SATISFACTION WITH THERAPY, EARLY TERMINATION, MISSED SESSIONS, AND PATIENTS' VIEWS OF THEIR THERAPISTS AS A FUNCTION OF PATIENT-THERAPIST PERSONALITY SIMILARITY.

by

Richard John Howes

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ABSTRACT

The present study was designed to investigate the effects of patient-therapist personality similarity on the psychotherapeutic relationship. It was hypothesized that a curvilinear relationship would exist such that when patients and their therapists were moderately similar they would evaluate the relationship significantly more positively than would those patients and their therapists who were either highly similar or highly different. Similarity and difference between patients and their therapists were operationally defined on the basis of the number of personality dimensions (as measured by the Myers-Briggs Type Indicator) which each therapeutic dyad shared in common. This research was also designed to examine the personality types of both therapists and patients utilizing the Psychological Services Centre at the University of Manitoba. Additionally, this research was designed to collect comprehensive therapy outcome data based on the population at this outpatient clinic. All patients and therapists involved in the present study were administered the MBTI prior to treatment, and upon termination both patients and therapists completed questionnaires designed to assess their impressions of each other, levels of improvement, and satisfaction with therapy. Results accorded moderate support to the curvilinear hypothesis on some of the measures including length of therapy and therapists' ratings of

their patients' satisfaction with therapy. It was also observed that when patients and their therapists were extremely different (i.e. they shared not a single one of the four MBTI personality dimensions in common) there was a pronounced tendency for the patients to terminate therapy early and both patients and their therapists evaluated the relationships in a negative fashion. An examination of the personality types of the patient and therapist samples revealed that both groups were quite distinct, both from each other and from the general population. The evaluation of therapy data obtained was interesting in many respects, and it led to the unequivocal conclusion that patients attending the PSC were emminently satisfied with therapy and assessed themselves as having made considerable gains following therapy. These findings were discussed, and the admonition that definitive conclusions should not be drawn without further research involving much larger samples was advanced.

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I would also like to express gratitude and love to my parents for giving me their unending support and encouragement, their wise counsel, and their unconditional love.

Finally, I dedicate this work to Virginia, my wife and the woman whose strength, warmth, and basic human dignity have so often touched and inspired me. If I had but a single wish in my lifetime, I would give it to her with love.

R.J.H.

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CHAPTER 1

INTRODUCTION

Although the infinite wisdom of folklore has long maintained that "opposites attract", the logic that such dissimilarity might enhance the psychotherapeutic process is no more compelling than the logic which suggests that similarity will maximize satisfaction with therapy. An aphorism which is heard at least as often, after all, is that "it takes one to know one". It is certainly not unreasonable to anticipate that therapists who share much in common with their patients may be able to show a greater understanding of and empathy towards them, but it is likewise not unreasonable to expect that an excessive number of shared characteristics may interfere with the therapist's capacity to view the patient as a unique individual.

While the research examining the effects of patient-therapist similarity is extremely limited (see Ross, 1977), possibly reflect-

ing a preoccupation with an exploration of the specific patient and therapist variables which appear to relate to satisfaction with therapy, there has nonetheless been at least some interest maintained over the years in examining the interaction of patient-therapist variables. In particular, patient-therapist similarity on sex, age, race, and other demographic variables has often been studied with relation to satisfaction with therapy. Utilizing the dependent variable of 118 female patients' self-reports of their satisfaction with psychotherapy, Howard, Orlinsky, and Hill (1970) determined that for their sample single women were generally most satisfied with female therapists, either married or unmarried, although single women under 22 did well only with therapists who were young family men. Married women generally reported little satisfaction with male therapists, with the exception of those over 35 who seemed most satisfied with male therapists who were married and of a similar age. One of the strongest findings was that young divorcees (under 28) reported extremely low satisfaction when paired with married male therapists unless those therapists were about the same age. Certainly such results offer support to the concept that the personal characteristics of the patient and therapist who are paired together can influence the reported satisfaction of the patient, with same-sex pairings generally seeming to produce the most rewarding experiences.

Hill (1975) obtained results which lent support to Howard *et al*'s findings when she reported that analysis of taped therapy sessions revealed that same-sex pairings resulted in more empathic and facilitative behavior by the therapists. In an examination of the effect of

sex of patients and therapists on dropout from psychotherapy, on the other hand, Vail (1974) found that his prediction of same-sex pairings resulting in a longer continuation of treatment was not supported. In fact, it was observed that the male patients remained longer with female therapists and female patients remained longer with male therapists, a finding inconsistent with much of the research but nonetheless also suggestive of the fact that the variable of sex is not to be ignored.

The conclusion of these and other studies (Lawless & Nowicki, 1972; Kohan, 1975) has been that matching of patients and therapists by sex has a significant effect on the outcome of therapy, although there is disagreement over whether same-sex or opposite-sex pairings are best. This conclusion is by no means generally accepted, however, and there are at least a similar number of studies which suggest that the variable of sex exerts no influence on the psychotherapeutic process. Goldenholz (1975), for example, who studied a sample of almost 500 patients from two outpatient mental health clinics, arrived at the conclusion that there were no significant differences between same-sex and opposite-sex pairings on any of the dependent variables including: patients' and therapists' ratings of therapeutic outcome; number of therapy sessions; and dropout from psychotherapy.

While race has less often been studied, there have nonetheless been some recent studies which have focused on this variable. In an examination of black therapist-black patient and black therapist-white patient dyads, Merriouns (1975) conducted one of the few studies where therapeutic change was measured on standardized instru-

ments. Utilizing pre- and post-treatment scores from the MMPI, certain subscales from the WAIS, and Trait anxiety scores from the STAI, he concluded that patient-therapist matching by race had no effect on therapeutic outcome insofar as similar improvement was evident in patients in all of the dyads. Interestingly enough, however, Merriouns arrived at some conclusions which suggest that he attended more to a subjective interpretation of therapy tapes, as evidenced by his observation, for example, that "Oedipal transference issues are especially active in the Black therapist-white patient dyad" (p.5647). In a study where both race and sex were examined, Slaughter (1975) also concluded that the variable of race exerted no influence on the therapeutic relationship, as well as obtaining results which revealed that neither sex nor an interaction of the two variables exerted any measurable effect. Vail (1977) came to the similar conclusion that matching by race was an irrelevant variable in his study of factors which influenced remaining in therapy, although his results also indicated that sex was the only variable where patient-therapist similarity exerted a significant effect on continuation in therapy.

In one of the most recent studies examining patient-therapist similarity on other than personality variables, Lasky and Solomone (1977) undertook an analysis of variance on the variables of patient's age, therapist's age, and therapist's status utilizing the dependent variable of rated attraction to the therapist. Results revealed a number of significant and interesting findings (two adjectives which are not necessarily synonymous in research studies), such as the observation that patients under the age of 30 were more attract-

ed to younger, low-status therapists than to any other therapists. Patients over 45 were most attracted to older, high-status therapists, while patients between 30 and 45 showed no significant differences in attraction to any therapists of any status. Certainly these results are not great revelations, for they perhaps merely provide empirical verification for the personal observations of many clinicians, although they are important in that they point out that matching of patients and therapists on these variables should be considered as a potential influence on the therapeutic process.

Given the inconsistency and inconclusiveness of many of the studies examining patient-therapist similarity on demographic variables, it would appear to be unscientific at this time to try and arrive at any specific conclusions which might guide clinical practice. Almost as often as not such variables have been shown to exert no significant influence on the therapeutic process, and attention is perhaps better directed to an examination of the effects of patient-therapist similarity on psychological variables. In this area as well there are inconsistencies, but the majority of studies have concluded that matching of patients and their therapists along certain personality dimensions tends to enhance therapeutic progress.

Among the studies which suggest that such matching exerts no effect, however, Tuma and Gustad's (1957) is one of the earliest published works. Utilizing ten indices of similarity based on certain of the California Personality Inventory scales, and three dependent variables designed to measure learning about self by the patients, a series of 30 Pearson product-moment correlation coefficients was com-

puted. Of these, only a single correlation was modestly significant, indicating an even less-than-chance relationship between patient-therapist similarity and the dependent variables. It should be noted, however, that this conclusion of no relationship is not that which was advanced by the authors, who were apparently unaware of the correct interpretation of a single significant finding in the midst of an overwhelming number of statistically insignificant findings. In a study which examined patient-therapist similarity of self-actualization levels as measured by the Personal Orientation Inventory, Hood (1969) divided both patients and therapists into high and low scoring groups and then paired them so that all possible combinations of dyads were represented. Results revealed no significant differences between any of the groups in terms of self-actualization score gains, and it was concluded that patient-therapist similarity (or dissimilarity) on this dimension was entirely unrelated to psychotherapeutic outcome. Assessing patient-therapist similarity in terms of distance between profiles on the Vocational Preference Inventory, Whittlesey (1972) found no support for his hypothesis that similarity was related to any of the outcome criteria which included: measures of early termination; number of missed sessions; total number of sessions; therapists' ratings of goal achievement; and therapists' ratings of attraction to their patients. Although this is one of the better studies in that it utilized a number of very relevant outcome variables, it is nonetheless unfortunate that patients' perceptions of therapeutic outcome and their attraction to their therapists were not included as additional dependent variables.

Despite such negative findings, Meltzoff and Kornreich's (1970) statement that "we can find no solid evidence that patient-therapist similarity or dissimilarity either aids, abets, or hampers effectiveness" (p.325) would seem to be a much too drastic conclusion in light of more recent research. While such a conclusion may have been appropriate at the time it was written, when as many studies confirmed as disconfirmed the similarity hypothesis, the bulk of recent research is supportive. Swenson (1967) obtained equivocal but nonetheless supportive evidence for his hypothesis that complementarity on the dimensions of dominance-submission and interpersonal approach-avoidance led to a more positive relationship. Gassner (1969) measured patient-therapist similarity on the Fundamental Interpersonal Relationship Orientation scale, and subsequently assigned two patients to each of 24 therapists such that one patient was highly similar and the other quite dissimilar on this dimension.All therapists and their patients completed a questionnaire at the end of the third and eleventh weeks of therapy to assess their satisfaction with the relationship, and it was determined that patients matched with their therapists in terms of similarity had a significantly more favourable view of their therapists at both points in time. Perhaps even more interesting was the finding that while therapists indicated a preference for relating to the highly similar patients after three weeks, at the end of eleven weeks they reported an equal attraction to both similar and dissimilar patients. This might be interpreted as a reassuring finding, for it would be somewhat disheartening to believe that the therapists were unable to overcome whatever initial negative feelings

they may have had.

In a study where interpretation of the results should probably go far beyond that offered by the authors, Welkowitz, Cohen, and Ortmeyer (1967) found support for their hypothesis that the value similarity between therapists and their own patients was greater than the similarity in values between therapists and randomly-selected patients of other therapists. In this study, Welkowitz *et al* used both the Ways To Live scale and the Strong Vocational Interest Blank to obtain an index of value similarity, at least the former of which would appear to be a very apt measure of values. Further results indicated a significant relationship between the extent of patient-therapist value similarity and perception of patient improvement by the therapist. While the authors suggested that there is naturally movement towards similarity in any social interaction in a dyad, this does not explain why the "improved" patients obviously moved closer to their therapists' values than did the "unimproved" patients. This observation should certainly lead to speculation that such changes in values may be inaccurately perceived as therapeutically-derived improvement, a speculation which serves to remind us of the possible dangers inherrent in an entirely subjective assessment of therapeutic progress.

As indicated earlier, the majority of research studies since Metzoff and Kornreich affirmed that similarity exerted no effect on the therapeutic relationship have also rejected this conclusion. Certainly it has long been observed that similarity between friends and even strangers has enhanced the formation of a stronger relationship,

and as Fishbein and Ajzen (1972) stated, "a positive relationship between attraction and similarity of beliefs, values, attitudes, personality characteristics, interests, etc. has been found consistently" (p.513). It is not difficult to generalize this conclusion to include psychotherapeutic relationships, nor would it seem inappropriate to do so. In an examination of the effects of matching patients and therapists on conceptual level (which has been determined to be positively correlated with a number of ego strength, moral maturity, and social competence scales), McLachlan (1972) determined that a large conceptual level gap between patient and therapist resulted in significantly lower ratings of improvement by both the patient and therapist. In the realm of attitude similarity, Beutler, Jobe, and Elkins (1974) found that when patients' and therapists' attitudes were sufficiently similar so that the therapist's attitudes were acceptable to the patient, positive outcome was more likely to occur as measured by the patients' perceptions of therapeutic success. Therapists' perceptions of attitude similarity are likewise important, as evidenced by the results of a study by Good and Good (1976) where ratings were made of ficticious patients who were either similar or dissimilar to the therapists in attitudes. Those patients whose attitudes were similar to the therapists were rated as likely to be more sincere, industrious, and cooperative than those whose attitudes were dissimilar.

Mahrer (1975) examined the effect on therapeutic progress of patient-therapist similarity on the external-internal dimension of interaction, a measure which is quite like the Jungian Extraversion-

Introversion dimension. He concluded that outcome was not affected as much by a patient's location on this dimension as it was by the "goodness of fit" between patient and therapist. Anchor (1977) conducted one of the most recent studies examining the effect of similarity of psychological variables on the therapeutic process, focusing on patient-therapist similarity in terms of personality integration. Extracting information from a number of scales, Anchor attempted an objective measurement of this construct of "personality integration" (a construct which reflected such factors as positive self-concept, stable mood, and internal locus of control). Not surprisingly, he determined that therapy was significantly more likely to be rated as successful (by both the graduate student therapists and their supervisors) when both patient and therapist were high in personality integration. His conclusion that the findings strengthened the argument for systematic matching of patients and therapists on this variable in order to reduce counterproductive therapy may be frivolous, however, in that it at least implies that 'low-level' patients (i.e. low personality integration) should be matched with low-level' therapists for the most productive therapeutic sessions.

Not all of the studies which have concluded that degree of similarity exerts an influence on therapeutic progress have suggested that the benefits lie in matching, and in fact a number have concluded that the importance lies in ensuring that patients and therapists differ on certain dimensions. Lasser's (1961) study was the first to conclude that therapeutic progress was negatively related to similarity between patients' and therapists' self-perceptions, and

that dissimilarity was most productive. Bare (1967) studied the relationships between 47 therapists and over 200 patients, and he concluded that there were areas where dissimilarity enhanced therapeutic progress. His results indicated that patients believed their therapists "got to know them better" when the therapists had higher abasement and lower aggression scores than the patients. Murstein (1971) also asserted that there were times when dissimilarity might be ideal when he suggested that if an individual possesses traits which he evaluates as desirable, he will prefer to interact with someone possessing similar traits. If the individual evaluates his traits negatively, however, he will prefer to interact with someone less similar. Again these results are not very startling, and they appear almost axiomatic. Although Murstein was referring only to general aspects of interpersonal attraction, it is not difficult to relate such conclusions to therapeutic relationships which, although they are not simply 'the purchase of friendship', do certainly follow many of the general 'laws' of relationship building. Further support for the view that dissimilarity may actually enhance the psychotherapeutic process was obtained by Beutler, Johnson, Neville, Elkins, and Jobe (1975), who determined that patient-therapist similarity was inversely related to the therapist's persuasive influence. One might wish to question what is meant by "persuasive influence" and whether or not it is indeed related to therapeutic progress, but it would seem likely that this construct would correlate with such factors as respect for the therapist and attraction towards him, factors which are certainly related to the therapeutic process.

Another focus of exploration, and one which seems to have generated the most research, has involved an examination of the effects of matching patients and therapists on the A-B dimension. This variable was originally reported to denote differences in the clinical style of different therapists' treatment of schizophrenics (Whitehorn & Betz, 1954), with A-type therapists behaving in an active and experiential manner whereas B-types appeared to be more passive when conducting therapy. This original distinction has been supported by more recent research, as evidenced by Segal's (1971) findings that B-therapists tended to be less directive and less interpretive than A-types, and that they typically responded in a manner designed to encourage greater self-exploration by the patient. These and other studies (Stern & Bierman, 1973; Chartier, 1971) suggest that while there is still much disagreement about which of the many scales designed to measure this variable is best, there is nonetheless a legitimate distinction to be made between these types of therapists. Perhaps the most compelling evidence for accepting this distinction comes from the recent study by Geller and Berzins (1976), who had a large sample of prominent psychotherapists complete the original A-B scale. Among those identified as A-therapists (ie. more active and directive) were Lazarus, Patterson, and Rachman, while those identified as B-type therapists included Rogers, Perls, and Truax.

More important than simply identifying therapists on the A-B dimension, however, is the concept of matching patients and therapists on this variable, and an examination of this has been the intent of much of the contemporary research in this area. Berzins,

Friedman, and Seidman (1968) were the first to suggest that complementarity rather than similarity was the important aspect of matching on this dimension. Evidence supporting this view was obtained by Kennedy and Chartier (1976), who found that dissimilarity in A-B scores was associated with more positive ratings of the therapeutic relationship by both patients and objective raters. The authors also noted that similarity in A-B scores was readily perceived by the patients, an observation which lends confirmation to Whitehorn *et al*'s earlier contention that the A-B variable is an index of attitudes and behaviors which is reflected in the actions of the therapists and their conduct of therapy.

In a study involving nine A and nine B therapists who were each paired with one A and one B patient, Hill, Snyder, and Schill (1974) had all the patients rate their therapists on the Barrett-Lennard Relationship Inventory and on two patient satisfaction scales. The results revealed that there were no significant differences in reported satisfaction between similar and dissimilar pairs, and that the presence of high Regard and Empathic Understanding was a more potent variable than A-B status in determining patient satisfaction. It should also be noted that Hill *et al* reported that their A therapists were rated significantly higher than the B therapists on such measures as Unconditional Regard and Empathic Understanding. Although the authors made no comment on this finding, it seems incongruous in light of the previously-cited research which revealed that, for example, Lazarus is classified as an A-type therapist while Rogers is classified as a B-type therapist.

There seems something grossly amiss with research in this particular area, for not only is there inconclusiveness and contradiction (which is not in and of itself negative or discouraging), but there is also much inconsistency in the measurement of the very variable purported to be under study. As Kennedy *et al* noted, there are no less than ten scales designed to measure the A-B variable, and both their reliability and validity are at best questionable. Perhaps Kulberg and Franco (1975) were closest to the mark when they concluded that the effect of the A-B variable is due to personality characteristics of A and B individuals and not to matching on either similarity or dissimilarity. While this general area is certainly deserving of much more research, it seems legitimate to conclude at this time that a knowledge of the A and B status of patients and therapists enables little in the way of prediction of the success of the therapeutic venture to be made.

Although some recent research has been at least somewhat supportive of the concept that matching a patient and therapist on certain dimensions will exert an effect on therapeutic outcome, the hallmark of research in this area continues to be its inconsistency. While many studies have concluded that patient-therapist similarity exerts a beneficial effect on therapeutic outcome (Beutler *et al*, 1974; Good *et al*, 1976; and others), other studies have concluded that dissimilarity on some measures is most beneficial (Meltzoff *et al*, 1970; Whittlesey, 1972; and others). In addition to the often contradictory nature of such studies, it should also be noted that the research on the effects of patient-therapist personality simi-

larity has sometimes been ill-conceived and quite often poorly defined. More often than not similarity has been measured by such obscure scales that one study may, in fact, bear little relation to others in the area in that there is often no way of telling either just what construct is being measured or if what is considered similar on one scale would be considered likewise on the others. The kalaidoscope of devices used has ranged from the Marcia Ego Identity Incomplete Sentences Blank (Anchor, 1977) to the Barrett-Lennard Relationship Inventory (Slaughter, 1975), as well as innumerable attitude and value scales. While research in this area will, of necessity, involve the utilization of a variety of instruments in order to tap various aspects of patient-therapist personality similarity, some attempt must be undertaken to bridge the gap between global (and thus unrealistic) indices of similarity and overly complex indices which often yield uninterpretable results. In just such an attempt, some research studies (including the present one) have utilized the Myers-Briggs Type Indicator (MBTI, see Appendix A), a device which appears ideally suited for research in this area.

The MBTI is a forced-choice, self-report personality inventory designed to reveal systematic preferences in an individual's approach to life. A basic assumption of the MBTI and of Jungian theory upon which it is based is that there is a consistent and orderly pattern to most human behavior, however random it may sometimes appear, and that this consistency reflects stable preferences in the use of processes by which people perceive the world and arrive at conclusions about it. The 166 items of the MBTI yield four scales which measure

the four dichotomous dimensions of: Extraversion-Introversion (E-I); Sensing-Intuition (S-N); Thinking-Feeling (T-F); and Judgment-Perception (J-P). Each of these scales or dimensions is designed to reflect habitual choices between opposites, such that any particular answer indicates either one or the other element of the dichotomous dimension, and not some point on a continuum between the two extremes. Responses are, however, assigned varying weights in an attempt to correct for the bias of social desirability.

The fact that the MBTI is not a global measure of personality involving scales that are not independent of one another is clearly evidenced by research examining this question. Intercorrelations for various populations confirm that three of the MBTI dimensions (E-I, S-N, and T-F) are virtually independent of each other. Based on populations totalling almost 5,000 males and over 3,500 females, Stricker and Ross (1962) obtained median absolute intercorrelations of +.03 for males and +.06 for females. The J-P dimension, however, correlated consistently with the S-N dimension, with an average correlation of +.33. The observation advanced by the authors was that Intuitive types were somewhat more frequent among Perceptive types than would be expected by chance. Nonetheless, the MBTI is clearly not a measure of any solitary index of personality type and does, in fact, measure certain relatively discrete personality characteristics.

While the MBTI classifies each individual completing the inventory on the above four dimensions, it should be remembered that it is measuring preferences only, and a preference on any one dimension does not imply an inability to function adequately in the less pre-

ferred way on that dimension. The major implication of any preference score is that a person prefers to behave in a particular manner as measured on that dimension, and will thus have more fully developed those particular abilities which normally enhance implementation of that preference.

Extraversion vs Introversion E-I)

Extraverts typically focus their attention on the environment, while introverts show a preference towards focusing their attention on the inner world of thoughts and ideas. While extraverts exhibit more of a flair for dealing with the environment and appear more at ease while doing so, introverts appear most comfortable at the stages of inner concentration and reflection. While extraverts appreciate variety and action, introverts enjoy quiet and concentration, and while extraverts may exhibit impatience and occasionally act without thinking, introverts are typically somewhat contemplative. Differences also appear in the realm of communication, insofar as effective communication appears to be a quality indigenous to the extravert, whereas introverts sometimes display a distinct lack of *savoir faire* when it comes to communication skills.

Sensing vs Intuition (S-N)

Sensing types, in their perception of people, things, and ideas, prefer to rely on direct observation and objective data. Intuitive types, however, have more fully developed the capacity to intuit beyond the data provided by the senses and envision the possible im-

plications. While sensing types are primarily interested in realities and actualities, intuitive types show more interest in possibilities and potentialities. An established routine would contain little to upset a sensing type, whereas an intuitive type would not be enamoured of such repetitiousness. Furthermore, sensing types less frequently get inspired and would not be likely to trust such inspirations, while intuitive types tend to exhibit considerably more creative inspiration and tend to follow these inspirations, good or bad. Sensing types tend to make few errors of fact and are consequently ideally suited for tasks involving precision, while intuitive types tend not to display the same degree of methodical accuracy and are usually disinclined to take the time to be precise. Basically, sensing types prefer to be observant, realistic, and practical, while intuitive types display more qualities of insight, originality, and creativity.

Thinking vs Feeling (T-F)

Thinking types exhibit a strong preference for making judgements on the basis of logical and impersonal analysis, relatively uninfluenced by subjective feelings. Feeling types, however, prefer to make judgements subjectively on the basis of their feelings, feelings which are based not primarily on a pattern of logical analysis, but more on their internalized beliefs and values. Whereas feeling types are typically quite aware of the feelings or sensitivities of others and tend to enjoy bringing pleasure to them, thinking types are largely uninterested in people's feelings and may actually hurt the feelings of others without being aware of it because of this in-

difference. Also, while feeling types typically appreciate and encourage harmony, thinking types tend to function about as effectively in the presence or absence of harmony. A further characterization of feeling types reveals that they relate well to most people and are usually perceived as somewhat sympathetic and concerned, whereas thinking types appear to relate best to other thinking types and are sometimes perceived by people as indifferent.

Judgment vs Perception (J-P)

Judging types tend to be planned, orderly, and regulated in their approach to the outside world, while perceptive types tend to be more flexible and spontaneous. While judging types have little trouble in making decisions, and may in fact sometimes decide too hastily, perceptive types prefer to defer judgments and decisions and remain adaptable to changing situations. Thus, while judging types are most effective when they can bring order to their environment rather than adapt to it, perceptive types prefer to maintain maximum adaptability to the environment rather than attempting to organize it.

The Myers-Briggs Type Indicator, although a relatively new instrument on the Canadian scene, has achieved fairly wide popularity throughout many of the United States. This is certainly evidenced by the birth of *Research in Psychological Type* in 1977, a journal devoted entirely to research utilizing the MBTI. In addition, the Typology Laboratory at the University of Florida was established in

the early seventies under a continuing Health, Education, and Welfare grant to coordinate MBTI research efforts and to catalyze interest in the instrument.

The increasing acceptance of the MBTI would appear to be justified, insofar as a large number of studies have provided evidence that it is both a stable and valid instrument. Stricker and Ross (1964) administered both the MBTI and the Gray-Wheelwright Questionnaire, an independently developed instrument which also identifies individuals along the E-I, S-N, and T-F dimensions, and evidence of concurrent validity was revealed. All the correlations between the continuous scores on corresponding scales were significant, with correlations of .79 on the E-I dimension, .58 on the S-N dimension, and .60 on the T-F dimension. Several other studies have linked the scales of the MBTI with abilities, interests, and personality variables in attempts to establish concurrent and predictive validity. Stricker and Ross (1963) administered both the MBTI and the Personality Research Inventory to a sample of over 500 undergraduates at Cornell. The Personality Research Inventory is designed to measure subjects' self-perceptions on 25 scales from gregariousness to foresight and from creativity to impulsiveness. Results indicated that all 25 of the scales correlated significantly with one or more scales of the MBTI in ways that were entirely predictable. Stricker, Schiffman, and Ross (1965) examined the predictive validity of the MBTI by attempting to predict grades and dropout rates for college students. Using MBTI continuous scores in addition to Scholastic Aptitude Test results and high school rank produced a significant improvement in

the accuracy of predictions.

Sundberg (1965), in his review of the Myers-Briggs Type Indicator, suggested that the relationship of MBTI scores to a large number of scales on tests of interests, values, and personality were largely in the predicted direction. On the Strong Vocational Interest Blank, for example, an interest in sales was significantly correlated with extraversion, and an interest in psychology significantly correlated with intuition. As another example, Edwards Personal Preference scores on 'need for nurturance' were shown to correlate significantly with a preference toward feeling on the MBTI. Knapp (1964) found significant correlations between MBTI preferences and appreciation of different painting styles that were as predicted within the theoretical framework of the MBTI. Sensing types, who typically rely on their observation of objective data rather than on intuition were shown to have a preference for representational paintings, while intuitive types, who tend to exhibit more originality and creativity, showed a preference for expressionistic abstracts. There has also been research on creativity in which levels of creativity were operationally defined in part by MBTI intuitive scores on the Sensing-Intuition dimension (Richter & Winter, 1966).

Another rather unique approach in examining the validity of the MBTI was used by Bradway (1964), who administered the MBTI and the Gray-Wheelwright Questionnaire to a group of practising Jungian analysts in California, and also asked them to predict their psychological types. It was observed that all analysts correctly predicted the preferences indicated for them on the E-I dimension of both

tests, and there was also significant agreement on the S-N dimension. While only the Gray-Wheelwright scores were significantly correlated with subjects' predictions on the T-F dimension, the overall accuracy of self-prediction of psychological type was interpreted as indicating that both tests measure what Jungian analysts regard as Jungian types.

Efforts to establish an empirical link between behavior and type theory have met with only moderate success (Shapiro & Alexander, 1969; Stone, 1975). One study by Carlson and Levy (1973), however, did provide strong behavioral validation of the MBTI's theoretical assumptions. They determined that intuitive-perceptive types were significantly more accurate in their ability to recognize emotions correctly, based on facial cues, than were sensing-judging types. Also, extraverted-feeling types were better at remembering names, while introverted-thinking types were better with numbers, and it was observed that extraverted-intuitive-perceptive types were significantly more likely to volunteer for social service work. All of these findings were readily predictable within the framework of Jungian theory on which the MBTI is based.

Thus, while the support is not awesome, there is certainly evidence which offers support for the construct, concurrent, and predictive validity of the Myers-Briggs Type Indicator. Psychological type appears to relate meaningfully to a large number and a wide variety of variables. Although there are probably better predictors available for particular variables, there is much to be said for Mendelsohn's (1965) assertion that "few instruments appear to provide

as much information as can be derived efficiently from the MBTI" (p. 1247).

Many studies examining the reliability of the MBTI have also been undertaken, generally investigating split-half reliability as corrected for by the Spearman-Brown prophecy formula. In the MBTI manual (Myers, 1962), the internal consistency of the continuous scores is reported using split-half correlations with the Spearman-Brown correction. Samples studied ranged from college populations to underachieving eighth graders, and the correlations ranged from .77 to .87 on the E-I dimension, .70 to .87 for S-N, .44 to .86 for T-F, and correlations of from .71 to .84 on the J-P dimension. The correlation of .44 was obtained on the T-F dimension from a sample of underachieving eighth graders, and it was suggested that this apparent uncertainty might simply reflect a less well-developed judging process in this population.

The Typology Laboratory at the University of Florida determined a series of reliability coefficients based on raw data which were furnished over the period 1963 to 1972 from a number of colleges throughout the United States. The only reliability coefficient below .66 was again found on the T-F dimension, and most of the coefficients were considered creditable for an instrument that is a self-descriptive inventory. This alleged creditability was based on Nunnally's (1959) findings that reliability coefficients for the better-established self-descriptive inventories usually range between .75 and .85 .

Test-retest reliabilities have been reported in a number of

studies. Stricker and Ross (1963) obtained continuous score test-retest reliabilities based on a 14 month interval of .73 for the E-I dimension, .69 for S-N, .48 for T-F, and .69 for the J-P dimension. Wright's (1966) study of 94 elementary school teachers showed that following a six year interval, 61% of the teachers remained in the same category on all four dimensions of the MBTI. Stalcup (1967) used a two year interval and noted that in her sample of 329 students, not one had changed on all four type classifications and only 7% had changed on three. While an additional 22% changed on two dimensions, fully 70% changed on only one dimension or showed no change in their original psychological types. Levy, Murphy, and Carlson (1972) used a two month interval for a Negro college student population and reported test-retest reliabilities of .80 for males and .83 for females on the E-I dimension, .69 for males and .78 for females on the S-N dimension, .73 for males and .82 for females on T-F, and .80 for males and .82 for females on the J-P dimension.

In one of the most recent studies, Howes and Carskadon (1979) experimentally investigated the stability of MBTI scores over a five week interval when the mood of the respondents was manipulated during the second session. Not only was the MBTI shown to be largely uninfluenced by the mood of the respondents (whether elevated or depressed), but its overall reliability was considerably higher than that of the Sixteen Personality Factor Questionnaire which was examined at the same time. The specific reliability coefficients were determined to be .82 for the E-I dimension, .87 for S-N, .78 for T-F, and .81 for the J-P dimension. The 16PF did not fare so well, with re-

liability coefficients ranging from a low of .46 to a high of .86 . Certainly the conclusion that the MBTI is an instrument whose reliability is well within acceptable limits appears justified.

The first study utilizing the MBTI as an index of patient-therapist personality similarity was that conducted by Mendelsohn and Geller (1963), where the dependent variable was the length of stay in therapy. Results revealed a significant Pearson r between difference scores and the number of sessions, $r = -.31$, $p < .01$. The data showed that there was a consistent decline in the number of sessions as the difference score increased, such that for a difference score of 25 and below a mean number of 3.0 sessions was completed, while for a difference score of 86 and above a mean of only 1.3 sessions was completed. The authors' conclusion that high similarity between therapist and patient appears to relate to therapeutic outcome may be legitimate, insofar as it seems axiomatic that there is a generally positive relationship between the number of therapy sessions and therapeutic outcome. In spite of these results, a later study by these same researchers obtained somewhat different findings in an examination of missed sessions and early termination among 128 patients and their eleven therapists (Mendelsohn & Geller, 1967). In this study, both missing sessions and terminating early were determined to be positively related to similarity of patient and therapist as measured by MBTI scores. The authors offered the interpretation that high similarity, which typically facilitates communication, may encourage the exploration of personal areas before the patient is actually ready for such exploration.

In a rather unique and well-designed study, Thompson (1969) compared the degree of similarity on the MBTI of highly successful and highly unsuccessful psychotherapeutic relationships. Ten therapists were each asked to isolate their ten most successful and ten least successful therapeutic relationships, thus creating two groups of 100 patients. It was observed that a significantly higher degree of patient-therapist dissimilarity existed for the unsuccessful group, especially on the Extraversion-Introversion and Judging-Perceiving dimensions of the MBTI. The conclusion was drawn that the presence of patient-therapist differences on these dimensions appeared to exert a detrimental effect on the therapeutic relationship.

Some studies seeking to examine the effect of patient-therapist similarity on therapeutic progress have hypothesized a curvilinear relationship between similarity and therapeutic satisfaction. Using a simple rank-order correlation of T scores on the MMPI as the index of similarity, Carson and Heine (1962) obtained results which revealed that extreme similarity or extreme dissimilarity impeded the therapeutic process. The external validity of this study is questionable, however, as the authors do not appear to have examined typical therapeutic relationships. The therapists in the study consisted of 60 medical students who were beginning an 18 week course in a psychiatric clinic and who, by the authors' own admission, were essentially untrained. The utilization of a single, global index of similarity also suggests a cautious interpretation of the results.

Only two other studies have attempted to examine this curvilinear hypothesis, and both have utilized the Myers-Briggs Type Indicator.

Mendelsohn (1966), in a replication and extension of his earlier study, observed that increasing similarity was positively correlated with the number of therapy sessions, except when the difference scores fell below 15 (thus reflecting high similarity). Mendelsohn concluded that these results indicated the presence of a mildly curvilinear relationship between patient-therapist similarity and the number of therapy sessions. The importance of patient-therapist personality similarity on the progress of therapy was also alluded to in a study by Gray (1973), who examined the relationship between similarity and levels of self-disclosure. Again using the MBTI as the instrument to assess similarity, he found no support for his hypothesis that the highest levels of self-disclosure would occur in those relationships characterized by a moderate degree of similarity and lower levels of self-disclosure would occur when the relationships were characterized by either higher or lower degrees of similarity.

In spite of the absence of definitive evidence to support this curvilinear hypothesis, it is at least intuitively attractive and one which might indeed be quite viable. One is reminded of studies in the area of marital adjustment (Lindner, 1972; Williams, 1971) which have shown that there does indeed appear to be a curvilinear relationship such that a certain amount of dissimilarity (as measured by the MBTI) is associated with greater reported marital happiness than either extreme similarity or extreme dissimilarity. Certainly there are at least a few parallels between healthy nuptial and therapeutic relationships (in terms of warmth, trust, understanding, and caring), and there may be some legitimacy to the belief that the degree of

similarity which enhances one may well enhance the other in a similar curvilinear fashion.

As long ago as 1923, Van der Hoop suggested that dissimilar psychological types (as defined in the Jungian sense) seemed to "attract each other as if by magic" (p.197). He offered the explanation that many individuals recognize their own "shortcomings" (a rather unfortunate term) and for that very reason they might appreciate in others the special adaptations which they themselves lacked. Although he wrote that such dissimilar pairs of individuals could "complete each other, as often happens in marriage or in business associations" (p. 197), Van der Hoop also acknowledged that this effect would cease to operate when the dissimilarities in psychological type became too extreme.

Myers (1970), one of the co-authors of the Myers-Briggs Type Indicator, also found the curvilinear hypothesis attractive, although she offered no empirical support for this view. She suggested that opposite types can supplement each other in any joint undertaking, but she further suggested that the most compatible relationships would exist between individuals who differed on only one or two of the psychological type dimensions of the MBTI. It was her assertion that this much difference was ideal, and that the two or three dimensions such individuals had in common would enhance their ability to understand each other and communicate effectively.

A major problem associated with previous research efforts, however, has been in the operational definition of 'similarity' between therapists and their patients. All of the previously cited studies

which have utilized the MBTI as the measure of patient-therapist personality similarity (Carson *et al*, 1962; Mendelsohn *et al*, 1963; Mendelsohn *et al*, 1967; Thompson, 1969) have calculated a single 'similarity score' for each patient-therapist dyad. The apparent disadvantage of such a global index is that it equates dyads where, for example, a patient and therapist have an extremely high (60 point) and manifestly obvious difference on one dimension and high similarity on the others with a patient and therapist who have only relatively innocuous differences on all of the dimensions (but differences which would add to approximately the same 60 point total). The two previously cited studies which examined the effect of personality similarity on marital happiness (Lindner, 1972; Williams, 1971) attempted to correct for this by assessing similarity on each of the individual four MBTI dimensions. A problem associated with this, however, was that individuals were considered 'similar' on any of the dimensions if they both happened to fall on the same side of the mid-point of that dimension (and thus there was no concern about the relative scores of each individual). Thus, for example, an individual with an Extraversion score of 1 and an individual with an Extraversion score of 53 (thus reflecting a 52 point difference between the two on this dimension) were considered to be 'similar', whereas a person with an Extraversion score of 1 and an individual with an Introversion score of 1 (thus reflecting a 2 point difference between the two on this dimension) were considered to be 'different'.

The present research study was designed to correct for this incongruity by attending to the real difference between the scores of

therapists and their patients. As described more thoroughly in the Results chapter, every patient-therapist dyad was evaluated along each of the four dimensions such that patients and their therapists were determined to be similar on 0, 1, 2, 3, or all four dimensions of the MBTI. In order to adhere to appropriate scientific procedure, an operational definition of 'similarity' between therapists and their patients on each of the four MBTI dimensions was established. This operational definition involved considering as similar those dyads where the distance between their scores on each dimension was less than the mean difference between all therapists and patients on all of the dimensions. Thus, those patients and their therapists whose scores reflected a less than average difference were considered 'similar' on that dimension, whereas those whose scores reflected a greater than average difference were considered 'different' on that dimension. Insofar as each of the four MBTI dimensions represents a continuum (Myers, 1962) between two polar opposite types and because they may thus be considered continuous variables with no zero point, similarity scores based on an interval along these dimensions are certainly justified. This entire procedure ensures that not only are patients and their therapists assessed for overall 'similarity' on all four of the MBTI dimensions considered as a whole, but that only meaningful differences on each dimension are attended to.

Certainly, as indicated earlier, it seems intuitively reasonable to believe that an excessive number of shared characteristics may interfere with a therapist's capacity to view the patient as a totally unique individual, it is just as reasonable to believe that

an absence of shared characteristics may diminish a therapist's capacity to show an understanding of and empathy toward the patient. In order to provide empirical verification for this view, this research endeavored to further examine the possibility that a curvilinear relationship exists between patient-therapist personality similarity and satisfaction with psychotherapy.

Specifically, it was hypothesized that both too much similarity (i.e. a patient and therapist being similar on all four dimensions of the MBTI) or too little similarity (i.e. a patient and therapist similar on none or only one of the dimensions) would significantly diminish satisfaction with therapy as measured by the following dependent variables: patients' evaluations of therapy and their therapists (including patients' ratings of therapist warmth, therapist trustworthiness, therapist effectiveness, therapist understanding, level of comfort in talking to the therapist, strength of recommending the therapist, ratings of improvement, strength of recommending the PSC, and overall satisfaction with therapy); objective measures of length of therapeutic involvement (including number of therapy sessions, number of missed sessions, and number of patients terminating early); therapists' evaluations of their patients and the therapeutic relationship (including patient motivation, patient cooperation, patient improvement, ratings of how well the therapist 'got to know' the patient, and overall ratings of the relationship); and patients' reports of a change in the number of life problems following therapy. Concurrently, it was hypothesized that the highest degree of satisfaction with therapy (as measured by these same

dependent variables) would occur for the group of therapists and their patients who were similar to one another on two or three of the four MBTI dimensions.

The following chapter describes the methods by which these experimental hypotheses were empirically tested.

CHAPTER 2

METHOD

Subjects

The subjects in this research consisted in part of 29 female and 24 male therapists at the Psychological Services Centre (PSC) of the University of Manitoba who agreed to cooperate by completing a personality inventory. Of these 53 therapists, 14 were staff members and the remaining 39 were students. From this group of therapists, however, a total of only 42 were ultimately involved with patients for whom complete data collection was obtained. These 42 individuals consisted of 26 female and 16 male therapists, six of who were staff members and the remaining 36 were students. This group represented about 90% of the members of the graduate programs in Clinical Psychology and Social Work at the University of Manito-

ba, and the extent of this cooperation was a reflection in so small part of, at different times, the Director of the PSC (Dr. Morgan Wright) and the Acting Director (Professor Walter Dreidger). This support provided striking evidence of the desire of the PSC to provide for the fulfillment of one of its stated goals to "provide clinical cases for the training and research programs of the various professions utilizing the Centre" (excerpted from the *Operations Manual of the PSC*, September, 1978, page 1).

In addition, the subjects in this research consisted of the 67 adults who were involved with the above therapists in individual outpatient psychotherapy at the PSC and who agreed to cooperate by completing the necessary personality test and evaluation forms during the approximately one year data collection period (1979-1980). Demographic data for these 67 adult outpatients were purposely not recorded, with the rationale being the commitment to ensure the complete confidentiality and annonymity promised to each of them. Although 96 individual patients initially undertook to become involved in this research, data from 29 were eliminated from the final analysis for any of the following reasons: responding to tests in an incomplete or unscorable fashion (14); the unavailability of personality test results or evaluation data from their therapists (8); the subsequent involvement of a spouse or family in the psychotherapeutic relationship (5); or not returning to the PSC following the intake session (2).

Procedure

Initially, all PSC staff and students were informed by memo of the fact that a research project was being undertaken, and their cooperation in completing the Myers-Briggs Type Indicator (MBTI) was solicited. Although the initial response was less than gratifying, a combination of personal contact and further official directives eventually elicited a high level of cooperation.

At the same time, and throughout the following year, all new individuals (i.e. not couples, families, or groups) who attended the PSC for outpatient psychotherapy were provided with the appropriate research materials (the MBTI, and the Self-Report Behavioral Scale, SRBS, see Appendix D) during their first visit to the PSC. Accompanying these materials was a cover letter informing them of the existence of a research project and soliciting their cooperation in completing the enclosed materials. It was stressed that such cooperation must be entirely voluntary and that an unwillingness to become involved would in no way influence their receipt of services at the PSC (and, in fact, the therapist was unaware of whether or not the patient had or had not chosen to become involved in the research). Because it was recognized that some patients might be intimidated by a request to complete test materials prior to their intake session, they were allowed to take the materials home and return them when they appeared for their first therapy session. Whether it was because the research test materials were so innocuous (i.e. not a measure of psychopathology) and required only about a half hour to com-

plete, or because of a desire by the patients to assist an agency which they perceived would be a source of assistance to them, or perhaps for other reasons, the final result was that almost all of the patients completed the research materials as requested.

When each patient was terminated (for whatever reason), the therapist involved completed a Patient Termination Summary (see Appendix B). This form included such information as: the reason for termination; the number of missed sessions; the nature of the patient's problems; and the therapist's perceptions of the patient's improvement. At the same time, each patient was mailed two questionnaires with a cover letter requesting their help in evaluating the services at the PSC. The first of these questionnaires was the Psychological Services Centre Evaluation (see Appendix C), and the second was the same SRBS form which the patients had already completed once prior to treatment. The PSC evaluation form included such information as: the patient's perceptions of his or her improvement; how the patient viewed the therapist on a number of dimensions; and how strong was his or her recommendation of the therapist and the PSC to others. Accompanying these materials was a stamped return envelope provided for the convenience of respondents and to encourage them to respond. A response rate of 37% was ultimately obtained.

Following the completion of the data collection, written feedback based on their MBTI results was provided to all the PSC therapists who expressed an interest in receiving such feedback. This courtesy was not extended to the patients, however, a decision based largely on the belief that without an adequate personal interpreta-

tion of their personality test results such feedback might prove to be either harmful or at least confusing.

CHAPTER 3

RESULTS

As described briefly in chapter 1, each of the 67 patient-therapist dyads was evaluated to determine if the patient and therapist were 'similar' or 'different' on each of the four MBTI dimensions. The operational definition of similarity and difference was chosen to be the mean difference score for all patients and therapists on all MBTI dimensions. Based on this mean difference score ($\overline{X}_d$=30), all therapists and their patients who were less than 30 points apart on a particular dimension were considered to be 'similar' on that dimension for the purposes of data analysis. In like fashion, all therapists and their patients who were at least 30 points or more apart on a particular dimension were considered to be 'different' on that dimension for purposes of data analysis. Using this technique, the number of patient-therapist dyads who are similar or dif-

ferent on individual MBTI dimensions is indicated in table 1.

Table 1

Number of Patients and Their Therapists Who Are Similar or Different on Individual MBTI Dimensions

scale	$\overline{D}$	range	$\overline{X}_d$	# similar	# different
E-I	32.1	2-82	30	35	32
S-N	29.6	0-90	30	39	28
T-F	29.3	2-66	30	33	34
J-P	27.6	2-86	30	38	29

Having thus operationally defined similarity and difference on each of the four MBTI dimensions, all of the 67 patient-therapist dyads involved in this research were examined to determine how many of the dyads were similar on 0, 1, 2, 3, or all 4 of the MBTI dimensions. For purposes of simplicity of definition, these groups were respectively labeled groups A, B, C, D, and E. Thus, for example, group A consisted of all patient-therapist dyads who were similar on none of the four MBTI dimensions. The results of this determination are indicated in table 2.

Table 2

Number of Patient-Therapist Dyads Which Are Similar on From 0 to all 4 MBTI Dimensions

group	shared dimensions	number of dyads
A	0	5
B	1	8

(continued)

Table 2 (cont'd)

group	shared dimensions	number of dyads
C	2	30
D	3	19
E	4	5

Although it had been intended that MANOVA procedures be used in the data analysis, the limited number of dyads comprising the sample (N=67) precluded this insofar as there would have been insufficient observations in certain of the cells. As a consequence of this, a series of one-way ANOVAs for unequal sample sizes was undertaken to compare groups A, B, C, D, and E on a number of dependent variables. The initial series of one-way ANOVAs was designed to compare all five groups on the six dependent variables which were based on therapists' ratings on a number of likert scales. Specifically, the six dependent variables were the therapists' ratings of the following measures: patients' improvement (PI); patients' satisfaction with therapy (ST); patients' cooperation (PC); patients' motivation (PM); how well the therapists understood their patients (UP); and an overall rating of the relationship (RR).

Because it was suspected that some of these dependent variables might be measures of the same factor, a factor analysis was done in an attempt to identify those highly correlated variables and collapse them together. Using this procedure, a correlation matrix revealed Pearson r values between the variables ranging from +.38 (between PM and RR) to +.78 (between PM and PC). A summary of these cor-

relations is provided in table 3. On the basis of the obtained correlation coefficients, *Beta* coefficients were calculated and it was determined that the variables PM and PC could be collapsed together (*B*=130), as could variables UP and RR (*B*=128). No other combination of variables yielded a significant *B* coefficient, nor did the addition of other variables to the two new collapsed variables. Thus, four dependent variables emerged for further analysis, specifically: variable PI (therapists' ratings of patients' improvement); variable PS (a new variable, termed patients' sincerity, based on therapists' ratings of patients' motivation and cooperation); variable ER (a new variable, termed evaluation of the relationship, based on therapists' ratings of the overall relationship and the extent to which they believed they had developed an understanding of their patients); and variable ST (therapists' ratings of their patients' satisfaction with therapy).

Table 3

Correlation Matrix of the Six Therapist Rating Variables (N=67)

	PI	PM	PC	UP	RR	ST
1) improvement (PI)	--	.58	.66	.64	.63	.73
2) motivation (PM)	.58	--	.78	.41	.38	.69
3) cooperation (PC)	.66	.78	--	.66	.71	.69
4) understanding (UP)	.64	.41	.66	--	.73	.56
5) relationship (RR)	.63	.38	.71	.73	--	.55
6) satisfaction (ST)	.73	.69	.69	.56	.55	--

Using the four dependent variables thus obtained from the original six dependent variables, four one-way ANOVAs for unequal sample sizes were undertaken to compare the five patient-therapist groups on each of these variables. The results of these analyses are shown in Table 4.

Table 4

Summary of Analysis of Variance
Tests on Therapist Rating Variables

Dependent Variable	Source	SS	df	MS	*F*	*p*
PI	between	5.49	4	1.373	1.489	NS
	within	57.17	62	0.922		
	total	62.66	66			
PS	between	9.77	4	2.443	2.175	NS
	within	63.36	62	1.022		
	total	73.13	66			
ER	between	17.29	4	4.325	2.755	$<.05$
	within	97.36	62	1.570		
	total	114.65	66			
ST	between	17.82	4	4.455	4.775	$<.01$
	within	57.85	62	0.933		
	total	75.67	66			

For each of the two significant *F* values, two *a priori* non-orthogonal multiple comparisons between independent groups were un-

dertaken using t ratios. The first comparison involved groups C and D with groups A, B, and E, and this was a test of the experimental (curvilinear) hypothesis in that it compared groups that were moderately similar with groups that were either highly similar or highly different. The second comparison involved groups A, B, and C with groups D and E, and this was a test of the alternative hypothesis in that it compared the groups that were low in similarity with the groups that were highly similar.

The first of these Dunn's Multiple Comparison procedures between groups C and D versus groups A, B, and E on the dependent variable ER yielded a t value of 2.104 (one-tailed $p < .05$). The second comparison between groups A, B, and C versus groups D and E on this same variable yielded a t value of 1.881 (NS). Additionally, because of the observed differences between group means (see Table 5), the mean of group A was compared with the means of the other groups. While no significant t values were obtained, probably due to the small sample size in group A, it should at least be noted that the means for group A on all four dependent variables were noticeably lower than every other group mean.

A second set of multiple comparison procedures was undertaken for the dependent variable ST. Comparing groups C and D with groups A, B, and E yielded a t value of 2.534 (one-tailed $p < .01$). For the comparison between groups A, B, and C with groups D and E, a t value of 1.562 was calculated (NS). No further t values were calculated to compare the noticeably lower group A means with the other groups because of the small sample size. The means of all groups on each

of the four dependent variables are indicated in Table 5.

Table 5

Summary of Group Means on
Therapist Rating Variables

dependent vrble.	group A	group B	group C	group D	group E
PI	4.6	5.9	5.5	5.4	5.6
PS	4.6	5.8	5.6	6.1	5.6
ER	4.4	5.9	5.1	6.0	5.3
ST	4.0	5.8	5.6	5.9	6.4

Since the curvilinear hypothesis asserts that the mid-range values of similarity will have higher scores than the extremes of the range, the hypothesis predicts a quadratic function over the dependent measures. To confirm the quadratic function represented in Table 5, quadratic orthogonal components for trend were applied to each of the four therapists' ratings variables. For the variable PS, a significant F was obtained reflecting support for the curvilinear hypothesis in the predicted direction ($F = 6.827$, $p < .05$). Similar findings emerged for the variable ER ($F = 4.444$, $p < .05$) and the variable ST ($F = 4.520$, $p < .05$). For the dependent variable PI a non-significant F was calculated, but this approached significance and again the trend was in the direction predicted by the curvilinear hypothesis ($F = 3.746$, $p < .07$).

A second set of one-way ANOVAs was undertaken to examine the

five patient-therapist groups on the two dependent variables of total number of therapy sessions and total number of missed sessions. Although no statistically significant *F* values were obtained, it should be noted that the average number of sessions for group A ($\overline{X}_a$=7.4) and group E ($\overline{X}_e$=7.0) was less than half that of any of the other groups ($\overline{X}_b$=15.3; $\overline{X}_c$=15.2; $\overline{X}_d$=18.8). The results of these ANOVAs are shown in Table 6.

Table 6

Summary of Analysis of Variance Tests
On Length of Therapy and Missed Sessions

Dependent Variable	Source	SS	df	MS	*F*	*p*
# of sessions	between	890.8	4	222.7	1.437	NS
	within	9608.1	62	154.9		
	total	10498.9	66			
missed sessions	between	6.44	4	1.66	1.935	NS
	within	53.20	62	0.86		
	total	59.64	66			

To further test the curvilinear hypothesis, a trend analysis for quadratic trends was undertaken on these same two objective dependent variables. For the dependent variable of number of therapy sessions, a significant *F* was obtained reflecting support for the

curvilinear hypothesis in the predicted direction (F = 7.875 , $p < .01$). For the dependent variable of missed sessions, however, no such support was obtained (F = 0.196, NS).

Initially, a series of one-way ANOVAs was planned to compare the five patient-therapist groups on the nine dependent variables which were based on the patients' own ratings of the therapeutic relationship and their therapists. These nine dependent variables were the patients' ratings of: their level of comfort in talking about their problems (CT); therapist warmth (TW); trust of the therapist (TT); therapist understanding (TU); therapist effectiveness (TE); recommendation of their therapists (RT); degree of improvement (DI); satisfaction with therapy (PS); and strength of recommendation of the PSC (RP). Because it was anticipated that some of these variables might be measures of the same factor, a factor analysis was undertaken in an attempt to identify highly correlated variables and collapse them together. Using this procedure, a correlation matrix revealed Pearson r values between the variables ranging from -.70 (between DI and PS) to +.96 (between TU and RT). Even a visual inspection of this correlation matrix readily reveals a number of intercorrelations reflecting the fact that many of the dependent variables are not independent. A summary of these correlation coefficients is provided in Table 7.

On the basis of the obtained correlation coefficients, *Beta* coefficients were calculated and it was determined that the variables CT, TW, TT, TU, TE, RT, and RP could be collapsed together (B=282).

No other combination of variables yielded a higher significant *B* coefficient, nor did the addition of either of the two remaining variables to the configuration. Thus, three dependent variables emerged for further analyses, specifically: variable ET (a new variable termed evaluation of the therapist, based on collapsing the seven dependent variables which are highly correlated); variable DI (patients' ratings of their degree of improvement); and variable PS (patients' satisfaction with therapy).

Table 7

Correlation Matrix of the Nine Patient Rating Variables (N=25)

	CT	TW	TT	TU	TE	RT	DI	PS	RP
1) comfort (CT)	--	.58	.33	.35	.53	.38	.21	.76	.72
2) warmth (TW)	.58	--	.44	.74	.84	.82	-.23	.78	.71
3) trust (TT)	.33	.44	--	.84	.23	.73	-.47	.50	.81
4) understand (TU)	.35	.74	.84	--	.50	.96	-.34	.56	.71
5) effective (TE)	.53	.84	.23	.50	--	.64	-.06	.75	.56
6) recommend T (RT)	.38	.82	.73	.96	.64	--	-.22	.57	.65
7) improvement (DI)	.21	-.23	-.47	-.34	-.06	-.22	--	-.70	-.37
8) satisfaction (PS)	.76	.78	.50	.56	.75	.57	-.70	--	.87
9) recommend PSC (RP)	.72	.71	.81	.71	.56	.65	-.37	.87	--

As indicated earlier, a series of one-way ANOVAs was planned to compare all groups on the three variables which emerged through factor analysis from the original nine dependent variables, but the

small number of respondents (N=25) precluded this possibility. Instead, Dunn's Multiple Comparison procedures were undertaken for each of the three variables such that two *a priori* comparisons between independent means were made to examine the experimental (curvilinear) hypothesis and the alternative hypothesis. Comparing groups C and D with groups A, B, and E on the new dependent variable ET yielded a t value of 3.125 (one-tailed $p < .01$), although this reflected a significant difference which was not in the predicted direction. Comparing groups A, B, and C with groups D and E yielded a t value of 0.431 (NS).

On the second dependent variable DI, comparing groups C and D with groups A, B, and E yielded a t value of 0.864 (NS). A comparison of groups A, B, and C with groups D and E on this variable yielded a t value of 0.298 (NS). For the third and last dependent variable PS, comparing groups C and D with groups A, B, and E yielded a t value of 0.455 (NS). The final comparison of groups A, B, and C with groups D and E on this variable yielded a t value of 0.646 (NS).

A one-way ANOVA was also planned to compare all five patient-therapist groups in terms of their Self-Report Behavioral Scale results, utilizing change scores for each group in the number of problems reported pre- and post-treatment. Again, however, the small sample size (N=24, one patient did not complete the post-treatment SRBS) precluded this possibility. Because of this, multiple comparison procedures were undertaken to test the experimental (curvilinear) hypothesis and the alternative hypothesis. Comparing groups C and D

with groups A, B, and E yielded a t value of 1.101 (NS). A comparison of groups A, B, and C with groups D and E yielded a t value of 0.504 (NS).

A final one-way analysis of variance test was originally planned to compare the relative effectiveness of the different modes of psychotherapy utilized by the therapists (ie. behavioral, psychodynamic, ego therapy, humanistic, or eclectic). This analysis could not be undertaken, however, due to a preponderance of 'eclectic' therapists and the resulting insufficient sample size for the other therapeutic modes.

In an effort to explore patients' perceptions of their therapists as a function of the psychological type of the therapists, and to further assess the validity of the Thinking-Feeling psychological type dimension, the ten therapists who were identified as Thinking types were compared with the fifteen therapists identified as Feeling types on five dependent variables. Thus, patients' ratings of these two types of therapists were compared in five areas, specifically: warmth; trustworthiness; understanding; effectiveness; and strength of recommendation of the therapists. A series of five t tests was conducted to compare Thinking versus Feeling type therapists on all five dimensions, with the following results being obtained: warmth (t = 2.813, $p < .05$); trustworthiness (t = 0.802, NS); understanding (t = 2.171, $p < .05$); effectiveness (t = 1.583, NS); and strength of recommendation (t = 1.962, NS). While only two of these comparisons yielded significant t values, it should be noted that Feeling type therapists were rated higher on all five di-

mensions. The mean ratings for these two types of therapist on the five dependent variables are indicated in Table 8.

Table 8

Patients' Ratings of Their Therapists As A Function of Therapist Psychological Type

		TYPE OF THERAPIST	
		Thinking (N=10)	Feeling (N=15)
THERAPIST QUALITIES	1) warmth	4.75	6.67
	2) trust	6.25	6.83
	3) understanding	4.50	5.92
	4) effectiveness	5.25	6.33
	5) recommendation	5.00	6.17

Numerous descriptive statistics were also obtained as a result of this research, including the specific psychological types of the patient and therapist samples studied. As indicated in Figure 1, some rather dramatic differences were observed between the psychological types of the patients and therapists. In addition, both of these samples differed considerably from the adult norms which are also presented in Figure 1. Specifically, the continuous scores for the two samples are: E-I, therapists = 130.9, patients = 113.7; S-N, therapists = 118.3, patients = 91.7; T-F, therapists = 104.1, patients = 111.7; and J-P, therapists = 115.7, patients = 99.5. A comparison of the percentages of therapists and patients of each psychological type with adult norms is found in Appendix E.

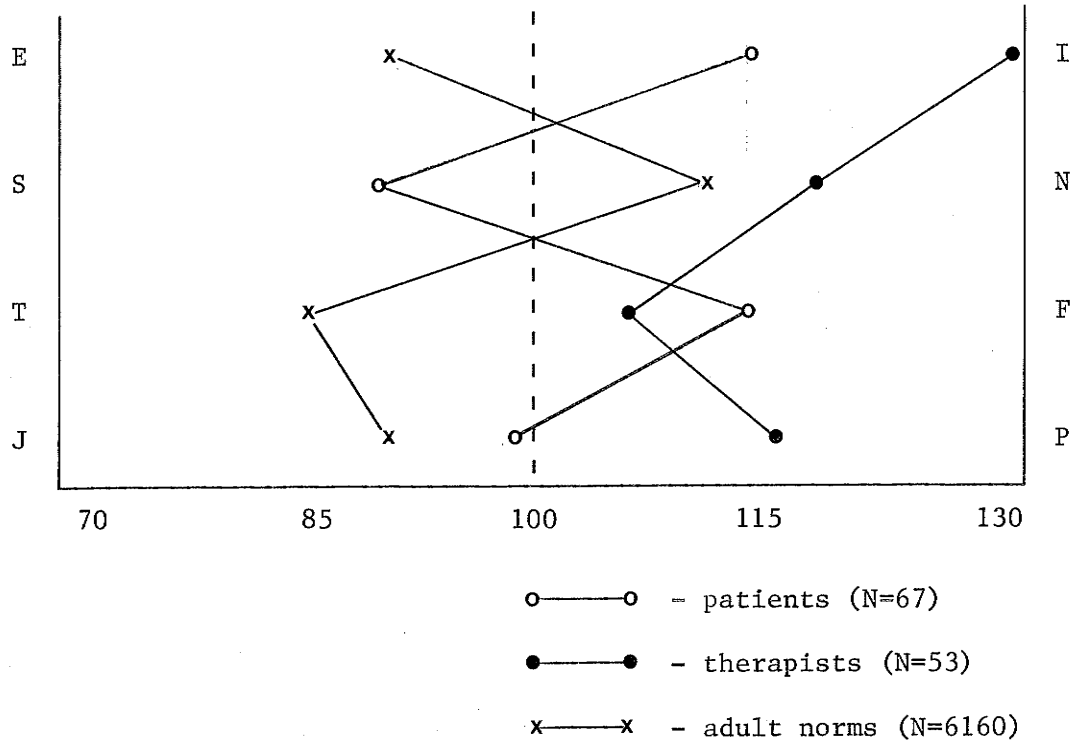

Figure 1. A comparison of the psychological types of therapists and patients with the adult population.

Among the other descriptive statistics obtained for the sample of 67 patients was that the average number of sessions was 15.2, ranging from 2 to 64 sessions with a mode of 7. The average number of missed sessions was 0.8, ranging from 0 to 3 missed sessions with a mode of 0. The reasons for terminating therapy in this sample consisted of the following: treatment completed, with both the therapist and patient agreeing that termination was appropriate (33); patient withdrew without consulting the therapist (16); patient withdrew against the advice of the therapist (10); patient moved (4); treatment completed with the therapist effecting termination but the patient reluctant to terminate (3); and the therapist leaving

the PSC (1). Thus, for this sample of 67 patients, a total of 39% terminated therapy either against their therapists' advice or without consulting their therapists. An indication of the number of early terminators as a function of patient-therapist personality (ie. according to group) is provided in Table 9. Although the small cell sizes precluded meaningful statistical analysis, the number of early terminators in the patient-therapist group that had no commonalities in psychological type was striking.

Table 9

Patients Terminating Therapy Early As A Function of Patient-Therapist Personality Similarity

Group	n	Early Terminators	% Terminating Early
A	5	4	80.0
B	8	3	37.5
C	30	13	43.3
D	19	4	21.1
E	5	2	40.0

Data from the evaluation forms provided an interesting and objective means to assess patients' satisfaction with therapy and their own ratings of improvement following therapy. Both the therapists and the patients were provided with the same 7 point likert scale ranging from 1 (very much worse) to 7 (very much improved) to rate the patients' level of improvement with regard to the problems that brought them into therapy. For the sample of 67 patients who

were evaluated by their therapists, the mean rating of improvement was 5.4 (ranging from 4 to 7). For the sample of 25 patients who evaluated themselves, the mean rating of improvement was 6.1 (ranging from 5 to 7). It was reassuring to observe that none of the 67 patients rated by their therapists were believed to have deteriorated rather than improved or at least remained stable, and every one of the 25 patients who evaluated themselves indicated that they experienced at least some measure of improvement. A Pearson *r* was calculated between patients' and their therapists' ratings of improvement for the sample of 25 for whom joint evaluations were available, and a correlation coefficient of +.34 was obtained. This statistically significant but relatively low correlation was due to the fact that the majority of therapists underestimated their patients' assessments of their own improvement.

In terms of satisfaction with therapy, both therapists and their patients were provided with a 7 point likert scale ranging from 1 (very dissatisfied) to 7 (very satisfied) to rate the patients' satisfaction with therapy. For the sample of 67 patients whose perceived level of satisfaction was rated by their therapists, the mean satisfaction rating was 5.6 (ranging from 3 to 7). For the sample of 25 patients who rated their own satisfaction with therapy, the mean satisfaction rating was 6.0 (ranging from 4 to 7). A pearson *r* was calculated between patients' and their therapists' ratings of satisfaction for the sample of 25 for whom joint ratings were available, and a correlation coefficient of +.54 was obtained. This statistically significant but less-than-perfect correlation was again a reflection

of the fact that nearly three-quarters of the therapists underestimated their patients' self-reported satisfaction with therapy.

The administration of the Self-Report Behavioral Scale (SRBS) both before and after treatment allowed some interesting observations to be made. The average number of life problems reported on the pre-treatment SRBS among the sample of 67 patients was 14.0, ranging from 2 to 38 reported problems. For the sample of 24 patients who completed a post-treatment SRBS, the average number of reported problems rose to 21.6 (ranging from 3 to 33 problems). Comparing the pre- and post-treatment SRBS scores of this sample of 24 patients, 11 reported more problems at termination, 11 reported fewer problems, and three reported no change in the number of life problems.

Finally, it is of considerable interest to note the response of patients to the question "Would you recommend the PSC to someone if you believed they were having problems?". A 7 point likert scale was provided for responding, ranging from 1 (not at all) to 7 (very strongly). For the sample of 25 patients who returned their evaluation forms, a mean of 6.0 was obtained (with responses ranging from 1 to 7 and a mode of 7).

An interpretation and discussion of the results of this research is undertaken in the following chapter.

CHAPTER 4

DISCUSSION

The research presented here was designed primarily to explore the influence of patient-therapist personality similarity on the psychotherapeutic relationship. The results provided a moderate degree of confirmation for the experimental hypothesis that a curvilinear relationship would exist between patient-therapist personality similarity and satisfaction with the therapeutic relationship as measured by a number of dependent variables. Support for this hypothesis was obtained on one objective and three subjective dependent variables, and for certain variables the support was quite pronounced.

The first series of dependent variables was based on therapists' ratings of their patients and the therapeutic relationships. On three of the four dependent variables a significant quadratic trend was

demonstrated indicating that the mid-range of scores was superior to the extremes and thus confirmed the curvilinear hypothesis. The first of these dependent variables was the therapists' evaluations of the psychotherapeutic relationships, and the groups comprised of patients and their therapists who were moderately similar achieved significantly higher therapist ratings than did those groups where patients and their therapists were either highly similar or highly different. A further comparison of the groups which were highly similar with those groups which were highly different revealed that the original observed significant difference between them was not merely a function of the extent of the personality differences between patients and their therapists (but rather it was indeed a reflection of a curvilinear relationship).

The second dependent variable showing a curvilinear form was therapists' evaluations of their patients' satisfaction with therapy. Again, the patients who were moderately similar to their therapists were judged to have been significantly more satisfied with therapy than either those patients who were highly similar to or highly different from their therapists. And finally, the third dependent variable showing curvilinear form was based on therapists' ratings of their patients' sincerity (i.e. motivation and cooperation). Patients who were moderately similar to their therapists were rated significantly higher on this dimension than those patients who were either highly similar to or highly different from their therapists.

On the final dependent variable based on therapists' ratings

of their patients' levels of improvement, however, only a quadratic trend which approached significance was evident. This existing trend, although not achieving statistical significance, was nonetheless in the direction predicted by the curvilinear hypothesis advanced in this research effort. The major conclusion which can be drawn from these results is that for those dependent variables based on therapists' impressions of the therapeutic relationships, fairly consistent support for the curvilinear hypothesis was obtained. Thus it seems that when therapists and their patients are moderately similar, the therapists rate their patients and the therapeutic relationships significantly higher than do those therapists who are highly similar to or highly different from their patients.

A final observation based on therapists' evaluations of the therapeutic relationships was that the group of patients and their therapists who were most different (i.e. they shared not one of the four MBTI dimensions in common) received noticeably lower evaluations on every factor being examined. Analysis of these differences did not result in any statistical significance, however, probably due to the small sample size, but it would be frivolous to ignore the fact that this group was perceived by their therapists to be the least satisfied with therapy on every rated dimension. This finding may have important implications in clinical practice, and a hypothesis which clinicians might entertain if a therapeutic relationship is not proceeding well is that it may be in part a function of extremely large differences between their psychological types. If such differences are truly present, type theory suggests that the

therapist and patient will be communicating and perceiving things on completely different levels and will never properly 'connect' without an awareness of this phenomenon.

In terms of the more objective dependent variables (i.e. length of therapy and missed sessions), only equivocal support for the curvilinear hypothesis was obtained. In terms of the dependent variable of length of therapy, a very strong quadratic trend was present in the direction predicted by the curvilinear hypothesis. Thus, patients seeing therapists who were moderately similar to them tended to remain in therapy for approximately twice as many sessions as did those patients seeing therapists who were highly similar to or highly different from them. On the dependent variable of missed sessions, however, the degree of patient-therapist personality similarity did not exert any influence over how often patients failed to keep scheduled appointments.

An exploration of the curvilinear hypothesis based on patients' evaluations of their therapists and therapy afforded no support for this hypothesis. Of all the analyses conducted using patients' ratings as the dependent variables, only a single statistically significant finding was obtained. This finding was based on patients' evaluations of their therapists along a number of dimensions which factor analysis allowed to be collapsed together, and it actually contradicted the curvilinear hypothesis in that those patients who were moderately similar to their therapists evaluated these therapists less positively than those patients who were either highly similar to or highly different from their therapists. This is a

rather fascinating finding, as is the additional finding that patients' ratings of their own improvement were negatively correlated with ratings of their therapists. Thus, for example, negative correlations existed between patients' ratings of their therapists' qualities of warmth and understanding and their ratings of their own levels of improvement. The seemingly incongruous conclusion is that patients who perceive their therapists in the most positive terms are the very ones who judge themselves to be the least improved following therapy. There are a number of possible interpretations of this finding, such as the possibility that when patients viewed their therapists as highly warm and understanding they were in effect evaluating what was more of a social rather than a therapeutic relationship, but there is certainly no definitive conclusion which can be advanced to explain this apparent incongruity without further research into the matter.

The final comparison of patient-therapist groups utilized the dependent variable of changes in the number of self-reported life-problems following therapy, and no significant differences were observed between any of the groups. Thus, on this particular dependent variable, no support for the curvilinear hypothesis was obtained.

In spite of the fact that no support was accorded the curvilinear hypothesis on the basis of patient rating variables, the fact that the power of the statistical techniques utilized was limited by the small sample size should not be ignored. The attrition rate of 63% (meaning that only one in three patients completed the evaluation materials) might well have exerted an effect in any one of a

number of unpredictable ways. One possible influence might be that only patients who were generally satisfied with their experience in therapy would have chosen to complete the evaluation forms, and thus if there were more dissatisfied patients in the dyads characterized by high similarity or high difference (which is what the curvilinear hypothesis would predict) the data from them would be unavailable. The major conclusion which might be drawn from this is the obvious fact that an absence of support for the curvilinear hypothesis on these particular dependent variables should not be treated as any serious disconfirmation of this hypothesis.

In summary, moderate support for the curvilinear hypothesis was obtained on one objective and three subjective dependent variables. It was observed that patients who were moderately similar to their therapists tended to remain in therapy significantly longer than those patients who were either quite similar to or quite different from their therapists. Also, for these moderately similar therapeutic relationships, therapists perceived their patients to be significantly more satisfied with therapy and rated them significantly higher on other dimensions. Although support was not evidenced by those dependent variables which were based on patients' own ratings, the limited responding sample of patients precludes any precise interpretation of this observation. Thus, although no definitive conclusions may legitimately be drawn, there is at least some evidence suggesting that patient-therapist personality similarity may exert an effect on the therapeutic relationship in a curvilinear fashion.

The comparison of Thinking *vs* Feeling psychological type therapists revealed somewhat predictable findings. Feeling type therapists were rated as having significantly more 'warmth' and understanding by their patients as compared to the Thinking type therapists. No significant differences were obtained on measures of therapists' effectiveness, trustworthiness, or how strongly their patients would recommend them, however, which suggests that the more 'humanistic' therapists were not evaluated by patients as being superior on these important dimensions. It seems obvious that patients do not necessarily equate therapist warmth and understanding with therapist effectiveness. These results also lend concurrent validity to the descriptions provided on the T-F dimension of the MBTI.

A number of interesting descriptive statistics emerged with regard to the psychological types of the PSC patients and therapists who comprised the present research sample, and it appears obvious that these patients and therapists were quite distinct from the general population and from each other. On the Extroversion-Introversion (E-I) dimension of the MBTI, adult norms indicate that most individuals are somewhat extroverted. In the present samples, however, the PSC patients were determined to be moderately introverted and the therapists were determined to be extremely introverted. Differences on the Sensing-Intuition (S-N) dimension between therapists and adult norms were quite modest, with both groups being mildly Intuitive, but the PSC patients were quite different from both these groups in that their scores reflected a mild Sensing preference. On the Thinking-Feeling (T-F) dimension, both patients and therapists

were determined to be mildly Feeling types, whereas adult norms indicate that most of the population are moderately Thinking types. Finally, on the Judging-Perceiving dimension of the MBTI, the patients were quite similar to the general population in that both were mildly Judging, but the therapist group differed in that their average scores reflected a moderately strong preference for Perceiving.

On the basis of these observed differences, quite distinct descriptions of these three groups can be provided. The general adult population would be described in terms such as: slightly outgoing; somewhat intuitive and creative; logical and objective to a slight degree; and generally orderly and regulated in their lives. The PSC patient group, however, would be described in terms such as: slightly introverted and withdrawn; somewhat realistic and practical; moderately sensitive; and possessing a good balance between being regulated and being spontaneous in their daily affairs. Finally, the PSC therapists would be described in terms such as: extremely introverted, withdrawn, and contemplative; moderately insightful, original, and creative; mildly sensitive, sympathetic, and concerned; and quite flexible and spontaneous in their daily lives. It seems evident from this research that individuals approaching an outpatient clinic for help are not typical of a 'normal' adult population (a finding which is almost axiomatic), and it is also evident that those individuals who pursue a career in the field of mental health are markedly different from the 'normal' adult population in certain ways.

Many of the data which emerged describing the involvement of patients at the PSC were quite interesting. While the average length

of stay in therapy was just over 15 sessions, this is not an altogether meaningful statistic in that it includes both patients who were seen only twice and those who were seen for well over a year. It is heartening to note, however, that a majority of the patients never missed a single session during the course of therapy at the PSC. For the majority of patients treatment was also carried through to a mutually agreed termination, and only a minority terminated before the completion of treatment. Although early termination did not appear to be consistently related to patient-therapist personality similarity, a striking observation was that four of the five patients who were identified as sharing not a single MBTI personality dimension in common with their therapists terminated therapy early. In conjunction with previously mentioned findings about this admittedly small group, it appears that there is at least some evidence to suggest that this degree of extreme difference between patients and their therapists is not beneficial to the psychotherapeutic relationship.

One finding which emerged from this research which is ostensibly incongruous is that a great many patients reported more life problems (on the SRBS) following therapy than they had reported prior to the commencement of therapy. The apparent incongruity lies in the fact that these same patients reported themselves as considerably improved following therapy. There are many plausible explanations which might explain this phenomenon, all of which suggest that pre-post treatment measures of self-reported problems may not be good indices of treatment outcome. One possibility is that at intake many patients may simply be reluctant to acknowledge problem areas on a formal question-

naire even if they are acutely aware of these problems. It may also be that at termination patients are simply more psychologically aware and thus willing to acknowledge problem areas, or they may be less likely to use the defence mechanism of denial which may have been one of their pre-treatment coping strategies. In any case, even if more life problems are identified at termination it may well be that patients have a greater ability to deal with these problems following therapy, and it does not necessarily mean that their lives are more troubled or emotionally distraught. These views are consistent with Reid (1978) who suggested that it is not uncommon for patients to experience difficulty acknowledging the existence of problems at intake because of shyness, a lack of trust, or other reasons. He suggested that once a therapeutic relationship has been established, new information invariably comes to light. He further observed that patients at termination did not seem unusually troubled by their newly acknowledged problems, and he suggested that this might well be a function of their having developed new coping skills based on an ability to generalize from their experience in psychotherapy.

The numerous data designed to evaluate patients' satisfaction with therapy were also interesting and generally reflected well on both the PSC therapists and the Psychological Services Centre itself. The overwhelming majority of patients assessed themselves as having made important gains as a result of therapy, and *every* one of them indicated that they had experienced improvement to some degree. While their therapists were slightly less positive in assessing the

improvement of their patients, again all of the therapists assessed these patients as having improved or at least remained stable. Whether or not the patients themselves or their therapists are best equipped to evaluate improvement is a point open to considerable debate, but by both measures it would seem that involvement at the PSC was a beneficial experience to all of those who sought help.

A similar finding emerged on the basis of patients' reported satisfaction with therapy, for the overwhelming majority asserted that they were quite satisfied with the therapy they received at the PSC. Their therapists' assessments concurred with this, although again the therapists tended to be somewhat less positive in their evaluations. This tendency for the therapists to underestimate their patients' reported satisfaction with therapy was quite consistent, and it might be interpreted as either a reflection of a more rigid set of personal evaluative criteria or simply a basic sense of humility and a belief that as neophyte therapists (as a small majority were) it would be grandiose to assert that they had been of considerable help to their patients. Notwithstanding these interpretations, however, the undeniable conclusion is that the overwhelming majority of patients *did* perceive their therapists as being of considerable help to them. In a similar fashion, this same large majority of patients was emminently satisfied with the PSC and asserted that they would strongly recommend the PSC to anyone they believed was experiencing emotional problems.

CHAPTER 5

CONCLUSIONS

Based on an analysis of the basic findings of this research endeavor, the following conclusions can be presented with a fair degree of confidence:

1) For the present sample, moderate support for the curvilinear hypothesis was obtained on a number of measures. Thus, on some but not all of the dependent variables, patient-therapist personality similarity was related to satisfaction with therapy such that those patients and their therapists who were moderately similar reported greater satisfaction than those patients and their therapists who were either highly similar or highly different. The results were somewhat equivocal, however, suggesting that further research in this area involving much larger samples would be worthwhile.

2) For the present sample, no support was obtained for the hypothesis that satisfaction with therapy would be a function of the level of patient-therapist personality similarity such that those patients and their therapists who were highly similar would report more satisfaction with therapy than those patients and their therapists who were highly different.

3) Those therapeutic relationships where patients and their therapists were extremely different (ie. they shared not a single one of the four MBTI dimensions in common) were evaluated by both the patients and therapists in generally negative terms. Thus, when such a situation existed, the patients and therapists reported more dissatisfaction and less improvement than for any other group, and a large majority of the patients terminated therapy prior to its completion. This was the only level of patient-therapist personality similarity where generally consistent findings were obtained, and it suggests that extreme differences in personality type are not beneficial to the psychotherapeutic relationship.

4) A measure of concurrent validation for the Thinking-Feeling dimension of the MBTI was obtained on the basis of patients' varying perceptions of therapists whose psychological types were known. Thus, in accordance with what would be predicted by the MBTI, patients perceived Feeling-type therapists as possessing significantly more 'warmth' and understanding than Thinking-type therapists.

5) For the present sample of patients attending the PSC, their psychological type profiles were markedly different from the norms

established for a 'normal' adult population. Specifically, the patients were: more introverted; more sensing (ie. practical and 'down-to-earth'); more feeling (ie. sensitive and sympathetic); and somewhat less rigid or structured in their lives.

6) For the sample of PSC therapists studied in this research (a sample which represented about 95% of the therapists practicing at the PSC during the data collection period), their psychological type profiles were also markedly different from the norms for a 'normal' adult population. Specifically, the therapists were: much more introverted; slightly more intuitive (ie. insightful and creative); much more feeling (ie. sensitive and sympathetic); and much more perceiving (ie. flexible and spontaneous).

7) The large majority of patients seen at the PSC during the 1979-1980 data collection period reported substantial gains following therapy and they reported a high level of satisfaction with therapy and their therapists. Also, they almost universally asserted that they would recommend the PSC to individuals experiencing emotional problems. The unequivocal conclusion would appear to be that the PSC is indeed performing a worthwhile service in a laudable fashion.

8) In spite of the majority of patients evaluating themselves as being greatly improved following therapy, a great many of these same patients reported more problems on their post-treatment forms than they had upon entering treatment. This suggests that problem checklists may not be valid indicators of therapeutic outcome, especially when the therapists of these patients concurred with

their patients' evaluations of considerable improvement being obtained following treatment.

9) For the present sample, the therapists generally underestimated their patients' own reports of levels of improvement and satisfaction with therapy. Although it may also be concluded that the patients were overestimating their own improvement and exaggerating their satisfaction with therapy, this finding suggests that any therapy outcome research should attend to the collective impressions of both patients and therapists rather than either group alone.

10) A conclusion which is based on the experience of undertaking research such as this rather than the empirical results of such research is that the difficulties inherrent in conducting such research should not be underestimated. The logistics of involving even a relatively small number of patients and therapists in ongoing data collection are almost overwhelming, and future researchers in this area should appreciate fully the many difficulties they will have to overcome in securing and maintaining the interest and involvement of such diverse groups of individuals.

Thus, these research findings have accorded moderate support to the hypothesis of a curvilinear relationship between patient-therapist personality similarity and satisfaction with therapy, and a number of additional interesting findings emerged. Because of the equivocal nature of some of these findings, however, and because of the relatively small samples involved in the present research, it

is to be hoped that this study might catalyze an interest in exploring certain of these areas in considerably more depth. The number of grand revelations offered by the present research may be limited, depending upon the particular view of the individual reader, but should it indeed catalyze such an interest in further research endeavours then it will have truly served a legitimate and worthwhile function.

APPENDICES

APPENDIX A

MYERS-BRIGGS TYPE INDICATOR*

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MYERS-BRIGGS TYPE INDICATOR

FORM F

by Katharine C. Briggs and Isabel Briggs Myers

DIRECTIONS:

There are no "right" or "wrong" answers to these questions. Your answers will help show how you like to look at things and how you like to go about deciding things. Knowing your own preferences and learning about other people's can help you understand where your special strengths are, what kinds of work you might enjoy and be successful doing, and how people with different preferences can relate to each other and be valuable to society.

Read each question carefully and mark your answer on the separate answer sheet. *Make no marks on the question booklet.* Do not think too long about any question. If you cannot decide on a question, skip it but be careful that the *next* space you mark on the answer sheet has the same number as the question you are then answering.

Read the directions on your answer sheet, fill in your name and any other facts asked for, and work through until you have answered all the questions.

Consulting Psychologists Press, Inc. 577 College Ave., Palo Alto, California 94306.

Which answer comes closest to telling how you usually feel or act?

1. Does following a schedule
   (A) appeal to you, or
   (B) cramp you?

2. Do you usually get along better with
   (A) imaginative people, or
   (B) realistic people?

3. If strangers are staring at you in a crowd, do you
   (A) often become aware of it, or
   (B) seldom notice it?

4. Are you more careful about
   (A) people's feelings, or
   (B) their rights?

5. Are you
   (A) inclined to enjoy deciding things, or
   (B) just as glad to have circumstances decide a matter for you?

6. When you are with a group of people, would you usually rather
   (A) join in the talk of the group, or
   (B) talk individually with people you know well?

7. When you have more knowledge or skill in something than the people around you, is it more satisfying
   (A) to guard your superior knowledge, or
   (B) to share it with those who want to learn?

8. When you have done all you can to remedy a troublesome situation, are you
   (A) able to stop worrying about it, or
   (B) still more or less haunted by it?

9. If you were asked on a Saturday morning what you were going to do that day, would you
   (A) be able to tell pretty well, or
   (B) list twice too many things, or
   (C) have to wait and see?

10. Do you think on the whole that
    (A) children have the best of it, or
    (B) life is more interesting for grown-ups?

11. In doing something that many other people do, does it appeal to you more to
    (A) do it in the accepted way, or
    (B) invent a way of your own?

12. When you were small, did you
    (A) feel sure of your parents' love and devotion to you, or
    (B) feel that they admired and approved of some other child more than they did of you?

13. Do you
    (A) rather prefer to do things at the last minute, or
    (B) find that hard on the nerves?

14. If a breakdown or mix-up halted a job on which you and a lot of others were working, would your impulse be to
    (A) enjoy the breathing spell, or
    (B) look for some part of the work where you could still make progress, or
    (C) join the "trouble-shooters" who were wrestling with the difficulty?

15. Do you usually
    (A) show your feelings freely, or
    (B) keep your feelings to yourself?

16. When you have decided upon a course of action, do you
    (A) reconsider it if unforeseen disadvantages are pointed out to you, or
    (B) usually put it through to a finish, however it may inconvenience yourself and others?

17. In reading for pleasure, do you
    (A) enjoy odd or original ways of saying things, or
    (B) like writers to say exactly what they mean?

18. In any of the ordinary emergencies of everyday life, do you prefer to
    (A) take orders and be helpful, or
    (B) give orders and be responsible?

19. At parties, do you
    (A) sometimes get bored, or
    (B) always have fun?

20. Is it harder for you to adapt to
    (A) routine, or
    (B) constant change?

21. Would you be more willing to take on a heavy load of extra work for the sake of
    (A) extra comforts and luxuries, or
    (B) a chance to achieve something important?

22. Are the things you plan or undertake
    (A) almost always things you can finish, or
    (B) often things that prove too difficult to carry through?

23. Are you more attracted to
    (A) a person with a quick and brilliant mind, or
    (B) a practical person with a lot of common sense?

24. Do you find people in general
    (A) slow to appreciate and accept ideas not their own, or
    (B) reasonably open-minded?

25. When you have to meet strangers, do you find it
    (A) pleasant, or at least easy, or
    (B) something that takes a good deal of effort?

26. Are you inclined to
    (A) value sentiment more than logic, or
    (B) value logic more than sentiment?

27. Do you prefer to
    (A) arrange dates, parties, etc. well in advance, or
    (B) be free to do whatever looks like fun when the time comes?

28. In making plans which concern other people, do you prefer to
    (A) take them into your confidence, or
    (B) keep them in the dark until the last possible moment?

29. Is it a higher compliment to be called
    (A) a person of real feeling, or
    (B) a consistently reasonable person?

30. When you have a decision to make, do you usually
    (A) make it right away, or
    (B) wait as long as you reasonably can before deciding?

31. When you run into an unexpected difficulty in something you are doing, do you feel it to be
    (A) a piece of bad luck, or
    (B) a nuisance, or
    (C) all in the day's work?

32. Do you almost always
    (A) enjoy the present moment and make the most of it, or
    (B) feel that something just ahead is more important?

33. Are you
    (A) easy to get to know, or
    (B) hard to get to know?

34. With most of the people you know, do you
    (A) feel that they mean what they say, or
    (B) feel you must watch for a hidden meaning?

35. When you start a big project that is due in a week, do you
    (A) take time to list the separate things to be done and the order of doing them, or
    (B) plunge in?

36. In solving a personal problem, do you
    (A) feel more confident about it if you have asked other people's advice, or
    (B) feel that nobody else is in as good a position to judge as you are?

37. Do you admire more the people who are
    (A) conventional enough never to make themselves conspicuous, or
    (B) too original and individual to care whether they are conspicuous or not?

38. Which mistake would be more natural for you:
    (A) to drift from one thing to another all your life, or
    (B) to stay in a rut that didn't suit you?

Go on to the next page.

39. When you run across people who are mistaken in their beliefs, do you feel that
    (A) it is your duty to set them right, or
    (B) it is their privilege to be wrong?

40. When an attractive chance for leadership comes to you, do you
    (A) accept it if it is something you can really swing, or
    (B) sometimes let it slip because you are too modest about your own abilities,
    (C) or doesn't leadership ever attract you?

41. Among your friends, are you
    (A) one of the last to hear what is going on, or
    (B) full of news about everybody?

42. Are you at your best
    (A) when dealing with the unexpected, or
    (B) when following a carefully worked-out plan?

43. Does the importance of doing well on a test make it generally
    (A) easier for you to concentrate and do your best, or
    (B) harder for you to concentrate and do yourself justice?

44. In your free hours, do you
    (A) very much enjoy stopping somewhere for refreshments, or
    (B) usually want to use the time and money another way?

45. At the time in your life when things piled up on you the worst, did you find
    (A) that you had gotten into an impossible situation, or
    (B) that by doing only the necessary things you could work your way out?

46. Do most of the people you know
    (A) take their fair share of praise and blame, or
    (B) grab all the credit they can but shift any blame on to someone else?

47. When you are in an embarrassing spot, do you usually
    (A) change the subject, or
    (B) turn it into a joke, or
    (C) days later, think of what you should have said?

48. Are such emotional "ups and downs" as you may feel
    (A) very marked, or
    (B) rather moderate?

49. Do you think that having a daily routine is
    (A) a comfortable way to get things done, or
    (B) painful even when necessary?

50. Are you usually
    (A) a "good mixer", or
    (B) rather quiet and reserved?

51. In your early childhood (at six or eight), did you
    (A) feel your parents were very wise people who should be obeyed, or
    (B) find their authority irksome and escape it when possible?

52. When you have a suggestion that ought to be made at a meeting, do you
    (A) stand up and make it as a matter of course, or
    (B) hesitate to do so?

53. Do you get more annoyed at
    (A) fancy theories, or
    (B) people who don't like theories?

54. When you are helping in a group undertaking, are you more often struck by
    (A) the cooperation, or
    (B) the inefficiency,
    (C) or don't you get involved in group undertakings?

55. When you go somewhere for the day, would you rather
    (A) plan what you will do and when, or
    (B) just go?

56. Are the things you worry about
    (A) often really not worth it, or
    (B) always more or less serious?

57. In deciding something important, do you
    (A) find you can trust your feeling about what is best to do, or
    (B) think you should do the *logical* thing, no matter how you feel about it?

58. Do you tend to have
    (A) deep friendships with a very few people, or
    (B) broad friendships with many different people?

59. Do you think your friends
    (A) feel you are open to suggestions, or
    (B) know better than to try to talk you out of anything you've decided to do?

60. Does the idea of making a list of what you should get done over a week-end
    (A) appeal to you, or
    (B) leave you cold, or
    (C) positively depress you?

61. In traveling, would you rather go
    (A) with a companion who had made the trip before and "knew the ropes", or
    (B) alone or with someone greener at it than yourself?

62. Would you rather have
    (A) an opportunity that may lead to bigger things, or
    (B) an experience that you are sure to enjoy?

63. Among your personal beliefs, are there
    (A) some things that cannot be proved, or
    (B) only things than *can* be proved?

64. Would you rather
    (A) support the established methods of doing good, or
    (B) analyze what is still wrong and attack unsolved problems?

65. Has it been your experience that you
    (A) often fall in love with a notion or project that turns out to be a disappointment—so that you "go up like a rocket and come down like the stick", or do you
    (B) use enough judgment on your enthusiasms so that they do not let you down?

66. Do you think you get
    (A) more enthusiastic about things than the average person, or
    (B) less enthusiastic about things than the average person?

67. If you divided all the people you know into those you like, those you dislike, and those toward whom you feel indifferent, would there be more of
    (A) those you like, or
    (B) those you dislike?

[On this next question *only*, if two answers are true, mark both.]

68. In your daily work, do you
    (A) rather enjoy an emergency that makes you work against time, or
    (B) hate to work under pressure, or
    (C) usually plan your work so you won't *need* to work under pressure?

69. Are you more likely to speak up in
    (A) praise, or
    (B) blame?

70. Is it higher praise to say someone has
    (A) vision, or
    (B) common sense?

71. When playing cards, do you enjoy most
    (A) the sociability,
    (B) the excitement of winning,
    (C) the problem of getting the most out of each hand,
    (D) the risk of playing for stakes,
    (E) or don't you enjoy playing cards?

Go on to the next page.

Which word in each pair appeals to you more?

72.	(A) firm-minded	warm-hearted	(B)	
73.	(A) imaginative	matter-of-fact	(B)	
74.	(A) systematic	spontaneous	(B)	
75.	(A) congenial	effective	(B)	
76.	(A) theory	certainty	(B)	
77.	(A) party	theater	(B)	
78.	(A) build	invent	(B)	
79.	(A) analyze	sympathize	(B)	
80.	(A) popular	intimate	(B)	
81.	(A) benefits	blessings	(B)	
82.	(A) casual	correct	(B)	
83.	(A) active	intellectual	(B)	
84.	(A) uncritical	critical	(B)	
85.	(A) scheduled	unplanned	(B)	
86.	(A) convincing	touching	(B)	
87.	(A) reserved	talkative	(B)	
88.	(A) statement	concept	(B)	
89.	(A) soft	hard	(B)	
90.	(A) production	design	(B)	
91.	(A) forgive	tolerate	(B)	
92.	(A) hearty	quiet	(B)	
93.	(A) who	what	(B)	
94.	(A) impulse	decision	(B)	
95.	(A) speak	write	(B)	
96.	(A) affection	tenderness	(B)	
97.	(A) punctual	leisurely	(B)	
98.	(A) sensible	fascinating	(B)	
99.	(A) changing	permanent	(B)	
100.	(A) determined	devoted	(B)	
101.	(A) system	zest	(B)	
102.	(A) facts	ideas	(B)	
103.	(A) compassion	foresight	(B)	
104.	(A) concrete	abstract	(B)	
105.	(A) justice	mercy	(B)	
106.	(A) calm	lively	(B)	
107.	(A) make	create	(B)	
108.	(A) wary	trustful	(B)	
109.	(A) orderly	easy-going	(B)	
110.	(A) approve	question	(B)	
111.	(A) gentle	firm	(B)	
112.	(A) foundation	spire	(B)	
113.	(A) quick	careful	(B)	
114.	(A) thinking	feeling	(B)	
115.	(A) theory	experience	(B)	
116.	(A) sociable	detached	(B)	
117.	(A) sign	symbol	(B)	
118.	(A) systematic	casual	(B)	
119.	(A) literal	figurative	(B)	
120.	(A) peacemaker	judge	(B)	
121.	(A) accept	change	(B)	
122.	(A) agree	discuss	(B)	
123.	(A) executive	scholar	(B)	

Which answer comes closest to telling how you usually feel or act?

124. Do you find the more routine parts of your day
   (A) restful, or
   (B) boring?

125. If you think you are not getting a square deal in a club or team to which you belong, is it better to
   (A) shut up and take it, or
   (B) use the threat of resigning if necessary to get your rights?

126. Can you
   (A) talk easily to almost anyone for as long as you have to, or
   (B) find a lot to say only to certain people or under certain conditions?

127. When strangers notice you, does it
   (A) make you uncomfortable, or
   (B) not bother you at all?

128. If you were a teacher, would you rather teach
   (A) fact courses, or
   (B) courses involving theory?

129. When something starts to be the fashion, are you usually
   (A) one of the first to try it, or
   (B) not much interested?

130. In solving a difficult personal problem, do you
   (A) tend to do more worrying than is useful in reaching a decision, or
   (B) feel no more anxiety than the situation requires?

131. If people seem to slight you, do you
   (A) tell yourself they didn't mean anything by it, or
   (B) distrust their good will and stay on guard with them thereafter?

132. When you have a special job to do, do you like to
   (A) organize it carefully before you start, or
   (B) find out what is necessary as you go along?

133. Do you feel it is a worse fault
   (A) to show too much warmth, or
   (B) not to have warmth enough?

134. When you are at a party, do you like to
   (A) help get things going, or
   (B) let the others have fun in their own way?

135. When a new opportunity comes up, do you
   (A) decide about it fairly quickly, or
   (B) sometimes miss out through taking too long to make up your mind?

136. In managing your life, do you tend to
   (A) undertake too much and get into a tight spot, or
   (B) hold yourself down to what you can comfortably handle?

137. When you find yourself definitely in the wrong, would you rather
   (A) admit you are wrong, or
   (B) not admit it, though everyone knows it,
   (C) or don't you ever find yourself in the wrong?

138. Can the new people you meet tell what you are interested in
   (A) right away, or
   (B) only after they really get to know you?

139. In your home life, when you come to the end of some undertaking, are you
   (A) clear as to what comes next and ready to tackle it, or
   (B) glad to relax until the next inspiration hits you?

140. Do you think it more important to
   (A) be able to see the possibilities in a situation, or
   (B) be able to adjust to the facts as they are?

141. Do you feel that the people whom you know personally owe their successes more to
   (A) ability and hard work, or
   (B) luck, or
   (C) bluff, pull and shoving themselves ahead of others?

142. In getting a job done, do you depend upon
   (A) starting early, so as to finish with time to spare, or
   (B) the extra speed you develop at the last minute?

143. After associating with superstitious people, have you
   (A) found yourself slightly affected by their superstitions, or
   (B) remained entirely unaffected?

Go on to the next page.

144. When you don't agree with what has just been said, do you usually
   (A) let it go, or
   (B) put up an argument?

145. Would you rather be considered
   (A) a practical person, or
   (B) an ingenious person?

146. Out of all the good resolutions you may have made, are there
   (A) some you have kept to this day, or
   (B) none that have really lasted?

147. Would you rather work under someone who is
   (A) always kind, or
   (B) always fair?

148. In a large group, do you more often
   (A) introduce others, or
   (B) get introduced?

149. Would you rather have as a friend someone who
   (A) is always coming up with new ideas, or
   (B) has both feet on the ground?

150. When you have to do business with strangers, do you feel
   (A) confident and at ease, or
   (B) a little fussed or afraid that they won't want to bother with you?

151. When it is settled well in advance that you will do a certain thing at a certain time, do you find it
   (A) nice to be able to plan accordingly, or
   (B) a little unpleasant to be tied down?

152. Do you feel that sarcasm
   (A) should never be used where it can hurt people's feelings, or
   (B) is too effective a form of speech to be discarded for such a reason?

153. When you think of some little thing you should do or buy, do you
   (A) often forget it till much later, or
   (B) usually get it down on paper to remind yourself, or
   (C) always carry through on it without reminders?

154. Do you more often let
   (A) your heart rule your head, or
   (B) your head rule your heart?

155. In listening to a new idea, are you more anxious to
   (A) find out all about it, or
   (B) judge whether it is right or wrong?

156. Are you oppressed by
   (A) many different worries, or
   (B) comparatively few?

157. When you don't approve of the way a friend is acting, do you
   (A) wait and see what happens, or
   (B) do or say something about it?

158. Do you feel it is a worse fault to be
   (A) unsympathetic, or
   (B) unreasonable?

159. When a new situation comes up which conflicts with your plans, do you try first to
   (A) change your plans to fit the situation, or
   (B) change the situation to fit your plans?

160. Do you think the people close to you know how you feel
   (A) about most things, or
   (B) only when you have had some special reason to tell them?

161. When you have a serious choice to make, do you
   (A) almost always come to a clear-cut decision, or
   (B) sometimes find it so hard to decide that you do not wholeheartedly follow up either choice?

162. On most matters, do you
   (A) have a pretty definite opinion, or
   (B) like to keep an open mind?

163. As you get to know people better, do you more often find that they
   (A) let you down or disappoint you in some way, or
   (B) improve upon acquaintance?

164. When the truth would not be polite, are you more likely to tell
   (A) a polite lie, or
   (B) the impolite truth?

165. In your way of living, do you prefer to be
   (A) original, or
   (B) conventional?

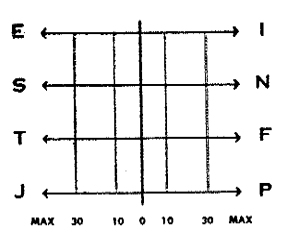
166. Would you have liked to argue the meaning of
   (A) a lot of these questions, or
   (B) only a few?

PRINT NAME _____ (LAST) (FIRST) (MIDDLE)

SEX _____ (M or F) TODAY'S DATE _____ BIRTHDATE _____

AGE _____ UNIT _____ (ORGANIZATION OR SCHOOL GIVING YOU THIS TEST)

OCCUPATION _____ IF NOW IN COLLEGE PUT CLASS (SR., JR., ETC.) AND MAJOR IF NOW IN SCHOOL PUT GRADE AND COURSE (ACADEMIC, BUSINESS, ETC.)



	POINTS	SCORES
E ___ I ___		
S ___ N ___		
T ___ F ___		
J ___ P ___		
	TYPE	TOTAL

A _____

B _____

C _____

D _____

Myers-Briggs Type Indicator—Form F

Make your marks HEAVY and BLACK.

Erase stray marks completely.

1	A B	25	A B	49	A B	72	A B	85	A B	98	A B	111	A B	124	A B	148	A B
2	A B	26	A B	50	A B									125	A B	149	A B
3	A B	27	A B	51	A B									126	A B	150	A B
4	A B	28	A B	52	A B									127	A B	151	A B
5	A B	29	A B	53	A B	73	A B	86	A B	99	A B	112	A B	128	A B	152	A B
6	A B	30	A B	54	A B C									129	A B	153	A B
7	A B	31	A B C	55	A B	74	A B	87	A B	100	A B	113	A B	130	A B		C
8	A B	32	A B	56	A B									131	A B	154	A B
9	A B C	33	A B	57	A B	75	A B	88	A B	101	A B	114	A B	132	A B	155	A B
10	A B	34	A B	58	A B	76	A B	89	A B	102	A B	115	A B	133	A B	156	A B
11	A B	35	A B	59	A B									134	A B	157	A B
12	A B	36	A B	60	A B C	77	A B	90	A B	103	A B	116	A B	135	A B	158	A B
13	A B	37	A B	61	A B									136	A B	159	A B
14	A B C	38	A B	62	A B	78	A B	91	A B	104	A B	117	A B	137	A B C	160	A B
15	A B	39	A B	63	A B	79	A B	92	A B	105	A B	118	A B	138	A B	161	A B
16	A B	40	A B C	64	A B									139	A B	162	A B
17	A B	41	A B	65	A B	80	A B	93	A B	106	A B	119	A B	140	A B	163	A B
18	A B	42	A B	66	A B									141	A B C	164	A B
19	A B	43	A B	67	A B	81	A B	94	A B	107	A B	120	A B	142	A B	165	A B
20	A B	44	A B	68	A B C	82	A B	95	A B	108	A B	121	A B	143	A B	166	A B
21	A B	45	A B	69	A B									144	A B		
22	A B	46	A B	70	A B	83	A B	96	A B	109	A B	122	A B	145	A B		
23	A B	47	A B C	71	A B C									146	A B		
24	A B	48	A B		D E	84	A B	97	A B	110	A B	123	A B	147	A B		

APPENDIX B

PATIENT TERMINATION SUMMARY

PATIENT TERMINATION SUMMARY

NOTE: This form is to be completed for all terminated patients. It should not be viewed as taking the place of a more complete written summary, however, and ideally a written termination summary should accompany this form.

1) a) Patient's name _____ b) File Number _____

2) a) Total sessions (incl. intake) ____ b) missed sessions ____

3) Date of final session _____, 19____

4) Reason for termination:
____ - treatment completed, with patient agreeable to termination.
____ - treatment completed, with patient reluctant to terminate.
____ - patient withdrew against advice of the therapist.
____ - patient withdrew without consulting the therapist.
____ - other (please specify) _____
_____

5) Briefly, please describe the nature of the patient's problem(s) when therapy was started: _____
_____
_____
_____

6) With regard to the problem(s) you have described above, how improved do you believe the patient is overall?

1	2	3	4	5	6	7
very	moderately	slightly		slightly	moderately	very

WORSE . . . . . .IMPROVED

7. What was your predominant psychotherapeutic approach?

____ - behavioral

____ - ego therapy (eg. TA, RET)

____ - psychodynamic (eg. Adlerian, psychoanalytic)

____ - humanistic (eg Rogerian, gestalt)

____ - eclectic

____ - other (please specify) _____

8. Please rate the patient on the following dimensions:

1	2	3	4	5	6	7
very	moderately	slightly		slightly	moderately	very
UNMOTIVATED						MOTIVATED

1	2	3	4	5	6	7
very	moderately	slightly		slightly	moderately	very
UNCOOPERATIVE						COOPERATIVE

9. How thoroughly do you believe you got to know the patient?

1	2	3	4	5	6	7
NOT AT ALL						COMPLETELY

10. Overall, how would you rate your relationship with the patient?

1	2	3	4	5	6	7
very	moderately	slightly		slightly	moderately	very
NEGATIVE						POSITIVE

11. Please list any recommendations or suggestions to be considered if the patient should return to the PSC in the future.

_____

_____

_____

_____

12. How satisfied do you believe the patient was with the therapy he or she received at the PSC?

1	2	3	4	5	6	7
very	slightly	moderately		slightly	moderately	very
DISSATISFIED						.SATISFIED

13. Additional comments: _____

_____

_____

_____

_____

14. Has the PSC secretary been informed of termination in order that a follow-up questionnaire can be sent out?

___ -YES ___-NO

(note: it is the responsibility of the terminating therapist to inform the secretary upon termination)

signed: _____

primary therapist

date: _____, 19___

FOR OFFICE USE ONLY

a) date follow-up form sent: _____

b) date form returned: _____

APPENDIX C

PSYCHOLOGICAL SERVICE CENTRE EVALUATION

Questionnaire # _____

PSYCHOLOGICAL SERVICE CENTRE EVALUATION

We are in the process of evaluating the services at the Psychological Service Centre (PSC), and we are interested in your personal impressions of the service you received. We are also interested in any suggestions you may have that will enable us to better serve the people we see. In order to do this, we would like to ask that you take a few minutes to complete this questionnaire and return it to us in the stamped envelope we have enclosed for your convenience.

We would like to emphasize how important it is to receive your frank feedback. This is one way that we may be able to improve our services, and so we encourage you to be completely honest in your responses. In order to make it easier for you to provide this feedback to us, we have coded this questionnaire with an identifying number that is known only to an independent researcher. Only this researcher will have access to this questionnaire, and he will be keeping it confidential from all the staff at the PSC. Only the overall results of all the questionnaires will be available to them. Under no circumstances will the therapist you saw be able to learn how you have responded on this questionnaire. While most of you would probably be quite satisfied with less confidentiality on your answers, we want to do everything possible to encourage you to send us only your frank answers.

We wish to offer our thanks in advance for your cooperation in completing this questionnaire. We believe that this is an important matter, and we are grateful for your assistance.

* * * * * * * * * * * * * * * *

DIRECTIONS: Starting on the next page, please circle the number that best describes how you feel on each question or fill in the blanks where appropriate.

1) How comfortable did you feel in talking about your problems?

1	2	3	4	5	6	7
very	moderately	slightly		slightly	moderately	very
UNCOMFORTABLE						COMFORTABLE

2) I would rate the person I saw for help at the PSC as:

1	2	3	4	5	6	7
very	moderately	slightly		slightly	moderately	very
COLD						WARM

1	2	3	4	5	6	7
very	moderately	slightly		slightly	moderately	very
UNTRUSTWORTHY						TRUSTWORTHY

1	2	3	4	5	6	7
very	moderately	slightly		slightly	moderately	very
NOT UNDERSTANDING						UNDERSTANDING

1	2	3	4	5	6	7
very	moderately	slightly		slightly	moderately	very
INEFFECTIVE						EFFECTIVE

3) Would you recommend the person you saw to others who might be coming to the PSC?

1	2	3	4	5	6	7
NOT AT ALL						VERY STRONGLY

4) Briefly, please describe the problem(s) that brought you to the PSC: _____

_____

_____

5) With regard to the problem(s) you have described in question 4, how improved do you believe things are?

1	2	3	4	5	6	7
very	moderately	slightly		slightly	moderately	very

WORSE . . . . . IMPROVED

6) Please check which of the following applied to you when you terminated your sessions at the PSC:

____ - both my therapist and myself agreed that termination was appropriate.

____ - I decided to terminate, although my therapist was in favour of my continuing to come in.

____ - I stopped coming without consulting my therapist.

____ - My therapist encouraged termination, although I was not sure that this was a good idea.

____ - other reasons (please specify) _____

_____

7) What, if anything, do you believe helped you in the therapy you received at the PSC? _____

_____

_____

_____

8) What, if anything, did you dislike about the therapy you received at the PSC? _____

_____

_____

_____

9) Would you recommend the PSC to someone you knew if you believed that they were having problems?

1	2	3	4	5	6	7
NOT AT ALL						VERY STRONGLY

10) Overall, I would rate my satisfaction with the therapy I received at the PSC as:

1	2	3	4	5	6	7
very	moderately	slightly		slightly	moderately	very
DISSATISFIED						SATISFIED

11) If you have any comments or suggestions that might improve the services at the PSC, please mention them here.

_____

_____

_____

_____

_____

_____

_____

_____

* * * * * * * * * * * * * * * *

THANK-YOU

FOR YOUR COOPERATION

APPENDIX D

SELF-RATING BEHAVIORAL SCALE (SRBS)

SELF-RATING BEHAVIORAL SCALE (SRBS)

DIRECTIONS: The behaviors which a person learns determine to a large extent how well he or she gets along in life. Below is a list of behaviors which can be learned. Please check the ones which you think you need to learn in order to function more effectively or to be more comfortable.

I need to learn:

____ 1. to stop drinking too much.
____ 2. to stop smoking too much.
____ 3. to stop eating too much
____ 4. to control my feelings of attraction to members of my own sex.
____ 5. to control my feelings of attraction to the opposite sex.
____ 6. to overcome my feelings of nausea when Im nervous.
____ 7. to stop thinking about things that depress me.
____ 8. to stop thinking about things that make me anxious.
____ 9. to feel less anxious in crowds.
____ 10. to feel less anxious in high places.
____ 11. to stop worrying about my physical condition.
____ 12. to feel less anxious in airplanes.
____ 13. to stop stuttering.
____ 14. to stop washing my hands so often.
____ 15. to stop cleaning or straightening things up so often.
____ 16. to stop biting my fingernails.
____ 17. to take better care of my physical appearance.
____ 18. to feel less anxious in enclosed places.
____ 19. to feel less anxious in open places.
____ 20. to feel less afraid of pain.
____ 21. to feel less afraid of blood.
____ 22. to feel less anxious about contamination or germs.
____ 23. to feel less anxious about being alone.
____ 24. to feel less afraid of the darkness.
____ 25. to feel less afraid of certain animals.
____ 26. to stop thinking the same thoughts over and over.

____ 27. to stop counting my heartbeats.
____ 28. to stop hearing voices.
____ 29. to stop thinking people are against me or out to get me.
____ 30. to stop seeing strange things.
____ 31. to stop wetting the bed at night.
____ 32. to stop taking medicine too much.
____ 33. to stop taking too many pills.
____ 34. to stop taking dope.
____ 35. to stop having headaches.
____ 36. to control my urge to gamble.
____ 37. to be able to fall asleep at night.
____ 38. to control my desire to expose myself.
____ 39. to control my desire to put on clothing of the other sex.
____ 40. to control my sexual attraction to people's belongings.
____ 41. to control my desire to hurt other people or to be hurt.
____ 42. to control my sexual feelings towards young children.
____ 43. to control my desire to steal.
____ 44. to control my tendency to lie.
____ 45. to stop daydreaming a lot.
____ 46. to control my desire to yell or hit others when I'm angry.
____ 47. to manage money better so I have enough for what I need.
____ 48. to stop saying "crazy" things to other people.
____ 49. how to carry on a conversation with other people.
____ 50. to be more comfortable talking with other people.
____ 51. to stop bugging other people too much.
____ 52. to be less forgetful.
____ 53. to stop thinking about committing suicide.
____ 54. to control my urge to set fires.
____ 55. to hold down a steady job.
____ 56. to feel more comfortable on my job.
____ 57. to stop swearing at other people.
____ 58. how not to be upset when others criticize me.
____ 59. to speak up when I feel I'm right.
____ 60. to stop putting things off that need to be done.

____ 61. to stop thinking so much about things that make me feel guilty.

____ 62. to feel less anxious when my work is being supervised.

____ 63. to feel less anxious about sexual thoughts.

____ 64. to feel less anxious about kissing.

____ 65. to feel less anxious about petting.

____ 66. to feel less anxious about sexual intercourse.

____ 67. to be able to make decisions when I have to.

____ 68. to feel at ease just being with others in a group.

____ 69. to feel at ease talking to other people in a group.

____ 70. to feel less anxious about _____.

____ 71. to feel less guilty about _____.

____ 72. to control my desire to _____.

____ 73. to change my _____.

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APPENDIX E

PSYCHOLOGICAL TYPE TABLES

MYERS-BRIGGS TYPE INDICATOR

TYPE SCORES FOR 53 PSC THERAPISTS

SENSING TYPES with THINKING	SENSING TYPES with FEELING	INTUITIVE TYPES with FEELING	INTUITIVE TYPES with THINKING	
ISTJ N= 0 %= 0	*ISFJ* N= 1 %= 2	*INFJ* N= 5 %= 9.5	*INTJ* N= 5 %= 9.5	JUDGING
ISTP N= 1 %= 2	*ISFP* N= 1 %= 2	*INFP* N= 8 %= 15	*INTP* N= 6 %= 11	INTROVERTS PERCEPTIVE
ESTP N= 0 %= 0	*ESFP* N= 2 %= 4	*ENFP* N= 8 %= 15	*ENTP* N= 3 %= 5.5	PERCEPTIVE EXTRAVERTS
ESTJ N= 2 %= 4	*ESFJ* N= 3 %= 5.5	*ENFJ* N= 5 %= 9.5	*ENTJ* N= 3 %= 5.5	JUDGING

	PSC therapists (N=53)	adult norms (N=6160)
E	49%	54%
I	51%	46%
S	19%	39%
N	81%	61%
T	38%	61%
F	62%	39%
J	45%	59%
P	55%	41%

MYERS-BRIGGS TYPE INDICATOR

TYPE SCORES FOR 67 PSC PATIENTS

SENSING TYPES with THINKING	SENSING TYPES with FEELING	INTUITIVE TYPES with FEELING	INTUITIVE TYPES with THINKING	
ISTJ N= 5 %= 7.5	*ISFJ* N= 13 %= 19	*INFJ* N= 6 %= 9	*INTJ* N= 1 %= 1.5	JUDGING
ISTP N= 4 %= 6	*ISFP* N= 8 %= 12	*INFP* N= 5 %= 7.5	*INTP* N= 4 %= 6	PERCEPTIVE — INTROVERTS
ESTP N= 1 %= 1.5	*ESFP* N= 4 %= 6	*ENFP* N= 4 %= 6	*ENTP* N= 0 %= 0	PERCEPTIVE — EXTRAVERTS
ESTJ N= 3 %= 4.5	*ESFJ* N= 5 %= 7.5	*ENFJ* N= 4 %= 6	*ENTJ* N= 0 %= 0	JUDGING

	PSC patients (N=67)	adult norms (N=6160)
E	31%	54%
I	69%	46%
S	64%	39%
N	36%	61%
T	27%	61%
F	73%	39%
J	55%	59%
P	45%	41%

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