several therapists expressed interest in knowing of their evaluations by clients and these were provided in collated form and, obviously, without client identification.

Soon after the project had been established it became necessary to exclude those clients requiring the services of an interpreter. Prior to this being done, in one particular incident an interpreter sat with a client for more than an hour trying to communicate the content of the instructions and questionnaires before being interrupted. Given the demands on the Sections and the constraints on interpreters' time, it was untenable to have more than the allotted time (approximately 20 minutes) devoted to completion of the pre-therapy and post-therapy measures. Consequently, instructions were given to secretaries in all Sections that clients who required an interpreter were to be excluded from the study.

Follow-Up Strategies

Partly to ease the load on each Section, the author assumed responsibility for posting-out the follow-up questionnaires. Keeping track of which clients had

concluded their therapy in which Registry, when, while being often hundreds of kilometres from the event presented a challenge. Complex arrangements were devised to accomplish the objective, as follows. The important consideration was that clients receive their questionnaires three months, or eight months, from the time their therapy ended. (Mendelsohn & Geller, 1965, also employed a three month follow-up.) When the author visited a Registry it was ascertained which clients had completed therapy since the last visit. A follow-up questionnaire set (comprising the instruction sheet presented in Appendix 6C, the PAQ and follow-up evaluation questionnaires and a pre-paid return envelope) was organized for each client who had completed therapy. Appended to each set was the date it would need to be posted in order to arrive three months or eight months post-therapy. In this way, without requiring the author's presence, secretaries could post the sets on the indicated due date, thereby enabling their arrival at the desired time. Secretaries placed returns in a box awaiting the author's next visit. The author kept a record of who had been sent and who had returned a follow-up set. Clients who did not return the set were sent a written reminder requesting that they do so. Those who did not respond to this second request were telephoned by the author and requested to complete and return the set. Those who still

did not respond received a second telephone call from the author requesting the same. Although several clients who received a second telephone call were angry and abusive, it was regarded as desirable to gain as high a return rate as possible.

As discussed, not all participating clients received the end-of-therapy questionnaire set from their therapist and nor did they all have a therapist evaluation completed in their regard. All participating clients, however, were sent a follow-up questionnaire set. Of clients who initially did not reply to the follow-up questionnaire, 14% eventually responded to the written and telephone reminders provided and 5% had changed their address at the time the follow-up questionnaires were posted and could not subsequently be located. Overall, 49% (n=333) of those clients who could be contacted completed and returned a follow-up questionnaire.

RESULTS

SECTION A : DATA DESCRIPTION AND INTRODUCTORY ANALYSES

To allow for a comprehensive presentation of findings, the reporting of results has been divided into three sections: (1) Section A presents a description of the data and introductory analyses and results; (2) Section B details findings relating directly to the three hypotheses of the study outlined in Chapter 1; and (3) Section C reports analyses and results associated with the more general aims of the research, also outlined in Chapter 1.

The present Section presents information pertaining to FIRO-B need measure analyses, PAQ sex-role orientation analyses and Evaluation Data analyses.

FIRO-B Need Measure Analyses

Preliminary Considerations

Of the 137 clients from City B, 69 did not complete the immediate post-therapy evaluation questionnaire, but were given the follow-up questionnaire eight months following the termination of therapy. Whether clients who completed and returned the latter questionnaire (n=30) differed

significantly in their responses on the FIRO-B from clients who completed the three months follow-up (n=684) was tested via t-tests on each of the nine sub-scales comprising the FIRO-B, that is, Originator, Reciprocal and Interchange Compatibility, *by* the Inclusion, Control and Affection dimensions. None of these tests indicated significant differences. Consequently, in all subsequent analyses FIRO-B data from the two subject groups were combined, resulting in a total of 714 FIRO-B client respondents.

Using analysis of variance, demographic and related data were analysed to determine whether there were differences between clients who agreed to be involved in the study and clients who declined to be involved (n=61). No significant differences were found.

Demographic and related data from the 39 therapists in the present study were compared to data from the 60 therapists in the previous study (cf., Chapter 5). In the current sample there were significantly fewer males (9/39 versus 27/57: χ^2=6.28, df=1, p<.01) and significantly more reported years of full-time therapy practice (t=2.01, df=97, p<.05).

Scale Parameters

Reliability coefficients were computed based on clients' FIRO-B need data. As FIRO-B responses are scored either 0 for rejection of an item or 1 for acceptance of an item (cf., Chapter 3), the Kuder-Richardson-20 (Richardson & Kuder, 1939) reliability coefficient was employed. When data are in dichotomous form, Cronbach's (1951) *alpha* (α) is equivalent to the Kuder-Richardson-20 coefficient (*Statistical Package for the Social Sciences*, 1983, p.717). Cronbach's alpha was .63 for the Expressed Inclusion sub-scale, .85 for the Wanted Inclusion sub-scale, .77 for the Expressed Control sub-scale, .79 for the Wanted Control sub-scale, .69 for the Expressed Affection sub-scale, .79 for the Wanted Affection sub-scale and .85 for the entire scale. These values are slightly higher than those reported by Gluck (1983) for a sample of 378 law students, but the *means* of the summed sub-scale coefficients are similar: in Gluck's study, *mean* α=.71, and in the present case, *mean* α=.75. The mean corrected item-total correlation was .27 and ranged from a minimum of .03 to a maximum of .57. The item-total correlation for each scale item is presented in Appendix 6D. Similar findings resulted from using therapist data.

Data Description and Introductory Analyses : Client and Therapist Data

As has already been described, the FIRO-B need measure consists of six sub-scales, each comprising nine items. In all analyses to be presented, cases were deleted where client or therapist ratings were given to less than six items on *any* of the six sub-scales describing the measure. Cases with fewer than three missing items were included using mean substitution. Conceivably, then, a person may have answered 50 of the 54 available items on the FIRO-B and have been excluded from the analyses if the 4 missing items were part of the same sub-scale. Nevertheless, for the purposes of increasing the potential power and generalizability of predictive models, the application of stringent conditions pertaining to data inclusion was considered desirable.

Applying the above condition, 34 cases were deleted from the initial pool of 714 client respondents. All therapists completed all items. Although representing less than 5% of the sample, all the available demographic and related data and PAQ and therapy evaluation data of those not meeting the criterion outlined were compared, via *t*-tests, to the corresponding data of those meeting the criterion. Although no differences were found based on the demographic and

related data, significant differences *were* located between responses on the Femininity scale of the PAQ. Clients *not* completing the sufficient number of FIRO-B items had significantly lower Femininity scale scores (t=2.19, df=291, p<.05). Furthermore, upon therapy termination, but not at follow-up, the outcome of therapy was rated significantly less favourably by clients (n=12) who had *not* completed the requisite number of sub-scale items (t=3.20, df=285, p<.01). In respect of these clients at follow-up (n=8), the opposite finding held t=-2.89, df=307, p<.01). These data suggest that clients unwilling to give the research their full attention before therapy were more willing at therapy termination to take the opportunity afforded by the same research to express their dissatisfaction and some months later to reverse their stance.

Using analysis of variance, clients' FIRO-B need scores were analysed to determine the relationships between sub-scale scores and demographic and other related data. Several variables were found to be significantly related and tables displaying these findings are contained in Appendix 6E. Wanted Inclusion scores were negatively related to the number of years married, with those married less than 5 years having the highest scores and those married more than 20 years the lowest scores (F=2.48;

df=4,608; *p*<.05). Number of years married was also significantly related to the Degree of Wanted Affection, though in a positive direction. Those married less than 5 years gave the lowest scores, followed by those married: more than 20 years, 15 to 20 years, 10 to 15 years and 5 to 10 years, respectively (*F*=2.73; *df*=4,607; *p*<.05).

Five variables were significantly related to Expressed Control scores: Those from City D rated items the highest, followed by those from City B, C and A, respectively (*F*=3.44; *df*=3,646; *p*<.05); males expressed a greater need to exercise control than did females (*F*=32.70; *df*=1,648; *p*<.01); the scores of clients who had not had previous counselling were negatively related and significantly lower than those who had had previous counselling (*F*=4.39; *df*=1,648; *p*<.05); clients with some of the children in their care rated items the highest, followed, in order, by those with none of the children, all of the children and no children (*F*=5.25; *df*=3,537; *p*<.01); and highest scores were given by those in the manager/self-employed occupation category, followed by professionals, armed forces/ corrective services personnel, tradespersons, customer services personnel, manual/unskilled workers, unemployed persons and those engaged in home duties, respectively (*F*=6.81; *df*=7,570; *p*<.01).

Wanted Control scores were found to be significantly related to whether clients had contacted their solicitor regarding an issue related to the matter for which they were seeking counselling. Those clients who had sought-out a solicitor gave scores significantly lower than those who had not sought-out a solicitor (F=3.85; df=1,655; p<.05).

The City in which counselling had occurred was significantly related to Expressed Affection sub-scale scores. Clients in City D gave the highest scores, followed by those in City: C, A and B, respectively (F=3.76; df=3,658; p<.01).

Finally, age was found to be significantly related to Wanted Affection scores. Those aged 50 years and older gave the highest ratings, followed, in order, by those aged 15 to 20 years, 30 to 40 years, 40 to 50 years and 20 to 30 years (F=2.90; df=4,582; p<.05).

Following Schutz (1958) and Spence and Helmreich (1978), because of the current sample size, very low correlations (often less than 0.1) were significantly different from zero. Consequently, the significance levels of individual correlations are not presented, but each table reports the level of r required to reach the .05 probability level based on the comparison in the table involving the smallest

number of cases. (For example, with an *n* of 680, the value of *r* required to reach the .05 level of significance is approximately .07 [Edwards, 1972].)

A full table of correlations among clients' FIRO-B sub-scale need scores and demographic and related data is presented in Appendix 6F. Although a number of variables were found to reach statistical significance (including city, age, gender, occupation, source of referral, having or not having custody of the children and whether previous therapy had occurred), the highest correlation was .21 (between gender and the Expressed Control sub-scale). Therefore, although statistically significant, the substantive and conceptual import of these correlations would appear minimal and, because of their weakness, should not impinge on the interpretation of predictive models which could include the correlated variables described (Cunningham, 1988).[1] It is of interest, however, that of the 17 significant correlations determined across the six sub-scales, 8 were found to relate to the Expressed Control dimension. This finding suggests that the expression of control may be related to a number of factors other than those pertaining to interpersonal need.

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[1]Ross Cunningham, Department of Statistics, The Australian National University. Personal communication.

Analysis of variance also was employed to determine relationships between therapists' FIRO-B need scores and demographic and related data. Appendix 6G presents tables reporting the results of these analyses. The following significant findings were located: Females expressed a greater need for inclusion than did males (F=4.27; df=1,37; p<.05); the number of years of full-time practice of Court-Counselling was negatively related to the expression of affection (F=4.08; df=1,37; p<.05); and the number of years of full-time practice of therapy was negatively related to the need for affection (F=6.51; df=1,37; p<.05). A full table of correlations among therapists' FIRO-B need scores and demographic and related data is presented in Appendix 6H.

It will be recalled from Chapter 3 that the FIRO-B *Total Sum* measure indicates an individual's characteristic total amount of interaction, while the *Total Difference* measure relates to the degree of preference for interaction with others and indicates an individual's preference for taking the initiative in relating, regardless of the need area being considered. For the purposes of comparison with Schutz's (1958) findings, for both clients and therapists, *means* and *standard deviations* on each of the FIRO-B sub-scales were calculated, together with the sums and differences in

each of the need areas. These results are presented in Table 6.05. Also for comparative purposes, included with the client and therapist results are findings from different populations provided by Schutz (1978).

As indicated in Table 6.05, the largest differences between clients and therapists occurred on the Control dimension, with therapists recording both higher Expressed and higher Wanted levels of Control. *T*-tests were conducted to determine whether sub-scale differences between the groups were statistically significant. The only significant difference detected was on the Expressed Control dimension: Therapists expressed a greater need to exercise control than did clients (t=3.69, df=717, p<.01).

Correlations among clients' FIRO-B sub-scale need scores were computed and these results appear in Table 6.06.

In accord with Schutz's (1958) findings, the present findings support the nonindependence of some of the FIRO-B sub-scales. In particular, higher correlations occurred between the Expressed and Wanted dimensions of the Affection and Inclusion scales than between any other pair of scales. In general, these findings replicate those reported by Schutz (1978), although the correlations in the present case are stronger.

Table 6.05

Clients' and Therapists' Expressed and Wanted FIRO-B Sub-Scale Need Scores

	Clients (n=680)	Therapists (n=39)	Psych Majors (n=35)[a]	Teachers (n=677)[a]
Scale	*Means (Standard Deviations)*			
Expressed Inclusion	4.2 (2.1)	4.3 (2.0)	5.4 (2.2)	5.2 (2.0)
Wanted Inclusion	2.9 (3.2)	2.2 (2.6)	4.0 (3.5)	3.4 (3.4)
Expressed Control	1.5 (1.9)	2.6 (2.2)	3.4 (2.0)	3.1 (2.4)
Wanted Control	2.5 (2.2)	3.0 (1.9)	5.0 (1.7)	5.1 (1.9)
Expressed Affection	3.5 (2.1)	3.6 (2.2)	3.6 (2.1)	3.7 (2.1)
Wanted Affection	4.6 (2.2)	4.6 (1.9)	4.9 (2.2)	4.3 (2.4)

[a] From Schutz (1978)

(table continues)

Table 6.05 (Contd.)

Clients' and Therapists' Expressed

and Wanted FIRO-B Sub-Scale Need Scores

Scale	Clients (n=680)	Therapists (n=39)	Psych Majors (n=35)[a]	Teachers (n=677)[a]
	Means (Standard Deviations)			
	Sums Within Need Areas (*e+w*)[b]			
Sum				
Inclusion	7.1	6.5	9.4	8.6
Control	4.0	5.6	8.4	8.2
Affection	8.1	8.2	8.5	8.0
Total Sum	19.1	20.3	26.3	24.8
	Differences Within Need Areas (*e-w*)[b]			
Difference				
Inclusion	1.4	2.1	1.4	1.8
Control	-1.1	-0.4	-1.6	-2.0
Affection	-1.1	-1.0	-1.3	-0.6
Total Difference	-0.8	0.7	-1.5	-0.8

[a] From Schutz (1978)

[b] *e*=Expressed behaviour, *w*=Wanted behaviour

Table 6.06

Product-Moment Correlations among Clients' FIRO-B Sub-Scale Need Scores

Sub-Scales[a]	eI	wI	eC	wC	eA	wA
eI	-	.48	.05	.00	.44	.35
wI		-	.11	.11	.37	.50
eC			-	.11	.02	-.05
wC				-	.04	.07
eA					-	.53
wA						-

(n = 680)

Note. Where n = 680, $r_{.05}$ = .08

[a] e=Expressed behaviour, w=Wanted behaviour
I=Inclusion, C=Control, A=Affection

Couple Compatibility

The compatibility of couples was assessed using the formulae provided by Schutz (1958) in conjunction with the revisions proposed by Malloy (1980a) and Malloy and Copeland (1980) and described in Chapters 1 and 3. Briefly, compatibility is assessed by using the client's and therapist's six FIRO-B sub-scale scores to derive three

measures each of Reciprocal, Originator and Interchange Compatibility, namely, Reciprocal: Inclusion (*RKinc*), Control (*RKcon*) and Affection (*RKaff*); Originator: Inclusion (*OKinc*), Control (*OKcon*) and Affection (*OKaff*); and Interchange: Inclusion (*XKinc*), Control (*XKcon*) and Affection (*XKaff*). These values are summed to provide the Total Compatibility measure, *K*.

Based on the indices described, compatibility scores between clients and their (ex)spouses were calculated and are recorded in Table 6.07.

It might have been expected that the mean level of compatibility between married persons in the turmoil of divorce proceedings would be relatively lower than that of married persons not in this situation. Unfortunately, there are no standard data available to which the present findings can be compared. However, some comparison possibilities are afforded by the compatibility data of clients and therapists, both from the current work and from the literature. Table 6.08 presents findings from each of these contexts.

As may be seen from Table 6.08, there is little difference between the *K* value for the couple sample above, the client and therapist sample of the present work

Table 6.07

FIRO-B Need Compatibility Scores

between Clients and their (ex)Spouses

Compatibility Measure	*M*	*SD*
RK (& Kinc)	16.5	5.5
OK (& Kcon)	10.4	4.5
XK (& Kaff)	12.3	6.7
Sum Total	18.8	8.2
Difference Total	-0.6	4.5
K	39.2	12.7

(*n* = 232)

and the client (undergraduate female students) and therapist (post-graduate students) sample of Malloy's (1980a) study. Given the very different samples, however, interpretation of these similarities is difficult. The data suggest that need compatibility may be a robust construct which remains constant across cultures and across changing life situations.

Table 6.08

FIRO-B Need Compatibility Scores between Clients and Therapists

Compatibility Measure	*M*	*SD*
RK (& Kinc)	16.7	5.5
OK (& Kcon)	11.6	4.1
XK (& Kaff)	12.8	6.7
Total Sum	19.1	8.3
Total Difference	-0.8	4.4
K	40.1	12.7
(K)[a]	(39.8)	(11.7)

(n = 680)

[a] Corresponding data from Malloy (1980a), n = 48

PAQ Sex-Role Orientation Analyses

Client data are presented first, followed by therapist data. Clients completed the PAQ pre-therapy, post-therapy and at three months following therapy. Therapists only completed the PAQ sex-role orientation measure before therapy, at the same time as they completed the FIRO-B need measure. As some clients completed the PAQ who did not have some demographic and/or related data recorded, the *n* reported in the tables that follow varies accordingly.

Scale Parameters

Reliability coefficients were computed on clients' PAQ sex-role orientation data. Cronbach's alpha was .74 for the Masculinity scale, .80 for the Femininity scale, .62 for the Masculinity-Femininity scale and .71 for the entire scale. The mean corrected item-total correlation was .28 and ranged from a minimum of .05 to a maximum of .61. The item-total correlation for each scale item is presented in Appendix 6K. Similar findings resulted from using therapist data. These coefficients, although not as high as would have been preferred, were nevertheless regarded as satisfactory and were not very different from those reported by Antill, Cunningham, Russell and Thompson (1981) for the sex-role orientation scales which comprise their Personal Description Questionnaire (Form A: α=.81 for males and α=.80 for females on the Masculinity scale; α=.77 for males and α=.77 for females on the Femininity scale; and α=.55 for males and α=.63 for females on the social desirability scale). Compared to the present findings, Spence and Helmreich (1978) reported higher reliability coefficients for their sample of high school students (α=.85, α=.82 and α=.78 for the Masculinity, Femininity and Masculinity-Femininity scales, respectively). Although heterogeneous groups are believed to produce larger

reliability coefficients than homogeneous groups (Anastasi, 1982), it seems unlikely that the current client sample could be regarded as a more homogeneous group than Spence and Helmreich's sample of students. The differences between coefficients in the current case might partly be explained by age, status and motivation differences between students and clients. Clients (*mean* age = 34.00 years) were very likely older than Spence and Helmreich's (1978) student sample (the ages of the students on which the reliability coefficients detailed above were based were not reported by Spence & Helmreich), held the status of distressed persons seeking help and were motivated to seek to change their situation.

Data Description and Introductory Analyses : Client Data

Analysis of variance was used to establish the relationships between client PAQ sex-role orientation data and demographic and related data. Tables reporting these analyses are presented in Appendix 6I. Masculinity scores were significantly related to whether clients had received previous therapy, as were Femininity scores. Clients not having received previous therapy had higher Masculinity scores (F=8.48; df=1,665; p<.01) and also higher Femininity scores (F=8.15; df=1,664; p<.01). Femininity scores were

significantly related to whether clients had contacted a solicitor on a matter related to the reason they were seeking therapy: Those who had sought-out a solicitor had higher scores (F=5.83; df=1,664; p<.05). Femininity scores also were significantly related to the number of children of the marriage, as were Masculinity-Femininity scores. Clients with four or more children had the highest Femininity scores, followed, in order, by those with no children, one child, three children and two children (F=3.61; df=4,637; p<.01). Clients with two children had the highest Masculinity-Femininity scores, followed by those with one child, three children, four or more children and one child, respectively (F=4.99; df=4,639; p<.01).

A full table of correlations among clients' PAQ scores and demographic and related data is contained in Appendix 6J. Although some of the correlations reported in Appendix 6J are statistically significant, most of these hover near 0.1. As noted earlier, the substantive or conceptual import of such correlations appears minimal.

Means and *standard deviations* of clients' pre-therapy PAQ scale scores, by sex, are presented in Table 6.09.

Male and female scores were found to be significantly different on each PAQ scale. In accord with Spence and

Table 6.09

Means and Standard Deviations of
Clients' Sex-Role Orientation Scores by Sex

	Scale[a]					
	M		F		M-F	
Sex	*M*	*SD*	*M*	*SD*	*M*	*SD*
Males (*n*=316)	21.2	4.7	22.9	4.4	13.8	4.1
Females (*n*=325)	19.0	5.0	24.9	4.7	11.1	4.0
Total (*n*=641)	20.1	4.9	23.9	4.6	12.5	4.1

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

Helmreich's (1978) predictions: On the Masculinity scale, males scored higher than females (t=5.80, df=639, p<.01) and on the Femininity scale, females scored higher than males (t=5.51, df=639, p<.01). In addition, on the Masculinity-Femininity scale, males scored higher than females (t=8.62, df=639, p<.01).

Table 6.10 shows the relationship between clients' median scores and those reported by Spence and Helmreich (1978). Scores on the Masculinity scale were equal, those on the Femininity scale higher and those on the Masculinity-Femininity scale lower, though not significantly so in either case.

Table 6.10

Clients' Median Sex-Role Orientation Scores on the Three Scales of the Personal Attributes Questionnaire

Scale[a]		
M	F	M-F
21	24	13
(21)	(23)	(15)

(n = 666)

Note. Spence & Helmreich's (1978) findings are in parentheses

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

Clients' median scores were used to divide their responses into the four sex-role orientation categories described by Spence and Helmreich (1978). Cross-sexed individuals are those in the masculine-female and

feminine-male categories. As can be seen from Table 6.11, more male and female clients held an androgynous sex-role orientation than any other single orientation and differences between the androgynous group and other groups and the undifferentiated group and other groups were statistically significant (total χ^2=53.97, *df*=3, *p*<.01).

Table 6.11

Frequency of Male and Female Clients in Each of Four Sex-Role Orientation Categories

Sex-Role Orientation	Males	Females
Androgynous	112	119
	(35%)	(37%)
Masculine	105	44
	(33%)	(13%)
Feminine	39	103
	(12%)	(32%)
Undifferentiated	62	60
	(20%)	(18%)
Total	318	326
	(100%)	(100%)

Table 6.12 displays the correlations among the Masculinity, Femininity and Masculinity-Femininity scales of the PAQ. Spence and Helmreich's (1978) androgyny construct predicts that the Masculinity and Femininity scales should be independent, that the Masculinity scale should be positively correlated with the Masculinity-Femininity scale, that the Femininity scale should be negatively correlated with the Masculinity-Femininity scale and that males should score higher on the Masculinity scale and females higher on the Femininity scale.

Table 6.12

Product-Moment Correlations among Clients' Sex-Role Orientation Scores on the Three Scales of the Personal Attributes Questionnaire

Scale[a]	M	F	M-F
M	-	.16	.43
F		-	-.42
M-F			-

(n = 666)

Note. Where n = 666, $r_{.05}$ = .08

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

These features were evident in the client data, except that the Masculinity and Femininity scales were significantly correlated. As with the FIRO-B need data above, given the sample size, the conceptual import of this statistically significant, though relatively weak correlation appears minimal, and should not impinge on the interpretation of predictive models which could include these scales.

Data Description and Introductory Analyses : Therapist Data

Of the sample of 39 therapists, 3 indicated they recognized and had previously completed the measure (two, five and two years ago). As assessed by *t* tests, the PAQ scores of the latter therapists were not significantly different from the PAQ scores of therapists who reported they had not recognized or previously completed the measure.

Means and *standard deviations* of therapists' PAQ scale scores, by sex, are presented in Table 6.13.

Based on demographic and related data and using the analysis of variance procedure, no significant differences were located between male and female therapists; however, the 9 male therapists from the present sample scored

Table 6.13

Means and Standard Deviations of Therapists' Sex-Role Orientation Scores by Sex

	Scale[a]					
	M		F		M-F	
Sex	*M*	*SD*	*M*	*SD*	*M*	*SD*
Males (*n*=9)	24.2	2.9	24.2	3.3	17.4	2.8
Females (*n*=30)	22.2	3.9	23.9	3.1	14.2	3.7
Total (*n*=39)	23.2	3.4	24.1	3.2	15.8	6.5

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

significantly higher on the Masculinity-Femininity scale than did the 27 male therapists from the second study reported in Chapter 5 (t=2.05, df=34, p<.05).

To determine the relationships between therapist PAQ scores and therapist demographic and related data, analysis of variance was employed. Three variables were found to be

significantly related to PAQ sub-scale scores, namely, gender, age and years of employment as a Court Counsellor. Tables reporting these analyses are presented in Appendix 6L. Males scored significantly higher on the Masculinity-Femininity scale than did females (F=5.98; df=1,37; p<.05); age was found to be positively related to Masculinity-Femininity scores (F=4.91; df=1,37; p<.05); and years of employment as a Court Counsellor was negatively related to Femininity scores (F=7.36; df=1,37; p<.01).

Therapists scored significantly higher than clients both on the Masculinity scale (t=3.19, df=669, p<.01) and on the Masculinity-Femininity scale (t=3.49, df=669, p<.01).

The full table of correlations between information collected from therapists and therapists' PAQ scores is presented in Appendix 6M.

Table 6.14 shows that, compared to Spence and Helmreich's (1978) findings, therapists' median scores on the Masculinity-Femininity scale were identical and those on the Masculinity and Femininity scales were higher, but not significantly so.

The groups' median scores were used to divide responses into the four sex-role categories described by Spence and

Table 6.14

Therapists' Median Sex-Role Orientation Scores on Each of the Three Scales of the Personal Attributes Questionnaire

Scale[a]		
M	F	M-F
24	24	15
(21)	(23)	(15)

(n = 39)

Note. Spence & Helmreich's (1978) findings are in parentheses

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

Helmreich (1978). As may be seen from Table 6.15, more male and female therapists held an androgynous sex-role orientation than any other single orientation.

Table 6.16 displays the correlations among therapists' PAQ scale scores.

The androgyny construct predicts that the Masculinity and Femininity scales should be independent, that the Masculinity scale should be positively correlated with the Masculinity-Femininity scale, that the Femininity scale should be negatively correlated with the Masculinity-

Table 6.15

Frequency of Male and Female Therapists in Each of Four Sex-Role Orientation Categories

Sex-Role Orientation	Males	Females
Androgynous	4 (44%)	9 (30%)
Masculine	2 (22%)	6 (20%)
Feminine	0 (0%)	8 (27%)
Undifferentiated	3 (33%)	7 (23%)
Total	9 (100%)	30 (100%)

Femininity scale and that males should score higher on the Masculinity scale and females higher on the Femininity scale. These features were evident in the therapist data, except that males scored more highly on the Femininity scale than did females (by 0.3 of a scale point). Given the relatively small size and selected nature of the sample, especially when comparing it to Spence and Helmreich's (1978) college student samples, this difference was not unexpected.

Table 6.16

Product-Moment Correlations among Therapists' Sex-Role Orientation Scores on Each of the Three Scales of the Personal Attributes Questionnaire

Scale[a]	M	F	M-F
M	-	.25	.41
F		-	-.10
M-F			-

(n = 39)

Note. Where n = 39, $r_{.05}$ = .30

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

Evaluation Data Analyses

Where more than 4 out of 21 responses were missing on any evaluation questionnaire, the case was deleted from analyses. Where four or fewer responses were missing on a questionnaire, (i.e., at least 17 questions answered), the case was included using mean substitution.

Scale Parameters

Reliability coefficients were computed on clients' responses to the follow-up evaluation questionnaire because more clients completed that questionnaire than any other evaluation questionnaire. Cronbach's alpha for Factor One items was .91, for Factor Two items .84, for Factor Three items .84, for the entire scale .92 and for the group of six negative items added to the scale .72. Including the only negative item from the original scale raised alpha for the resulting group of seven negative items to .77. The mean item-total correlation was .57 and ranged from a minimum of .28 to a maximum of .77. The only positive item added to the scale obtained the highest item-total correlation (r=.77). Corrected item-total correlations for each scale item are presented in Appendix 6P.

Residuals corresponding to Factors One, Two and Three of all client and therapist evaluation data sets were subjected to analysis. All were found to be normally distributed.

Data Description and Introductory Analyses : Client and Therapist Data

Analyses were undertaken to determine whether clients from City B who completed follow-up evaluations eight months

post-therapy responded significantly differently to clients from other cities who completed follow-up evaluations three months post-therapy. *T*-tests were conducted between the two groups on each of the 21 items comprising the evaluation instruments. None of these tests were significant. As a result, in all subsequent analyses, follow-up evaluations by the 30 City B clients were combined with those by all other clients, resulting in a client pool of 333 respondents.

In total, 181 clients completed both the post-therapy questionnaire and the follow-up questionnaire. To determine whether the post-therapy and follow-up responses were sufficiently well related to be combined in some manner, Pearson correlation coefficients were computed. Significantly high correlations were evident between responses to each item and ranged from .19 to .49, where $r_{.05}$=.15. The full table of these correlations appears in Appendix 6N. Then, to establish whether responses were similar on the two occasions, change scores (each follow-up item value minus its corresponding post-therapy item value) were calculated for each question for each subject and *t*-tests conducted. The change scores were found to be normally distributed and the resulting *means*, *t* values and associated probabilities are presented in Appendix 6O. (As

will be indicated in Section C, these scores were subsequently employed as dependent measures in order to determine possible reasons for the observed differences.) Of the 21 items comprising each of the questionnaires, responses differed significantly on 14 items (at a minimum $p<.05$ level), resulting also in a significant overall difference value ($t=6.51$, $n=181$, $p<.01$). At the end of therapy clients consistently rated items significantly higher than they rated the same items at follow-up. As a consequence of these findings, in all subsequent analyses these data sets could not logically be combined, but were treated separately.

Table 6.17 presents the evaluation response *means* and *standard deviations* for clients' post-therapy and follow-up evaluations and therapists' post-therapy evaluations. Therapist post-therapy evaluation responses were not detected to be significantly different from client post-therapy responses. It can be seen from Table 6.17 that at the end of therapy, the therapist and client groups rated therapy similarly.

Given these similarities and the differences noted above between clients' ratings at the end of therapy compared with three months later, it might be expected that

Table 6.17

Clients' Mean Post-Therapy and Follow-Up Evaluations and Therapists' Mean Post-Therapy Evaluations

Group	*N*	*M*	*SD*
Client Post-Therapy Responses	318	4.03	0.91
Client Follow-Up Responses	333	3.54	1.00
Therapist Post-Therapy Responses	270	3.96	0.83

therapist post-therapy ratings and client follow-up ratings would also differ significantly. This was in fact the case. At the three months follow-up-evaluation clients rated therapy significantly less favourably than therapists had done immediately following the termination of therapy (total difference t=6.69, df=601, p<.01).

In order to equate them with post-therapy responses, it was possible to weight the follow-up responses. Before this could be done, it was necessary to ascertain whether the group of clients who answered both the evaluation questionnaires responded differently to clients who

completed only one such questionnaire. To test for this, repeated measures *MANOVAS* were conducted. As may be seen in Table 6.18, clients from the two groups responded significantly differently on both the post-therapy and follow-up measures. Those clients who completed all items on both evaluation measures gave post-therapy and follow-up ratings which were significantly higher than the ratings given by clients who completed all items on only one of these measures. (Any case which did not have values for *all* the dependent and independent variables was excluded from the repeated measures *MANOVA* procedure. The reduced *df'* s reported in Table 6.18 are a result of the application of this criterion.)

As a result of these findings, in all subsequent analyses evaluation responses were analysed separately and according to the following groupings:

1. clients (*n*=318) who completed only the post-therapy evaluation
2. clients (*n*=333) who completed only the follow-up evaluation
3. clients (*n*=181) who completed both post-therapy and follow-up evaluations and
4. therapists (*n*=39) who completed the post-therapy measure

Clients who completed both questionnaires (*n*=181) are included in 1 and 2 above. To take into account the group

Table 6.18

Multivariate Analysis of Variance Results from Comparing the Post-Therapy and Follow-Up Responses of Clients who Completed Both Evaluation Questionnaires with Clients who Completed One Such Questionnaire

Effect	Wilk's Criterion	*df*	*F*
Post-Therapy Evaluations	0.86	21, 273	2.15**
Follow-Up Evaluations	0.87	21, 238	1.73*

*$p<.05$ **$p<.01$

differences just noted, in all analyses where the two groups' responses were pooled, for example, when analysing all the follow-up data, a variable was added accounting for whether one or both evaluation questionnaires had been answered.

Analyses were performed to determine whether there were differences based on the demographic and related data of those who completed both evaluation questionnaires (n=181) compared to those who completed only the post-therapy questionnaire (n=137), or only the follow-up questionnaire (n=152). Clients who completed both questionnaires had

fewer children than those who completed only one questionnaire (F=3.83, p<.05). In addition, a significantly greater number of clients who completed both questionnaires had attended therapy with their (ex)spouse (n=123), rather than on their own (n=58) (χ^2=7.22, df=2, p<.05). Further, when compared to other clients, those clients who completed only the follow-up measure had significantly lower client-therapist compatibility scores (F=3.24, p<.05). This difference was due primarily to reduced compatibility on the Control dimension of the FIRO-B. No PAQ score differences between the groups were identified.

Initial Factor Analysis

In order to verify the underlying structures anticipated in the evaluation measures and because more clients responded to the follow-up measure than any of the other evaluation instruments, responses to it were subjected to factor analysis. For the purpose of parsimony, the data first were subjected to a principal components analysis. This resulted in a four-factor solution which accounted for 60% of the variance. However, as a scree plot indicated, the contribution of the first factor (39%) to the total variance explained, and its associated eigenvalue (8.23), was such that the other three factors contributed

relatively very little. This observation led to the conclusion that the scale being examined might adequately be explained by a single score constituted from the addition of scale item ratings. However, retaining this single factor solution would have entailed a substantial loss of information and a single factor representation would not have accommodated the testing of underlying structures expected in the present data and identified by Friedlander (1982). In addition, maximum likelihood factor analysis is amongst the most preferred methods (Lawley & Maxwell, 1971) and in large samples gives better estimates than principal factor analysis (Sarle, 1985).

Subsequent Factor Analysis

As a result of the above reasoning, the therapy follow-up data were factor analysed using the same procedure reported by Friedlander (1982). First, the data were analysed to enable comparison with Friedlander's original 14-item scale. Second, the present revised scale comprising 21 items was analysed. Cattell's (1966) scree test and factor interpretability were used as criteria for the retention of factors and both orthogonal and oblique rotations were computed to determine the factor solution that best approximated the requirements for simple structure

(Zamostny, Corrigan & Eggert, 1981). Following maximum likelihood extraction, varimax rotation of the 14-item response data resulted in a three-factor solution, as Friedlander had determined. This solution is presented in Table 6.19.

Italicized weights in Table 6.19 signify which high-loading items were in common with Friedlander's (1982) findings. Using an arbitrary cut-off loading of .40 (similar to that employed by Friedlander), of the 14 items in Table 6.19, 9 were identified as loading on Factor One, 5 on Factor Two and 3 on Factor Three. These Factors corresponded to Friedlander's Factors Two (comprising six items), Three (comprising three items) and One (comprising six items), respectively.

Again, following maximum likelihood extraction, varimax rotation of the 21-item response data set also resulted in a three-factor solution. This is presented in Table 6.20.

Italicized weights in Table 6.20 signify which high-loading items were in common with Friedlander's (1982) findings. Scores on each of the three factors were found to be normally distributed. Using an arbitrary cut-off loading of .40, of the 21 items, 11 were found to load on Factor One, 7 on Factor Two and 7 on Factor Three. (As indicated

Table 6.19

Three-Factor Solution of the

14-Item Client Satisfaction Questionnaire

Questionnaire Items[a]	Factor 1	Factor 2	Factor 3
1	*.61*	.44	.11
3	.19	.67	.29
4	.46	*.57*	.20
6	.58	.34	.33
7	*.72*	.30	.16
8	*.77*	.24	.14
9	.37	*.62*	.31
11	.24	.17	*.61*
13	*.56*	.17	.14
14	.41	*.63*	.25
17	.01	.25	*.75*
18	*.52*	.18	.59
20	.22	.15	.17
- 21	*.43*	.36	.11

(n = 333)

Notes. Italicized weights are those in common with Friedlander (1982)

Factor 1 = Mastery/Insight, Factor 2 = Therapeutic Outcome, Factor 3 = Therapeutic Relationship

[a] Item order as per Client Satisfaction Questionnaire presented in Appendix 3F

- Negative item

in Chapter 3, to accommodate the contribution of each item to the scale under consideration, *all* item weights were employed in the determination of predictive models.) These

Table 6.20

Three-Factor Solution of the Revised

21-Item Client Satisfaction Questionnaire

Questionnaire Items[a]	Factor 1	Factor 2	Factor 3
1	*.53*	*.48*	.23
- 2	.17	.40	.16
3	.35	.21	.57
4	*.50*	.39	.33
- 5	.08	.32	.56
6	*.61*	.34	.25
7	*.68*	.37	.08
8	*.63*	*.50*	.06
9	.48	.28	.56
- 10	.03	.23	.61
11	.50	-.03	.32
- 12	.11	.22	.56
13	*.56*	.29	-.04
14	*.50*	.37	*.45*
15	.49	.56	.34
- 16	.16	.54	.25
17	.33	-.10	*.54*
18	*.68*	.14	.28
- 19	.13	.62	.08
20	.28	.05	.15
- 21	.22	.65	.23

(n = 333)

Notes. Italicized weights are those in common with Friedlander (1982)

Factor 1 = Mastery/Insight, Factor 2 = Therapeutic Outcome, Factor 3 = Therapeutic Relationship

[a] Item order as per Client Satisfaction Questionnaire presented in Appendix 3F

- Negative items and weights

Factors will be referred to as: *Mastery/Insight* (after Howard, Orlinsky & Hill, 1970), *Therapeutic Outcome* and *Client/Therapist Relationship*, respectively. Variance explained by this three-factor solution was similar to that explained by the four-factor principal components solution detailed earlier. (Notions of variance explained by a rotated solution are less easily interpreted because of the possibility of spuriously inflated communality values [Maxwell, 1977]). In the revised 21-item follow-up questionnaire version, 10 items maintained their 14-item factor position and 4 items shifted. One item shifted from Factor One to Factor Two, one from Factor Three to Factor One, and two from Factor Two to Factor Three. Of the seven negative items, four loaded on Factor Two and three on Factor Three.

Client and therapist scores on the extracted factors comprising the evaluation measures were correlated and are detailed in Table 6.21. Client and therapist ratings of both Therapeutic Outcome (Factor Two) and the Client-Therapist Relationship (Factor Three) were significantly correlated.

Table 6.21

Product-Moment Correlations among Client and Therapist Scores on Each of the Factors Comprising the Client and Therapist Post-Therapy and Client Follow-Up Evaluation Measures

	Scales[a]								
	CPQ1			CSQ			CPQ2		
Factors[b]	1	2	3	1	2	3	1	2	3
CPQ1 Factor 1	-	.14	.10	.04	.00	.01	.13	.03	.01
CPQ1 Factor 2		-	.14	-.03	-.05	-.02	-.00	-.04	-.06
CPQ1 Factor 3			-	-.03	-.12	.01	-.05	-.06	-.09
CSQ Factor 1				-	.44	-.01	.06	.19	.06
CSQ Factor 2					-	.09	.23	.41	.06
CSQ Factor 3						-	.16	.05	.21
CPQ2 Factor 1							-	.19	.08
CPQ2 Factor 2								-	.20
CPQ2 Factor 3									-

(n = 270)

Note. Where n = 270, $r_{.05}$ = .11

[a] CPQ1 = Client Post-Therapy Evaluation Questionnaire
CPQ2 = Therapist Post-Therapy Evaluation Questionnaire
CSQ = Client Follow-Up Evaluation Questionnaire

[b] Factor 1 = Mastery/Insight, Factor 2 = Therapeutic Outcome, Factor 3 = Therapeutic Relationship

RESULTS

SECTION B : HYPOTHESIS TESTING

As described in Section A, this section reports the results from testing the specific hypotheses associated with the study as outlined below and in Chapter 1.

Preliminary Considerations

To allow each variable an equal opportunity of entering any predictive model developed, the forward-stepwise multiple regression procedure was adopted throughout. Higher order interactions were entered into equations only after inclusion of the corresponding main effects (Allison, 1977; Cohen, 1978; Lubinski, 1983). This was achieved in the stepwise procedure by disabling the automatic compute process, which in turn enabled manual control over when first and second order effects could be admitted.

Dummy variables were employed to facilitate inclusion in the regression modelling procedure of noncontinuous variables such as gender, city, occupation, source of referral and so on (Bohrnstedt & Knoke, 1982). The *SAS* general linear models option was used. This option automatically sets the last level of each categorical

variable as the reference level to which the other levels comprising the variable are compared. As a result of this process, a variable can appear as significant in a model without any of the comparisons between levels of the variable appearing significant. In such a case, at least one level of the variable is significantly different from another, but only when based on a reference level different to that being employed. Typically, also, the arithmetic signs of variable levels are different in these cases (Ramsay, 1988).[1] In any event, the diagrammatic presentation of *least-squares means* and associated confidence intervals for each level, described below, provide unequivocal information as to which pairs of variable levels are significantly different.

The presentation of regression tables follows that employed by Bohrnstedt and Knoke (1982). Several models resulted in a dependent variable with a small *standard deviation* and noncontinuous regressors with relatively large *standard deviations* and *regression coefficients*. In such models, some standardized *beta weights* (β's) appeared as rather large for certain levels of categorical variables. For the purposes of comparison, however, it was considered more informative

[1]Mark Ramsay, Australian Bureau of Statistics, Canberra. Personal communication.

to present standardized *beta's* rather than unstandardized regression coefficients (Scott, 1988).[2]

The listwise, rather than the pairwise deletion option was chosen, such that a case was deleted from an analysis if scores were missing for that case on *any* variable in the model being investigated. Although the use of this option often led to cases being omitted from analyses, these were not sufficiently large in number or sufficiently consistent in identity as to constitute a recognizable or nonrandom group capable of threatening the validity of the findings. In addition, providing the latter conditions are known to obtain, even though a cost attaches to its use, listwise deletion is the preferred procedure (Bohrnstedt & Knoke, 1982).

For each regression model, multicollinearity was addressed by direct analysis using the *SAS* multicollinearity diagnostic programme (Ihnen & Sall, 1985). In none of the models developed was a component with a high condition index found to contribute strongly to the variance of two or more variables.

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[2]William Scott, Department of Psychology, The Australian National University. Personal communication.

As a consequence of often large group size differences, the *least-squares means* (Finney, 1980), or *population marginal mean* option (Searle, Speed & Millikan, 1980) was adopted throughout. *Least-squares means* are raw score means adjusted for a non-balanced design and represent the average values that would be predicted if the design was balanced (the mathematical derivation of *least-squares means* is outlined by Searle, et al.). Confidence intervals were calculated from twice the *standard error* of the corresponding *least-squares means*. The latter calculation results in a confidence interval about the *mean* of approximately 95%. *Least-squares means* and associated confidence intervals will be displayed graphically (Andrews, Snee & Sarner, 1980). While confidence intervals provide an effective measure of uncertainty about the *mean*, they do not provide a direct or accurate procedure for making decisions concerning the statistical significance of differences between pairs of *means*. However, such intervals can be used to develop a simple, though approximate decision rule, as follows: Any two *means* are significantly different at approximately $p<.01$ if their 95% confidence intervals do not overlap (Andrews, Snee & Sarner, 1980). The corollary to this is that if the confidence intervals of any two *means* do

overlap, their *means* may be significant at a probability level less stringent than $p<.01$ (Cunningham, 1988).[3]

It will be recalled from Chapter 3 that maximum compatibility on the FIRO-B is represented by a score of *0* and maximum incompatibility by a score of *108*. In the current work, to maintain a logical sense of lesser and greater degrees of compatibility, the latter will be referred to as increasing or decreasing in relation to other variables. The consequence of this is that although the arithmetical sign of a compatibility dimension's *beta* weight might appear as positive in a regression table, to take account of the scale ranging in *in*creasing size from 108 to 0, the relationship will be reported and interpreted in the text as negative, and vice versa.

Client Post-Therapy Evaluations

Post-Therapy Evaluations Modelled on Joint Client and Therapist Variables

The first hypothesis of this study was that a positive relationship would obtain between the Control area pre-therapy interpersonal need compatibility of (male and

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[3]Ross Cunningham, Department of Statistics, The Australian National University. Personal communication.

female) therapists and female clients, and their favourable ratings of therapy. To test this prediction, for each of the three factors defining the evaluation data, all client and therapist demographic and related variables and FIRO-B need scores and PAQ sex-role orientation scores were entered into three forward-stepwise multiple regressions. These analyses were conducted using client and therapist post-therapy evaluations and client follow-up evaluations.

The significant variables to emerge from analysing clients' post-therapy appraisals and corresponding to Factors One, Two and Three, are presented in Tables 6.22, 6.23 and 6.24, respectively. Modelling all predictor variables using Mastery/Insight (Factor One) items resulted in three-variables accounting for 14% of the variance (Table 6.22).

Clients presenting for therapy on their own rated items more favourably than those presenting with their (ex)spouse (F=5.19; df=1,245; p<.05). Unemployed persons rated items the most favourably, followed, in order, by those engaged in: management/self-employment, unskilled labour, home duties, trades, armed forces/corrective services, customer services and professions (F=2.83; df=7,245; p<.01). Those married more than 20 years rated items the most positively, followed by those married: 15 to 20 years, less than 5

Table 6.22

Regression Results from Analysing Client Post-Therapy Ratings of Mastery/Insight Gains as a Function of Combined Client and Therapist Demographic, Need and Sex-Role Orientation Data

Independent Variable	β	*Standard Error*	*t*
Presented for Therapy with (ex) Spouse	-.14*	.19	-2.28
Presented for Therapy Alone	-	-	-
Occupation			
Corrective Services	-.18*	.30	-2.42
Customer Services	-.15*	.38	-2.32
Home Duties	-.08	.28	-1.05
Manager/Self-Employed	-.03	.42	-0.42
Manual/Unskilled	-.04	.33	-0.59
Professional	-.26**	.38	-3.70
Tradesperson	-.11	.30	-1.47
Unemployed	-	-	-
Years Married			
five to ten years	-.14*	.22	-2.09
ten to fifteen years	-.15*	.22	-2.21
fifteen to twenty years	.03	.30	0.45
more than twenty years	.03	.56	0.56
under five years	-	-	-
Intercept		.25	17.91
	R^2 = .14**		

*p<.05 **p<.01 (n = 243)

years, 5 to 10 years and 10 to 15 years, respectively (F=2.49; df=4,245; p<.05). Figures 6.01 and 6.02 display the confidence intervals associated with the relevant *least-squares means*.

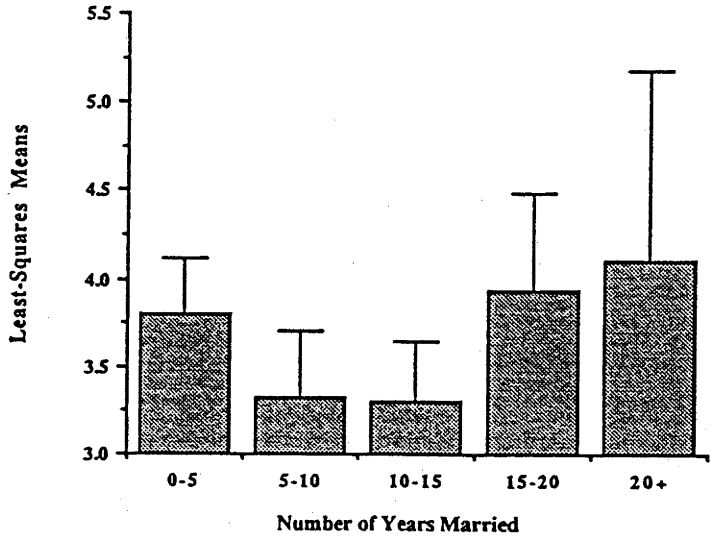


Figure 6.01 **Client Factor 1 least-squares means associated with the number of years married**

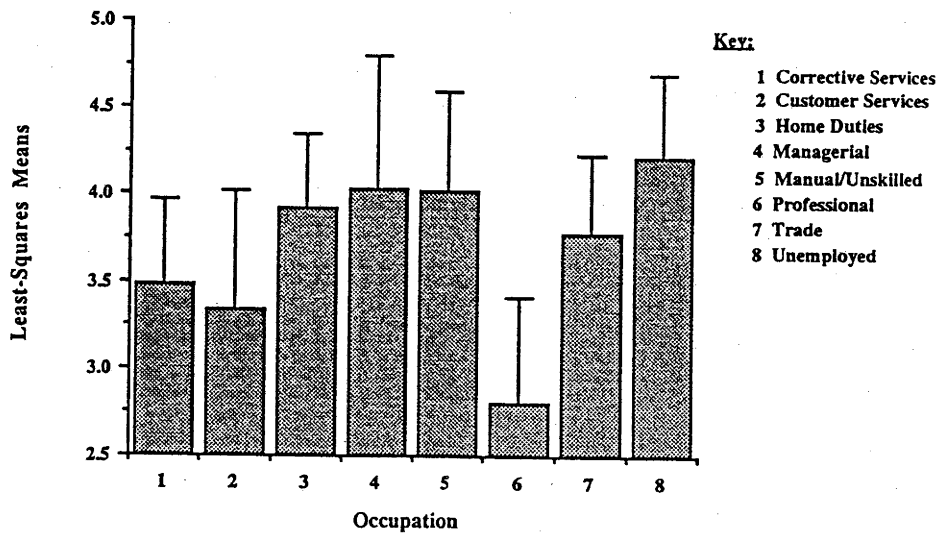


Figure 6.02 **Client Factor 1 least-squares means associated with occupation**

Three variables explained 10% of the variance employing Therapeutic Outcome (Factor Two) items (Table 6.23).

Table 6.23

Regression Results from Analysing Client Post-Therapy Ratings of Therapeutic Outcome as a Function of Combined Client and Therapist Demographic, Need and Sex-Role Orientation Data

Independent Variable	β	*Standard Error*	*t*
City:			
A	-.08	.25	-1.26
B	.16**	.29	2.63
C	-.08	.19	-1.19
D	-	-	-
Couple Living:			
Apart	.28*	.56	2.31
Together	.29**	.68	2.69
Together, but Separate	-	-	-
Years Married			
five to ten years	.05	.22	0.73
ten to fifteen years	-.13*	.21	-1.96
fifteen to twenty years	-.11	.31	-1.64
more than twenty years	-.07	.42	-1.61
under five years	-	-	-
Intercept		.60	2.32
	R^2 = .10**		

*$p<.05$ **$p<.01$ ($n = 261$)

Clients from City B rated items the most favourably, followed, in order, by clients from City D, C and A (F=4.56; df=3,263; p<.01). Clients living separately in the same house rated items the most positively, followed, in order, by those living apart and those living as spouses (F=3.64; df=2,263; p<.05). Those married 5 to 10 years gave the most favourable Factor One ratings, followed by those married: less than 5 years, 10 to 15 years, 15 to 20 years and more than 20 years, respectively (F=2.72; df=4,263; p<.05). Figures 6.03, 6.04 and 6.05 display the associated *least-squares means* and confidence intervals.

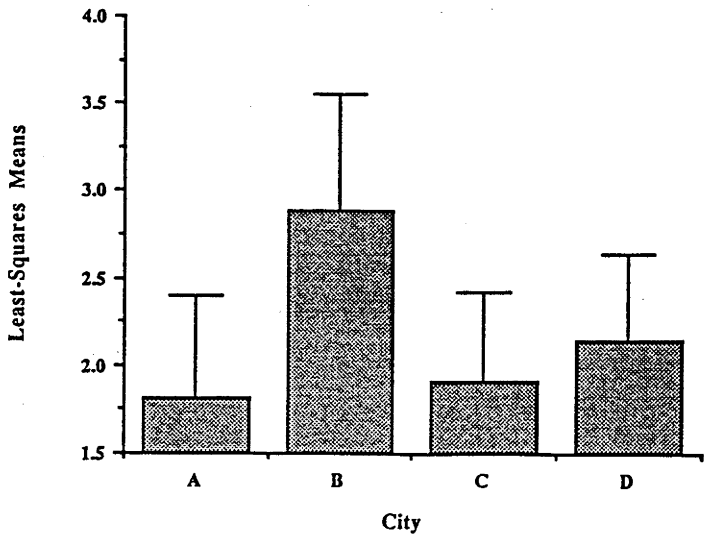


Figure 6.03 **Client Factor 2 least-squares means associated with the city effect**

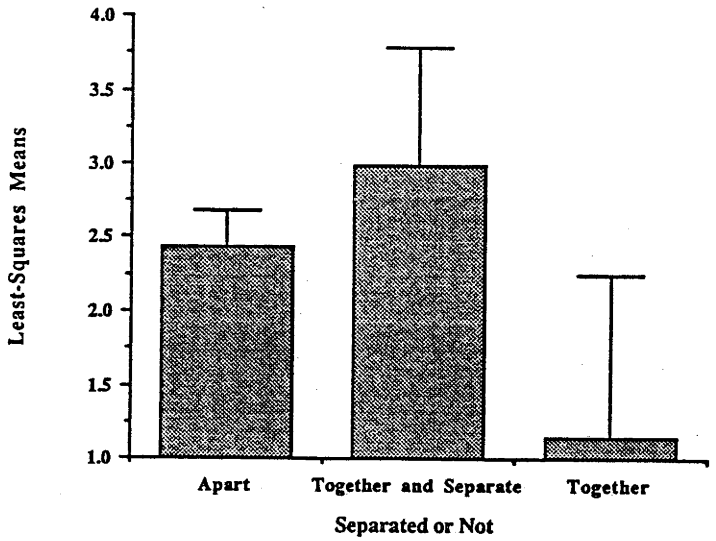


Figure 6.04 **Client Factor 2 least-squares means associated with whether clients are separated**

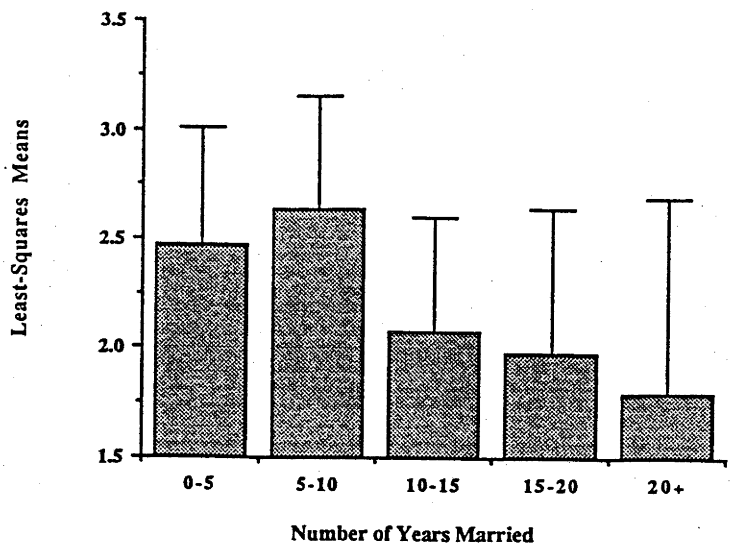


Figure 6.05 **Client Factor 2 least-squares means associated with the number of years married**

Table 6.24 shows that the variables Interchange Control, Source of Referral and the Percentage of Children Living With the Client together accounted for 15% of the variance as a result of employing items describing the Therapeutic Relationship (Factor Three).

Table 6.24

Regression Results from Analysing Client Post-Therapy Ratings of the Therapeutic Relationship as a Function of Combined Client and Therapist Demographic, Need and Sex-Role Orientation Data

Independent Variable	β	*Standard Error*	*t*
Source of Referral:			
Other Helping Agency	-.08	.37	-1.11
Court Judge	-.02	.25	-0.21
Court Registrar	-.03	.26	-0.35
Self	.19*	.26	2.08
Solicitor	-	-	-
Who has Living with them:			
All the Children	.71**	.44	3.87
None of the Children	.61**	.44	3.46
No Children of Marriage	.34**	.53	3.19
Some of the Children	-	-	-
The FIRO-B *XKCON* Dimension[a]	-.19**	.03	-2.73
Intercept		.49	6.39
	R^2 = .15**		

*$p<.05$ **$p<.01$ ($n = 198$)

[a] *XKCON* = Interchange Compatibility on the Control dimension

Interchange Control (*XKCON*) compatibility was positively associated with favourable ratings (F=7.48; df=1,199; p<.01). Clients with all of the children in their care rated items the most positively, followed, in order, by those with: no children, none of the children in their care and some of the children in their care (F=5.10; df=3,199; p<.01). Those self-referred to therapy gave the most favourable ratings of the relationship, followed by those: solicitor-referred, judge-referred, registrar-referred and helping-agency-referred, respectively (F=3.25; df=4,199; p<.01). Figures 6.06 and 6.07 illustrate these findings.

Client Follow-Up Evaluations

Follow-Up Evaluations Modelled on Joint Client and Therapist Variables

Applying each of the three factors identified, and together with client and therapist demographic and related data, FIRO-B need scores and PAQ sex-role orientation scores were entered as predictors into three forward-stepwise multiple regressions using client follow-up ratings as outcome measures. The significant variables to emerge from these analyses are presented in Tables 6.25, 6.26 and 6.27, corresponding to Factors One, Two and Three, respectively.

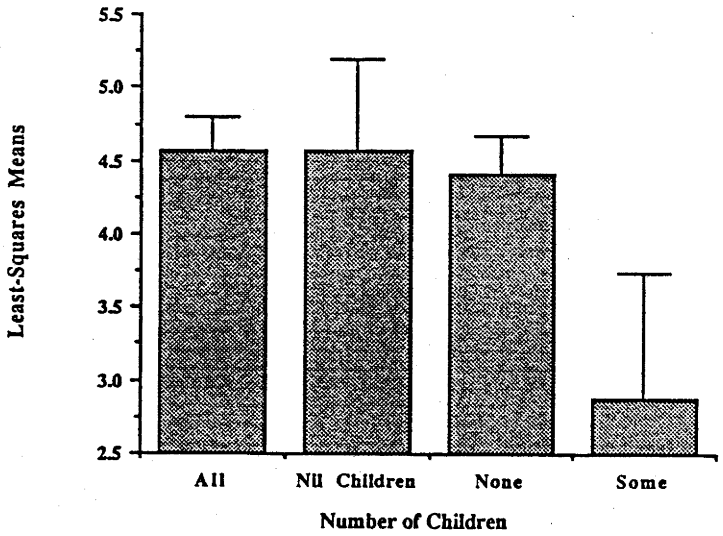


Figure 6.06 **Client Factor 3 least-squares means associated with how many children live with each client**

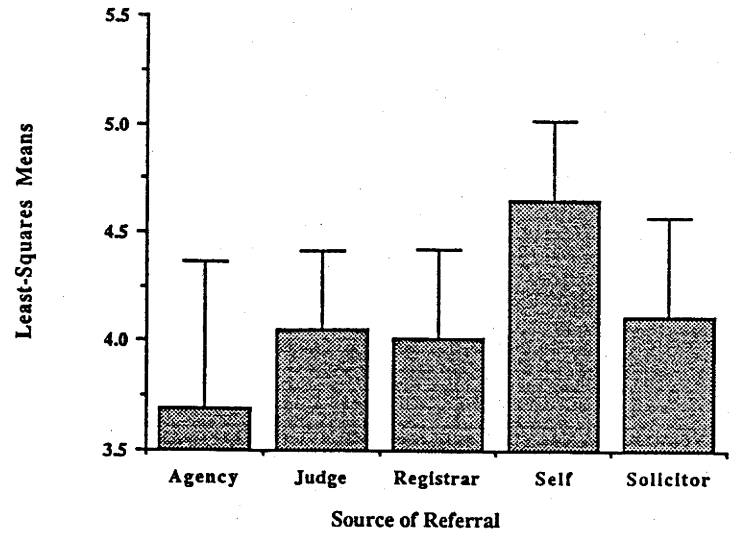


Figure 6.07 **Client Factor 3 least-squares means associated with the source of referral**

Utilizing Mastery/Insight (Factor One) items, client scores on the Masculinity scale of the PAQ was the only significant variable found to explain the data and accounted for 2% of the variance (Table 6.25). Masculinity scale scores were negatively related to follow-up evaluations (F=7.31; df=1,306; p<.01).

Table 6.25

Regression Results from Analysing Client Follow-Up Ratings of Mastery/Insight Gains as a Function of Combined Client and Therapist Demographic, Need and Sex-Role Orientation Data

Independent Variable	β	*Standard Error*	*t*
Clients' PAQ Masculinity Scores	-.15**	.02	-2.70
Intercept		.35	11.36
	R^2 = .02**		

**p<.01 (n = 305)

Modelling all variables with the follow-up data employing Therapeutic Outcome (Factor Two) items concluded in two variables accounting for 6% of the variance (Table 6.26).

Table 6.26

Regression Results from Analysing Client Follow-Up Ratings of Therapeutic Outcome as a Function of Combined Client and Therapist Demographic, Need and Sex-Role Orientation Data

Independent Variable	β	*Standard Error*	*t*
Number of Children:			
0	.13	.50	1.84
1	-.13	.33	-1.23
2	-.00	.32	-0.01
3	-.08	.36	-0.90
4+	-	-	-
The FIRO-B *XKINC* Dimension[a]	-.15**	.02	-2.59
Intercept		.32	7.43
	R^2 = .06**		

**$p<.01$ ($n=293$)

[a] *XKINC* = Interchange Compatibility on the Inclusion dimension

Interchange Compatibility on the Inclusion dimension (*XKINC*) was found to be positively related to follow-up evaluations ($F=6.68$; $df=1,294$; $p<.01$). Clients with no children rated items the most favourably, followed by those with: four or more children, two children, three children and one child, respectively ($F=3.14$; $df=4,294$; $p<.05$). Figure 6.08 displays this finding.

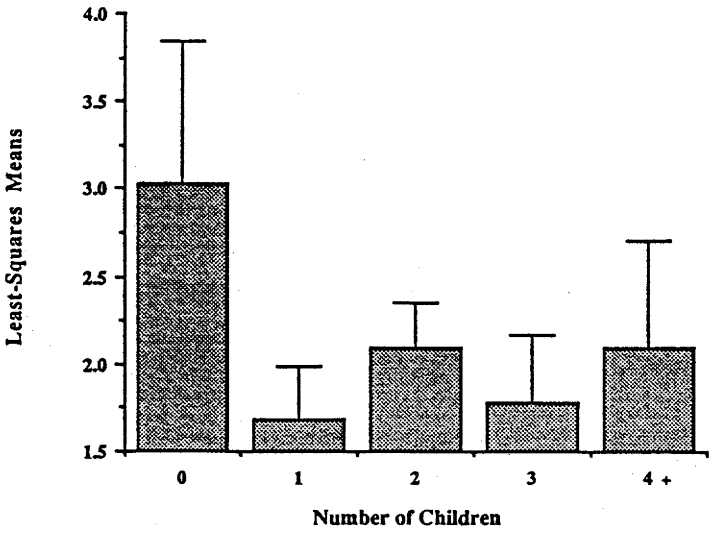


Figure 6.08 **Follow-up Factor 2 least-squares means associated with the number of children of the marriage**

Modelling client and therapist variables with follow-up ratings using Therapeutic Relationship (Factor Three) items resulted in six variables explaining 19% of the variance (Table 6.27).

Clients presenting for therapy on their own rated items more favourably than those presenting with their (ex)spouse (F=13.76; df=1,283; p<.01). Females rated items more favourably than males (F=7.83; df=1,283; p<.01). Clients from City D gave the most positive ratings, followed, in order, by those from City B, C and A (F=4.13; df=3,283; p<.01). Clients married 5 to 10 years gave the most positive ratings, followed by those married: 15 to 20

Table 6.27

Regression Results from Analysing Client Follow-Up Ratings of the Therapeutic Relationship as a Function of Combined Client and Therapist Demographic, Need and Sex-Role Orientation Data

Independent Variable	β	*Standard Error*	*t*
City:			
A	-.18**	.27	-3.15
B	-.11	.23	-1.82
C	-.16**	.20	-2.60
D	-	-	-
Client Gender:			
Female	.15**	.16	2.80
Male	-	-	-
Presented for Therapy with (ex) Spouse	-.20**	.16	-3.71
Presented for Therapy Alone	-	-	-
Was a Solicitor Contacted Before Therapy:			
No	.12*	.18	2.14
Yes	-	-	-
Years Married			
five to ten years	.21**	.21	3.49
ten to fifteen years	.05	.21	0.79
fifteen to twenty years	.15*	.27	2.40
more than twenty years	.03	.40	0.67
under five years	-	-	-
Therapist Gender:			
Female	.15**	.20	2.69
Male	-	-	-
Intercept		.29	12.35
	R^2 = .19**		

*$p<.05$ **$p<.01$ ($n = 282$)

years, more than 20 years, 10 to 15 years and less than 5 years, respectively (F=3.75; df=4,283; p<.01). Clients not having had contact with a solicitor at some time prior to therapy rated items more positively than those having had such contact (F=4.60; df=1,283; p<.05). Clients counselled by a female therapist rated items more favourably than those counselled by a male therapist (F=7.23; df=1,283; p<.01). Figures 6.09 and 6.10 display the *least-squares means* and confidence intervals associated with these findings.

Therapist Post-Therapy Evaluations

Post-Therapy Evaluations Modelled on Joint Client and Therapist Variables

To determine whether therapist post-therapy ratings could be accounted for by client and/or therapist demographic and related variables and/or FIRO-B need compatibility and/or PAQ sex-role orientation scores, three forward-stepwise multiple regressions were completed for each of the three factors already defined for the client and therapist evaluation data.

Modelling client and therapist variables jointly with therapist post-therapy ratings and applying Mastery/Insight

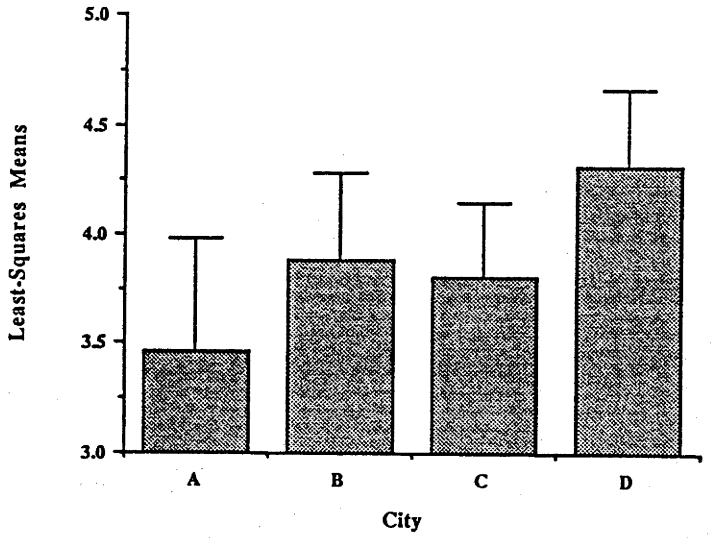


Figure 6.09 **Follow-up Factor 3 least-squares means associated with the city effect**

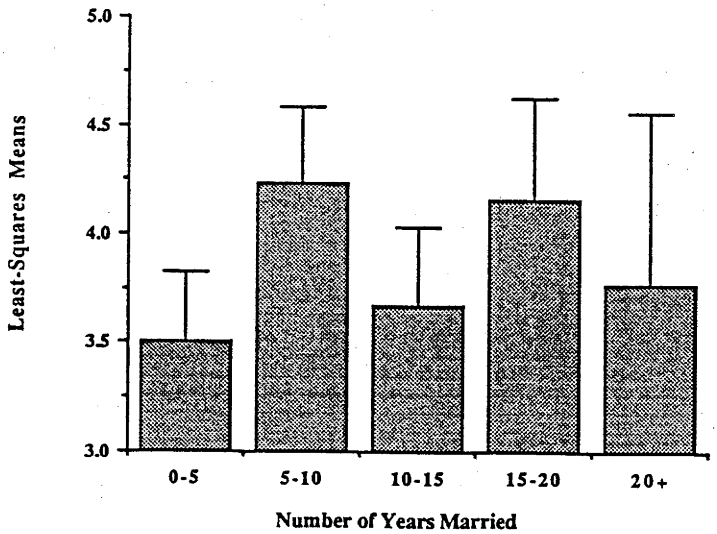


Figure 6.10 **Follow-up Factor 3 least-squares means associated with the number of years married**

(Factor One) loadings resulted in three-variables that accounted for 10% of the variance (Table 6.28).

Need compatibility on the Control dimension of the FIRO-B was negatively associated with favourable ratings (F=9.17;

Table 6.28

Regression Results from Analysing Therapist Ratings of Client Mastery/Insight Gains as a Function of Combined Client and Therapist Demographic, Need and Sex-Role Orientation Data

Independent Variable	β	*Standard Error*	*t*
City:			
A	-.18**	.18	-2.59
B	.08	.22	1.14
C	.05	.13	0.77
D	-	-	-
The FIRO-B *K* Dimension[a]	-.23**	.24	-3.03
The FIRO-B *KCON* Dimension[b]	.16*	.11	2.12
Intercept		.80	6.21
	R^2 = .10**		

*p<.05 **p<.01 (n = 241)

[a] *K* = Total Compatibility

[b] *KCON* = Compatibility on the Control dimension

df=1,242; *p*<.01) and Total Compatibility was positively associated (*F*=4.50; *df*=1,242; *p*<.05). Mastery/Insight (Factor One) items were rated most positively for clients from City B, followed by those from City C, D and A, respectively (*F*=4.33; *df*=1,242; *p*<.01). Figure 6.11 displays this finding.

Therapist scores on both the Masculinity and Femininity scales of the PAQ and clients' Number of Years Married were the significant variables to result from modelling all the data engaging Therapeutic Outcome (Factor Two) items and accounted for 19% of the variance (Table 6.29). Therapist

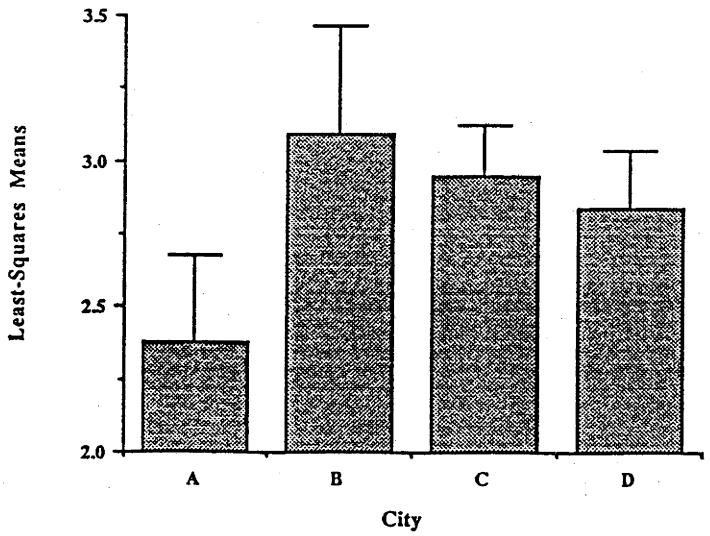


Figure 6.11 **Therapist Factor 1 least-squares means associated with the city effect**

Table 6.29

Regression Results from Analysing Therapist Ratings of Therapeutic Outcome as a Function of Combined Client and Therapist Demographic, Need and Sex-Role Orientation Data

Independent Variable	β	*Standard Error*	*t*
Years Married			
five to ten years	.00	.19	0.04
ten to fifteen years	-.09	.17	-1.47
fifteen to twenty years	-.15*	.25	-2.42
more than twenty years	-.18	.39	-4.73
under five years	-	-	-
Therapists' PAQ Femininity Scores	.21**	.02	3.39
Therapists' PAQ Masculinity Scores	.18**	.02	2.76
Intercept		.57	0.17
	R^2 = .19**		

*$p<.05$ **$p<.01$ ($n = 250$)

scores on the Masculinity (F=7.61; df=1,251; p<.01) and Femininity (F=11.50; df=1,251; p<.01) scales of the PAQ were both positively related to favourable therapist evaluations. The therapeutic outcome of clients married 5 to 10 years was given the most favourable rating, followed by that of clients married: less than 5 years, 10 to 15

years, 15 to 20 years and more than 20 years, respectively (F=7.07; df=4,251; p<.01). Figure 6.12 shows these results.

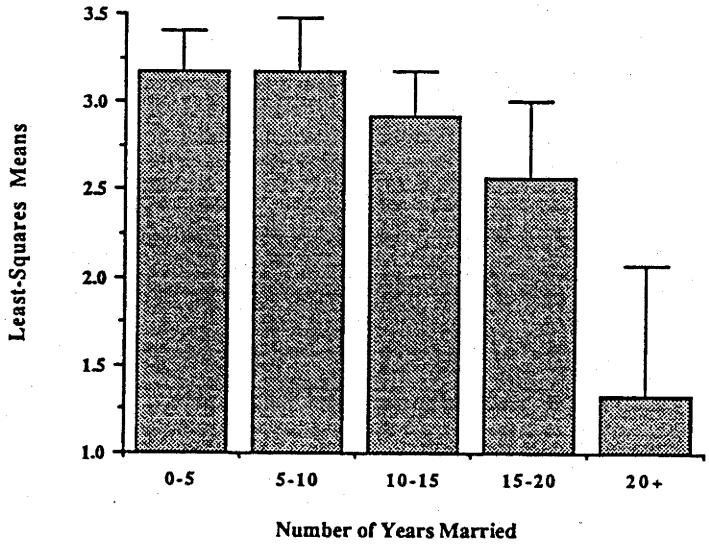


Figure 6.12 **Therapist Factor 2 least-squares means associated with the number of years married**

Modelling the combined client and therapist variables with therapist post-therapy evaluations utilizing Therapeutic Relationship (Factor Three) loadings resulted in four-variables that accounted for 28% of the variance (Table 6.30).

Years of part-time training in therapy was negatively associated with favourable therapist post-therapy ratings (F=14.89; df=1,194; p<.01) and therapists rated items comprising the therapeutic relationship factor more favourably if clients had had previous therapy (F=15.68; df=1,194; p<.01). The factor was rated most favourably for

Table 6.30

Regression Results from Analysing Therapist Ratings of the Therapeutic Relationship as a Function of Combined Client and Therapist Demographic, Need and Sex-Role Orientation Data

Independent Variable	β	*Standard Error*	*t*
Source of Referral:			
Other Helping Agency	.01	.31	0.15
Court Judge	-.29**	.20	-3.17
Court Registrar	-.04	.20	-0.45
Self	.19*	.21	2.19
Solicitor	-	-	-
Previous Therapy:			
No	-.28**	.19	-3.96
Yes	-	-	-
Who has Living with them:			
All the Children	.79**	.35	4.49
None of the Children	.68**	.35	4.00
No Children of Marriage	.34**	.42	3.39
Some of the Children	-	-	-
Years of Part-Time Training in Therapy	-.25**	.05	-3.86
Intercept		.40	9.98
	R^2 = .28**		

*p<.05 **p<.01 (n = 193)

clients self-referred, followed by those: helping-agency-, solicitor-, registrar- and judge-referred, respectively (F=9.52; df=4,194; p<.01). Clients having all

of the children in their care had items rated the most favourably, followed, in order, by those having: no children, none of the children in their care and some of the children in their care (F=6.79; df=3,194; p<.01). Figures 6.13 and 6.14 present these findings.

The second hypothesis of this study was that when either the client or the therapist holds an androgynous sex-role orientation, so will the client and therapist rate therapy more favourably. Three analyses were conducted to directly test this hypothesis, as follows. First, androgynous, masculine, feminine and undifferentiated sex-role oriented clients (as defined by the methods recommended by Spence & Helmreich, 1978) were compared to each other on the basis of post-therapy and follow-up evaluations. The same comparisons were made between the effects of different therapist sex-role orientations on therapist post-therapy responses. The only significant results related to the latter analyses. Examination of Tables 6.31, 6.32 and 6.33 and Figures 6.15, 6.16 and 6.17 shows that: (1) feminine-oriented therapists gave the highest ratings of client Mastery/Insight gains (F=8.77; df=3,266; p<.01) and the Therapeutic Relationship (F=7.13; df=3,266; p<.01); (2) androgynous therapists gave the highest ratings of Therapeutic Outcome (F=5.83; df=3,266; p<.01); and (3) undifferentiated therapists consistently gave the lowest

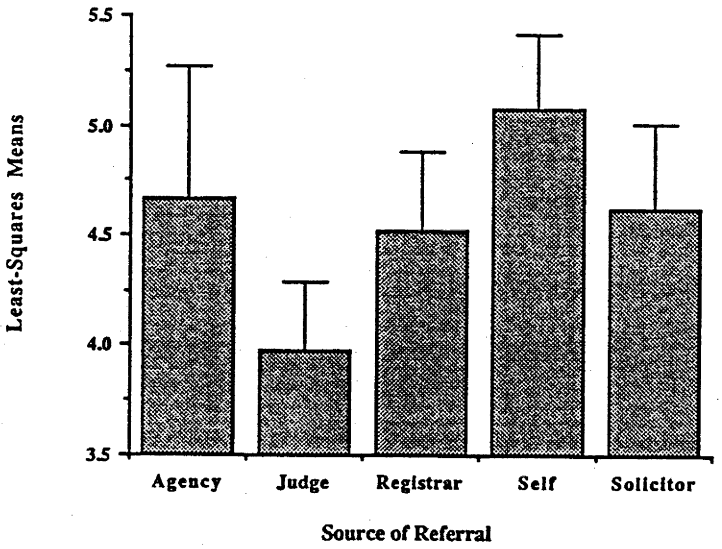


Figure 6.13 **Therapist Factor 3 least-squares means associated with the source of referral**

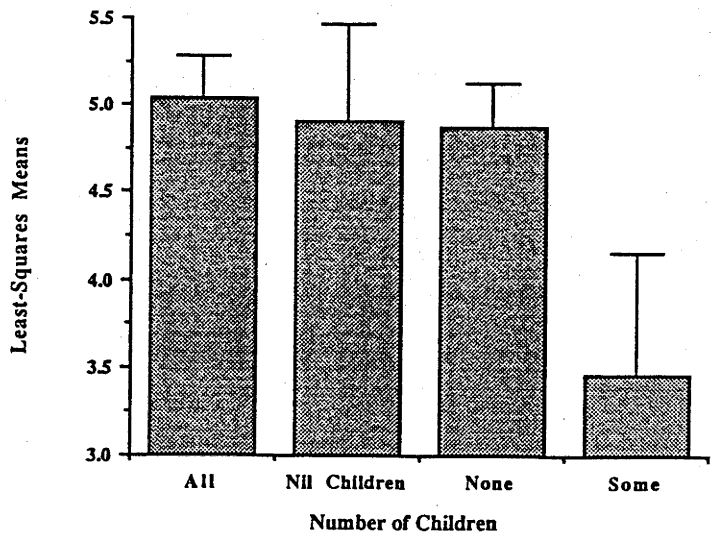


Figure 6.14 **Therapist Factor 3 least-squares means associated with the number of children living with each client**

Table 6.31

Regression Results from Analysing Therapist Ratings of Client Mastery/Insight Gains as a Function of Therapist Sex-Role Orientations

Independent Variable	β	*Standard Error*	*t*
Therapists' Androgynous Orientations	.40**	.17	4.56
Therapists' Feminine Orientations	.30**	.21	4.08
Therapists' Masculine Orientations	.39**	.18	4.61
Therapists' Undifferentiated Orientations	-	-	-
Intercept		.15	14.82
	R^2 = .09**		

**$p<.01$ ($n = 265$)

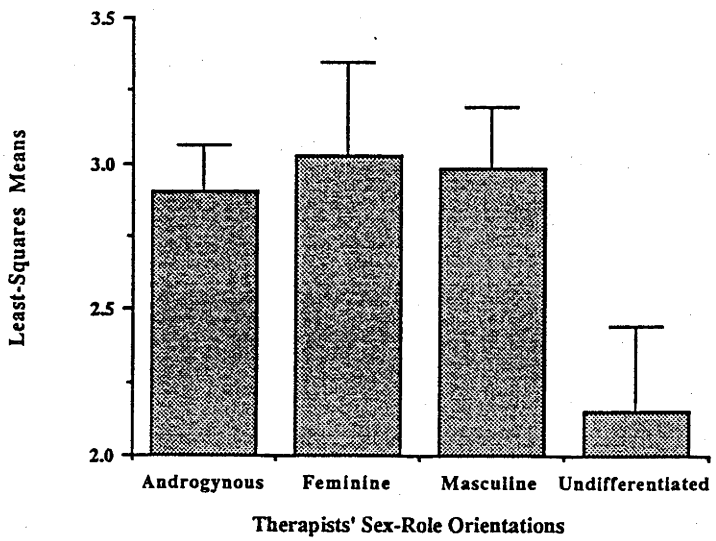


Figure 6.15 **Therapist Factor 1 least-squares means associated with therapists' sex-role orientations**

Table 6.32

Regression Results from Analysing Therapist Ratings of the Therapeutic Outcome as a Function of Therapist Sex-Role Orientations

Independent Variable	β	*Standard Error*	*t*
Therapists' Androgynous Orientations	.34**	.22	3.77
Therapists' Feminine Orientations	.12	.28	1.61
Therapists' Masculine Orientations	.12	.24	1.45
Therapists' Undifferentiated Orientations	-	-	-
Intercept		.19	12.58
	R^2 = .06**		

**$p<.01$ ($n = 265$)

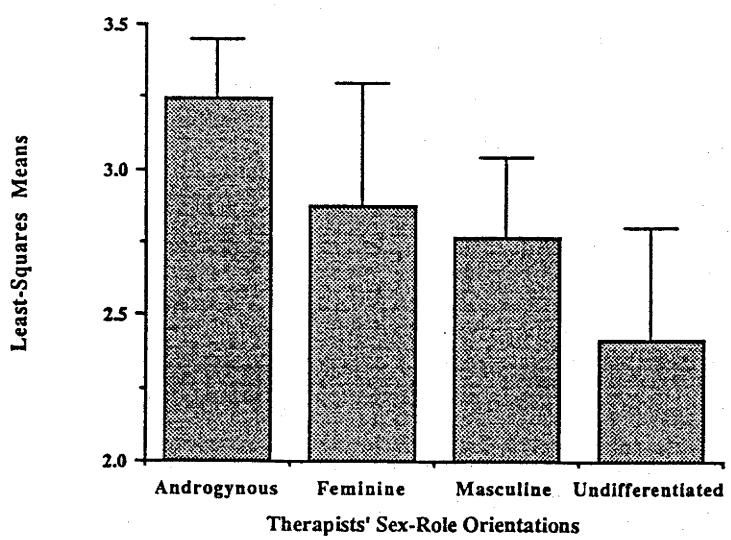


Figure 6.16 **Therapist Factor 2 least-squares means associated with therapists' sex-role orientations**

Table 6.33

Regression Results from Analysing Therapist Ratings of the Therapeutic Relationship as a Function of Therapist Sex-Role Orientations

Independent Variable	β	*Standard Error*	*t*
Therapists' Androgynous Orientations	.28**	.17	3.08
Therapists' Feminine Orientations	.19**	.23	2.47
Therapists' Masculine Orientations	.00	.19	0.00
Therapists' Undifferentiated Orientations	-	-	-
Intercept		.19	27.86
	R^2 = .07**		

**$p<.01$ ($n = 265$)

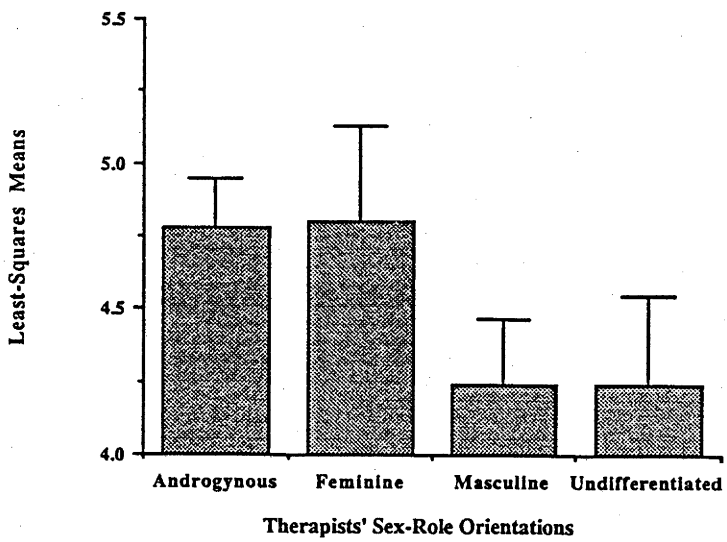


Figure 6.17 **Therapist Factor 3 least-squares means associated with therapists' sex-role orientations**

ratings. Therefore, the second hypothesis was supported only to the extent that therapists', but not clients' androgynous orientations were significantly related to their appraisals of Therapeutic Outcome. Even so, the result was weakened by the findings that therapists' estimations of both the Therapeutic Relationship and clients' Mastery/Insight gains were significantly related to a Feminine sex-role orientation.

In a second analysis, cases where a client *or* a therapist held an androgynous sex-role orientation were compared to cases where this was not the case. Once again it was only the therapist data that was significant, but not when using Mastery/Insight factor items. Tables 6.34 and 6.35 respectively show that therapists rated the outcome of therapy (F=6.75; df=1,267; p<.01) and the client/therapist relationship (F=5.06; df=1,267; p<.05) more favourably if they, or the client, or both, were androgynous in orientation, than if neither one was so oriented. Again, the second hypothesis was supported only insofar as it related to therapists.

The third hypothesis of this study was that clients not possessing an androgynous sex-role orientation before therapy, should modify their position towards such an

Table 6.34

Regression Results from Analysing Therapist Ratings of the Therapeutic Outcome as a Function of Clients' and/or Therapists' Androgynous v. Other Sex-Role Orientations

Independent Variable	β	*Standard Error*	*t*
Therapists' and/or Clients' Androgynous Orientation	.16**	.15	2.60
Therapists' and/or Clients' Other Orientation	-	-	-
Intercept		.12	21.54
	R^2 = .02**		

**$p<.01$ ($n=266$)

orientation by the termination of therapy, or by three or eight months later. To test this hypothesis, clients' pre-therapy sex-role orientations were compared to their post-therapy orientations to determine whether any changes had occurred. Change scores were calculated and a pair-wise *t*-test conducted. No significant differences were noted between the scores. However, as can be seen from the ***means*** presented in Appendix 6Q, clients did increase their scores on the Masculinity, Femininity and Masculinity-Femininity

Table 6.35

Regression Results from Analysing Therapist Ratings of the Therapeutic Relationship as a Function of Clients' and/or Therapists' Androgynous v. Other Sex-Role Orientations

Independent Variable	β	*Standard Error*	*t*
Therapists' and/or Clients' Androgynous Orientation	.14*	.12	2.25
Therapists' and/or Clients' Other Orientation	-	-	-
Intercept		.10	43.81
	R^2 = .02**		

*$p<.05$ ($n = 266$)

scales of the PAQ from pre- to post-therapy. A similar analysis was conducted between clients' pre-therapy and follow-up scores. No significant differences were detected. Appendix 6Q also shows that clients increased their scores more from pre-therapy to follow-up than they did from pre- to post-therapy. Insofar as the changes in orientation scores were not statistically significant, the hypothesis was not supported. That scores did change, and in the predicted direction, offers limited support for the expectation that scores should be influenced by the therapy

experience. Given the lack of (significant) differences between pre, post and follow-up scores, only pre-therapy scores were utilized in subsequent analyses.

RESULTS

SECTION C : ANALYSES CORRESPONDING TO THE GENERAL RESEARCH AIMS

As described in Section A, the present section details findings in respect of some of the more general aims of the study, as outlined in Chapter 1. The section is organized as follows. First, the relationship between client FIRO-B need scores and client PAQ sex-role orientation scores is reported. Second, the effects on ratings of therapy of clients and therapists holding the same, versus different sex-role orientations, is explored. Third, the results from analysis of the combined client and therapist need compatibility data, sex-role orientation data and demographic and related data in respect of client post-therapy to follow-up change scores is detailed. Fourth, results from examination of the pervasive "City" effect are presented.

The Relationship between Client FIRO-B Need Data and Client PAQ Sex-Role Orientation Data

To determine the relationship between client FIRO-B need scores and PAQ sex-role orientation scores, a forward-stepwise multiple regression was conducted. These results are presented in Table 6.36.

Table 6.36

Regression Results from Analysing Client Need Scores as a Function of Client Sex-Role Orientation Scores

Independent Variable	β	*Standard Error*	*t*
Clients' PAQ Masculinity Scores	.23**	.04	5.49
Clients' PAQ Masculinity-Femininity Scores	.19**	.05	4.49
Intercept		.79	-10.01
	R^2 = .12**		

**$p<.01$ ($n = 638$)

The finding of particular interest was that clients' FIRO-B total difference need scores were significantly influenced by client scores on the Masculinity (F=30.14; df=1,639; $p<.01$) and on the Masculinity-Femininity (F=20.14; df=1,639; $p<.01$) scales of the PAQ. 12% of the variance in FIRO-B need scores could be explained in this way. In other words, clients' sex-role orientation scale scores served to influence significantly the degree to which clients preferred to interact with others. No therapist PAQ sex-role orientation scale scores were found to account significantly for therapist total difference need scores.

The Effects on Ratings of Therapy of Clients and Therapists Holding the Same, versus Different, Sex-Role Orientations

Clients and therapists holding the same sex-role orientation were compared to clients and therapists holding different sex-role orientations. As with the findings reported in Section A comparing clients or therapists holding an androgynous orientation with other orientation combinations, the only significant result was related to therapist data. Using Therapeutic Relationship (Factor Three) items, the highest post-therapy therapist ratings were given when ***both*** the client and the therapist held an androgynous orientation and the lowest ratings when ***both*** held a masculine orientation (F=2.86; df=4,264; p<.05). Table 6.37 and Figure 6.18 display these results. The findings confirm the importance of the androgynous orientation in influencing ratings of therapy, but only ratings made by therapists.

Client Change Scores

Change Scores Modelled on Joint Client and Therapist Variables

The data from the 181 clients who completed both the post-therapy and follow-up evaluation questionnaires were analysed and change scores calculated. Change scores were

Table 6.37

Regression Results from Analysing Therapist Ratings of the Therapeutic Relationship as a Function of Clients and Therapists Holding the Same or Different Sex-Role Orientations

Independent Variable	β	*Standard Error*	*t*
Androgynous Therapists and Clients	.15	.37	1.09
Feminine Therapists and Clients	.00	.45	0.05
Masculine Therapists and Clients	-.14	.45	-1.54
Therapists and Clients with Different Orientations	.04	.35	0.26
Undifferentiated Therapists and Clients	-	-	-
Intercept		.34	13.16
	R^2 = .04*		

*$p<.05$ ($n = 263$)

employed as dependent measures and modelled with other data in order to determine possible reasons for the observed differences between responses on the two occasions. For each of the three Factors already identified for clients' follow-up data, factor weights associated with client

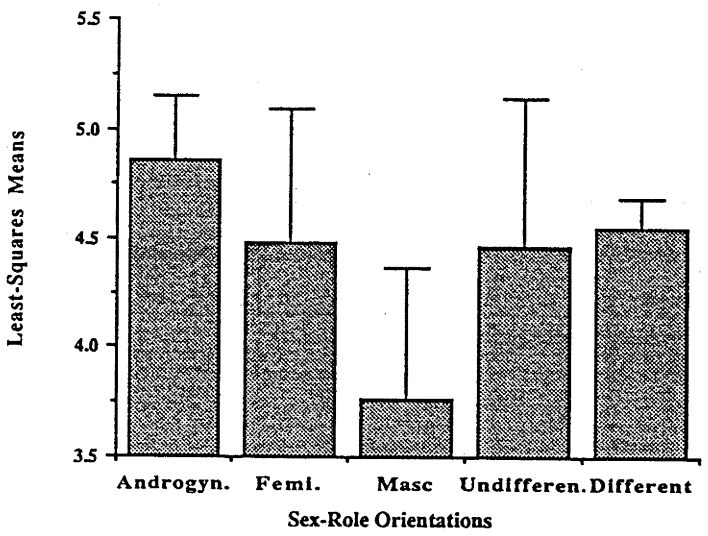


Figure 6.18 **Therapist Factor 3 least-squares means associated with clients and therapists having the same or different SRO's**

post-therapy evaluations were subtracted from factor weights associated with client follow-up evaluations. (Given that post-therapy scores were generally higher than follow-up scores, subtracting post-therapy weights from follow-up weights gave an accurate indication of the direction of any rating changes. Therefore, a negative change score signals dissatisfaction from post-therapy to follow-up, and vice versa.) The resulting three change score distributions were not significantly different from normal. The change score weights were then modelled with the variables of interest in three forward-stepwise

multiple regressions corresponding to the three Factors described earlier. Results from these analyses are presented in Tables 6.38, 6.39 and 6.40, respectively.

Modelling client and therapist variables with change scores while applying Mastery/Insight (Factor One) loadings concluded in two variables explaining 12% of the variance (Table 6.38). Compared to clients counselled by a male therapist, clients counselled by a female therapist were found to change their ratings in a significantly positive direction from post-therapy to follow-up (F=5.95; df=1,131; p<.05). Clients with all of the children in their care changed their ratings the least, followed by those with: some of the children in their care, no children and none of the children in their care, respectively (F=3.79; df=3,131; p<.01; Figure 6.19).

Client and therapist Masculinity-Femininity scores, together with whether the client presented for therapy alone or not, accounted for 12% of the variance utilizing Therapeutic Outcome (Factor Two) items (Table 6.39).

Client Masculinity-Femininity scores were positively related (F=7.02; df=1,162; p<.01) and therapist Masculinity-Femininity scores negatively related (F=9.75; df=1,162; p<.01) to favourable change ratings. Clients who

Table 6.38

Regression Results from Analysing Client Change Scores in Relation to Client Mastery/Insight Gains as a Function of Combined Client and Therapist Demographic, Need and Sex-Role Orientation Data

Independent Variable	β	*Standard Error*	*t*
Who has Living with them:			
All of the Children	.23	.69	0.98
None of the Children	-.04	.70	-0.17
No Children of Marriage	-.01	.83	-0.06
Some of the Children	-	-	-
Therapist Gender:			
Female	.18*	.32	2.44
Male	-	-	-
Intercept		.71	-2.05
	R^2 = .12**		

*$p<.05$ **$p<.01$ ($n = 130$)

presented for therapy with their (ex)spouse changed their ratings in a significantly more favourable direction than those who presented alone (F=6.16; df=1,162; p<.01).

The three variables *XK* Control, Clients' Sex and Number of Years Married explained 20% of the variance after employing Therapeutic Relationship (Factor Three) items (Table 6.40).

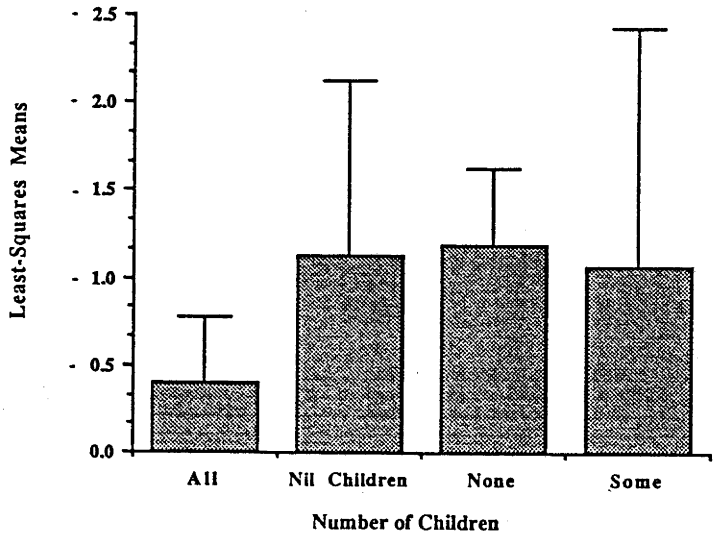


Figure 6.19 **Least-squares means corresponding to the number of children each person has living with them, using Factor 1 change scores**

Interchange Compatibility on the Control dimension (*XKCON*) was negatively associated with favourable change ratings (F=5.06; df=1,149; p<.05) and females changed their ratings in a significantly more positive direction than did males (F=4.01; df=1,149; p<.05). Clients married 5 to 10 years changed their ratings the least, followed by those married: 10 to 15 years, less than 5 years, 15 to 20 years, and more than 20 years, respectively (F=6.40; df=4,149; p<.01; Figure 6.20).

Table 6.39

Regression Results from Analysing Client Change Scores in Relation to Therapeutic Outcome as a Function of Combined Client and Therapist Demographic, Need and Sex-Role Orientation Data

Independent Variable	β	*Standard Error*	*t*
Presented for Therapy with (ex) Spouse	.18**	.22	2.48
Presented for Therapy Alone	-	-	-
Clients' PAQ Masculinity-Femininity Scores	.20**	.02	2.65
Therapists' PAQ Masculinity-Femininity Scores	-.23**	.03	-3.12
Intercept		.56	-0.26
	R^2 = .12**		

**$p<.01$ ($n = 161$)

Supplementary Data Explorations

A number of steps were taken to determine the possible reason(s) for City appearing as a significant variable in many of the analyses described. As one Registry Counselling Section was staffed by only psychologists and one by only social workers, it was possible the observed City effect was masking a therapist Social Worker/Psychologist effect.

Table 6.40

Regression Results from Analysing Client Change Scores in Relation to the Therapeutic Relationship as a Function of Combined Client and Therapist Demographic, Need and Sex-Role Orientation Data

Independent Variable	β	*Standard Error*	*t*
Client Gender:			
Female	.14*	.18	2.00
Male	-	-	-
Years Married			
five to ten years	.35**	.23	4.40
ten to fifteen years	.14	.23	1.78
fifteen to twenty years	-.02	.32	-0.28
more than twenty years	-.04	.52	-0.89
under five years	-	-	-
The FIRO-B *XKCON* Dimension[a]	.17*	.03	2.25
Intercept		.20	-6.94
	R^2 = .20**		

*$p<.05$ **$p<.01$ ($n = 148$)

[a] *XKCON* = Interchange Compatibility on the Control dimension

To examine this possibility, therapist profession was used as a "surrogate" variable for City in regression equations where the latter was present as a significant variable. Tests for possible interaction effects also were conducted. However, the change in variance explained by the equations

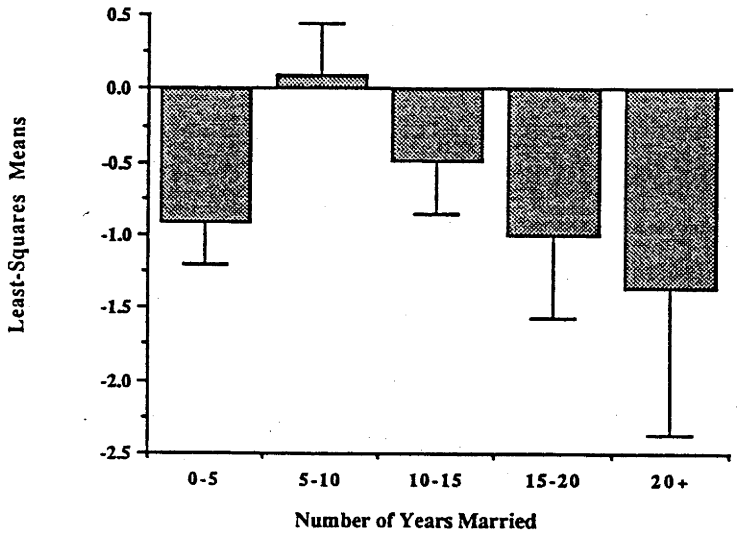


Figure 6.20 **Least-squares means associated with the number of years married, using Factor 3 change scores**

resulting from these procedures was only minimal and, when compared to the original equation, the amount of variance explained was consistently less. In addition, the *F*-test between the equations, $([\frac{ErrorSS1-ErrorSS2}{df1-df2}]$ / *MSi*, where *MSi* is the smaller mean square term) was nonsignificant. As the ratio of male to female therapists varied dramatically between cities, the same analyses as those just reported were performed using City and Therapist Sex as individual and interactive predictors. The same result obtained as that described above for City. It also was possible that the observed City effect was masking a significant compatibil-

ity and/or sex-role orientation effect, such that clients in different cities might have been in fact expressing the differential influence of these effects. To test for this, interactions between City and compatibility scores, City and sex-role orientation scores and City and compatibility and sex-role orientation scores were examined. None of these analyses produced significant results. Consequently, it was concluded that the City effect was genuine and not artifactual.

DISCUSSION

This study aimed to contribute to the social influence model of therapy as denoted by Strong (1968) and Strong and Matross (1973) and Merluzzi, Merluzzi and Kaul (1977) by examining the effects on client and therapist appraisals of therapy of particular client and therapist characteristics believed to be important in influencing such appraisals. The variables of client and therapist need expression and sex-role orientation, together with large numbers of demographic and related variables were modelled on client and therapist evaluations of the therapeutic relationship, therapeutic outcome and client mastery/insight gains. These endeavours were designed to produce a predictive model of therapy appraisal based on the variables under scrutiny and add to a large body of evidence which suggested that such prediction would be possible and profitable. The main finding from the study was that no such model evolved from consideration of the available data. Rather, what emerged were consistent patterns of findings indicating that the variables which influenced client and therapist ratings of therapy were many and varied. No single variable was found to dominate an explanation of the data and no single cluster of variables could be said to be more powerful than

another. It should be added that when *all* available data were included in some of the models tested, up to 85% of the variance was explained, although, as is obvious from the eventual models developed, most of the variables comprising these models did not reach the .05 level of statistical significance. These findings substantiate a literature replete with research undertakings which have consistently failed to identify variables which might be termed predictive of therapy evaluation (e.g., Malloy, 1981; Mendelsohn & Rankin, 1969; Sapolsky, 1965). While the variables studied lacked the power to predict how clients and therapists would assess therapy, many of them nevertheless significantly influenced such assessments. Some of these will be addressed here and in the concluding chapter which follows, a chapter which also includes some detailed discussion of specific and more general findings from this study.

Client and Therapist Need Profiles

Based on each of the three Fundamental Interpersonal Relations Orientation - Behavior (FIRO-B) dimensions, the *average* client profiles to emerge were as follows (from Ryan, 1977):

(i) Based on their Inclusion scores, clients occupied the *Socially Flexible* category.

> Persons with moderate Expressed and moderate Wanted Inclusion scores not only reveal a moderate level of social interaction but also manifest flexibility. These persons tend to be comfortable both in large groups [and when] alone ... they reveal little concern over rejection or being accepted by others. (p.14).

(ii) Based on their Control scores, clients occupied the *Rebel* category (whether the means were rounded up or down did not change the profile category occupied).

> When both Control scores are very low, these individuals not only *avoid* making decisions and taking on responsibility, but also are most comfortable when others do not attempt to control them. They do not tell others what to do, but by the same token they do not want others to tell them what to do. (p.17).

(iii) Based on their Affection scores, clients occupied the *Warm Individual* category (again, whether the means were rounded up or down did not change the profile category occupied).

> They neither make excessive demands on others for affection, nor tend to be overly cautious in expressing affection. They tend to be realistic and practical both in the amount of affection desired and the number of individuals from whom affection is sought. Although they want to be liked and prefer most people to be warm, they do not need or demand affection from everyone. (p.27).

Based on each of the three FIRO-B dimensions, the *average* therapist profiles to emerge were as follows (from Ryan, 1977):

Based on their Inclusion scores, therapists occupied the *Now You See Him, Now You Don't* category.

> These persons are social in their Expressed Inclusion behavior, but have no need for constant socialization with people in general. They have many acquaintances but very few persons with whom they care to spend any great amount of time. Although these persons may be highly skilled at socializing, they maintain an "exclusive club," and a selective attitude reflected in the statement, "I'll call you, don't you call me". (p.11).

Therapists occupied the same Control and Affection categories as did clients. (Once again, the same profile categories held, regardless of whether means were rounded up or down.)

Specific Considerations

In supporting the reliability of the FIRO-B, results confirm some research findings (Gard & Bendig, 1964; Gluck, 1979, 1983; Kramer, 1967; Schutz, 1958, 1978; Ullman et al., 1964; Vraa, 1971) and disconfirm others (Froehle, 1970; Ryan, Maguire & Ryan, 1970). In addition to the sample and methodological differences discussed in Chapter 3 of this thesis, differences noted between the results of the present study and those of the latter group of studies might be culturally mediated. That is, important differences may exist between the need expression of

Australian and American subjects. The present data do not support this contention, however, because of their similarity to other American findings. Clearly, the current findings require empirical verification.

That very high correlations were found between the Expressed and Wanted dimensions of the Inclusion and Affection sub-scales of the FIRO-B confirms findings by Schutz (1958, 1978) that the FIRO-B contains nonindependent dimensions. However, although Schutz (1958, 1978) argued for the retention of all FIRO-B sub-scales (without providing justification), it is the contention here that doing so adds nothing to the explanation being offered. Retaining all postulated scales may serve to maintain the integrity of FIRO theory, but the results from this study suggest that there is no functional utility in doing so. Additional evidence that the Inclusion and Affection domains may in fact measure similar needs - and not different aspects of the same need dimension - was apparent from perusal of both the client and therapist models developed and reported in this study. For clients, the only need ratings related to negative follow-up appraisals of therapy were significantly and predominantly tied to both Inclusion and Affection scores. For therapists, the need ratings related to negative appraisal of the mastery/

insight factor items were tied significantly to both Inclusion and Affection Scores. Although there seems sufficient evidence in this study to warrant reappraisal of the utility and appropriateness of these separate dimensions, additional research is needed to substantiate the claim.

The finding that clients' sex-role orientations increased from pre- to post-therapy and from post-therapy to follow-up (though these differences were not statistically significant in either case) suggests, as indicated in the introduction to this study, that assessing clients' sex-role orientations after therapy has begun may cause misleading results if what is being studied relates to aspects of clients' sex-role orientations considered important in the determination of satisfaction with therapy. The results of studies such as that conducted by Petry and Thomas (1986) then, where subjects' sex-role orientations were assessed after therapy had begun, need to be considered in the light of these findings. Further, while it is not possible here to identify the precise mechanism(s) by which such changes in orientation occurred (that is, increased scores on both the Masculine and Feminine scales of the Personal Attributes Questionnaire [PAQ]), the explanation offered in the Introduction

relating client change to witting or unwitting therapist direction or clients' modelling of their therapists' perceived desirable instrumental and/or expressive traits, seems a feasible one. Unlike the Petry and Thomas findings, therapist gender *was* found to influence clients' ratings of the client/therapist relationship, with female therapists evoking more favourable responses than male therapists. *Client* gender, however, did not consistently feature as a significant variable influencing therapist assessments of therapy.

Given the results from other research in the area, the finding in the present work that a larger number of male and female clients held an androgynous orientation than any other single orientation was rather surprising. Research by Spence and Helmreich (1978), for example, indicated that: In a college student sample, there were a larger number of masculine males and undifferentiated females; in a high school student sample, a larger number of masculine males and androgynous females; in a Lebanese college student sample, a larger number of masculine males and feminine females; in an Israeli student sample, a larger number of undifferentiated males and masculine females; in a Brazilian student sample, a larger number of undifferentiated males and feminine females; in a

homosexual sample, a larger number of undifferentiated males and androgynous females; and in a sample of scientists, a larger number of masculine males and androgynous females. It should be noted that although in the current work there were more androgynous clients than clients of any other orientation, there were nearly as many masculine males as androgynous males and nearly as many feminine females as androgynous females, such that differences between the androgynous and sex-typed groups were not statistically significant. Even so, as an androgynous orientation has been shown to be related to indices of well-being, and as post-divorce measures of adjustment have been found to be more related to an androgynous orientation than to any other orientation (Alain & Lussier, 1988), the finding reported above augers well for Australian clients.

Whether Australian Family Court clients are representative of the Australian client and/or general population at large with regard to sex-role orientation as measured by the PAQ, or whether they represent a unique group in some sense is not known. The single known distinguishing feature of the present Family Court counselling sample was that all clients were, or had been, married. (As indicated in Chapter 2, the section of the

Family Law Act that precluded unmarried persons from receiving Family Court service has since been removed.) In 1981, using their Australian Personal Description Questionnaire, Antill, Cunningham, Russell and Thompson reported that from their sample of high school students, more males were categorized as masculine and more females as feminine. The authors stated that this result "would be expected," although, why it would be expected is not known, as the statement appeared without justification. Apart from results from the sample of Lebanese college students studied by Spence and Helmreich (1978) and reported above, no group studied by the latter researchers was found to hold the orientations reported by Antill et al. (1981). Further, in relation to the PAQ, predictions made by Spence and Helmreich pertain to whether males score more highly on the Masculinity scale and females more highly on the Femininity scale, not to whether males are more likely to hold masculine and females more likely to hold feminine orientations. It would appear, then, that the finding reported by Antill et al. is one *other* than would be expected. The comparability of PAQ and Personal Description Questionnaire results based on responses from Australian clients awaits investigation, as does the comparability of results based on responses from Australian clients and Australian high school students.

As there were no significant Masculinity x Femininity interactions detected, results from the present study do not support a connection between client or therapist assessment of therapy and the balance conception of androgyny as proposed by Bem (1974). That significant main effects were found in the same direction in models containing both Masculinity and Femininity scales of the PAQ *does* provide confirmation of a relationship between therapy evaluation and the additive, or main effects conception of androgyny as proposed by Spence, Helmreich and Stapp (1975) and in so doing substantiates other evidence (e.g., Barron & Harrington, 1981; Cook, 1985). The findings demonstrated that therapists' increasing levels of both instrumental and expressive traits as conceptualized by Spence (1983) were significantly related to therapists' increasingly favourable assessments of both therapeutic outcome and the therapeutic relationship. Additionally, therapists low in both these traits were consistently found to rate therapy the least favourably.

It is not known why male therapist Masculinity-Femininity scale scores were significantly higher in this study when compared to the Masculinity-Femininity scale scores of male therapists from the rest of Australia reported in the previous study (in Chapter 5). No significant differences

between the available demographic or related data of the groups were established. That is, there were no differences in age, professional affiliation (psychologist versus social worker), years in full-time practice of therapy, or years in full- or part-time practice of Court Counselling. Perhaps other demographic or related information not collected, such as ethnic origin or marital status could help explain some of the difference noted. Another explanation concerns the nature of the Masculinity-Femininity scale itself. That neither the Masculinity nor Femininity scales were observed to be rated differently by the two groups of male therapists suggests that the Masculinity-Femininity scale may not be as *pure* an indicator of sex-role orientation type as either of the separate scales individually might be. Insofar as the Masculinity-Femininity scale is a *combination* of Masculine and Feminine trait descriptors, the latter observation is plain. However, it is suggested that the scale may measure something more than, or something different from either of the other scales comprising the PAQ. Adding weight to this possibility is the fact that males and females made significantly different ratings on the scale, indicating the differential valence accorded the traits described. Furthermore, this effect was consistent for both clients and therapists. Comments on the difficulty in interpreting

the Masculinity-Femininity scale also have appeared in the literature (e.g., Taylor & Hall, 1982).

It was encouraging to observe the congruence between clients' and therapists' ratings of clients' mastery/ insight gains, the therapeutic outcome and the therapeutic relationship. The finding that participants' mean ratings fell in the upper half of the evaluation scales provided some verification that therapy experiences were regarded as more worthwhile than otherwise - or at least that the belief as to how worthwhile they were was shared in common - and confirmed similar findings from the literature (Friedlander, 1982).

One of the most likely causes for the significant reduction in satisfaction evidenced by clients from post-therapy to follow-up relates to Court proceedings external to the therapy process. For example, clients *not* gaining custody of their child(ren) at some time following the termination of therapy (or, perhaps equally, not gaining the increase/decrease in maintenance payments sought, or the like), may have taken the opportunity to vent their disapproval of the Court's decision by expressing a lack of satisfaction with the therapy they received. Limited additional support for this view was

contained in the converse finding that some clients (n=8), who upon therapy termination declared a disapproving view of therapy, had changed their stance to one of approval by the time of follow-up. This finding suggests that such clients may have either received a favourably regarded Court ruling, or believed that positive therapy ratings might confer an advantage in their quest to overturn or influence an unfavourably regarded Court ruling (though the very small sample size makes interpretation difficult).

Significantly more clients who completed both the end-of-therapy and follow-up evaluations were found to have attended therapy with their (ex)spouse. The most parsimonious explanations for this finding are that: (1) clients felt motivated to be involved in the research from witnessing their (ex)spouse's involvement (although, given that most clients lived apart from their [ex]spouses, the high follow-up questionnaire completion rates remains unexplained by this interpretation); and (2) clients agreed to become involved in the project because they believed some advantage might accrue from such involvement and, perhaps further, because they did not want to lose any imagined advantage to a (ex)spouse who was already involved. Persons attending therapy alone, on the other hand, had no such referents and perhaps were more likely

to/not to comply to the request to become involved based on their first reaction.

The finding that lower client-therapist compatibility was significantly associated with an increased likelihood that clients in such dyads would complete *only* the follow-up evaluation questionnaire may be understood as evidence for such clients being less compliant. The evidence is bolstered by the added finding that it was reduced compatibility on the Control dimension, in particular, that was responsible for the observed effect. However, closer examination of the finding suggests an alternative explanation. As the end-of-therapy questionnaires were given to clients by therapists and, as therapists were repeatedly requested to give *every* client a questionnaire, it may be that therapists were not as consistent in giving questionnaires to clients with whom they had low compatibility. This would indeed be a finding of significant import, with obvious implications for client-therapist matching on the basis of compatibility as measured in this study. However, as no record was made of which clients were actually handed and completed an evaluation, as opposed to which clients were handed, but did not complete an evaluation, it is not possible to confirm or refute the interpretation offered. It would not

be difficult to examine the accuracy of this account, however, and the question could serve as a profitable starting point for further research.

As with findings from the other studies reported in this series, the findings from this study are elaborated in the next chapter.

CHAPTER 7

SYNTHESIS AND EXTENSION

In General

Since Strong (1968) first introduced the notion of counselling as a process of social influence, researchers have focussed almost exclusively on examining the effects on therapy evaluations of therapists being perceived by clients as *attractive*, *trustworthy*, or *expert* individuals. In spite of a large number of research papers reporting investigations into aspects believed important in the determination of therapeutic outcome (Corrigan, Dell, Lewis & Schmidt, 1980, reviewed 70 such papers), very few have involved client characteristics as independent variables and, of those that have done so, client gender has often been the only such variable included. In the present case, in addition to the inclusion of standard demographic and related variables in an investigation of therapy as social influence, variables were included that have not before been effectively examined in a genuine therapy setting. Specifically, exploration of client and therapist need and client and therapist sex-role orientation was undertaken in

the belief (shared by Berzins, 1977, Dorn, 1984a, 1984c, and Heppner & Dixon, 1981) that these variables might elucidate the model of social influence as conceived by Strong (1968), Strong and Matross (1973) and Merluzzi, Merluzzi and Kaul (1977).

Given the potential import of sex-role orientation as a determinant of, or influencing construct upon the appraisal of therapy, it was considered desirable to investigate, in the first instance, the manner in which clients might regard the construct as it applies to therapists, or, indeed, whether they regard it at all. A second stage was concerned with identifying the sex-role orientations held by therapists. Other evidence had suggested that clients would prefer a feminine oriented therapist more than an androgynous or masculine oriented therapist (Highlen & Russell, 1980) and that social workers would more likely manifest an androgynous orientation than any other orientation (Dailey, 1983). To the extent that they might generalize to genuine therapy settings, the first two studies undertaken here were respectively concerned with these questions.

In general, then, this thesis was concerned with the explication of the theory of social influence in

counselling. It sought to determine, in therapeutic settings, the influence of client and therapist need, sex-role orientation and demographic and related variables on client and therapist judgments of aspects of therapy. Interestingly, the variables found consistently to influence clients' and therapists' assessments were those variables that have not before been examined in the model in detail, yet which would seem the ones most deserving of, at the least, initial exploration: namely, demographic and related background variables. That this should have been the case adds weight to the observation proferred earlier in this work that indeed more difficult questions have been posed with respect to the need and androgyny models discussed before answers to quite simple questions have been provided. It is likely that one of the reasons little has been achieved in the way of progress towards more robust constructs predictive of therapy evaluation has to do with this fact. It seems self-evident that because we all have them in a relatively stable form, demographic and related variables are amongst the easiest to work with. It is perhaps because of this invariance that researchers find more dynamic variables of greater interest. However, if demographic variables are able to act as powerful predictors in a particular circumstance, further model development as it relates to that circumstance may well be,

at best, superfluous to the purpose, or, at worst, misleading. The findings of the current work strongly indicate that future work exploring therapy as a process of social influence should include both client and therapist demographic and related variables *as a matter of course.*

The findings in respect of demographic variables supports their inclusion in the social influence model of therapy as proposed by Merluzzi, Merluzzi and Kaul (1977). However, that client-therapist interpersonal need compatibility was found to influence both client and therapist estimations of therapeutic outcome - rather than client need per se - suggests that some revision of the model may be warranted. Neither the latter authors, nor Strong (1968), nor Strong and Matross (1973) specified that the appearance of the variable "need" in their models pertained to interpersonal need. The present findings suggest that the inclusion of this component may be justified. Such an inclusion also would enable consideration of the conjoint influence of clients and therapists in a way similar to that advocated by Mendelsohn and Geller (1967) and reported in the introduction to this thesis. Whether the degree of influence that need compatibility exerted over therapy evaluations in the current case would have been sufficient to motivate behaviour change different in kind to that

which might be tapped by a rating response, is an interesting question deserving investigation.

Although demographic and related data were certainly present as significant variables in many of the models developed, they were not alone. Both the compatibility and the sex-role orientation data acted as significant variables in many models. A question that can be asked at this point is, which model, of the many developed, best represents the data collected. Of course, there is no single answer to this, as *the best model* is a misnomer. Models only make sense in the light of theory and expectation or prediction. It is theory that can, or cannot, make sense of data, not vice versa (Forsyth & Strong, 1986). The role of data and its subsequent manipulation is the substantiation or refutation of propositions. Spence has been at pains to make this point with respect to androgyny research (e.g., Spence, 1983). Mindful of Spence's admonitions, to be examined in detail in this chapter is whether the data support the available theories and corroborate other findings in the area, or whether some minor/major reformulations or additional questions present themselves as warranted propositions deserving scrutiny.

The Preferred Therapist Sex-Role Orientations

In the first study of this series, clients were asked to rate their willingness to see and to disclose to each of three written therapist sex-role orientation descriptions. Clients rated masculine and androgynous therapist descriptions the most positively and gave feminine male therapists the lowest ratings of all. The latter finding may be interpreted as reflecting a societal prejudice. Namely, that a male perceived to possess and/or display feminine attributes is undesirable. Indeed, "Experience shows that a man's dread of being feminine is so generally pervasive as to be a universal component of masculinity" (Rochlin, 1980, p.67) and, "Stress is experienced when [men] have difficulties living up to male imperatives and/or [when they] find themselves in situations that require 'feminine' behaviors" (Eisler, Skidmore & Ward, 1988, p.139). In its typical form, the prejudice may extend across the sexes, such that the stereotype may be as castigated by females as it is by males. The comment provided 15 years ago that "Women are relatively free to become more like men in their sex-role attitudes, but men are most unfree to become more like women" (Seyfried & Hendrick, 1973, p.20) finds support in the present results.

By contrast, the masculine male therapist was accorded the highest ratings, significantly higher than those given the masculine female therapist. Again, the highly rated positive aspects of stereotypical masculinity may reflect a societal prejudice. Namely, that it is desirable for males, but not females, to display the positive attributes of masculinity. This was the only significant therapist gender effect located. The androgynous therapist was clearly seen as being the equal of the masculine therapist and, together with the masculine therapist, superior to the feminine therapist. For women, compounding this bind is the double bind illustrated by research which on the one hand demonstrates that females are disadvantaged by their display of what might be regarded as masculine behaviours (Shaffer & Wegley, 1974), but on the other hand demonstrates that if they wish to move into powerful organizational positions, females need to look as masculine and as unattractive as possible (Cash & Janda, 1984). Findings that more positive qualities are attributed to attractive than moderately or unattractive stimulus persons (Moore, Graziano & Millar, 1987) do nothing to mitigate the dilemma.

The findings from the first study were not in agreement with those of Highlen and Russell (1980) who found that

therapists with a feminine sex-role orientation were rated the most favourably. However, a number of important sample and setting differences existed between the present research and that of Highlen and Russell's. The present sample consisted of nearly equal numbers of male and female genuine clients sampled in a genuine therapy setting. Highlen and Russell employed only female student nonclients in a nontherapy setting. These age, gender, status, motivation and environment disparities are probably sufficient to explain the differences noted. Similar age, status and motivation differences can also be detected between the present client sample and the client sample of students employed by Blier, Atkinson and Geer (1987). That the current findings find some support in common stereotypical formulations also lends weight to their face validity, as do other research findings which confirm that on some indices there is little difference between androgynous and masculine individuals (Spence & Helmreich, 1979c) and that clients counselled by androgynous therapists rate the therapeutic relationship more favourably (Bloom, Weigel & Truatt, 1977, and Merluzzi & Merluzzi, 1981).

Insofar as clients were able to discriminate between the three therapist sex-role orientation descriptions, the

latter appear to adequately represent what they were designed to. The very high correlations between responses to the two questions appended to each of the descriptions signal a redundancy which could easily be remedied by omitting either of the questions. In the present case, it will be recalled, responses to each of the two questions were combined.

It is interesting to compare the mean ratings given by clients in the present study with the mean ratings given by students in the Highlen and Russell study and the university student clients in the Blier et al. study. Every rating given by the present sample of clients was lower than that given by subjects in the latter studies. Whether these disparities can be fully reconciled by the sample and setting differences noted above or whether they might also be culturally mediated cannot be teased-out here, but the question could serve as a focus for future research.

Client gender was not related to the way any of the therapist descriptions were rated. However, that therapist gender influenced client ratings was of significant import. The finding was opposite to that of Highlen and Russell's and Blier at al.'s and confirms the desirability of including demographic and related variables in research

examining sex-role orientation (Berzins, 1977) and social influence (Corrigan et al., 1980; Dorn, 1984a; Heppner & Dixon, 1981).

The first hypothesis, then, was not supported. Feminine sex-role oriented therapists, far from being rated the most positively, were rated the least positively. Following the results of this study, it was expected that androgynous and masculine sex-role oriented therapists would receive more favourable ratings from genuine clients than would feminine sex-role oriented therapists. This proposition had yet to be tested. Prior to its testing, however, whether therapists exhibited the kinds of sex-role orientations favoured by clients was considered to be the next necessary step in delineating the part played by such orientations in influencing therapy appraisals. This question directed a second study in the series.

Therapists' Actual Sex-Role Orientations

The sex-role orientations of a group of psychologists and social workers were determined from a sample of 99 practicing and experienced professionals Australia-wide. A greater proportion of practitioners were found to hold an androgynous sex-role orientation than any other single

orientation (33% of males and 30% of females), although, the majority of practitioners held nonandrogynous orientations. There were no sex differences in the number of therapists occupying each orientation group, or between their scores on the Masculinity, Femininity, or Masculinity-Femininity scales of Spence and Helmreich's (1978) Personal Attributes Questionnaire (PAQ).

Although findings from the PAQ and Bem's (1974) Sex-Role Inventory (BSRI) should not be considered equivalent (as discussed in Chapter 5), the present findings are in broad agreement with those of Dailey (1983) who found that, based on the BSRI, more American social workers held an androgynous orientation (47%) than any other orientation. The present result confirms androgyny as the single sex-role orientation most likely held by a group of mental health professionals and, if it is accepted that mental health professionals might score highly on indicators of mental health, the result also furnishes support for a not inconsiderable body of literature upholding the notion that androgyny is related to indices of well-being and adjustment (Antill, 1983; Bassoff, 1984; Bem, 1974; Hinrichsen, Follansbee & Ganellan, 1981; Moore & Rosenthal, 1984; Murstein & Williams, 1983; Patterson & McCubbin, 1984; Spence, Helmreich & Stapp, 1975).

The second hypothesis, then, that social workers would more than likely manifest an androgynous sex-role orientation than any other orientation, was confirmed. A number of other factors may be considered as having possibly influenced the sample studied to respond to the PAQ instrument as they did. Psychologists and social workers are as exposed to the changing social conditions of the times as is any other person. It can be expected that the anti sex discrimination legislations in general and the prohibition on, or at least the sanction against sex-typing in particular, have not escaped their attentions. Indeed, it can be argued that these professionals may be *more* exposed to such influences than are others, due to the areas in which they read, the conferences they attend, the associations with other professionals who, often, work directly in the area of sex research, and so on. To not appear to sex-type and, in the current context, to not appear sex-typed, may well be powerful motivators and determinants of how therapists rate themselves in terms of sex-role orientation. The data may suggest the successful management by therapists of sexist behaviour and attitudes or genuine changes the result of having actively overcome inclinations towards sexism (Dailey, 1983). Also to be considered is the presence or absence of naivety in the sample with regard to the PAQ and its purpose. Although the

majority of therapists (90/99) reported not having seen the PAQ, it is probably reasonable to suppose that many of them would have recognized the intention of the instrument, if not its form.

Just as a sample of Australian clients was shown to favour androgynous and masculine sex-role oriented therapists, so findings from the second study demonstrated that these were the orientations held by the majority of an Australian therapist sample. Based on these findings, it was expected in a next study that clients might indicate satisfaction with their therapy in part as a favourable response to their therapists' sex-role orientations. If support in the therapy arena was to be found for the proposition that an androgynous sex-role orientation is important in determining dyad satisfaction (Antill, 1983; Ickes & Barnes, 1978), then clients paired with androgynous therapists should report greater satisfaction with therapy than those not so paired (Petry & Thomas, 1986). In addition, given that the feminine male and feminine female therapist sex-role orientation categories were those rated least desirably by a majority of clients in the first study reported here, and given that 19% of male therapists and 20% of female therapists in the second study described themselves as belonging to these categories, respectively,

contemplation of the effects on adjudged aspects of therapy of clients seen for therapy by therapists of differing orientations became increasingly engaging. This examination, together with the role played by client and therapist need and need compatibility in influencing such judgments, guided the direction of a third and final study.

The Compatibility Data

Research was conducted to explore the influence of client-therapist Fundamental Interpersonal Relations Orientation - Behavior (FIRO-B) need compatibility on client-therapist short- and long-term evaluations of aspects of therapy. It was expected that compatibility in the Control area between therapists and female clients would positively influence their therapy appraisals (Mendelsohn & Rankin, 1969), while the findings in general would have bearing on the relationship between therapy evaluations and the need complementarity (*opposites attract*: Antill, 1983) and need similarity (*birds of a feather flock together*: Antill, 1983) constructs.

The three factors found to describe client evaluations on the Client Satisfaction Questionnaire (CSQ) follow-up measure were subsequently applied to evaluations on the

post-therapy Client Perception Questionnaire (CPQ1) and post-therapy Counselor Perception Questionnaire (CPQ2). These factors were defined as *Mastery/Insight* (Factor 1), *Therapeutic Outcome* (Factor Two) and *Therapeutic Relationship* (Factor Three). Change scores were calculated by subtracting clients' post-therapy evaluation responses from their follow-up evaluation responses. These scores enabled investigation of the reasons for the different ratings observed on the two assessment occasions.

From the models incorporating both FIRO-B need scores and PAQ sex-role orientation scores as independent variables modelled individually with client, therapist and client-therapist combined ratings, the FIRO-B Total Compatibility measure K was found to influence clients' change scores and therapists' post-therapy evaluations. Though the K Compatibility index did not consistently feature in models as often as might have been expected, several of its constituent dimensions did. The components of K observed to influence client post-therapy and follow-up evaluations in a significantly positive direction included compatibility on the Originator Affection and Interchange Inclusion, Control and Affection dimensions. Components observed to have a negative influence on ratings included compatibility on the Reciprocal Affection

dimension. Components exerting a positive influence on clients' change scores included *K* Inclusion and Interchange Inclusion, while the Originator Inclusion and Interchange Control dimensions were negatively related. Concerning therapist post-therapy ratings, the compatibility components of Reciprocal Inclusion, Reciprocal Affection and Interchange Affection were positively associated, and *K* Control negatively associated.

As described, *K* was found to be negatively associated with change score data. This indicated that the level of client-therapist compatibility significantly influenced the extent to which clients changed their assessments from post-therapy to follow-up and that clients in compatible client-therapist pairs altered their ratings less than clients in less compatible pairs who, in turn, reported a decreased level of satisfaction. Therapist ratings were significantly positively associated with *K* Compatibility, signifying that, as compatibility increased, so did favourable therapist ratings of client gains. The findings, almost without exception, revealed a positive relationship between client-therapist need compatibility and client-therapist judgments of therapy. This proved to be the case whether the data examined were provided by clients or therapists.

Additional evidence of the robustness of these findings was provided by the consistency of results across all data formulations tested. When the modelling process included as independent variables only FIRO-B need scores and demographic and related data, the same result obtained as when all available data were admitted for analysis. Considered separately across the two evaluation time periods, Interchange Control Compatibility significantly influenced post-therapy evaluations, while Inclusion and Affection Compatibility were more important at follow-up. These findings confirm need compatibility (as defined by Schutz, 1958, and incorporating the modifications of Mendelsohn & Rankin, 1969, Malloy, 1980a, 1980b, and Malloy & Copeland, 1980, and described in Chapters 1 and 3 of this thesis) as a variable which significantly influences client and therapist appraisals of therapy and lend generous support to similar findings reported elsewhere (Gassner, 1970; Malloy, 1981; Mendelsohn & Rankin, 1969; Sapolsky, 1960, 1965) and to the expectations of a number of writers (Berzins, 1977; Mendelsohn & Rankin, 1969). Mendelsohn and Rankin (1969) found a relationship between therapy evaluation and compatibility in the Control need area only, and then only for female clients. Although in the current study there was considerable confirmation obtained for the former of these findings, males and females were not found to judge therapy significantly differently from each other.

It is interesting to note that different need areas were found to correspond to different aspects of evaluation. The following patterns were detected. For clients, favourable post-therapy judgments of the client-therapist relationship were influenced by the level of client-therapist Control Compatibility and favourable judgments of therapy at follow-up were influenced by the level of client-therapist Inclusion and Affection Compatibility. For therapists, favourable judgments of client mastery/insight factor items were influenced by client-therapist Inclusion and Affection Compatibility and judgments of therapeutic outcome and the client-therapist relationship by the level of Affection Compatibility. Unfavourable judgments of therapeutic outcome by clients and mastery/insight factor items by therapists were influenced by Reciprocal Affection Compatibility and *K* Control Compatibility, respectively.

These results may now be considered in light of the need descriptions and definitions provided by Schutz (1958) and incorporating the modifications referred to above. That clients based their judgments of the client-therapist relationship so heavily on Interchange Compatibility in the Control area is consonant with the fact that these dimensions measure the extent to which there is general agreement between participants with respect to the

formation and maintenance of satisfactory relations in the areas of control and power. In terms of Schutz's postulate, clients' and therapists' desires for exchange on the Control dimension were similar. However, the degree of client-therapist similarity on these composite compatibility measures did not mask important differences between clients and therapists on individual Expressed and Wanted spheres in particular need areas. It seems that clients were willing to have therapists take the lead in the therapeutic relationship, while therapists were more than willing to accept the role. This interpretation gained support from the fact that therapists expressed a significantly greater need to exercise control than did clients. That this should have been the case is also perhaps reflective of the medical-model expectation of many clients that the therapist (physician) should *cure* all problems presented while the client (patient) maintains a composure of passive acceptance and expectant healing. Within the Family Court, because of the clear professional, social and administrative division between client and "Officer of the Court" (Court Counsellor), this process of "therapist as leader" and "client as follower" may have occurred more quickly, and appeared more exaggerated, than it might have done in another therapeutic setting. While such an interpretation awaits empirical validation, the

important finding to emerge from the present investigation is that as client-therapist compatibility in the terms discussed increased, so did clients rate the therapeutic relationship more favourably.

Clients' ratings of therapeutic outcome at follow-up were most often tied to Interchange Compatibility in the Inclusion and Affection domains. Again, clients and therapists expressed a similar desire for interaction corresponding to these dimensions. These findings suggest that clients believed they had satisfactorily interacted with their therapists during therapy and formed affectionate relationships with them to the extent that an increased level of satisfaction in such relations was accompanied by an increased level of satisfaction with therapeutic outcome. That increasing *K* Compatibility was found to be significantly related to an increasing tendency to evaluate therapeutic outcome more favourably from post-therapy to follow-up confirmed the result. These findings, together with those discussed above, point to the client perception of therapeutic outcome being significantly based on a positive perception of the therapist and, as such, provide additional support for the veracity of therapy conceived as a process of social influence (Dorn, 1984a, 1984c; Strong, 1968; Strong &

Matross, 1973). Insofar as the effects observed were not sex dependent, the third hypothesis was not upheld.

The most consistent finding from analysis of therapists' FIRO-B need data was that pre-therapy Affection Compatibility was significantly associated with positive ratings of all aspects of therapy, including client mastery/insight gains, general outcome and the client-therapist relationship. When coupled with the finding that with increasing years of full-time practice in both Court and general therapy therapists were found to indicate a significantly decreasing preference for either giving or receiving affection, these findings suggest that therapists experience an opposition between the valence they place on the existence of affection in a relationship and their reduced preference for either giving or receiving affection. For, although with increasing years of practice therapists indicated both an increasingly low need to express affection and an increasingly low need to receive affection, they rated both the therapy relationship and its outcome more favourably when such affection obtained. This position appears untenable and one wonders as to the likely consequences, not only for the therapy relationship and therapeutic outcome, but also for therapists' personal lives. Ryan (1977) described the profile of persons with

extremely low Expressed Affection and extremely low Wanted Affection thus:

> these individuals are not only cautious about expressing affection, but are most comfortable when other people do not attempt to become emotionally involved with them. They not only are cautious about affection, they are suspicious about it. Emotional involvement is dangerous. Their caution, suspicion, and pessimism protect them from being hurt. (p.24)

In spite of the association between years of full-time practice of therapy and FIRO-B Affection scores referred to above, therapists' mean Affection scores did not appear dissimilar to clients' scores, or the scores provided by Schutz (1978; cf., Table 6.05 in Chapter 6). The concern holds, however, that therapists' scores decreased with increasing professional practice. The result may be interpreted, of course, as simply reflecting a degree of professional distance that many therapists maintain between themselves and their clients as a way of enabling a more objective practice of therapy. However, the degree to which such a stance may generalize beyond a therapeutic milieu and become incorporated in a therapists' attitudinal and/or behavioural repertoire as a protection "from being hurt," represents the degree to which the behaviour may be considered dysfunctional.

It is not clear why *K* Control Compatibility should have been negatively related to therapists' evaluation of client mastery/insight factor items while *K* itself was positively related. It is evident that each of the three factors extracted are estimating quite different evaluation structures and that, at least for therapists, *K* Control is unrelated to evaluation of either the client-therapist relationship or the general measure of outcome. Further, positive compatibility effects resulting from consideration of both the Inclusion and Affection domains using the Factor One (mastery/insight) structure mitigates the likelihood that compatibility is unimportant in influencing ratings of items comprising the Factor. More likely is the possibility that Factor One items tapped the dissatisfaction of some therapists in their relations with some clients concerning issues of power and control. However, that this effect was insufficient to influence ratings beyond a relatively small amount was illustrated by the appearance of a positive *K* compatibility effect in the same model.

Implications of the data for the complementarity/ similarity hypotheses can now be examined. Need complementarity refers to the extent to which the need behaviour of one person results in satisfaction of the

opposing but interdependent needs of another. Type 1 complementarity references mutual gratification of identical needs. Type 2 complementarity alludes to the mutual gratification of differing, but related needs. Need similarity refers to the extent to which satisfaction is derived from others holding similar needs. In terms of Schutz's (1958) need theory, the similarity hypothesis most closely resembles the *Interchange Compatibility* construct, while the complementarity hypothesis most closely resembles the *Reciprocal Compatibility* construct (Campbell, 1980). These hypotheses can be tested directly, then, through consideration of the evidence provided in the present case.

Almost without exception, Interchange Compatibility was found to influence client evaluations of therapy in a significantly positive direction. This finding held whether evaluations were completed short-term (upon the termination of therapy) or long-term (at three months follow-up). On the only occasion Reciprocal Compatibility *did* feature as a significant variable in a client model, it was negatively associated with adjudged therapeutic outcome. Therapists, on the other hand, in their assessment of items comprising the mastery/insight factor, *were* influenced by the level of Reciprocal Compatibility. As already noted, however, it was the degree of *Interchange* Compatibility that affected their

assessment of both therapeutic outcome and the client-therapist relationship. The data are interpreted, therefore, as offering strong support for the similarity hypothesis as it relates to client and therapist estimations of therapeutic outcome and the therapeutic relationship. As such, the data corroborate other findings from diverse contexts which have related participant similarity to participant satisfaction (Antill, 1983; Blazer, 1963; Katz et al., 1960; Levinger et al., 1970; Meyer & Pepper, 1977; Murstein, 1961, 1967, 1980; Murstein & Beck, 1972; White & Hatcher, 1984). Like Reciprocal Compatibility, Originator Compatibility scarcely featured in the models developed. The present findings suggest, therefore, that the utility of these measures, at least as they pertain to client or therapist ratings of client mastery/insight gains, therapeutic outcome, or the client-therapist relationship, seems minimal.

The Sex-Role Orientation Data

A positive relationship was expected between clients' or therapists' manifestation of an androgynous sex-role orientation and their subsequent appraisals of therapy. With one exception, clients' Masculinity, Femininity and Masculinity-Femininity scores on the Personal Attributes

Questionnaire (PAQ) did not significantly influence their end-of-therapy or follow-up ratings of mastery/insight gains, therapeutic outcome, or the client-therapist relationship. The single exception related to Masculinity scores being negatively associated with follow-up ratings, using the Factor One structure (mastery/insight items). The latter finding suggests that at follow-up, clients with high masculinity scores believed that they had gained less from therapy than they believed they had done at the end of therapy, and vice versa. These data suggest that masculine traits may be important in the initiation of positive feelings about therapy, but not in the maintenance of such feelings.

Both client and therapist Masculinity-Femininity scores were found to be significantly related to clients' change scores, although the signs of these relationships were opposite: client scores were positively related and therapist scores negatively related. Increased client Masculinity-Femininity values were accompanied by increased change score values: the larger the latter, the larger the negative disparity between ratings given at the end of therapy and those given at follow-up and the greater the expressed dissatisfaction. Conversely, as *therapist* Masculinity-Femininity values increased, so did client

change score values decrease. Put another way, the maintenance of client satisfaction with therapeutic outcome was found to be related to therapist values on the Masculinity-Femininity scale. Due to conceptual confusion surrounding their derivation and meaning, there has been little research conducted employing Masculinity-Femininity scores. Interpretation of findings based on the measure and comparisons with other work are therefore made difficult. Though the scale consists of items describing characteristics which vary in terms of their social desirability in the sexes, there were no significant sex *by* scale interaction effects located for clients or therapists in any of the change score data.

The most striking and consistent findings in respect of the sex-role orientation data related to therapists. Therapist scores on both the Masculinity and Femininity dimensions of the PAQ significantly influenced their positive ratings of therapeutic outcome while scores on the Femininity dimension significantly influenced their positive ratings of the therapeutic relationship. Relationship issues may be more prone to influence by expressive or *communal* traits and "harder" outcome issues more by instrumental or *agentic* characteristics, the latter perhaps connoting an action phase of therapy. If this is

the case, the above results confirm other findings which have shown positive relationships between well-being and Masculinity scores (Bassoff, 1984) and happiness and Femininity scores (Antill, 1983).

Therapists, but not clients, were influenced to estimate the outcome of therapy more positively, dependent, in part, on their increasing expression of both instrumental and expressive traits. Confirmation of these findings was provided by additional analyses conducted specifically to explore related hypotheses. It was found that therapists, but not clients, with a feminine sex-role orientation consistently rated mastery/insight and therapeutic outcome and client-therapist relationship items more favourably than those oriented otherwise. Further, therapists, but not clients, who held an androgynous orientation rated both the therapeutic outcome and relationship more favourably than did therapists holding other orientations. Lastly, again therapists, but not clients, rated the therapeutic relationship more favourably when both therapists and clients were androgynous in orientation than when any other combination held. All these findings repeatedly tell the story that sex-role orientation is an important determinant of therapist, but not client appraisal of therapy. Inasmuch as the fourth hypothesis predicted a relationship between

positive ratings of therapy and either clients *or* therapists holding an androgynous sex-role orientation, the fourth hypothesis was confirmed, but only for ratings made by therapists.

The fifth hypothesis stated that nonandrogynous clients would modify their sex-role orientation towards a more androgynous orientation either by the time therapy was terminated, or by three or eight months later. Clients did increase both their Masculinity and Femininity scores on the PAQ from pre- to post-therapy and from post-therapy to follow-up, but the changes were not statistically significant. Even so, the findings point to the possibility that therapy conducted over a longer period of time may produce larger changes and offer some encouraging evidence in support of further inquiry.

The results discussed above, relating client and therapist positive impressions of therapy to when both hold an androgynous sex-role orientation, have potentially significant implications for the complementarity/similarity debate. Clients and therapists of different orientations were not found to rate mastery/insight, therapeutic outcome, or the client-therapist relationship significantly more positively than clients and therapists comprising

other orientation combinations. By contrast, as already noted, clients and therapists with the *same* (androgynous) orientation were found to rate the therapeutic relationship - but not client mastery/insight gains or therapeutic outcome - significantly more favourably than others holding different orientations. These results, together with those from analysis of the FIRO-B need data discussed earlier, offer support for the similarity construct and confirm similar findings from the literature (e.g., Antill, 1983; Meyer & Pepper, 1977; Murstein & Beck, 1972).

Demographic and Related Data : An Integration

Although the compatibility and sex-role orientation data were significant in some models, demographic and/or related variables appeared as significant in nearly all models. The following client variables appeared as significant in models accounting for either end-of-therapy or follow-up client evaluations of therapy: city; occupation; sex; the number of years married; the proportion of children lived with; whether the (ex)spouse was lived apart from, or apart from in the same house, or together with in the same house; the manner of referral to therapy; whether presentation to therapy was with a (ex)spouse or not; and whether a solicitor had been consulted at some time before the

beginning of therapy. Therapist variables significant in influencing therapist evaluations of end-of-therapy outcomes included: city, sex and years of part-time training in therapy. These findings underscore the importance of including demographic and related variables in research investigating client-therapist matching. Unfortunately, however, no consistent pattern of influential demographic or related variables emerged from consideration of the available data, except, that is, for the City effect, which has been discussed in detail already and which attracts additional scrutiny later in this section.

A recurring issue throughout this work has concerned the advisability of including biological sex as a predictor variable in models developed for the explanation of client and/or therapist exhibited or mediated phenomena. Views expressed regarding the study of gender have ranged from: "never has so much been said by so many about so little" (Pyke, 1982, p.127), to: "Just as the literature of the Victorian period distorted the view of children by treating them as miniature adults rather than as evolving human beings, so too have those psychologists who study the human condition ignored sexual differences" (Rochlin, 1980, p.x). In any event, consideration of the sex of both the

therapist and the client in research investigating aspects of therapy continues to be encouraged (Nadler, Maler & Friedman, 1984). Journal reports including gender as a subject variable increased in the period 1971/1972 to 1981/1982 and overgeneralization (from one sex to the other without specific measurement) decreased (Lee, Heppner, Gagliardi & Lee, 1987). Findings presented from the present series of studies in respect of biological sex are respectively consistent and inconsistent with a literature which has variously established gender as important (Cooke & Kipnis, 1986; Daane & Schmidt, 1957; Fuller, 1963; Harren, Kass, Tinsley & Moreland, 1979; Hill, 1975; Howard, Orlinsky & Hill, 1970; Kaschak, 1978; Luborsky, Chandler, Auerbach, Cohen & Bachrach, 1971; Persons, Persons & Newmark, 1974; Rhone, 1978; Simon, 1973) and unimportant (Angle & Goodyear, 1984; Blier, Atkinson & Geer, 1987; Breisinger, 1976; Feldstein, 1979; Heatherington, Stets & Mazzarella, 1986; Petro & Hansen, 1977; Zamostny, Corrigan & Eggert, 1981) in the determination of client and/or therapist assessments of therapy.

A number of extraneous influences may be considered as possibly underlying the sex differences noted above. Belle (1985) pointed out that the reluctance to give up unproven and even disproven beliefs about the sexes might be related

to the fact there are only two of them and that, when confronted by two of anything, there is a tendency to concentrate on their differences. While the study of sex differences might be considered as replete with ironies and paradoxes, there is none so telling as that put by Hare-Mustin and Marecek (1988):

> Qualities such as caring, expressiveness, and concern for relationships are extolled as women's superior virtues and the wellspring of public regeneration. At the same time, however, they are seen as arising from women's subordination ... When we extol such qualities, do we necessarily also extol women's subordination ... if subordination makes women "better people," then perpetuation of women's goodness would seem to require the perpetuation of inequality. (p.462)

That the foci for researchers for so long have been the *differences* between the sexes, to the virtual exclusion of their similarities, also merits regard. Perhaps it would be more constructive to focus attention on the latter, as efforts focussed on the former appear to be returning ever increasingly diminished returns. Findings by Eagly and Carli (1981) that authors were more likely to report sex differences that reflected favourably on their own sex and by Beauvais and Spence (1987) that subjects were far more likely to attribute suggestions to persons of their own gender, perhaps go part way towards explaining at least some of the disparate gender findings reported.

Lastly, and pertaining directly to the therapy context, Heatherington, Stets and Mazzarella (1986) asked therapists working in an outpatient mental health centre to rate clients on an interpersonal and control dimension and to record for each client their expectations of therapy. Findings indicated that, compared to females, males were ascribed less favourable interpersonal social characteristics - including poorer social skills - and were expected to remain in brief therapy for less time. The authors hypothesized that because women present themselves in ways more appealing to the therapist (e.g., by being more open and more willing to seek assistance), they may in fact have "an edge" (p.255) as therapy clients. There may be correspondence between what is believed by therapists to constitute "good" client behaviour and female clients' greater propensity to display such behaviour.

The seemingly all-pervasive City effect noted in many of the models presented - and discussed briefly in Chapter 6 - is deserving of further comment. Some of the four cities involved in the research were quite different in a number of important cultural and social respects. Two of the areas could be described as working- to middle-class and two as middle- to upper-class. The former had relatively high levels of unemployment, immigrant settlement and housing

shortages and were largely based on light- to heavy-industries. In contrast, the latter areas consisted primarily of centres for professional and commercial business interests. Given these differences, significant City *by* occupation and City *by* ethnicity interaction effects might have been expected from an analysis of data which included persons from each of these areas, as all the present data sets did. This, in fact, was not the case. Neither of the interaction effects described were found to be significant. Consequently, the explanation for the observed City effect remains elusive and, rather than background descriptors, probably involves intra-psychic phenomena not assessed in the present case. Adding to the disquiet caused by the observed locality effect for clients was the finding that when compared to male therapists from other parts of the country (involved in the study reported in Chapter 5), male therapists from New South Wales and the Australian Capital Territory (involved in the study reported in Chapter 6) scored significantly more highly on the Masculinity-Femininity scale of the PAQ. Explanation of this locality effect proved as elusive as that just reported for clients, but may simply reflect random variation.

A question arising at this point concerns which model best describes the data, given the results from analysis of the FIRO-B need data, PAQ sex-role orientation data and demographic and related data discussed. As noted earlier, there is no best model for this purpose and the models developed and presented are those resulting from application of the procedures adopted and detailed. Probably the most informative finding from analysis of all the data was that ratings of therapy were influenced by *combinations* of the above three sets of variables. This, of course, accords well with a view that humans are generally more complex than any one, or two, or three, or perhaps any number of variables, will adequately or sufficiently allow.

The next question of import concerns the utility of FIRO-B need compatibility measures and PAQ sex-role orientation scales in predicting client or therapist evaluations of therapy if neither performs much better, nor, at times, equal to what can be gleaned from inspection of participants' demographic and related details. Despite the results of the first study reported here which found that clients preferred a masculine or an androgynous oriented therapist, one conclusion from the findings of the third study could be that neither need compatibility nor sex-role orientation are very important in influencing

client or therapist assessments of the therapeutic interaction. Such a conclusion at this time, however, would be premature, for, although the present findings point toward the veracity of such a generalization, there exists at least some evidence suggesting otherwise (e.g., Malloy, 1981, in relation to need compatibility, and Petry & Thomas, 1986, in relation to sex-role orientation). Possible reasons for the disparity between this evidence and the present findings are discussed in the following sections.

Methodological Constraints

To be considered first in this section is the possible contribution of client acrimony to the findings reported. Family Court counselling is most often characterized by tremendous bitterness between the client (ex)spouses. Perhaps therapists find themselves in the invidious position of "doing no right," that is, perceived assistance of the wife may be resented by the husband as positive female bias, and vice versa. It is possible, therefore, that the extreme emotionality demonstrated by some clients may have exerted a more powerful influence over the way in which therapy and the therapeutic relationship was evaluated than did the other independent variables included

for examination. This explanation was strengthened by the finding that clients presenting for therapy alone rated the therapeutic relationship more favourably than did those presenting with their (ex)spouses. However, there are a number of features in the data mitigating the accuracy of this interpretation.

First, the refusal rate was quite low (8%) and unrelated to whether clients attended for therapy alone or not. Second, clients did not rate therapy outcomes significantly differently to therapists at the conclusion of therapy. This finding, of course, could be interpreted as evidence of the fact that clients and therapists simply agreed on how bad the therapy experience had been; however, that the mean ratings of both clients and therapists were found to fall in the positive half of the evaluation scales suggests otherwise. Finally, the follow-up return rate was high (47%). This finding could be interpreted as merely indicating clients' determination in making known their displeasure. Indeed, the ratings at follow-up were significantly less favourable than those given at the end of therapy. However, it would seem a more likely interpretation that many of the clients who returned their ratings questionnaire at follow-up did not get what they wanted from the *Court* (as opposed to therapy), including,

for example, custody of the children, or an increase or reduction in maintenance payments. Insofar as therapy (or the therapist) may have been perceived as aligned with the Court, criticism of therapy (or the therapist) may have been expressed by clients when in fact their criticism related to the Court and/or its finding in their matter.

Another fact to be considered in interpreting the results of the study is that all of the clients involved in the research were or had been married. Whether this feature had any effect on the results observed is not known, although, it might be assumed that it did not, save as outlined above with reference to partner conflict (which could not be manifest if a client presented for therapy alone). Whether client-therapist need compatibility or sex-role orientation functions to influence therapy outcome ratings any more or less significantly in married persons than in single persons - other, perhaps, than as a function of some other variable, such as age - invites empirical investigation.

To properly investigate the effect(s) of the City differences observed, replication and extension of the present work is required, with particular reference to background information not collected in the present case. For example, level of education reached could prove a

significant delimiter (though in the present case occupation did not), as could a range of personality characteristics not studied in the current project, an example of which is locus of control: In areas of high unemployment, it might be expected that people are less likely to believe they have control over their fate (employment), which in turn may have implications for their need expression. It should be noted, however, that although the City effect was certainly pervasive in the models developed and described, it generally did not account for more variance than any other independent variable.

More obvious in the range of variables which may have influenced results beyond the control of the author relate to the type of therapy conducted by, or, more accurately, the brief given to, counsellors of the Family Court. The brief given differs from that given in most therapy centres where usually therapists are not instructed on what to do in particular cases: Therapeutic decisions are usually made independent of the (formal) input of others. (The exception to this are therapies designed specifically to accommodate formal input from a number of sources, often sought *during* the actual therapy process. Some family therapies are based on this structure, an example being that practiced by the Milan Group.) A generally accepted brief might be the

definition of therapy offered in Chapter 1 of this thesis, namely, that the therapist should ethically do whatever is required to assist the client to achieve resolution of the presenting problem (Krumboltz, 1965; also Carkhuff, 1966), but the available latitude in following such a direction is very large indeed. Within the Family Court, guidelines are provided not only for how to "do" therapy, but also how to do what is best, when. Examples include strategies for beginning therapy and when to recommend to the Court that a report be prepared (as in the case of child abuse allegations). It could be argued that this adherence to a *formula* of action (formally) separates Family Court Counselling from the usual practice of therapy. It will be suggested here, however, that the similarities between Family Court Counselling and other therapeutic arenas by far outweigh any dissimilarities, thereby permitting comparisons and generalizations between them.

The first point to be made is that the existence of a formula for therapeutic action does not imply its being followed by even a minority of therapists. There is no "checking" undertaken by the Court to ensure that therapy is being conducted "according to guidelines." The therapist supervision undertaken is primarily an avenue for the therapist to voice concerns about cases and/or practices

than it is a check on the clinical practice techniques employed. It is further suggested that professionally qualified and experienced therapists would not, as a matter of course, conduct therapy according to any predetermined pattern, but would foremostly seek to fulfil their obligations as mental health personnel in ways similar to those advocated by Krumboltz (1965) and described above. It is contended, therefore, that the range of techniques utilized by Court Counsellors would likely be as wide and varied as those employed in any other therapeutic setting.

A second point relates to the generalizability of findings based on Family Court clients. The Family Court client sample in the present case can be distinguished from the client population at large by the fact that all of the former clients had at some stage been married. (As indicated in Chapter 2, having been married is no longer a prerequisite for receiving Family Court service.) However, that all clients in the present sample were or had been married can be balanced with other considerations. For example, within Family Court Counselling, the anguish that is seen, the personality problems that are evidenced, the ineffectual communication styles observed, the grief reactions witnessed, the acrimonious attacks heard, the feelings of helplessness and lack of control detected, the

fears expressed, the projections made, and the desire for things to be different, are all feelings and behaviours shared in common with distressed clients presenting in countless other counselling centres throughout the world. That, ostensibly, the problem (insofar as the Court may be concerned) is that the client couple cannot agree on how much access to the children should occur, or on how much maintenance should be paid in a month, does not detract from the authenticity of the pain, or the expression of it in forms not dissimilar to those just related and, while a side benefit of therapy might well be agreement on access or on a maintenance figure, of greater import for the therapist is alleviation of the personal impediments underlying the distress. Clearly, the veracity of this comparability argument invites empirical validation.

A third and final point concerns whether therapy conducted at the Family Court meets any definitional criteria of therapy from the relevant literature. It certainly meets Krumboltz's (1965) definition, although, as already noted, this meaning, while attractively parsimonious, has a wide latitude. Tiffen's (1984) definition is more precise and requires that clients and therapists collaborate on the issues, that therapists be empathic towards clients, that therapists follow ethical

standards of practice and that therapy sessions be confidential. All of these conditions also are met by confidential counselling in the Family Court. Further, Strong's (1971b) conditions for therapy are perhaps the most stringent and demand that therapy be a conversation between or among persons, that status differences between participants constrain the interaction, that the time length of therapy varies and sometimes is extended, that many clients are motivated to change and that many clients are psychologically distressed and heavily invested in the behaviours they seek to change. Again, therapy conducted in the Family Court satisfies these criteria. Clearly, then, Family Court Counselling encompasses all of what are regarded as the necessary ingredients of therapy, thereby attesting to the validity of direct comparison and generalization between it and other therapeutic forms and settings. This conclusion, also, invites empirical substantiation.

A further comment pertains to the number of therapy sessions typically attended by clients in the present research. The range was between one and nine sessions, with a *mean* of 2 and a *standard deviation* of 1.4. It needs to be pointed out that although the mean number of sessions clients attended was perhaps less than that typically

attended by clients in other therapy settings, the average length of each session was probably longer. A Family Court counselling session usually lasts approximately one and one half to two hours, but it is not uncommon for sessions to extend for several hours over the course of a day and still be counted as one session. Given these therapy time characteristics, it is fair to deduce that the emphasis is on brief therapy. In any event, in addition to brief therapy being regarded by some as the intervention of choice (Fisch, Weakland & Segal, 1983; Singh, 1982; Staples, 1979; Weakland, Fisch, Watzlawick & Bodin, 1974), it seems reasonable to believe that therapy time scales probably vary considerably from therapist to therapist and from setting to setting.

From having worked professionally with 23 of the counsellors involved in the third study and having talked at length with all 39, the author's impression was that the therapeutic style of counsellors most closely resembled the description of *action* therapists, more than of existentially oriented (Berliner, 1983), or *insight* therapists.

> Action types of therapies, which would include cognitive and behavioral approaches, brief psychotherapies, and hypnotherapy, require that counselors use their influence in a direct, overt manner. These counselors assume authority or expertness. They take most of the control in the counseling process and the major responsibility for structuring the sessions ... The goal of counseling is to

> relieve clients' symptoms, to help clients solve the problems that motivated them to seek counseling ... Insight therapists have the goal of "freeing" the client, whereas Action therapists seek to "cure" ... [Action therapists] can be bolder in using their influence because the [area of] control they assume is a finite [one] (Senour, 1982, p.348)

Given these comments, it needs to be added that neither clients' attitudes towards therapists, nor their involvement in the therapeutic process have been found to be affected by the theoretical orientations held by therapists (Gomes-Schwartz, 1978). Of course, the extent to which differential theoretical orientations translate into differential therapeutic practices, or whether they do at all, is a different matter. Further, although therapeutic techniques can be regarded as important in influencing change, "their power for change pales when compared with that of personal influence" (Bergin & Lambert, 1978, p.180).

Additional Implications for Theory

The significant relationships between FIRO-B need scores (difference score totals) and PAQ sex-role orientation scores demonstrated that increased difference score values were associated with commensurately increased Masculinity and Masculinity-Femininity scale scores. High difference

scores are related to taking the initiative in human relationships, regardless of the need area being considered (Schutz, 1978). This accords well with the meaning attributed to high scores on the Masculinity scale of the PAQ, namely, that the presence of such scores indicates the possession of strong instrumental or agentic traits (Spence, 1983, 1985). The import or implication of the significant association located between difference scores and the Masculinity-Femininity scale of the PAQ is not as readily discernable, partly because, as noted earlier, what the latter scale represents has not been unequivocally determined, or at least not unequivocally declared. (Taylor & Hall's, 1982, comments confirm the point.) Although the Masculinity scale is believed to have tapped a general instrumental trait inclination, that only two of the eight items comprising the Masculinity-Femininity scale are male-valued mitigates the likelihood that the latter scale did the same.

There was no gender effect detected in the model discussed above, but there was a significant gender difference located in the way Masculinity-Femininity scale items were rated, with males scoring higher than females. Positive feminine traits were useful for males (assuming that taking the initiative in human relationships is

regarded as a useful ability or skill), however, positive masculine traits were not useful for females. (Taylor & Hall, 1982, also reached the latter conclusion.) That masculine females were amongst the most lowly rated by clients in the first study of the present series serves to highlight the point. This finding has important and obvious implications for both sexes. Given that each sex benefits from traits commonly believed to be associated with the other, each would benefit from adopting the others' perceived positive aspects while continuing to affirm its own. This essentially is the logic underpinning notions of the androgynous ideal: Individuals accrue benefits from the incorporation of both instrumental and agentic characteristics which they do not from the adoption or maintenance of a strictly sex-typed orientation. The finding in respect of the Masculinity-Femininity scale, then, in spite of imprecision surrounding its meaning and use, confirms the substantial gains to be made from an androgynous stance for males, but not for females - at least insofar as taking the initiative in relationships is concerned - and adds to a large body of evidence demonstrating such gains in a variety of settings (Bem, 1974; Helmreich, Spence & Holahan, 1979). Whether the separate male- and female-valued items comprising the Masculinity-Femininity scale would show similar effects in

other contexts using different types of independent variables is a possibility which could direct future research attentions.

A question of some import which does not seem to have been addressed in the literature concerns the manner in which subjects have been asked to rate items for sex-role orientation scales in terms of the degree to which items represent maleness/masculineness or femaleness/femininess. Would subjects rate items in these terms at all if they were not asked to? In other words, do items *really* constitute what subjects believe to be representative attributes of the sexes, or are they merely assigning values in a forced-choice situation to descriptors which researchers believe have the meaning they intend? It seems likely that subjects may simply be responding to the gender markings already assigned and supplied by researchers. Both Bem (1975) and Spence et al. (1975) supplied subjects with items and asked them to choose the degree to which each item could be regarded as male- and/or female-valued. With the benefit of hindsight, in what might have been a more useful starting point, subjects were not asked to provide their own definitions of what it means to be male/female and/or masculine/feminine. Given that it can reasonably be assumed that what it means to be either is not only subject

to change at the individual level, but also at the generational level, it may have been inappropriate to base the selection of scale items on intuition (Bem, 1974) or on items generated many years earlier (Spence et al., 1975). It is perhaps partly for this reason that uncertainties have been cast on the utility of the BSRI and PAQ based on the failure of some factor analytical procedures to support the dimension structures the scales purportedly tap (Gaa, Liberman & Edwards, 1979; Gross, Batliss, Small & Erdwins, 1979; Pearson, 1980; Whetton & Swindells, 1977). Further, until empirical evidence is forthcoming concerning the effects of variables such as age and educational level on sex-role stereotypes and social desirability ratings of trait descriptive adjectives, the generalizability of research findings employing measures based on undergraduate student samples must be regarded as limited (Ramanaiah & Hoffman, 1984).

At least one effort has been made towards redressing some of the deficits referred to above. Myers and Gonda (1982), for example, asked a heterogeneous sample of museum visitors and a sample of students to define, via an open-ended format, the terms *masculine* and *feminine*. Astoundingly, 90% of responses for the definition of masculine and 94% of responses for the definition of

feminine did *not* reflect item content of the BSRI. In other words, only 10% of BSRI items were found to tap what it means to be masculine and 6% of items what it means to be feminine. Physical (e.g., "muscular" and "shapely") and gender-related (e.g., "I am a male" and "women who are ... ") descriptors were more frequently used by respondents than were stereotypic personality characteristics. In the light of their findings the authors question the purity and meaning of the androgyny construct as operationalized by instruments like the BSRI and urge consideration of masculinity and femininity in terms of self-schemata and cognitive complexity. The term *self-schema* refers to a cognitive structure that organizes information about the self (Markus, 1977) and can be assessed by requesting individuals to spontaneously generate their most self-descriptive traits (Deutsch, Kroll, Weible, Letourneau & Goss, 1988). Self-schema considerations would include such components as occupation or social role, physical appearance and biological sex differences. An example of a cognitive complexity consideration would include one's definition of adequacy as a male or female viewed from the standpoint of developmentally acquired standards of sex-role appropriateness. However, Spence and Helmreich (1983), in their response to the Nicholls, Licht and Pearl (1982) paper, commented that the "contention that the

trait-construct approach to personality can be supplanted by a cognitive approach appears to be gratuitous" (p.183). Presumably those authors would apply the same comment to the same part of Myers and Gonda's suggestion.

What Myers and Gonda (1982) did not suggest, however, was the development of a sex-role orientation measure based on the categories into which their data were organised. Four categories of response were identified and utilized: (1) gender reference, (2) physical reference, (3) personality or behavioural characteristics and (4) societal or biological reference. The only category into which Bem's BSRI items can be categorised is number (3). To extend this work into developing a measure which taps *all* the categories of attributes which people believe are important in the definition of gender would seem to be a worthwhile endeavour. For the reasons already identified, and because evidence has been documented relating the rapidity with which sex-role attitudes change (Helmreich, Spence & Gibson, 1982), a measure as described above would require frequent revision in order to accurately reflect at any given point in time the changing cultural conceptions of what it means to be male and female, masculine and feminine. This course of action would at least ensure that the items to be assessed by subjects for inclusion in any

scale were not only current, but also relevant and tailored to their purpose.

In 1981a Bem introduced the notion of *gender schema*, in which it was proposed that sex typing derives, in part, from a readiness to encode and organise information in terms of cultural definitions of what constitutes maleness and femaleness, which, in their turn, may be viewed as constituting a society's gender schema (Bem, 1981b, 1985; Frable & Bem, 1985). "Gender schematic processing ... involves spontaneously sorting persons, attributes, and behaviors into masculine and feminine categories or 'equivalence classes' regardless of their differences on a variety of dimensions unrelated to gender" (Bem, 1987, p.307). In 1976 Bem encouraged "Let sexual preference be ignored; Let sex roles be abolished; and Let gender move from figure to ground" (p.61) and in (1981a) urged that "society should stop projecting gender into situations irrelevant to genitalia" and that "The feminist prescription ... is not that the individual be androgynous, but that the society be aschematic" (p.363). By 1987 Bem had concluded that the distribution of activities and roles across males and females should reflect nothing but biology: "masculinity and femininity exist only in the mind of the perceiver" (p.309). Put another way, "as observers

of gender, we are also its creators" (Hare-Mustin & Marecek, 1988, p.462). Other writers have referred to a state of *sex-role transcendence* (Rebecca, Hefner & Oleshansky, 1976; Robinson & Green, 1981), epitomized by "an autonomous being with an idiosyncratic, complex, concatenation of habits, skills, attitudes and inclinations derived from a unique biology and articulated by a unique environment" (Pyke, 1982, p.132) "in which assigned gender is irrelevant" (Hefner, Rebecca & Oleshansky, 1975, p.143).

Bem's 1981a injunctions shared much in common with those expressed by the same author in 1978 (and critiqued by Zeldow in 1982) and by Gilbert (1979, 1981); however, by 1981a Bem had come to view androgyny as representing a double prescription with double demands: Be both masculine *and* feminine. (Harris had arrived at this conclusion seven years earlier, in 1974.) Such a focus had detracted, Bem argued, from a serious consideration of the fact that the very notions of masculinity and femininity derive from a gender schematic processing. Spence and Helmreich (1981) commented that, based on gender schema theory, Bem expected the BSRI to measure a unidimensional construct (e.g., gender schemata) and, *at the same time*, to measure the dual independent dimensions of masculinity and femininity. The authors concluded that tests of the theory would have to

await more appropriate measurement than either the BSRI or PAQ could provide. Later the same year Bem (1981b) rejoined, stating that Spence and Helmreich had missed the point and that in gender schema theory the BSRI had only one use: to identify sex-typed individuals. Identification would then enable assessment of whether such individuals display a greater inclination to engage in gender schematic encoding.

It seems that Bem may have discarded androgyny as a means by which to arrive at an aschematic society and in its stead adopted gender schema theory. However, the abandonment may have been hasty and, mindful of the fact that in order to generate novel ways of viewing the social world it is first necessary to audit the inventory of artifactual and conventional beliefs (Morawski, 1985), it is contended here that the concept of androgyny describes the product of such an audit. Further, the present research findings lend support to the view that it *is* possible to consider the conjoint influences of masculinity and femininity without recourse to "the ubiquitous functional importance of the gender dichotomy" (Bem, 1981a, p.363). Such consideration was directly attributable to application of the androgyny construct. It may be that as more *situations* are explored in which androgyny can be shown to act as a

significant predictor, the more useful the concept will become. It is known, for example, that whether more or less stereotypically masculine or feminine behaviours are employed depends more on the life situation in question than whether individuals hold a masculine or feminine sex-role orientation per se (Abrahams, Feldman & Nash, 1978). This type of predictive investigation could be extended, in the field of therapy research for example, to the conceptualization of clients' concerns in instrumental/expressive terms. Such a distinction may then facilitate the development of therapeutic strategies shaped for particular classes of presenting problems.

Additional Implications for Clinical Practice

Unfortunately, given the paucity of predictive power in all models developed, the implications of the current findings for clinical practice appear weakened. Although the most explanatory model developed (for therapists) included four demographic variables and accounted for 28% of the variance observed, none of the models established could be regarded as being predictive of client or therapist judgments of the therapeutic relationship, therapeutic outcome, or client mastery/insight gains.

Notwithstanding this, there are a number of features of the results which may have important implications for clinical practice. For example, the finding that, depending on when the evaluation of therapy occurs, so does the influence attributable to compatibility in a particular need area change, is certainly significant. Pre-therapy client-therapist need compatibility was important for clients to sense that they had experienced satisfactory relations with their therapists with respect to Control issues, while at follow-up, compatibility in the Inclusion and Affection domains was important. Overall compatibility (as measured by *K*) and compatibility in the area of Inclusion were important with respect to the *maintenance* of these evaluations.

Whether it is only psychologist and social worker therapists who decrease their Wanted and Expressed levels of Affection with increasing employment as helping professionals is not known. It also is not known whether a particular point is reached after which such effects are diminished. The implications of this finding are certainly serious. At a time when therapists might be expected to be very giving and very receiving of all the emotions, that is, after many years of therapeutic practice, the opposite result was found to hold in respect of the giving and

receiving of affection. Whether this reduced need resulted from a *blasé*, burnt-out attitude fostered by prolonged exposure to hostile emotions displayed by clients - often towards therapists - or whether a stance of increasing detachment had become part of a therapeutic armamentaria, or a manner of coping with perceived hostility, or whether there were other concomitant determinants, cannot be established in the present case. The high need to exercise control displayed by the therapists is at the very least suggestive of the possibility they may have developed a defensive stance, perhaps in response to the perceived hostility alluded to. When considered together with the finding that therapists' levels of pre-therapy Affection Compatibility was significantly associated with positive ratings of all aspects of therapy, therapist in-service courses would do well to focus on potential causes for the attenuation of both the expression and acceptance of affection as evidenced in therapists the subjects of this research, in conjunction with the effect this has, not only on the generation of effective client service, but also on therapists' personal well-being. In general terms, it seems likely that therapists functioning well below potential in their personal lives will deliver much less than their optimal in clinical practice.

Whether therapists' influence attempts were affected by, or whether clients' preparedness to respond to such attempts were modified as a reaction to the level of conflictual tension present between the client (ex)spouses, cannot be determined in the present work. A first reaction to the suggestion might be that such conflict would indeed act as a barrier, or at least as a filter to the therapist communications being offered. Similar to the connections between power positions and choices of therapeutic intervention (Pentony, 1981), if clients experience a degree of partner conflict as debilitating, then the therapist's intervention might be directed at a level different to that chosen in the absence of such high-level discord. Whether the *process* of therapy and, possibly as a consequence, the evaluated outcome of therapy is differentially affected by such tactical changes could serve as a productive focal point from which to explore the possibility in the context of couple therapy. A number of writers have developed conflict models which could facilitate such an endeavour (e.g., Baugh, Avery & Sheets-Haworth, 1982; Bell, Chafetz & Horn, 1982; Locke & Wallace, 1959; Roach, Frazier & Bowden, 1981; Rollin & Dowd, 1979; Straus, 1979; Wallace, 1979).

The current findings point to the need for future research which investigates therapists' abilities to facilitate processes which result in desired outcomes. This requires an integration of client and therapist characteristics, therapeutic skills and effective therapeutic relationships. Schmidt (1984) proposed that the construct of ***intentionality*** be examined as a way of addressing these issues, as a bridge between process and outcome. The construct was defined as "a characteristic that enables people to link their inner consciousness with their intentions, purposes, and behaviors" (p.383). Such process-outcome effects could be assessed using instruments designed specifically to the purpose (e.g., the Session Evaluation Questionnaire developed by Stiles & Snow, 1984). In addition, recent work by Strong, Hills, Kilmartin et al. (1988) investigating the connections between and consequences of interactants' interpersonal behaviours, has obvious implications for the examination of facilitative therapeutic manoeuvres.

Summary, Conclusions and Future Directions

The major findings from the research reported in this thesis may be summarized as follows.

1. Clients rated therapists with an androgynous or masculine sex-role orientation more favourably than they rated therapists with a feminine sex-role orientation and masculine males received the most favourable ratings and feminine males the least favourable ratings.

2. More psychologists and social workers held an androgynous sex-role orientation than any other single sex-role orientation, although, more therapists held nonandrogynous orientations.

3. Clients and therapists made similar ratings of the therapeutic relationship, therapeutic outcome and client mastery/insight gains.

4. Clients rated all aspects of therapy significantly less favourably at follow-up than they did upon the termination of therapy.

5. There were no differences in the way clients rated aspects of therapy at eight months follow-up compared to three months follow-up.

6. Independent of gender, favourable client and therapist appraisals of therapeutic outcome were found to be significantly related to client-therapist need

compatibility, primarily on the Interchange dimension. This finding suggests that the model of social influence in therapy may need to be revised to include client-therapist need compatibility, in addition to need per se and, in a more general way, points to the need for inclusion of a component in the model which takes account of client-therapist interaction effects.

7. Clients in compatible client-therapist pairs altered their post-therapy to follow-up evaluations less than clients in less compatible pairs who, in turn, reported an increased level of dissatisfaction with therapy.

8. With increasing years of full-time practice in both Court and general therapy, therapists were found to indicate a significantly decreasing preference for either giving or receiving affection.

9. Individual Masculinity and Femininity scores on the PAQ influenced therapist, but not client judgments of therapy and, client Masculinity-Femininity scores negatively influenced ratings of therapeutic outcome, while therapist Masculinity-Femininity scores positively influenced ratings of therapeutic outcome.

10. Clients and therapists rated therapy more positively when they *both* held an androgynous orientation.

11. Clients increased both their Masculinity and Femininity scores on the PAQ from pre- to post-therapy and from post-therapy to follow-up, though not significantly so in either case.

12. Results from analyses of the compatibility and sex-role orientation data overwhelmingly confirmed the similarity hypothesis of attraction while simultaneously refuting the complementarity hypothesis.

13. Just as the compatibility and sex-role orientation variables significantly influenced client and therapist appraisals of the therapeutic outcome, therapeutic relationship and client mastery/insight gains, so did several client and therapist demographic and related variables. Examples of the latter included client and therapist gender and client occupation and number of years married. These results support retention of client and therapist characteristics in the social influence model of therapy.

Based on these findings, the most immediate next step in maximizing the prediction of therapy assessments would seem to be to match clients and therapists on the variables found to be significant in the models developed. It is only in this way that the predictive strength of the findings presented can be determined independently of so many other extraneous influences. Additionally, although the sample of therapists utilized in the second study was large (n=99), there were small numbers in several of the sex-role orientation groups. Replication of the research with larger and more varied samples of mental health professionals would determine the robustness of the findings reported. Using a variety of androgyny measures could help reduce the likelihood of therapists recognizing the intent of the measures, however, achievement of this is mitigated by the similarity of androgyny measures. Further, whether therapists in other settings would exhibit high scores on the Control dimension of the FIRO-B requires additional examination. It may be that those who choose to train as therapists score highly on this measure before such training begins, or develop this profile as a result of exposure to clients perceived as threatening in some manner, as contemplated earlier. The extent to which the results obtained are in part a reflection of the contribution of particular treatment techniques, or

particular psychological problems, could also serve as a useful focus for further study (Rachman & Wilson, 1980). The findings outlined highlight a number of broad issues in conducting therapy research and, in terms of their ramifications for extension of the present work, these can now be considered in detail.

Although many of the models presented in the current work account for relatively small amounts of variance explained, the variables in the models are nonetheless significant. Research of the kind undertaken here provides fragments towards the piecing together of what might be described a mosaic. None of the pieces of data can be said to occupy a space large enough to tell the whole story, but together they help to fill out the picture. It seems unlikely that research in the area of client-therapist matching will ever result in what some might term a definitive model of explanation for the observed events during or subsequent to therapy. It may be counterproductive to believe that such explanation is possible. Not appreciating this perhaps goes part way towards illuminating why many researchers turn away from exploration of in-the-field therapy populations (Gelso, 1979) and why so few seemingly fundamental investigations have taken place exploring the (assumed) substantive underpinnings of much that passes for theory in

the therapy arena. The significant growth of theory occurs in an atmosphere of curiosity and expectation. The latter are undermined and diminished by the setting of unachievable goals.

The indication in a model that a variable does not offer predictive power is not the only test of its significance and significance at a level less than predictive power is not a result which should be ignored. In the present context, for example, it may well be that it is the *cumulative* effect of being compatibly matched with a therapist over an extended period of time that helps determine whether a client (or therapist) will regard therapy more favourably or not. The veracity of this, of course, is not known, as it has not yet received research attention, but could well serve as a working hypothesis worthy of examination. Furthermore, whether the present findings have applicability for long-term psychotherapy is not known, but the possibility that they might could be a profitable area for future research attentions, as could the intriguing question relating the extent to which a therapist's credibility is affected by a client's perception that the therapist's commitment to therapy seems split by a concomitant commitment to research (Ruppel & Kaul, 1982).

It might also be the case that significant predictors, as they relate to favourable evaluations of therapy, do not exist, and have never existed, except in the minds of those who would research the possibility that they might. That the volume of reported research devoted to uncovering these predictors has resulted in a paucity of supportive or heartening evidence is suggestive that it is perhaps time to look in a different direction. Part of the new direction referred to finds expression in Bem's (1981a) gender schema theory discussed above, which, in spite of the caveats outlined, has much to recommend it. In addition to what has been stated already, a large part of the problem in therapy research appears definitional. To take as an example an issue that demanded resolution in the present work: How is *therapeutic success* to be judged? It has been put that if a client terminates contact with a therapist and is still bothered by the problem that prompted contact with the therapist in the first place, then "that counselor has failed," but that if the client resolves the problem, or develops a plan of action which will eventually lead to resolution of the problem, then "the counselor has succeeded" (Krumboltz, 1965, p.384). It was added that "Within limits, it is each client's wishes that dictate the criteria of success for that client" (p.384).

In spite of such explanation, however, as every clinician attests, there continue to be as many descriptions of what successful therapy means as there are clinicians. This encapsulates the issue. If agreement cannot be reached on what it means to have conducted successful therapy, it is not then possible to measure such a construct in a manner acceptable to all those who would be concerned with such measurement. A clinical example serves to highlight the dilemma. If a client attends therapy thrice weekly for two months for the treatment of suicidal ideation and suicides the day following termination of therapy, there would probably be general agreement that the therapy had been unsuccessful. (Some, of course, would argue that the client's concerns *had* been ended in perhaps, for the client, a satisfactory manner. Yet others would argue that therapy had kept alive a client who lived life to the full for two months more than might otherwise have been the case.) In a similar way, if a client attends therapy thrice weekly for two months for the treatment of an obsessive-compulsive disorder with the result that the condition is alleviated for 15 years before it again returns, most would agree that the original therapy had been successful. (Again, some would argue that "real success" dictates *erradication* of the behaviour from the individual's behavioural repertoire, *never* to be experienced

again.) From the example given then, for *general* agreement, the time span for judging success on the one side, or its absence on the other, lies somewhere between 1 day and 15 years following termination of therapy. Making the judgment gives rise to the dilemma.

It might seem that a way out of the dilemma is to leave the decision as to whether therapy was successful or not with the client. Another set of problems accompanies this attractive solution. Clients may well decide, and declare, that therapy served no purpose, or was useless, or was a waste of time (or all three) and, perhaps as a consequence of such strong affect (e.g., Farrelly & Brandsma, 1974), change the behaviour they sought to change through therapy. Indeed, several therapeutic strategies have been developed and used with the specific intention of leaving the client in a state of confusion or frustration as a precursor to change (e.g., Bergantino, 1975; Cade, 1982; Erickson, 1964; Farrelly & Brandsma, 1974; Papp, 1980; Swann, Pelham & Chidester, 1988; Watzlawick, 1977; Watzlawick, Weakland & Fisch, 1974). It seems rather precarious, then, to judge the effectiveness of therapy based solely on clients' estimations.

Perhaps combining clients' and therapists' appraisals of therapy effectiveness might allay some of the problems discussed. In another way, this simply confounds the issue: Putting together two opinions, neither of which can be shown to sustain even the rigour of its own definition. Nevertheless, of the three available options, the combined approach seems the best because it affords the possibility of agreement between the interactants. Agreement is not a guarantee of accuracy, but it does provide more evidence than a single appraisal:

> outcome measurement needs to encompass as much consensus among sources of evaluation (e.g., therapists, patients, independent judges) as possible (Berzins, 1977, p.245)

Discussion of the behavioural change versus attitude change debate is beyond the scope of the present work; however, while not questioning the credibility of the attitude change hypothesis - and mindful of the strong case to be made for attitude change underpinning behavioural change - it can be noted that, in terms of assessing success, behavioural changes are more readily detectable than are the latter. More than 300 years ago it was put that "we shall never err if we give our assent only to what we clearly and distinctly perceive" (Descartes, 1637, p.181). However, it also is clear that what is perceived by one person is not necessarily perceived by another and,

more directly, the observation and monitoring of *in vivo* behaviour does not guarantee, in and of itself, the wide acceptance of what is subsequently revealed as an example of what therapeutic success might look like, or even that the methods employed to gather such data were appropriate to the end. The more general point to be made here can be summarized as follows:

> Although self-report has its limitations as a source of evaluation of success, it remains the least equivocal method of assessing the client's feelings about and perceptions of the counselor and the process of counseling (Mendelsohn & Rankin, 1969, p.160)

In a less than helpful or clarifying observation, Dorn (1984c) commented that "Counseling researchers are misleading themselves when they utilize client satisfaction as a criterion for successful counseling outcome. In essence they are equating satisfaction and success when, in fact, successful counseling outcome may be marked by initial dissatisfaction" (p.164). Although it seems likely that the latter point has accuracy, Dorn does not offer an alternative explanation or definition of the meaning of therapeutic success or how it might otherwise be conceptualized, but goes on to encourage the study of those clients who discontinue therapy as a way of "examining the threat that runs through" (p.164) the issue of successful therapeutic outcome and a number of other therapy issues.

Similarly, Berzins' (1977) closing comment that there exists a need to balance the extent to which client-therapist matching can add to clinical outcomes against replacing less competent with more competent therapists, seems to beg the question of how such competence is to be established. The difficulties that arise from such a determination relate in a similar way to the issue of success as addressed above.

Concerning the determination of success, the present discussion prompts consideration of another option and, regarding the appraisal of therapy, was the one adopted in the present work. Namely, that it matters less whether success can be *objectively* demonstrated to have taken place, than whether it is *believed* or *experienced* by clients and/or therapists to have, *in their realities*, taken place. Ignoring the fact that objective assessment presents itself as an impossible feat (given that when any person makes a judgment that person is, by definition, engaged in a *subjective* enterprise), if the client and therapist are satisfied with the therapeutic outcome, *at any given point in time* - and this time should be determined *a priori* - then further justification or elaboration or determination seems superfluous. Rather than seeking a *generally accepted* definition of what successful therapy entails, the *particular* definition

is sought. By way of elucidation, to further the example of the suicide case offered above, on the facts given, the case seems a monumental therapeutic failure, even though, had they been requested to do so, the client and/or therapist may have rated the therapy as successful. If, on the other hand, it was learned that upon arriving home after the final therapy session the client heard that his family had been killed in an accident, a different complexion is cast upon the suicide and the role therapy might have played in it. The client had the information needed to make some sense of the event, although others did not.

Strong (1970) delineated an issue pertinent to the present discussion via a succinct description of what can be regarded as restrictive forces which constrain therapist-originated persuasive messages from achieving more than a metered change in client behaviour (also Dill-Standiford, Stiles & Rorer, 1988; Jones, Cumming & Horowitz, 1988; Kaye, 1983). These forces were considered to be: (1) the therapist's ability to generate clients' beliefs in volition, (2) the therapist's ability to induce clients to comply with suggestions made and (3) the existence of environmental support for clients' new behaviours. The latter point has particular relevance in

the current context. Namely, what occurs in clients' lives outside of therapy is unpredictable and, because it cannot be controlled by the therapist (beyond a measured degree), is rendered beyond the province of continuous assessment, *except* by the client. What remains, as far as the therapeutic context is concerned, is client and therapist assessment: Insofar as no other interactants are involved, and aside from the environment in which therapy takes place, there is little else. For example, to remonstrate that a client did not experience positive effects from a therapeutic intervention in the face of that client protesting the contrary, would appear ludicrous.

The above logic underpinned the opportunities provided for client and therapist evaluations in the research reported in this thesis. Although therapists were asked to rate clients in terms of what they thought clients had gained from therapy, clearly they were, at the same time, rating how well they believed *they* had conducted therapy, or the degree of success likely to accompany their intervention. The current research, then, was concerned with the realities perceived, experienced and denoted by the interactants in a therapeutic event. It was not incumbent upon the author therefore to provide a definition of success or otherwise, only an instrument on which such

judgments could meaningfully (to the clients and therapists) be declared and interpreted. Although such a constructivist stance is not without support (e.g., Watzlawick, 1984), the above examples serve to illustrate the point that until it becomes the usual rather than the exceptional practice to define unequivocally and operationally the concepts employed and subsequently examined in therapy research, disparate and often irreconcilable findings will continue to follow.

In closing, nearly 25 years ago, Deutsch and Krauss (1965) [cited in Rosnow & Robinson, 1967, p.301] commented that:

> In the present state of development of social psychology, no one is ever 'right' for very long. The life span of any theory is short. By its very provocativeness and bold generalization, Festinger's work stimulates the research which will create new ideas, some of which constitute a more systematic development of ideas he first brought to life. (p.76)

Although recognizing abandonment of the need to be *right* as desirable (Frederick, 1976), it is contended here that these same sentiments hold true today, in particular - as have been delineated in the current work - with reference to the pioneering initiatives provided by Bem, Constantinople, Schutz, Spence, Strong, and their associates. Rather than their sometimes clashing doctrines

symbolizing a disaster for the field (terms borrowed from Ard, 1975), they introduce the opportunity for refinement and in so doing facilitate even more novel ways of viewing the social world of humans (Morawski, 1985).

As noted in Chapter 1, Mendelsohn and Rankin (1969) stated that "Effective [client-therapist] matching ... is a feasible and practicable way to facilitate favorable clinical outcomes" (p.163). At this point it seems apparent that the search for the single predictor which will make client-therapist matching profitable appears akin to the search for the single score which will adequately describe need compatibility or the single score sufficient to delineate sex-role orientation. The answer to each quest also seems similar: Humans are more complex than these attempted solutions allow. "The scientific method alone is clearly not a surefire means of unscrambling the complex intermixing of biological, individual, contextual, and cultural inputs that structure our views of the world around us" (Reinisch, Rosenblum & Sanders, 1987, p.4; cf., also Kiesler & Goldston, 1988). Pentony (1971) put it thus:

> Although the therapist starts with the advantages of differential status and a definition of the relationship in his favour, the actual working out of his encounter with the client over days, months, or years is a highly complex interpersonal process, much too powerful in its impact to be determined by some understandings arrived at in advance. Moreover it is a changing relationship for

> ideally the client will move toward a position of independence of the therapist. (p.13)

The central intent of this work was to contribute to the knowledge base of the social influence theory of therapy by formulating a predictive model of therapy estimation based on the constructs of need and androgyny and drawing from the client-therapist matching literature and the need complementarity/similarity hypotheses. The present findings permit the conclusion that, insofar as they pertain to the elucidation of factors significant in the *prediction* of therapy assessment, the utility of the propositions described appear minimal and, to the extent that a predictive model of therapy assessment could not be derived, the work did not achieve its end. However, that several models were developed, each with a high degree of ecological validity and each delineating variables important in significantly influencing the manner in which clients and therapists evaluate therapy, the merit of the project is substantial. Notwithstanding this, together with so much other research in the area, the conclusion of this work is that the explication of social influence theory, at least as it relates to variables predictive of client-therapist appraisals of therapy, awaits additional exploration.

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APPENDICES

Appendix 1

Worked Example of the Anomaly Accompanying FIRO-B Need Measurement when the Originator Compatibility Formula is Considered a Real Number Equation

In each of the Inclusion, Control, and Affection areas,

Reciprocal compatibility is measured by:

$$rK_{ij} = |e_i - w_j| + |e_j - w_i|$$

Originator compatibility is measured by:

$$oK_{ij} = (e_i - w_i) + (e_j - w_j)$$

Interchange compatibility is measured by:

$$xK_{ij} = |(e_i + w_i) - (e_j + w_j)|$$

and *Total compatibility* is measured by:

$$K = rK^{inc} + rK^{con} + rK^{aff} + oK^{inc} + oK^{con} + oK^{aff} + xK^{inc} + xK^{con} + xK^{aff}$$

Where:
e = expressed behaviour
w = wanted behaviour
ij = subjects
inc = inclusion need area
con = control need area
aff = affection need area

Appendix 1 (Contd.)

Worked Example of the Anomaly Accompanying FIRO-B Need Measurement when the Originator Compatibility Formula is Considered a Real Number Equation

Consider the following FIRO-B scores of persons *i* and *j*:

	Person *i*			Person *j*		
	I	C	A	I	C	A
e	9	9	9	9	9	9
w	0	0	0	0	0	0

From the previous formulae,

$$K = 18 + 18 + 18 + 18 + 18 + 18 + 0 + 0 + 0$$

$$= 108$$

= perfect incompatibility

Appendix 1 (Contd.)

Worked Example of the Anomaly Accompanying FIRO-B Need Measurement when the Originator Compatibility Formula is Considered a Real Number Equation

Now consider the following FIRO-B scores of persons *k* and *l*:

	Person *k*			Person *l*		
	I	C	A	I	C	A
e	0	0	0	0	0	0
w	9	9	9	9	9	9

Also from the previous formulae,

$$K = \begin{matrix} 18 & + & 18 & + & 18 & + \\ (-18) & + & (-18) & + & (-18) & + \\ 0 & + & 0 & + & 0 & \end{matrix}$$

$$= 0$$

= perfect compatibility

Appendix 1 (Contd.)

Worked Example of the Anomaly Accompanying FIRO-B Need Measurement when the Originator Compatibility Formula is Considered a Real Number Equation

Where a wanted behaviour score is greater than an expressed score, the *oK* score will be negative and mask incompatibility contributed from other areas which are always positive. The problem can be remedied by computing *oK* as an absolute value. (After Malloy & Copeland, 1980.)

Appendix 3A

The FIRO-B Interpersonal Needs Measure

CITY: _____ (Office Use Only)
(Counsellor: _____)

DATE: _____

NAME: _____

ADDRESS: _____ PHONE: _____

EMPLOYMENT: (please tick) : PART-TIME

FULL-TIME

NOT CURRENTLY EMPLOYED

DIRECTIONS

This questionnaire explores the typical ways you interact with people. There are no right or wrong answers.

Sometimes people are tempted to answer questions like these in terms of what they think a person should do. This is not what is wanted here. What is wanted is what you actually do.

Some items may seem similar to others. However, each item is different, so please answer each one without regard to the others. There is no time limit, but do not debate long over any item.

For each statement below, decide which of the following answers best applies to you. Place the number of the answer in the box at the left of the statement. Please be as honest as you can.

1. never 2. rarely 3. occasionally 4. sometimes 5. often 6. usually

☐ 1. I try to be with people.

☐ 2. I let other people decide what to do.

☐ 3. I join social groups.

☐ 4. I try to have close relationships with people.

☐ 5. I tend to join social organizations when I have an opportunity.

☐ 6. I let other people strongly influence my actions.

☐ 7. I try to be included in informal social activities.

☐ 8. I try to have close, personal relationships with people.

☐ 9. I try to include other people in my plans.

☐ 10. I let other people control my actions.

☐ 11. I try to have people around me.

☐ 12. I try to get close and personal with people.

☐ 13. When people are doing things together I tend to join them.

☐ 14. I am easily led by people.

☐ 15. I try to avoid being alone.

☐ 16. I try to participate in group activities.

For each of the next group of statements, choose one of the following answers:

1. nobody 2. one or two people 3. a few people 4. some people 5. many people 6. most people

☐ 17. I try to be friendly to people.

☐ 18. I let other people decide what to do.

☐ 19. My personal relations with people are cool and distant.

☐ 20. I let other people take charge of things.

☐ 21. I try to have close relationships with people.

☐ 22. I let other people strongly influence my actions.

☐ 23. I try to get close and personal with people.

☐ 24. I let other people control my actions.

☐ 25. I act cool and distant with people.

☐ 26. I am easily led by people.

☐ 27. I try to have close, personal relationships with people.

For each of the next group of statements, choose one of the following answers:

1. nobody 2. one or two people 3. a few people 4. some people 5. many people 6. most people

☐ 28. I like people to invite me to things.

☐ 29. I like people to act close and personal with me.

☐ 30. I try to influence strongly other people's actions.

☐ 31. I like people to invite me to join in their activities.

☐ 32. I like people to act close toward me.

☐ 33. I try to take charge of things when I am with people.

☐ 34. I like people to include me in their activities.

☐ 35. I like people to act cool and distant toward me.

☐ 36. I try to have other people do things the way I want them done.

☐ 37. I like people to ask me to participate in their discussions.

☐ 38. I like people to act friendly toward me.

☐ 39. I like people to invite me to participate in their activities.

☐ 40. I like people to act distant toward me.

For each of the next group of statements, choose one of the following answers:

1. never 2. rarely 3. occasionally 4. sometimes 5. often 6. usually

☐ 41. I try to be the dominant person when I am with people.

☐ 42. I like people to invite me to things.

☐ 43. I like people to act close toward me.

☐ 44. I try to have other people do things I want done.

☐ 45. I like people to invite me to join their activities.

☐ 46. I like people to act cool and distant toward me.

☐ 47. I try to influence strongly other people's actions.

☐ 48. I like people to include me in their activities.

☐ 49. I like people to act close and personal with me.

☐ 50. I try to take charge of things when I'm with people.

☐ 51. I like people to invite me to participate in their activities.

☐ 52. I like people to act distant toward me.

☐ 53. I try to have other people do things the way I want them done.

☐ 54. I take charge of things when I'm with people.

Appendix 3B

Worked Examples Demonstrating Determination of Maximum and Minimum FIRO-B Need Compatibility Scores

Consider the following FIRO-B scores of persons *i* and *j*:

	Person *i*			Person *j*		
	I	C	A	I	C	A
e	9	9	9	9	9	9
w	9	9	9	9	9	9

From the formulae presented in Appendix 1,

$$K = 0 + 0 + 0 + 0 + 0 + 0 + 0 + 0 + 0$$

$$= 0$$

= perfect compatibility

Appendix 3B (Contd.)

Worked Examples Demonstrating Determination of Maximum and Minimum FIRO-B Need Compatibility Scores

Now consider the following FIRO-B scores of persons *k* and *l*:

	Person *k*			Person *l*		
	I	C	A	I	C	A
e	9	9	9	9	9	9
w	0	0	0	0	0	0

From the same formulae,

$$K = 18 + 18 + 18 + 18 + 18 + 18 + 0 + 0 + 0$$

$$= 108$$

= perfect incompatibility

Appendix 3C

The Personal Attributes Questionnaire

QUESTIONNAIRE (PAQCLT 1)

The items below inquire about what kind of a person you think you are. Each item consists of a pair of characteristics, with the letters A-E in between.

For example:

Not at all artistic A....B....C....D....E Very artistic

Each pair describes contradictory characteristics - that is, you cannot be both at the same time, such as very artistic and not at all artistic.

The letters form a scale between the two extremes. You are to choose a letter which describes where you fall on the scale. For example, if you think you have no artistic ability, you would choose A. If you think you are pretty good, you might choose D. If you are only medium, you might choose C, and so forth.

Please circle your answer to each item.

1.	Not at all aggressive	A....B....C....D....E	Very aggressive
2.	Not at all independent	A....B....C....D....E	Very independent
3.	Not at all emotional	A....B....C....D....E	Very emotional
4.	Very submissive	A....B....C....D....E	Very dominant
5.	Not at all excitable in a major crisis	A....B....C....D....E	Very excitable in a major crisis
6.	Very passive	A....B....C....D....E	Very active
7.	Not at all able to devote self completely to others	A....B....C....D....E	Able to devote self completely to others
8.	Very rough	A....B....C....D....E	Very gentle
9.	Not at all helpful to others	A....B....C....D....E	Very helpful to others
10.	Not at all competitive	A....B....C....D....E	Very competitive
11.	Very home oriented	A....B....C....D....E	Very worldly

Appendix 3C (Contd.)

The Personal Attributes Questionnaire

12. Not at all kind	A....B....C....D....E	Very kind
13. Indifferent to others' approval	A....B....C....D....E	Highly needful of others' approval
14. Feelings not easily hurt	A....B....C....D....E	Feelings easily hurt
15. Not at all aware of feelings of others	A....B....C....D....E	Very aware of feelings of others
16. Can make decisions easily	A....B....C....D....E	Has difficulty making decisions
17. Gives up very easily	A....B....C....D....E	Never gives up easily
18. Never cries	A....B....C....D....E	Cries very easily
19. Not at all self-confident	A....B....C....D....E	Very self-confident
20. Feels very inferior	A....B....C....D....E	Feels very superior
21. Not at all understanding of others	A....B....C....D....E	Very understanding of others
22. Very cold in relations with others	A....B....C....D....E	Very warm in relations with others
23. Very little need for security	A....B....C....D....E	Very strong need for security
24. Goes to pieces under pressure	A....B....C....D....E	Stands up well under pressure

I agree to a questionnaire being posted-out to me 3-months following my final counselling interview,

SIGNED: _____

THANK YOU FOR YOUR CO-OPERATION

Appendix 3D

Items Comprising Howard, Orlinsky and Hill's (1970) Patient Satisfaction Questionnaire

"I feel that I got":

I. CATHARSIS

1. A chance to let go and get things off my chest.
3. Help in talking about what was really troubling me.
4. Relief from tensions or unpleasant feelings.

II. MASTERY-INSIGHT

5. More understanding of the reasons behind my behavior and feelings.
8. More ability to feel my feelings, to know what I really want.
9. Ideas for better ways of dealing with people and problems.
11. Better self control over my moods and actions.
12. A more realistic evaluation of my thoughts and feelings.

III. ENCOURAGEMENT

2. Hope: a feeling that things can work out for me.
6. Reassurance and encouragement about how I'm doing.
7. Confidence to try to do things differently.
10. More of a person-to-person relationship with my therapist.

IV. NOTHING

13. Nothing in particular: I feel the same as I did before the session.

Appendix 3E

The Client Perception Questionnaire (CPQ1)

CITY: _____

DATE: _____

NAME: _____

QUESTIONNAIRE (CPQ-1)

This questionnaire asks you to describe what you think happened in the counselling session which you just completed. There are no right or wrong answers. Please circle the number on the scale, from 1 to 6, which best expresses how you feel about each statement. Please try to answer every item, even if you are unsure.

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

	(DISAGREE)					(AGREE)
1. I had more ability to feel my feelings.	1	2	3	4	5	6
2. I was not given enough opportunity to express myself.	1	2	3	4	5	6
3. The counsellor gave me the confidence to do things differently.	1	2	3	4	5	6
4. I had more of a person-to-person relationship with my counsellor.	1	2	3	4	5	6
5. I did not like the counsellor I had.	1	2	3	4	5	6
6. I got better self-control over my actions.	1	2	3	4	5	6
7. I discovered what I really want.	1	2	3	4	5	6
8. I took the chance to let go and get things off my chest.	1	2	3	4	5	6

Appendix 3E (Contd.)

The Client Perception Questionnaire (CPQ1)

(CPQ1)	(DISAGREE)					(AGREE)
9. Counselling did not reduce the conflict between myself and my (ex)spouse.	1	2	3	4	5	6
10. I was more able to realistically evaluate my thoughts.	1	2	3	4	5	6
11. The counsellor did not seem to understand me.	1	2	3	4	5	6
12. The counsellor reassured and encouraged me about how I'm doing.	1	2	3	4	5	6
13. The counsellor gave me hope, a feeling that things will work out for me.	1	2	3	4	5	6
14. I felt relief from tension or unpleasant feelings.	1	2	3	4	5	6
15. I do not think that I will do anything differently as a result of counselling.	1	2	3	4	5	6
16. Counselling helped me to resolve some of my problems.	1	2	3	4	5	6
17. I talked about what was really troubling me.	1	2	3	4	5	6
18. I discovered ideas for better ways of dealing with people and problems.	1	2	3	4	5	6
19. I understood the reasons behind my behaviour.	1	2	3	4	5	6
20. Counselling has not changed the way I feel.	1	2	3	4	5	6
21. Nothing in particular happened. I have the same problems as I did before the counselling session.	1	2	3	4	5	6

PLEASE TURN THE PAGE

Appendix 3F

The Client Satisfaction Questionnaire (CSQ)

CITY: _____

DATE: _____

NAME: _____

QUESTIONNAIRE (CSQ)

This questionnaire asks you to describe what you think you got out of counselling overall. There are no right or wrong answers. Please circle the number on the scale, from 1 to 6, which best expresses how you feel about each statement. Please try to answer every item, even if you are unsure.

1 = Strongly Disagree	4 = Slightly Agree
2 = Moderately Disagree	5 = Moderately Agree
3 = Slightly Disagree	6 = Strongly Agree

	(DISAGREE)					(AGREE)
1. I was more able to realistically evaluate my thoughts.	1	2	3	4	5	6
2. Counselling has not changed the way I feel.	1	2	3	4	5	6
3. I had a person-to-person relationship with my counsellor.	1	2	3	4	5	6
4. The counsellor gave me the confidence to do things differently.	1	2	3	4	5	6
5. The counsellor did not seem to understand me.	1	2	3	4	5	6
6. I felt relief from tension or unpleasant feelings.	1	2	3	4	5	6
7. I got better self-control over my actions.	1	2	3	4	5	6

Appendix 3F (Contd.)

The Client Satisfaction Questionnaire (CSQ)

(CSQ)	(DISAGREE)					(AGREE)
8. I discovered ideas for better ways of dealing with people and problems.	1	2	3	4	5	6
9. The counsellor reassured and encouraged me about how I was doing.	1	2	3	4	5	6
10. I was not given enough opportunity to express myself.	1	2	3	4	5	6
11. I took the chance to let go and get things off my chest.	1	2	3	4	5	6
12. I did not like the counsellor I had.	1	2	3	4	5	6
13. I discovered what I really want.	1	2	3	4	5	6
14. The counsellor gave me hope, a feeling that things will work out for me.	1	2	3	4	5	6
15. Counselling helped me to resolve some of my problems.	1	2	3	4	5	6
16. I do not think that I will do anything differently as a result of counselling.	1	2	3	4	5	6
17. I talked about what was really troubling me.	1	2	3	4	5	6
18. I had more ability to feel my feelings.	1	2	3	4	5	6
19. Counselling did not reduce the conflict between myself and my (ex)spouse.	1	2	3	4	5	6
20. I understood the reasons behind my behaviour.	1	2	3	4	5	6
21. Nothing in particular happened. I have the same problems as I did before counselling.	1	2	3	4	5	6

PLEASE TURN THE PAGE

Appendix 3G

The Counselor Perception Questionnaire (CPQ2)

CITY: _____

DATE: _____

COUNSELLOR NAME: _____

NAME OF CLIENT THIS FORM SCORED FOR: _____
(1 form per individual client)

QUESTIONNAIRE (CPQ-2)

This questionnaire asks you to describe what you think happened in counselling with the client(s) you just interviewed. (1 form per individual client.) Please circle the number on the scale, from 1 to 6, which best expresses how you feel about each statement.

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

	(DISAGREE)					(AGREE)
1. S/he took the chance to let go and get things of his/her chest.	1	2	3	4	5	6
2. There was not enough opportunity for this client to express him/herself.	1	2	3	4	5	6
3. I gave him/her hope, a feeling that things would work out for him/her.	1	2	3	4	5	6
4. S/he talked about what was really troubling him/her.	1	2	3	4	5	6
5. S/he felt relief from tension or unpleasant feelings.	1	2	3	4	5	6
6. S/he understood the reasons behind his/her behaviour.	1	2	3	4	5	6

Appendix 3G (Contd.)

The Counselor Perception Questionnaire (CPQ2)

(CPQ1)	(DISAGREE)					(AGREE)
9. Counselling did not reduce the conflict between myself and my (ex)spouse.	1	2	3	4	5	6
10. I was more able to realistically evaluate my thoughts.	1	2	3	4	5	6
11. The counsellor did not seem to understand me.	1	2	3	4	5	6
12. The counsellor reassured and encouraged me about how I'm doing.	1	2	3	4	5	6
13. The counsellor gave me hope, a feeling that things will work out for me.	1	2	3	4	5	6
14. I felt relief from tension or unpleasant feelings.	1	2	3	4	5	6
15. I do not think that I will do anything differently as a result of counselling.	1	2	3	4	5	6
16. Counselling helped me to resolve some of my problems.	1	2	3	4	5	6
17. I talked about what was really troubling me.	1	2	3	4	5	6
18. I discovered ideas for better ways of dealing with people and problems.	1	2	3	4	5	6
19. I understood the reasons behind my behaviour.	1	2	3	4	5	6
20. Counselling has not changed the way I feel.	1	2	3	4	5	6
21. Nothing in particular happened. I have the same problems as I did before the counselling session.	1	2	3	4	5	6

PLEASE TURN THE PAGE

Appendix 4A

Study 1 Information and Request to Clients

YOUR VOLUNTARY PARTICIPATION IN THIS PROJECT WOULD BE GREATLY APPRECIATED

It is now 10 years since the Family Court Counselling Service began its operation. The Service is constantly reviewing its practices in efforts to become more effective and research is often undertaken to guide these efforts.

The present research is concerned with what helps to make counselling effective. It is part of a large-scale 3-year study which will seek the co-operation of hundreds of Family Court clients and is sponsored by the Family Court and supervised through the Australian National University.

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This phase of the research consists of the attached before-counselling questions, which take about 20 minutes to complete. (Your Counsellor has allowed for the time it will take you to finish the questions.)

Obviously, without the help of clients and counsellors in research, it is impossible to determine what, if anything, needs to be changed in the way in which service is provided.

THIS PROJECT PROVIDES AN OPPORTUNITY FOR YOU TO CONTRIBUTE TOWARD AN UNDERSTANDING OF WHAT HELPS TO MAKE COUNSELLING EFFECTIVE AND, AS A RESULT, TO BENEFIT FUTURE CLIENTS.

PLEASE HAVE YOUR SAY

(TURN THE PAGE TO BEGIN THE QUESTIONNAIRE)

Appendix 4B

Product-Moment Correlations among Client Ratings of Therapist Sex-Role Orientations and Client Demographic and Related Data

Client Variables	Therapist Sex-Role Orientations[a] A	M	F
Age	-.02	-.02	-.02
Gender	-.08	-.08	-.09
Country of Origin			
Americas	.08	-.03	-.01
Asia	.08	.07	-.02
Australia	-.09	.00	-.08
Europe	.06	-.05	.08
Oceania	-.02	09	.05
Occupation			
Corrective Services	.04	-.03	.04
Customer Services	-.03	.05	.00

(n = 210)

Note. Where n = 210, $r_{.05}$ = .13

[a] A=Androgynous, M=Masculine, F=Feminine description

(*table continues*)

Appendix 4B (Contd.)

Product-Moment Correlations among Client Ratings of Therapist Sex-Role Orientations and Client Demographic and Related Data

Client Variables	Therapist Sex-Role Orientations[a] A	M	F
Home Duties	.03	-.01	-.06
Manager	.00	.01	-.03
Professional	-.09	-.06	-.07
Tradesperson	.01	-.01	.01
Unemployed	.09	.05	.10
Unskilled	-.01	.00	-.05
Couple or Individual	-.06	.05	.05
Referral Source			
Helping Agency	-.05	-.04	-.04
Judge	.12	.02	-.01
Registrar	-.06	-.01	-.07
Self	-.01	.03	.13

(n = 210)

Note. Where n = 210, $r_{.05}$ = .13

[a] A=Androgynous, M=Masculine, F=Feminine description

(*table continues*)

Appendix 4B (Contd.)

Product-Moment Correlations among Client Ratings of Therapist Sex-Role Orientations and Client Demographic and Related Data

Client Variables	Therapist Sex-Role Orientations[a] A	M	F
Solicitor	-.07	-.03	-.03
Number of Children	.04	.03	-.01
Does Client have Custody of			
All Children	.06	.05	.08
Nil Children	-.08	-.17	-.16
None of Children	-.02	.07	.02
Some of Children	.00	.00	.03
Separated	.04	.02	.08
Number of Marriages	.12	.16	.15
Previous Therapy	.07	.08	.06
Contacted a Solicitor or Not	-.03	-.05	-.06

(n = 210)

Note. Where n = 210, $r_{.05}$ = .13

[a] A=Androgynous, M=Masculine, F=Feminine description

Appendix 5A

Study 2 Information and Request Sent to Therapists

Dear

My name is Dean McKinnon and I have worked as a Court Counsellor since 1982 in the Newcastle and Sydney Registries. I am currently on Study Leave from my position as Court Counsellor in the Sydney Registry and attend the Australian National University where I am conducting a research project into aspects of Family Court Counselling. The project, approved by the Chief Judge's Research Committee, has thus far involved forty Court Counsellors from four Registries in NSW and the ACT. Broadly, I am interested in Counsellor/Client variables and their relationship to counselling outcomes.

In this phase of the project, I am contacting all Court Counsellors Australia-wide and urging them to complete and return, anonymously, the attached 5-minutes-to-complete questionnaire. (A pre-paid return envelope is provided.)

Appendix 5A (Contd.)

Study 2 Information and Request Sent to Therapists

To safeguard against unwittingly setting-up expectations, which, in turn, could influence responses, there is little comment I can make concerning the attached questionnaire, except to note that all responses to it will be treated in the strictest of confidence, in accordance with Family Court Research guidelines. When results of the studies have been compiled they will be widely disseminated and, in any event, will be available upon request.

To date, the questionnaire return rate from Court Counsellors is 100%. I am striving to maintain this rate. Please assist the endeavour and make your contribution towards a project designed to investigate factors which may significantly influence counselling outcomes, by completing and returning the questionnaire.

If you have any questions or comments re the questionnaire, or the project in general, please contact me on the above number or at the above address.

Appendix 5B

Product-Moment Correlations among Therapist Sex-Role Orientation Scores and Demographic and Related Data

Variables	Scales[a] M	F	M-F
Age	.04	-.10	.29
Gender	.03	.05	.08
Profession	.28	.06	-.16
Full-Time Training in Therapy	.09	-.04	-.02
Part-Time Training in Therapy	.01	.02	-.11
Full-Time Practice of Therapy	.01	-.13	.06
Full-Time Practice of Family Court Counselling	.10	-.14	.22
City			
A	.00	.18	-.08
B	.04	.03	-.02
C	.01	-.06	.09
D	.06	-.19	-.08

(n = 96)

Note. Where n = 96, $r_{.05}$ = .20

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

Appendix 6A

Study 3 Information and Request to Clients

YOUR VOLUNTARY PARTICIPATION IN THIS PROJECT WOULD BE GREATLY APPRECIATED

It is now 10 years since the Family Court Counselling Service began its operation. The Service is constantly reviewing its practices in efforts to become more effective. Research is often undertaken to guide these efforts.

The present research is concerned with what helps to make counselling effective. It is part of a large-scale 3-year study which will seek the co-operation of hundreds of Family Court clients and is sponsored by the Family Court and supervised through the Australian National University.

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The research is divided into three parts:

A. The attached before-counselling questions (which take about 20 minutes to complete).

B. Questions after the final counselling interview (about 15 minutes to complete), and

C. Questions posted out to you 3-months after the final counselling interview (about 15 minutes to complete).

(Your Counsellor has allowed for the time it will take you to complete the before- and after-counselling questions.)

Obviously, without the help of clients and counsellors in research, it is impossible to determine what, if anything, needs to be changed in the way in which service is provided.

THIS PROJECT PROVIDES AN OPPORTUNITY FOR YOU TO CONTRIBUTE TOWARD AN UNDERSTANDING OF WHAT HELPS TO MAKE COUNSELLING EFFECTIVE, AS WELL AS AN OPPORTUNITY TO GIVE YOUR IMPRESSION OF THE EFFECTIVENESS OF THE PRESENT COUNSELLING SERVICE.

PLEASE HAVE YOUR SAY

(TURN THE PAGE TO BEGIN THE QUESTIONNAIRE.)

Appendix 6B

Memo to City B Therapists

Perusal of the questionnaires completed thus far reveal the following facts:

COUNSELLOR	NUMBER OF CLIENTS SEEN	NUMBER OF COUNSELLOR/ CLIENT EVALUATION QUESTIONNAIRES COMPLETED
A	27	0
B	13	1
C	12	1
D	12	6
E	10	1

While some of the 65 clients who have not completed an evaluation questionnaire nor had an evaluation questionnaire completed on them may not yet have had their final counselling interview, many probably have.

Without the 5-minutes-to-complete evaluation questionnaires (the only fixed counsellor commitment in the entire project) there is no purpose to the research and clients' time is being wasted in completing the initial questionnaire. Furthermore, without the evaluation questionnaires, nothing can be communicated to interested clients concerning results of the project.

The Family Court already has an image problem of some significance. Credibility of the Counselling Service will not be enhanced by at first offering our clients something and then demonstrating an unwillingness to deliver it.

YOUR CO-OPERATION IS AGAIN REQUESTED IN GETTING THE EVALUATION QUESTIONNAIRES COMPLETED

Appendix 6C

Study 3 Follow-Up Information and Request to Clients

DEAR _____ .

This is the final questionnaire of a project being conducted by the Family Court Counselling Service in which you took part about 3 months ago.

You will remember that the project is being conducted in three evaluation phases, consisting of: (1) pre-counselling measures,
(2) post-counselling measures, and
(3) 3-months-follow-up measures.

The attached questionnaire constitutes the 3rd evaluation phase measure and, when results of the project have been compiled, they will be available upon request.

In order to determine your long-term satisfaction, or otherwise, with Family Court Counselling, it is essential that the questionnaire be completed and returned (in the pre-paid envelope supplied).

This is an opportunity for you to contribute your experience of the counselling you received at the Family Court to a project designed to investigate what helps make counselling effective and, thereby, benefit not only the Counselling Service, but also the clients who use it.

WE VALUE YOUR COMMENTS. SO PLEASE, HAVE YOUR SAY

Appendix 6D

Corrected Item-Total Correlations for Each Item on the Fundamental Interpersonal Relations Orientation - Behavior Scale, Based on Client Responses

Scale Items[a]	Item-Total Correlations	Scale Items	Item-Total Correlations
EI 1	.15	WI 4	.53
EI 2	.27	WI 5	.57
EI 3	.28	WI 6	.34
EI 4	.28	WI 7	.45
EI 5	.26	WI 8	.56
EI 6	.03	WI 9	-
EI 7	.36	EC 1	.21
EI 8	.18	EC 2	.20
EI 9	.25	EC 3	.09
WI 1	.54	EC 4	.13
WI 2	-	EC 5	.11
WI 3	.55	EC 6	.12

(n = 693)

Note. - = item has zero variance

[a] EI=Expressed Inclusion, WI=Wanted Inclusion

[a] EC=Expressed Control

(*table continues*)

Appendix 6D (Contd.)

Corrected Item-Total Correlations for Each Item on the Fundamental Interpersonal Relations Orientation - Behavior Scale, Based on Client Responses

Scale Items[a]	Item-Total Correlations	Scale Items	Item-Total Correlations
EC 7	.19	EA 1	.38
EC 8	.12	EA 2	.43
EC 9	.17	EA 3	.26
WC 1	.20	EA 4	.24
WC 2	.24	EA 5	-
WC 3	.18	EA 6	.30
WC 4	.20	EA 7	.36
WC 5	.22	EA 8	.25
WC 6	.18	EA 9	.41
WC 7	.20	WA 1	.47
WC 8	.18	WA 2	.48
WC 9	.15	WA 3	.41

(n = 693)

Note. - = item has zero variance

[a] EC=Expressed Control, WC=Wanted Control

[a] EA=Expressed Affection, WA=Wanted Affection

(*table continues*)

Appendix 6D (Contd.)

Corrected Item-Total Correlations for Each Item on the Fundamental Interpersonal Relations Orientation - Behavior Scale, Based on Client Responses

Scale Items[a]	Item-Total Correlations	Scale Items	Item-Total Correlations
WA 4	.29	WA 7	.23
WA 5	.27	WA 8	.50
WA 6	.40	WA 9	.29

(n = 693)

[a] WA=Wanted Affection

Appendix 6E

Analyses of Variance between Client Need Scores and Demographic and Related Data

FIRO-B Sub-Scale	Source	*df*	*SS*	*F*
Wanted Inclusion	Years Married	4	101.95	2.48*
	Error	608	6250.47	
Expressed Control	City	3	35.60	3.44*
	Error	646	2226.26	
	Sex	1	108.65	32.70**
	Error	648	2153.21	
	Who has the Children	3	52.14	5.25**
	Error	537	1777.37	
	Previous Therapy	1	15.20	4.39*
	Error	648	2246.66	
	Occupation	7	145.52	6.81**
	Error	570	1740.75	
Wanted Control	Solicitor Contacted	1	18.44	3.85*
	Error	656	3134.42	
Expressed Affection	City	3	50.72	3.76**
	Error	658	2958.99	
Wanted Affection	Age	4	57.07	2.90*
	Error	582	2862.03	
	Years Married	4	54.03	2.73*
	Error	607	3058.90	

*$p<.05$ **$p<.01$

Appendix 6F

Product-Moment Correlations among Client Need Scores and Demographic and Related Data

Variables	Sub-Scales[a] eI	wI	eC	wC	eA	wA
Age	.05	-.10	.11	.01	.05	.10
Gender	-.00	.03	.21	-.02	-.04	-.05
Country of Origin						
Americas	.04	.07	-.05	-.04	.03	.03
Asia	.06	.04	-.03	.02	.02	.02
Australia	-.04	.05	.00	-.02	-.04	.03
Europe	.03	-.06	.04	.01	.03	-.02
Oceania	-.02	-.05	-.06	.04	-.02	-.04
Occupation						
Corrective Services	-.01	.00	.03	.00	-.02	.00
Customer Services	.02	-.02	.00	.04	-.04	-.03

(n = 680)

Note. Where n = 680, $r_{.05}$ = .08

[a] e=Expressed behaviour, w=Wanted behaviour
I=Inclusion, C=Control, A=Affection

(*table continues*)

Appendix 6F (Contd.)

Product-Moment Correlations among Client Need Scores and Demographic and Related Data

Variables	Sub-Scales[a] eI	wI	eC	wC	eA	wA
Home Duties	.00	.03	-.12	.00	.06	.07
Manager	-.02	-.01	.20	-.01	-.01	-.05
Professional	.09	.02	.04	.08	.05	.03
Tradesperson	.00	.02	.01	-.06	-.03	-.02
Unemployed	-.04	.00	-.07	-.01	-.04	-.01
Unskilled	-.05	-.02	-.05	.02	.02	-.03
Couple or Individual	.06	-.02	.03	.00	-.01	-.01
City						
A	.01	-.07	.01	.01	-.06	-.04
B	-.01	.03	-.06	.01	-.06	-.02
C	-.03	.01	-.07	-.01	-.03	-.05
D	.02	.06	.11	.01	.13	.10

(n = 680)

Note. Where n = 680, $r_{.05}$ = .08

[a] e=Expressed behaviour, w=Wanted behaviour
I=Inclusion, C=Control, A=Affection

(*table continues*)

Appendix 6F (Contd.)

Product-Moment Correlations among Client Need Scores and Demographic and Related Data

Variables	Sub-Scales[a] eI	wI	eC	wC	eA	wA
Referral Source						
Helping Agency	-.02	-.06	-.07	-.02	-.02	-.02
Judge	.02	.04	.00	-.07	.06	.05
Registrar	-.05	.00	.00	.00	-.02	-.02
Self	.03	.04	.07	.09	-.02	.03
Solicitor	.01	-.03	-.03	.02	-.02	-.03
Number of Children	-.01	-.02	.08	.07	.01	.02
Does Client have Custody of						
All Children	-.04	.01	-.13	-.05	.03	.08
Nil Children	.03	.00	-.04	-.01	.03	-.01
None of Chldn.	.01	.01	.12	.08	.01	-.06
Some of Chldn.	.04	.01	.03	.05	.01	.03

(n = 680)

Note. Where n = 680, $r_{.05}$ = .08

[a] e=Expressed behaviour, w=Wanted behaviour
I=Inclusion, C=Control, A=Affection

(*table continues*)

Appendix 6F (Contd.)

Product-Moment Correlations among Client Need Scores and Demographic and Related Data

Variables	Sub-Scales[a] eI	wI	eC	wC	eA	wA
Separated	-.03	.06	.04	-.02	.01	.00
Number of Marriages	.00	-.05	.08	.01	.07	.09
Previous Therapy	.01	-.01	.08	-.04	.04	.03
Number of Sessions	.04	-.01	.05	.05	.05	.04
Contacted a Solicitor or Not	.02	.02	.00	-.06	.04	.06

(n = 680)

Note. Where n = 680, $r_{.05}$ = .08

[a] e=Expressed behaviour, w=Wanted behaviour
I=Inclusion, C=Control, A=Affection

Appendix 6G

Analyses of Variance between Therapist Need Scores and Demographic and Related Data

FIRO-B Sub-Scale	Source	*df*	*SS*	*F*
Expressed Inclusion	Sex	1	16.22	4.27*
	Error	38	156.82	
Expressed Affection	Court Practice	1	18.18	4.08*
	Error	38	164.95	
Wanted Affection	General Practice	1	20.50	6.51*
	Error	38	113.44	

*$p<.05$ **$p<.01$

Appendix 6H

Product-Moment Correlations among Therapist Need Scores and Demographic and Related Data

Variables	Sub-Scales[a]					
	eI	wI	eC	wC	eA	wA
Gender	.32	.13	.05	.12	.07	.09
Age	-.14	-.17	-.28	-.11	-.07	.03
SW/Psych	-.18	-.08	.01	.07	-.06	.01
Years of Part-Time Training in Therapy	.13	.25	.08	.20	.25	.17
Years of Full-Time Training in Therapy	-.19	-.03	-.06	-.01	-.13	.03
Years of Full-Time Court Counselling	-.08	-.14	.08	-.10	-.32	-.22
Year of Full-Time Practice in Counselling	-.25	-.18	.00	-.13	-.28	-.39
City						
A	.14	.21	-.11	-.16	-.04	.00
B	.05	-.30	-.11	-.09	-.11	-.02
C	-.06	.21	.28	.26	.07	.03
D	-.06	.21	.28	.26	.07	.03

(n = 39)

Note. Where n = 39, $r_{.05}$ = .30

[a] e=Expressed behaviour, w=Wanted behaviour
I=Inclusion, C=Control, A=Affection

Appendix 6I

Analyses of Variance between Client

Sex-Role Orientation Scores and Demographic and Related Data

PAQ Sub-Scale	Source	*df*	*SS*	*F*
Femininity	Number of Children	4	313.57	3.61**
	Error	637	13833.13	
	Previous Therapy	1	175.13	8.15**
	Error	664	14271.13	
	Solicitor Contacted	1	125.78	5.83*
	Error	664	14320.49	
Masculinity	Previous Therapy	1	204.07	8.48**
	Error	665	15995.79	
Masculinity-Femininity	Number of Children	4	358.01	4.99**
	Error	639	11467.09	

*$p<.05$ **$p<.01$

Appendix 6J

Product-Moment Correlations among Client Sex-Role Orientation Scores and Demographic and Related Data

Variables	Scales[a] M	F	M-F
Age	.03	.03	.00
Gender	.05	-.01	.02
Country of Origin			
Americas	-.03	-.09	.05
Asia	.00	.00	.00
Australia	.00	.00	-.04
Europe	.02	.01	.03
Oceania	-.03	00	.01
Occupation			
Corrective Services	.03	.01	-.06
Customer Services	-.02	.06	-.03

(n = 714)

Note. Where n = 714, $r_{.05}$ = .07

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

(*table continues*)

Appendix 6J (Contd.)

Product-Moment Correlations among Client Sex-Role Orientation Scores and Demographic and Related Data

Variables	Scales[a] M	F	M-F
Home Duties	.00	.02	-.05
Manager	-.05	-.05	.01
Professional	-.02	.02	-.01
Tradesperson	.02	-.02	.00
Unemployed	-.04	-.03	.02
Unskilled	.05	-.05	.11
Couple or Individual	.02	.01	.00
City			
A	.00	-.06	.02
B	-.08	-.01	-.09
C	.02	-.03	.09

(n = 714)

Note. Where n = 714, $r_{.05}$ = .07

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

(*table continues*)

Appendix 6J (Contd.)

Product-Moment Correlations among Client Sex-Role Orientation Scores and Demographic and Related Data

Variables	Scales[a] M	F	M-F
D	.05	.05	.00
Referral Source			
Helping Agency	-.02	-.01	.02
Judge	-.03	-.06	.04
Registrar	-.02	-.02	-.03
Self	-.02	.04	-.08
Solicitor	.06	.00	.08
Number of Children	.02	.02	-.06
Does Client have Custody of			
All Children	-.04	-.03	-.01

(n = 714)

Note. Where n = 714, $r_{.05}$ = .07

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

(*table continues*)

Appendix 6J (Contd.)

Product-Moment Correlations among Client Sex-Role Orientation Scores and Demographic and Related Data

Variables	Scales[a] M	F	M-F
Nil Children	-.03	.06	-.09
None of Children	.02	-.01	.01
Some of Children	.05	.00	.01
Separated	-.04	-.07	-.01
Number of Marriages	.03	.05	-.03
Number of Sessions	.04	-.05	.08
Previous Therapy	-.11	-.11	.02
Contacted a Solicitor or Not	.01	-.09	.02

(n = 714)

Note. Where n = 714, $r_{.05}$ = .07

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

Appendix 6K

Corrected Item-Total Correlations for Each Item on the Personal Attributes Questionnaire, Based on Client Responses

Scale Items[a]	Item-Total Correlations
M-F1	.14
M1	.35
F1	.22
M-F2	.28
M-F3	.15
M2	.31
F2	.20
F3	.05
F4	.34
M3	.38
M-F4	.14
F5	.31
M-F5	.19

(n = 642)

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

(*table continues*)

Appendix 6K (Contd.)

Corrected Item-Total Correlations for Each Item on the Personal Attributes Questionnaire, Based on Client Responses

Scale Items[a]	Item-Total Correlations
M-F6	.12
F6	.16
M4	.36
M5	.47
M-F7	.24
M6	.61
M7	.47
F7	.29
F8	.21
M-F8	.15
M8	.53

(n = 642)

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

Appendix 6L

Analyses of Variance between Therapist

Sex-Role Orientation Scores and Demographic and Related Data

PAQ Sub-Scale	Source	*df*	*SS*	*F*
Femininity	Court Practice	1	61.98	7.36**
	Error	38	311.70	
Masculinity-Femininity	Age	1	64.41	4.91*
	Error	38	484.93	

*$p<.05$ **$p<.01$

Appendix 6M

Product-Moment Correlations among Therapist Sex-Role Orientation Scores and Demographic and Related Data

Variables	Scales[a] M	F	M-F
Age	.00	-.15	.34
Gender	.11	.11	.24
SW/Psych	.27	-.04	-.01
Full-Time Training in Therapy	.07	.03	-.05
Part-Time Training in Therapy	.03	.07	-.16
Full-Time Practice of Therapy	-.21	-.29	.19
Full-Time Practice of Family Court Counselling	-.13	-.41	.14
City			
A	-.02	.29	-.09
B	.03	.05	.01
C	-.09	-.05	.13
D	.07	-.20	-.07

(n = 39)

Note. Where n = 39, $r_{.05}$ = .30

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity

Appendix 6N

Product-Moment Correlations among Client Post-Therapy (CPQ1) and Follow-Up (CSQ) Evaluation Items

(n=181)

CSQ ITEMS	CPQ1 ITEMS 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1	**.28**	.15	.24	.27	.16	.14	.21	.35	.08	.24	.22	.41	.35	.30	.07	.17	.24	.19	.19	.18	.20
2	.10	**.22**	.06	.20	.23	-.05	-.05	.27	.05	-.01	.19	.31	.18	.14	.10	.09	.18	-.04	.00	.05	.12
3	.16	.13	**.34**	.27	.25	.17	.21	.28	.21	.25	.24	.41	.32	.30	.29	.26	.25	.32	.24	.27	.29
4	.17	.21	.20	**.48**	.31	-.02	.08	.26	.06	.15	.35	.41	.25	.19	.14	.14	.26	.08	.14	.05	.15
5	.17	.21	.16	.28	**.48**	.01	.02	.21	.00	.12	.31	.37	.31	.17	.16	.13	.14	.22	.03	.17	.15
6	.20	.11	.24	.23	.19	**.27**	.28	.25	.08	.27	.28	.32	.29	.27	.21	.24	.19	.36	.28	.12	.22
7	.18	-.06	.19	.23	.00	.32	**.46**	.24	.09	.39	.09	.23	.28	.19	.07	.31	.16	.35	.23	.07	.18
8	.09	.08	.11	.17	.09	.04	.10	**.39**	.04	.12	.20	.31	.14	.07	.07	.04	.32	.18	.19	-.05	.05
9	.03	.12	.07	.04	.06	.11	.13	.15	**.34**	.05	.10	.00	.09	.28	.24	.37	.11	.15	.09	.31	.39
10	.27	.19	.25	.27	.24	.20	.26	.35	.16	**.34**	.30	.39	.37	.32	.23	.25	.31	.30	.37	.15	.20
11	-.06	.26	.16	.17	.32	-.12	-.07	.12	.12	-.05	**.30**	.24	.12	.11	.18	.16	.13	.08	-.07	.11	.20
12	.11	.14	.23	.26	.26	-.02	.06	.23	.06	.09	.37	**.49**	.34	.25	.21	.23	.20	.11	.13	.22	.24
13	.21	.11	.26	.34	.22	.06	.21	.25	.11	.17	.23	.35	**.38**	.27	.16	.28	.19	.19	.18	.05	.25
14	.23	.13	.29	.17	.19	.24	.24	.25	.24	.23	.21	.27	.27	**.41**	.24	.34	.15	.24	.11	.31	.34
15	.11	.06	.19	.12	.15	.08	.15	.18	.29	.17	.23	.17	.17	.26	**.45**	.34	.14	.26	.18	.40	.35
16	.11	.16	.23	.14	.17	.11	.15	.28	.13	.14	.20	.19	.23	.33	.30	**.36**	.16	.22	.13	.23	.34
17	.12	.27	.11	.17	.20	.01	.00	.37	.08	.07	.25	.35	.17	.09	.07	.14	**.40**	.12	.11	-.07	.10
18	.19	.32	.32	.22	.12	.26	.28	.17	.28	.36	.31	.35	.30	.39	.25	.38	.18	**.44**	.16	.32	.29
19	.04	.07	.06	.07	.17	-.12	.02	.01	-.03	.05	.15	.07	.00	-.02	.02	.04	.00	.06	**.19**	-.08	-.05
20	.04	.10	.12	.08	.00	.11	.22	.17	.28	.14	-.01	.08	.21	.26	.30	.35	.13	.20	.18	**.27**	.20
21	.11	.25	.11	.12	.17	.11	.13	.18	.20	.09	.24	.14	.20	.33	.30	.31	.17	.14	.12	.25	**.31**

Note. Where $n = 181$, $r_{.05} = .146$

Appendix 6O

Paired T-Test Results between the 21 Questions of the Client Post-Therapy and Follow-Up Evaluations for Clients who Completed Both Evaluation Questionnaires

Item[a]	*Mean*	*SD*	*t*
1. CPQ1	4.27	1.33	6.64
CSQ	3.48	1.52	
2. CPQ1	4.43	1.73	1.15
CSQ	4.02	1.83	
3. CPQ1	4.15	1.45	6.90
CSQ	3.22	1.59	
4. CPQ1	4.30	1.40	8.26
CSQ	3.37	1.70	
5. CPQ1	5.32	1.30	3.64
CSQ	4.82	1.54	
6. CPQ1	4.00	1.47	1.97
CSQ	3.55	1.59	
7. CPQ1	3.96	1.74	3.68
CSQ	3.40	1.70	
8. CPQ1	4.07	1.60	0.66
CSQ	3.94	1.68	
9. CPQ1	2.84	1.79	3.82
CSQ	2.21	1.67	
10. CPQ1	4.18	1.39	2.19
CSQ	3.80	1.45	
11. CPQ1	4.85	1.48	4.09
CSQ	4.17	1.76	

(n = 181)

Note. Where n = 181, $t_{.05}$ = .14

[a] CPQ1 = Client Post-Therapy Evaluation Questionnaire

CSQ = Client Follow-Up Evaluation Questionnaire

Appendix 6O (Contd.)

Paired T-Test Results between the 21 Questions of the Client Post-Therapy and Follow-Up Evaluations for Clients who Completed Both Evaluation Questionnaires

Item[a]	*Mean*	*SD*	*t*
12. CPQ1	4.34	1.47	7.24
CSQ	3.59	1.66	
13. CPQ1	4.00	1.66	3.03
CSQ	3.51	1.66	
14. CPQ1	3.81	1.65	1.66
CSQ	3.33	1.69	
15. CPQ1	3.21	1.83	0.49
CSQ	3.01	1.72	
16. CPQ1	4.06	1.62	3.77
CSQ	3.47	1.63	
17. CPQ1	4.56	1.45	1.83
CSQ	4.36	1.49	
18. CPQ1	3.83	1.46	3.26
CSQ	3.37	1.49	
19. CPQ1	4.23	1.53	0.16
CSQ	4.19	1.59	
20. CPQ1	2.95	1.84	1.79
CSQ	2.71	1.67	
21. CPQ1	3.38	1.86	2.55
CSQ	2.89	1.81	
Total Difference	-	-	6.51

(n = 181)

Note. Where n = 181, $t_{.05}$ = .14

[a] CPQ1 = Client Post-Therapy Evaluation Questionnaire

CSQ = Client Follow-Up Evaluation Questionnaire

Appendix 6P

Corrected Item-Total Correlations for Each Item on the Client Follow-Up Questionnaire, Based on Client Responses

Scale Items[a]	Item-Total Correlations
CSQ1	.64
CSQ2	.44
CSQ3	.68
CSQ4	.62
CSQ5	.45
CSQ6	.64
CSQ7	.48
CSQ8	.46
CSQ9	.44
CSQ10	.68
CSQ11	.50
CSQ12	.71
CSQ13	.73
CSQ14	.68

(n = 333)

[a] CSQ = Client Follow-Up Evaluation Questionnaire

(*table continues*)

Appendix 6P (Contd.)

Corrected Item-Total Correlations for Each Item on the Client Follow-Up Questionnaire Based on Client Responses

Scale Items[a]	Item-Total Correlations
CSQ15	.53
CSQ16	.77
CSQ17	.43
CSQ18	.67
CSQ19	.28
CSQ20	.42
CSQ21	.61

(n = 333)

[a] CSQ = Client Follow-Up Evaluation Questionnaire

Appendix 6Q

Means and Standard Errors of Client Sex-Role Orientation Scores from Pre-Therapy, to Post-Therapy, to Follow-Up

Scale[a]	Pre *Means* *(SE)* *n*=280	Post *Means* *(SE)* *n*=280	Follow-Up *Means* *(SE)* *n*=158
M	20.09 (0.29)	20.13 (0.28)	20.82 (0.37)
F	23.88 (0.29)	24.07 (0.26)	24.39 (0.35)
M-F	12.35 (0.24)	12.49 (0.26)	13.01 (0.36)

[a] M=Masculinity, F=Femininity, M-F=Masculinity-Femininity