TREATMENT PREFERENCE AND ACCEPTABILITY:

PERSONAL EPISTEMOLOGY AND LOCUS OF CONTROL

BY

NORAH K. VINCENT

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF ARTS

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A Thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

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Abstract

Treatment preference and acceptability was investigated in 397 female university students. Three audiovisual vignettes depicting a client-therapist dyad discussing a body-image disturbance problem were presented to subjects. Predictions were that subjects would prefer one of three therapy approaches (behavioral, cognitive-rational, or cognitive-constructivist) as a function of personal epistemology and locus of control. Independent measures [eg., Psycho-Epistemological Profile (Royce & Mos, 1980), Locus of Control scale (Rotter, 1966)] were collected prior to viewing the vignettes. In addition, attitudes and behaviors relating to weight and eating were collected using the Eating Attitudes Test (Garner & Garfinkel, 1979) and the Bulimia Test (Smith & Thelen, 1983) so that a sub-clinical eating disturbed group could be identified. After each film, subjects completed two dependent measures [Counselling Satisfaction Questionnaire (Larsen, 1977); Counsellor Rating Form (Corrigan & Schmidt, 1983)], and after viewing all three films, completed a ranked preference measure. Results indicated that matching individuals of a particular epistemic style to a corresponding therapeutic modality does not produce significantly

elevated ratings of that approach or therapist. Results also showed that matching individuals on dimensions of locus of control to directive/non-directive treatments differentially influenced ratings of therapeutic approaches and therapists. Externals with elevated body-image dissatisfaction were found to rate the directive therapists (ie., behavioural, rational) more favourably than internals. In contrast, internals with elevated body-image dissatisfaction were noted to rate the non-directive therapists (ie., constructivist) more positively than externals. Implications for matching clients to different therapeutic modalities and therapists are discussed.

Treatment Preference and Acceptability : Personal Epistemology and Locus of Control

Anorexia nervosa and bulimia nervosa have been increasingly documented by physicians, nurses, dieticians and psychologists (Kerr, Skok, & McLaughlin, 1991). Current estimates are that, depending on population selected, .4 to 1% of females meet diagnostic criteria for anorexia and 2 to 15% meet diagnostic criteria for bulimia (National Institute of Nutrition, 1989)(See Appendix A for current diagnostic criteria). Far more numerous in number are documented cases of sub-clinical eating disturbances where clear symptoms of anorexia and bulimia are present in the absence of a full-syndrome. These cases have been termed partial syndromes or sub-clinical conditions (Mann, Wakeling, Wood, Monck, Dobbs, & Szmukler, 1983). Sub-clinical cases of anorexia and bulimia can be identified through a clinical interview or by scores on standard eating disorder indices, and depending on population sampled, anywhere from 5 to 40% of females can be classified as such (Pope, Hudson, Yurgelun-Todd, & Hudson, 1984).

Psychological features associated with eating disorders include elevated depression (Halmi, 1987;

Strauss & Ryan, 1987) psychopathic deviation, neuroticism, greater need for acceptance, lower physical self-esteem (Dykens & Gerrard, 1986) greater alcohol consumption (Manley, 1989), cognitive distortions (Schlundt & Johnson, 1990), simple, concrete, thinking styles (Manley, 1989), body-image disturbance (Halmi, 1987), and a more external locus of control (Dykens & Gerrard, 1986).

Treatment For Anorexia and Bulimia

While many different interventions are used to treat anorexia and bulimia (Appendix B), two of the more popular broad-spectrum approaches to treating eating disorders are those in the cognitive and behavioural classes. For a review of cognitive and behavioural approaches, see Appendix C.

Behaviour Therapy. Short-term outcomes of behaviour therapy are normally positive and include weight restoration and the return of menstruation, yet long-term outcomes are poor (Yates, 1989). Fifty percent of patients treated in hospital with behaviour therapy will relapse within a year (Schwartz & Thompson, 1981).

Cognitive-rational Therapy. Few studies have evaluated the outcome of cognitive-rational treatment

groups despite the finding that most psychological treatments have emphasized cognitive-restructuring in one way or another (Hawkins, Fremouw, & Clement, 1984). When used to treat bulimia, reductions in vomiting and binging frequency have been noted (Wilson et al., 1985). Compared to cognitive-behaviour therapy, rational treatments for anorexia and bulimia are not as effective in reducing depression, hostility, phobic anxiety, obsessive-compulsive symptomatology, bulimic symptomatology, and increasing confidence in dietary restraint (Fairburn, Sinclair, Turnbull, & Annandale, 1985; Wilson et al., 1985).

Cognitive-constructivist Therapy. Due to the relatively recent appearance of constructivist treatment descriptions, outcome data is not yet available.

In summary, despite assorted treatment efforts, Hall, Slim, Hawker, and Salmond (1984) note that most anorexics continue to diet and 79% consider themselves overweight. Nussbaum, Shenker, Baird, and Saravay (1985) comment that after treatment, 40% report chronic depression and 22%, unsatisfactory social relationships. Little is known about the long-term outcomes for bulimia (Steinhausen et al., 1991),

although Yager, Landsverk, and Edelstein (1987) comment that there is a general trend for modest improvement in bingeing and purging behaviours in about 25%. Yager et al. (1987) note that the degree of psychological distress in bulimics changes little after treatment.

Attrition

One frequent impediment to treatment is attrition (Pekarik & Finney-Owen, 1987). The great majority of studies investigating attrition in the general clinical population have focused on either client variables (ie., education, socioeconomic status) or therapist variables (ie., age, ethnicity), with equivocal findings. More recent research efforts have been directed at client-therapist variables and their relationship to attrition. It has been demonstrated that therapist ratings of client involvement in therapy predicts likelihood of dropout (Kolb, Beutler, Davis, Crago, & Shanfield, 1985). It has also been shown that client perception of therapist trustworthiness, expertness, and attractiveness is related to premature termination, with clients who rate their therapist as high on these dimensions, less likely to drop-out (McNeill, Lee, & May, 1987; Pekarik, 1985). Additionally, client satisfaction or dissatisfaction

with intake interview has been found to be the best predictor of premature termination (Koktovic & Tracey, 1987; Pekarik, 1985). In a review of client satisfaction with mental health treatment Lebow (1983) notes a correlation between successful completion of therapy and client satisfaction.

Attrition in eating disorders. Attrition in the eating disordered population has been investigated only minimally. In a meta-survey of drop-out rates for anorexia treatments between 1953-1981, the mean drop-out rate was found to be 11%, with a range from 0-77. This rate has increased to 24% in the 1980's, with a range from 0-27 (Steinhausen, Rauss-Mason, & Seidel, 1991). This increase in attrition can be viewed optimistically or otherwise; as due to increased effectiveness of treatment with clients dropping out because their problem has been resolved or due to increased dissatisfaction with treatment. A similar survey has not been conducted for the bulimic population.

Two studies examined inpatient attrition in behavioural treatment for anorexia nervosa (Pierloot, Vandereycken, & Verhaest, 1982; Vandereycken & Pierloot, 1983). No research investigations of

attrition in cognitive-rational, constructivist, psychoanalytic, or multi-modal interventions for anorexia have been conducted.

Pierloot et al. (1982) examined attrition in a group of 145 anorexic patients treated between 1967-1969 by psychiatrists and psychiatric nurses. The primary treatment technique employed was operant conditioning and the mean attrition rate was 49%.

Vandereycken and Pierloot (1983) investigated attrition in female inpatient anorexics. Treatment lasted 11 months and subjects received one of three different forms of behavioural therapy differing in the amount of reinforcement deprivation and social isolation. All treatments were administered by psychiatrists or psychiatric nurses. A total attrition rate of 50% was found and follow-ups on 28% of the drop-outs (95 subjects) were completed. Findings indicate that dropping out was a function of the following: age at admission (younger were more likely to drop-out); duration of illness (earlier drop-outs had longer durations than later drop-outs); educational level (less education in drop-outs); social class (early drop-outs came from lower social classes than later drop-outs); and treatment method. Subjects in the

behavioural treatment which had a contract system, relatively large amounts of freedom, and no strict deprivation, were more likely to drop out, and to do so early on in treatment. This might suggest that a more directive environment lessens attrition.

Difficulties in Treatment

Foreyt and McGavin (1989) note that other problems encountered when treating anorexics and bulimics include client resistance, major depression, the presence of severe personality disorders (ie., Borderline Personality Disorder), and accompanying medical complications (gastrointestinal pain, erosion of teeth enamel).

Matching Hypothesis

Having suggested that treatment gains for the eating disordered population have been modest and difficulties with treatment abound, the more general question remains "What can be done about it?" The "matching model" thesis may be useful in exploring this question. This thesis states that superior outcomes will be achieved when there is a match between client and counselling approach. Similarly, the "matching thesis" claims that clients will prefer therapy approaches which are more similar to their specific

cognitive or attitudinal styles (Fry & Charron, 1980).

Evidence for the matching model thesis can be found in social psychology research. Simons, Berkowtiz, and Moyer (1970) note that "various types of similarity and dissimilarity have differential effects on various credibility factors and that different components of credibility in turn have differential effects on message acceptance (p. 2). Receivers of information perceive sources similar to themselves as more attractive and credible than dissimilar sources. Additionally, similarities in areas of interests, beliefs, and feelings plays a more significant role in determining attraction and credibility than does similarities in demographic characteristics such as race or sex. Simon et al. (1970) conclude that source attractiveness, credibility, and influence are enhanced by relevant similarities between source and receiver.

Based on the findings in social influence research, many have advocated a connection between social psychology and psychotherapeutic research (Goldstein, Heller, & Sechrest, 1966; Levy, 1963; Strong, 1968). This is the idea that enhancing the optimal match between therapist and client will increase client ratings of therapist attractiveness,

credibility, and influence.

Atkinson and Schein (1986) reviewed studies examining client-therapist attitude similarity in psychotherapy. Of 16 studies reviewed, ten found evidence that client-therapist attitude similarity effected client ratings of perceived therapist attractiveness, credibility, and willingness to see the therapist. In a later review on social influence research in counselling, Heppner and Claiborn (1988) comment that research on client-counsellor similarity provides some support for the similarity hypothesis, although complex interactions between client, message, and therapist variables are also indicated. For example, Berry and Sipps (1991) note the interactive effect of client self-esteem in moderating the positive effects of client-therapist similarity. They illustrate that if a client devalues characteristics of himself or herself, then the client may also devalue these characteristics in the therapist, so that a more similar therapist will appear less attractive. These researchers found that premature termination was a function of the relationship between client-therapist similarity and client self-esteem. The greater the similarity between client and therapist, and the lower

the client's self-esteem, the more likely the client was to terminate prematurely.

Other complexities in the relationship between client counsellor similarity and positive client evaluations/outcomes of therapy may depend on the quality of what is said by the therapist and the client's motivation and ability to process the message. Petty and Cacioppo (1981) note that if the client lacks motivation or the ability to think about a message, then the client is more likely to be effected by characteristics of the communicator, such as therapist sex or race. If the client is motivated to think about the message, perhaps because the topic is relevant to the client, then attitude change will be more a function of information provided by the therapist. For example, Glidden and Tracey (1989) presented subjects with either a personal or a sociocultural explanation for a body-image disturbance problem. The authors found that subjects with high levels of body-image disatisfaction had elevated scores on indices measuring satisfaction with therapy compared to subjects with low levels of body-image disatisfaction. Identification with the target problem produced elevated ratings of all types of therapy.

Matching Client to Therapy Type

Clients have been matched to therapy types on variables such as conceptual level (Stoppard & Miller, 1985), acculturation level (Pomales & Williams, 1989), self-disclosure style (Kowitt & Garske, 1978); sex role attitude, severity and concern for weight and body image disturbance (Glidden & Tracey, 1989), theoretical orientation (Madell, 1982), locus of control (Foon, 1987; Hood, Moore, & Garner, 1982) and personal epistemology (Lyddon, 1989).

It appears that matching on some variables, for some populations, increases ratings of client satisfaction and improves outcome, although, overall the findings are mixed. In view of the necessary complexities of a matching model, a more preferred approach may be to consider matching client and therapy meta-systems. Preferably the matched meta-system should relate to cognitive functioning since the most positive results derived from matching clients to therapists have been in areas of belief and attitude (Atkinson & Schein, 1986). Two such meta-systems are world view and locus of control.

Locus of Control. Locus of control refers to a person's belief about the way his or her behaviour will

affect the control of life events (Rotter, 1966). In Rotter's (1966) locus of control theory, beliefs about control are described as generalized expectancies reflecting individual differences in the degree to which people perceive contingencies (or independence) between their actions and subsequent events. Differences in control orientation in the population are thought to occur on a continuum from external locus of control to internal locus of control. Individuals on the internal end of the continuum are thought to view personal outcomes as dependent on personal actions, whereas individuals on the external end are thought to view personal outcomes as controlled by external agents and thus independent of one's actions.

Based on Rotter's (1966) locus of control theory, individuals with an external locus of control are predicted to prefer and perform better in more directive treatments, whereas individuals with an internal locus of control are predicted to prefer and perform better in more non-directive treatments. One explanation for these predictions is that externals and internals may differ in their capacity to self-regulate (Bellack, 1975). Bellack comments that individuals who are more able to administer self-reinforcement will be

less dependent on external consequation for behaviour, and thus more internally oriented. Alternatively, individuals who are less able to administer self-reinforcement will be more dependent on external consequation for behaviour, and thus more externally oriented. Bellack concludes that external locus of control may be a self-regulation deficit, wherein externals are unable to evaluate their behaviour adequately without external input, and so do not effectively use self-reinforcement.

Evidence confirming the prediction that internals prefer more non-directive treatments exists (Friedman & Dies, 1974; Jacobson, 1970; Killman & Sotile, 1976). Contradictory results, however, have also been obtained (Killmann, 1974; Stuehm, Cashen, & Johnson, 1977). Many studies report that individuals with an external locus of control have better outcomes in structured therapies (Abramowitz et al., 1974; Balch & Ross, 1975; Best & Steffy, 1975; Chambliss & Murray, 1979; Foon, 1987; Kilmann, Albert, & Sotile, 1975; Killman & Sotile, 1976), and some fail to find this (Kinder & Kilmann, 1976; Meinster, 1974). Perhaps an explanation for the equivocal findings concerning whether locus of control predicts therapy preference

and outcome is that the issue of control may be more relevant for certain populations with certain problems. For some, feelings of being in control may be more central to their difficulties. For example, several have commented on the importance of control in initiating and maintaining anorexic and bulimic symptomatology (Bruch, 1973; Mahoney, 1991). Anorexics and bulimics frequently report the need to highly control their environments including their weight, body shape, and caloric intake. When unable to do so, these individuals report feelings of failure, guilt, and shame. Thus, anorexia and bulimia have been conceptualized as disorders of control (Bruch, 1973; Mahoney, 1991). Individuals with these disorders would be expected to have an external locus of control and assorted research efforts confirm this (Swain, Crago, & Shisslak, 1991).

Personal Epistemology. Personal epistemologies are different ways of knowing that each person uses in order to obtain information about the nature of the world around them. Research reveals that differences in personal epistemology are a function of relative commitments to different approaches to knowing (Kearsley, 1976; Nosal, 1984; Royce & Mos, 1980; Royce

& Powell, 1983). These approaches to knowing are termed epistemic styles and several claim that there are three basic epistemic styles: rationalism; empiricism; and metaphorism (Diamond & Royce, 1980; Royce & Powell, 1983; Wardell & Royce, 1978). These epistemic styles are conceptualized as higher order personality factors which can be thought of as different ways to integrate new experiences, observations, and facts, and to re-organize pre-existing knowledge (Kearsley, 1976). Epistemic styles are distinct from one another in underlying cognitive processes and underlying epistemological justifiability (how beliefs are justified)(Appendix D).

These three approaches to knowing (rationalism, empiricism, metaphorism) are not mutually exclusive. Individuals use all of these three approaches to knowing (epistemic styles) but vary on their degree of reliance on each of the three styles (Royce & Powell, 1983). Royce and Powell (1983) note that there are wide variations in the possible combination of epistemological profiles within an individual, and that people have a hierarchical commitment with respect to these three epistemologies. An individual might have a dominant metaphoric way of knowing, followed by a less

dominant empirical way of knowing, which in turn is followed by a rational way of knowing. For example, the scientist conceptualizes, symbolizes, and perceives, but may minimize metaphoric symbolizing as the final criterion.

The idea that each person has a dominant or preferred theory of knowledge (epistemology) is not an unusual or novel assertion. Since the 18-19th centuries, philosophers and psychologists have been suggesting that humans are limited in their knowledge of reality. The idea that we are unable to know the totality of reality and are constrained by the psychological limits of being a knower is an old one. Moreover, more recently, researchers have suggested that personality differences may determine our view of reality and in so doing, serve to further encapsulate us (Royce, 1964).

Epistemic Styles and Psychotherapy

Rationalism. Rationalism's main claim is that thought is superior to the senses for knowledge acquisition and represents a commitment to testing ideas about reality in terms of their logical consistency. Individuals with rationalist epistemic styles would agree with the propositions of Beck (1976)

and Ellis (1958) that psychological dysfunction is caused by irrational, illogical beliefs. Additionally, rationalists would argue that irrational emotions or behaviours can, and ought to be controlled by rational thought. This is illustrated in cognitive-rational therapy by the process of systematically analyzing and refuting personal beliefs and arguments, in favour of more rational alternatives. Thus, the epistemological world view underlying cognitive-rational therapy is rationalism (Liotti & Reda, 1981; Lyddon, 1989; Mahoney, 1991; Messer & Winokur, 1980).

Empiricism. Empiricism's central tenet is that the senses are the primary and only way to know something and that we know to the extent that we perceive correctly. For example, empiricists are hesitant to believe in anything or any method not involving behaviour. Thus, an empiricist would be unlikely to put much faith in private internal experiences and the introspective method. Individuals with empirical epistemic styles would view psychological dysfunction as one or more dysfunctional learned behaviours. To help reduce psychological distress, empiricists would advise changing behaviours to promote changes in affect and cognition. Thus, the philosophical foundation or

world view underlying behavioural therapy is empiricism (Bandura, 1977; Schact & Black, 1985; Skinner, 1953; Mahoney, 1991).

Metaphorism. Metaphorists view knowledge not as necessarily fixed, but as rooted in individually and socially constructed symbolic processes. Metaphorism represents the idea that personal realities are changeable and that what we know is constructed by our external experience, our own unique learning histories, and by our own subjective constructive processes. This is the notion that reality is a dynamic whose parts are mutually determined and in a state of flux. Individuals with metaphoric epistemic styles would view psychological dysfunction as an individual's imperfect attempt to adapt and develop, or a lack of resilience to adjustment. Metaphorists, unlike empiricists and rationalists would not view psychological problems and emotional distress as inherently negative. Emotional distress is conceptualized as representing a limit in any one individual's current capacities to adapt and develop. To a metaphorist, the person who engages in regular cycles of emotional disorganization is just as psychologically healthy as someone who is relatively unbothered by periods of emotional distress.

Metaphorists promote cognitive change in the form of taking new perspectives, but do not believe in abandoning entire systems of beliefs, as a rationalist would advise. Metaphorists also promote behavioural change in the form of experimenting with new ways of behaving and being. This is different from the empiricist approach, in that empiricists focus on reinforcing particular behaviours. The metaphorist would reinforce all attempts made at experimenting with new behaviours within a reasonable limit. Unlike empiricist and rationalist world views, validity of knowledge is less important than its viability, meaning that development does not occur because our mental representations of self and world are progressively more valid, accurate, or true, but instead because they are more viable, flexible, and resilient (Mahoney, 1991). This is exemplified in constructivist therapy by the therapist encouragement in client perspective-taking and client interpretation of events. Thus, the philosophical foundation or world view underlying constructivist and also psychoanalytic therapy is metaphorism (Guidano & Liotti, 1983; Lyddon, 1989; Mahoney, 1991; Neimeyer, 1993; Schact & Black, 1985; Siegelman, 1990).

Personal Epistemology and Treatment Acceptability

In view of the finding that people tend to have a single dominant epistemic style (Royce & Mos, 1980), it follows from the matching model hypothesis, that the most preferred client-therapy match would be one in which the clients' epistemic style is mirrored in the underlying epistemic style of the therapeutic approach.

Lyddon (1989) examined the relationship between epistemological style and therapy preference. Three written descriptions of therapy approaches were presented to subjects. The scripts disclosed the goals, philosophies, and treatment strategies for behavioral, rational, and constructivist interventions. Subjects completed a measure assessing personal epistemic style, and then ranked their therapy preference from most to least preferred. Results indicated that when presented with three therapeutic approaches, subjects with dominant empirical epistemic styles preferred behavioral approaches, subjects with dominant rational epistemic styles preferred rational approaches, and subjects with dominant metaphoric epistemic styles preferred constructivist approaches. Lyddon's findings support the hypothesis that individuals will prefer therapy approaches which have similar epistemological

bases as they themselves have. Research is lacking that examines whether a particular epistemic style characterizes the eating disorder population or if epistemic styles are predictive of therapy preference for this group.

Locus of Control and Treatment Acceptability

In view of the finding that people prefer different amounts of control in their lives, it follows from Bellack's hypothesis that the most preferred client-therapy match would be one in which clients with an external locus of control are matched with directive therapy approaches, such as behavioural or cognitive-rational, and clients with an internal locus of control are matched with non-directive approaches, such as a cognitive-constructivist approach. Alternatively, individuals with an external locus of control may recognize their inability to evaluate their own behaviour adequately in the absence of external input, and so would therefore prefer a directive approach. Similarly, individuals with an internal locus of control may recognize their ability to evaluate their behaviour in the absence of external input, and so would therefore be more amenable to a non-directive approach. Further, there is evidence that individuals

with anorexia or bulimia have an external locus of control and there is some evidence that external locus of control is associated with a preference for more directiveness in therapy and better therapy outcomes in more directive conditions. There has been no research examining the association between locus of control and personal epistemology.

Current Study

The purpose of this study was to assess eating disturbance, locus of control, and epistemic styles in a female university sample. The study examined the relationship of these variables to assessments of therapeutic preference and ratings of treatment acceptability by having subjects view three audiovisual vignettes of a behavioural, cognitive-rational, and cognitive-constructivist intake interview. Thus, the study examined whether subjects' preferences for therapeutic approach were mediated by the effects of individual differences in personal epistemology and locus of control.

Of particular interest was preferred therapeutic modality for a sub-clinical eating disturbed sample. The study examined whether or not topic relevance would influence satisfaction scores for a sub-clinical group

and whether individuals with sub-clinical anorexic and bulimic-like conditions would have a more external locus of control.

Hypotheses.

1. Subjects with more disturbed eating attitudes and behaviours will have a more external locus of control compared to subjects with less eating pathology.
2. Subjects with sub-clinical eating disorders will have stronger preferences for therapy approach compared to subjects with no eating pathology.
3. Subjects with an external locus of control will prefer either the behavioural or the cognitive-rational therapy vignettes over the constructivist therapy vignette.
4. Subjects with an external locus of control will prefer the behavioural or the cognitive-rational therapist over the constructivist therapist.
5. Subjects with dominant empirical epistemic styles will prefer the behavioural approach, those with dominant rational epistemic styles will prefer the rational approach, and those with dominant metaphoric epistemic styles will prefer the constructivist therapeutic intervention.
6. Subjects with dominant empirical epistemic styles

will prefer the behaviour therapist, those with dominant rational epistemic styles will prefer the rational therapist, and those with dominant metaphoric epistemic styles will prefer the constructivist therapist.

Method

Design

Three independent variables were arranged in a 3 X 3 X 2 (Therapy approach X Epistemic style X Locus of Control) repeated measures design.

Subjects

Subjects were 397 female, full-time (63.5%), single (89%), university psychology undergraduates with a mean age of 20.4 years (*SD* = 6.52). Eighty-one percent of the sample was Caucasian, 9.1% Asian, 2.5% East Indian, 2.5% West Indian, and 2% North American Indian. The remainder was Black or described themselves as some combination of the above. Fifty-five percent of the sample had some previous university, 39.3% were high school graduates, 2.6% had trade school or community college backgrounds, 1.1% had some graduate school, and 2% had some combination. Eight percent of the sample was employed part-time.

Of the total sample of 397 subjects, 60% (237) had

a dominant commitment to empiricism, 27.1% (107) showed a profile highest in rationalism, and 12.9% (51) indicated metaphorism to be their dominant epistemology. Seven percent (27) of the sample had equivalent t-scores in two or more of the dimensions. Ties were resolved by randomly assigning each subject to one of two equivalent dimensions.

Based on a median split of scores from the Locus of Control scale, 49% (193) of the sample was categorized as having an internal locus of control and 51% (204) as having an external locus of control.

Demographic questions pertaining to dissatisfaction with personal body shape revealed that 6% (24) of the sample was 'extremely dissatisfied' with body shape, 17.6% (70) indicated being 'very dissatisfied', and 34.3% (135) reported being 'moderately dissatisfied' with personal shape. The remainder was not at all dissatisfied or endorsed more than one response to this question. Satisfaction with body shape correlated positively with income $r(397) = .12$, $p = .02$ and negatively with both BMI $r(395) = -.27$, $p = .0001$ and frequency of binge eating episodes $r(397) = -.13$, $p = .008$. Subjects who were more satisfied with their body shape tended to have parents

with higher incomes, to have lower BMI scores, and to report less binge eating compared to those who were less satisfied with personal body shape.

Sixty-nine percent (274) of subjects met criteria for a sub-clinical eating disturbance. Of this sub-clinical group, 64% (175) had a dominant commitment to empiricism, 24.5% (67) showed a profile highest in rationalism, and 11.4% (31) indicated metaphorism to be their dominant epistemology. The same locus of control distribution was found for the sub-clinical eating disturbed sample (n = 274).

Eighteen percent (73) of the entire sample reported previous therapy experience. Seventy-three percent of subjects with a prior therapy history reported that treatment was successful in helping them with their problem. Of these subjects, equal numbers (n = 20) reported prior behavioral, interpersonal, or psychoanalytic therapy, seven subjects noted past cognitive therapy, and six subjects had past group therapy experience. Seventy-seven percent of past therapy utilizers reported having personal therapy sometime between 1990 and 1992. Mean number of sessions of therapy was 12.84 (SD = 20.67) and mean duration of sessions was 20.4 weeks (SD = 25.02).

Materials

Eating Disorder Survey (EDS)-Modified. A modified version of the Eating Disorder Survey (Johnson, 1985; Appendix E) was used to collect demographic information (socio-economic status, age, height, weight, Body Mass Index), as well as information on attitudes and behaviours associated with eating and weight (menstrual history, bingeing, vomiting, fasting, fear of fatness), and on previous therapy experience. Approximately 50% of Johnson's original survey items were omitted for the purposes of brevity. Subjects were asked to identify themselves for the purposes of recontacting for follow-up research.

Eating Attitudes Test (EAT). The Eating Attitudes Test measured disturbed beliefs and attitudes characteristic of anorexia nervosa (Garner & Garfinkel, 1979)(Appendix F). Subjects scoring between 10 and 30 on the EAT were considered to have sub-clinical anorexia nervosa (Turcotte, 1990). Concurrent validity for the EAT has been established by Garner and Garfinkel (1979) who report that 38 of the 40 EAT items, and total EAT scores correlate significantly with criterion group membership as established by a clinical interview. While bulimics often score

significantly higher than controls and within the same range as anorexia nervosa patients on the EAT (Srikameswaran, Leichner, & Harper, 1984), mean group scores of bulimics are often lower than those of anorexics (Fairburn & Cooper, 1984). Internal reliability for a combined control and anorexia nervosa sample has been found to be .94 (Garner & Garfinkel, 1979). The EAT has been found to be sensitive to the recovery of anorexic symptoms, with recovered anorexics scoring in the normal range on the EAT (Garner & Garfinkel, 1979). Additionally, the EAT is sensitive to the severity of the disorder (Garner & Garfinkel, 1979; Leichner, Arnett, Rallo, Srikameswaran, & Vulcano, 1986). Table F-1 provides descriptive data on the EAT.

The Bulimia Test (BULIT). The Bulimia test (BULIT) measured bulimic symptomatology (Smith & Thelen, 1984)(Appendix G). Subjects scoring between 53 and 102 were considered to have sub-clinical bulimia nervosa (Turcotte, 1990). Concurrent validity has been demonstrated (Smith & Thelen, 1984) by correlating both individual BULIT item score, and total BULIT score with criterion group membership as established by clinical interviews. The BULIT is highly correlated ($r = .93$) with another measure of bulimia, the Binge Scale

(Hawkins & Clement, 1980) and a satisfactory two month test re-test reliability has been noted (.87)(Smith & Thelen, 1984). See Table G-1 for descriptive data on the BULIT.

Psycho-Epistemological Profile (PEP). The Psycho-Epistemological Profile measured the epistemological dimensions of rationalism, empiricism, and metaphorism, associated with Royce's theory of knowledge (Royce & Mos, 1980)(Appendix H). Concurrent validity of the PEP has been demonstrated by contrasting different occupational and professional groups which personify specific epistemological profiles (e.g., mathematicians as rational). Construct validity has been demonstrated by analysing theoretically predicted relations between the PEP and various occupational interest scales (ie., Allport-Vernon-Lindzey Study of Values, Myers-Briggs Type Indicator). Results of an item factor analysis of the PEP with high school and college students were consistent with the theoretical 3-dimensional structure (Schopflocher & Royce, 1978). Nine month test re-test reliabilities for 43 first year university students were .87 for empiricism, .68 for rationalism, and .66 for metaphorism. Royce and Mos (1980) note that since reliability is partially a function of sample size, it

is likely that the correlations will be in the range of .8 to .9 as sample size increases. Split-half correlation coefficients were r = .77 for rational, r = .88 for metaphoric, and r = .77 for empirical. See Table H-1 for descriptive data on PEP.

Rosenberg Self-Esteem Scale (RSE). The RSE (Rosenberg, 1965)(Appendix I) measured self-esteem as defined by Rosenberg as "being satisfied with oneself to believing that one is a person of worth" (Rosenberg, 1985, p. 210). Convergent and discriminant validity for the RSE was determined by correlating RSE scores against three other measures of self-esteem in a sample of 44 college students. Correlations were reported to be between .56 and .83 with similar measures of self-esteem and with a clinical assessment (Wylie, 1974). Adequate test re-test reliability (.92) and scalability (.72) have been found (Rosenberg, 1965). Internal reliabilities have been found to range from .69 to .77 (Wylie, 1977). Table I-1 provides further description of the RSE.

Locus of Control Scale (LOCS). The Locus of Control Scale measured internal-external locus of control orientation (Rotter, 1966)(Appendix J). A median split of Locus of Control scores determined

internal/external classification. Concurrent validity for the LOCS has been demonstrated by significant correlations between independent clinical raters and LOCS total scores (Marsh & Richards, 1986). Convergent validity has been found by the significant correlations between self-responses, responses by external observers, and two different sets of observers (Marsh & Richards, 1986). One month and two month test re-test reliability for the LOCS has been found to be between .49 and .83 (Rotter, 1966). Table J-1 provides descriptive data on the LOCS.

Counsellor Rating Form-Short Version (CRF-S). The Counsellor Rating Form (short version) measured therapist expertness, attractiveness, and trustworthiness (Corrigan & Schmidt, 1983)(Appendix K). Factor analysis supports the proposed the three factor structure of the CRF-S and the three factors have been found to correlate with each other (Corrigan & Schmidt, 1983), with client income, and with marital status. Corrigan and Schmidt (1983) found that ratings of therapist attributes decreased as client income increased. Additionally, these authors found that clients with a previous marriage tend to rate their therapists higher on trustworthiness, expertness, and

attractiveness. Split-half reliability of r = .87 for expertness, r = .85 for attractiveness and r = .91 for trustworthiness has been found. Table K-1 provides further description of the CRF-S.

Counselling Satisfaction Questionnaire (CSQ-8). The CSQ measured client satisfaction with counselling (Larsen, 1977)(Appendix L). Construct validity of the CSQ-8 has been established by comparing expert ratings of client satisfaction to scores on the CSQ-8 (Larsen et al., 1979). Therapist estimates of client satisfaction with CSQ score significantly correlate (r = .53) (Derogatis, Lipman, & Lovi, 1973). The CSQ-8 has been found to correlate significantly with global self ratings of improvement and with other therapy outcome measures (Larsen et al., 1979). Additionally, the CSQ-8 correlates with early treatment drop-out (r = .37) (Larsen, 1977), and number of missed therapy appointments (r = .27)(Larsen, 1977), but not with number of years of education, family income, marital status, amount of service, age at admission, social class, or previous treatment at another facility (Larsen et al., 1979). Internal consistency for the CSQ-8 has been found to range from .87 to .93 (Attkisson & Zwick, 1982; Larsen, 1979). See Table L-1

for description of the CSQ-8.

Structural Rating Scale-Modified. The Structural Rating Scale measured perceptions of structure in a counselling situation (Stoppard and Henri, 1987) (Appendix M). While no psychometrics are available on the scale, it is currently the only of its kind in the literature. See Table M-1 for description of scale.

Post Experimental Questionnaire. The Post Experimental Questionnaire assessed subject's perceptions of the study and was composed of two questions: (1) Why did you most prefer the approach that you ranked #1? (2) Did any of the therapy vignettes pose a novel perspective to weight preoccupation for you?

Scripts. Session scripts (Appendix N) for the three types of counselling intervention reflected basic theoretical and practical differences associated with cognitive-rationalist, cognitive-constructivist, and behavioural approaches to counselling and were created by the principal investigator. The target problem of body-image dissatisfaction was selected since it underlies both clinical and sub-clinical anorexia and bulimia.

The scripts were equivalent in the amount of time

allocated for the introduction, background, and exposition of treatment ideas, the number of client versus therapist statements, the number of times the client affirms the therapist or therapist remarks, and the number of times the therapist assures the client of proposed treatment efficacy.

Three seven-minute audiovisual vignettes were developed from the scripts. Two individuals from the Drama Department at the University of Manitoba were hired to play the part of the therapist and the client. The same two actors portrayed the client and therapist in the three vignettes so that the participants would be more likely to respond to treatment differences, rather than different characteristic of the actors.

Procedure

First Pilot. Before formal data collection, construct validity of the vignettes was assessed using a sample of seven graduate students in Clinical Psychology at the University of Manitoba (Appendix O). All raters had completed a course in psychopathology which had, in part, included a detailed overview of theoretical and practical differences associated with cognitive and behavioural therapeutic approaches. In addition, all raters had first-hand knowledge of

therapy procedures and intake interviews and were currently functioning as student therapists. Raters judged the vignettes equivalent on therapist variables (expertness, attractiveness, skill, sincerity, neutrality) and client variables (amount of client disturbance, responsiveness to therapy), in addition to presumed efficacy, pacing, and representativeness of an early approach to counselling. Raters correctly matched each vignette with the corresponding theoretical approach (cognitive-rational, cognitive-constructivist, or behavioral), providing support for the construct validity of the vignettes. Raters correctly matched 3 phrases representative of each epistemology (rationalism, empiricism, and metaphorism) with the corresponding vignette. Lastly, raters detected significant differences in the amount of structure portrayed in each of the therapy vignettes. See Tables N-1 and N-2 for a review of pilot results. Following the collection of these preliminary findings, the second pilot study ensued.

Second Pilot. Twenty-nine female undergraduate psychology students from the University of Manitoba were subjects in the second pilot investigation. Subjects were given the experimental questionnaires and

asked to view the 3 videotapes. Results from tests relating to epistemological foundation and therapeutic structure are presented in Tables N-1 and N-2. Based on these findings, the investigator was satisfied that the basic assumptions of the study had not been violated.

Experiment. Subjects volunteered to participate in the experiment to obtain course credit and gave informed consent (Appendix P) after being notified that responses would be kept confidential. All subjects were told that they were free to leave at any time without penalty. In groups of 33, subjects completed experimental questionnaires in the following order: Eating Disorder Survey (EDS), Eating Attitude Test (EAT), Bulimia Test (BULIT), Rosenberg Self-Esteem Scale (RSE), Psycho-Epistemological Profile (PEP), and the Locus of Control Scale (LOCS). Questionnaires took approximately 1 hour to complete, following which subjects were exposed to the three videos in counterbalanced order. Prior to watching each video, subjects were given brief one-page written descriptions of the upcoming therapy approach, identical to those given by Lyddon (1989). After presentation of each vignette, subjects completed the dependent measures (CRF-S, CSQ-8). After viewing all three videos,

subjects ranked their preferences for therapy approach and completed the PEQ. Next, participants were debriefed (Appendix Q) and provided with referrals to appropriate clinical agencies.

Results

Initially, a manipulation check was conducted on the data to determine whether the order of video presentation influenced ratings of therapies and therapists. Main and interactive effects were examined. Three 6 X 3 ANOVAS (Order X Therapy approach) were conducted. A significant interaction between order and therapy was found for ratings of therapy approaches $F(10, 780) = 8.89$, $MSe = 27.36$, $p = .0001$, therapist's characteristics $F(10, 778) = 9.14$, $MSe = 108.54$, $p = .0001$, and ranked preferences for therapy approaches $F(10, 742) = 13.96$, $MSe = .81$, $p = .0001$. The Least Square Means (LSM) procedure was implemented for planned comparisons as it is recommended for repeated measures designs when group sizes are unequal. Contrasts revealed that in any series, therapies presented first were rated as less satisfactory compared to the same therapy presented at the end of a sequence, and that this effect was magnified for ratings of the constructivist video. Subjects' ratings

of therapies and therapist characteristics improved with repeated exposure to different therapy approaches. Effects due to presentation order were attenuated by counterbalancing all orders with equivalent numbers of subjects in each order, thereby reducing effects due to practice. The same pattern was detected for both a sub-clinical eating disturbed sample and the entire sample.

A second check on the data was conducted by examining group means on the Psycho-Epistemological Profile and Locus of Control scales. This was performed to determine whether the sample was typical with respect to mean scores on the independent variables (ie., Locus of Control, Personal Epistemology). Obtained mean scores for the three PEP dimensions

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Table 1

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approximated those found by Royce and Mos (1980) in their sample of 417 college female juniors. Similar LOCS values have been obtained by other investigators using university samples (Layton, 1985; Stuehm, Cashen, & Johnson, 1977).

Hypotheses of the study were tested using both multiple regression and analysis of variance (ANOVA)

approaches. Hypothesis one was tested using a multiple regression analysis to maximize the statistical power of the test. Cohen's post-data collection power analysis was conducted and found to be .72 for this test which was deemed acceptable. Assumptions of the regression model were evaluated prior to use (normality, homogeneity of variance, linearity, homoscedasticity, sphericity) and found to be intact. The remaining hypotheses were tested using a repeated measures, fixed-effects, analysis of variance (ANOVA) model. This model was selected for ease of comparison with research in this area. It was also selected because there was some concern regarding possible power reduction in a regression model because one of the two main independent variables (epistemology) was a categorical measure. Cohen's post-data collection power analysis on the ANOVA model was conducted and found to be satisfactory for the locus of control main effect (.88), epistemology main effect (.71), and the locus of control*epistemology interactive effect (.84). Assumptions of independence, sphericity, and homogeneity of variance were intact. Distributions of the dependent measures (CRF-S, CSQ-8) were found to be non-normal however. Lebow (1983) comments on the

typically negatively skewed, non-normal distribution of satisfaction ratings in therapy research. Based on the large N (397) of the sample, and the absence of skewed data, the ANOVA procedure was considered robust to this violation of normality.

Three statistical tests (locus of control main effect, epistemology main effect, locus of control*epistemology interaction) were performed on each of the dependent measures (Counselor Rating Form, Counselling Satisfaction Questionnaire, ranked preference). Maxwell and DeLaney (1990) comment that each statistical test within a model in three factor designs should be conceptualized as a separate family of tests because each test (ie., main, interactive) represents a conceptually distinct question. These authors suggest a family-wise error rate of .05. Based on recommended practice, a Bonferroni correction procedure was used for post-hoc and planned comparisons to control for Type I error rates.

Hypothesis one examined whether subjects with more disturbed eating attitudes and behaviours would have a more external locus of control orientation. Results indicated a relationship between eating disturbance scores (EAT and BULIT) and locus of control scores F(2,

392) = 4.05, MSe = 18.75. The adjusted proportion of variance (R^2adj) in locus of control scores explained by BULIT and EAT scores was .02. Only the intercept was a significant contributor to predicting the variance in Locus of Control scores $t(1, 392) = 12.60$, $p = .0001$. Analysis of plotted data revealed that subjects' locus of control scores were uniform regardless of EAT or BULIT score. Additionally, as Table 2 indicates, significant Pearson correlations were found between self-esteem and EAT, BULIT, and LOCS total scores. Subjects with low self-esteem tended to report more

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Table 2
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disturbed eating attitudes and behaviours and a more external locus of control compared to those with high self-esteem. Hence, self-esteem may mediate the link between eating pathology and locus of control orientation.

Strength of Preference

Based on previous research, it was hypothesized that subjects with sub-clinical eating disturbances would have elevated scores on therapy satisfaction indices compared to subjects without eating

disturbances. Based on total scores on the EAT and BULIT, subjects were divided into either a sub-clinical eating disturbed group or a non-eating disturbed group. A main effect of group on ratings of therapy approach was examined. Results revealed a significant between-subjects effect $F(1, 395) = 4.71$, $MSe = 30.09$, $p = .03$. Unexpectedly, subjects in the non-eating disturbed group were found to assign consistently higher satisfaction ratings to the three therapy approaches compared to the eating-disturbed group.

Effect of Locus of Control and Epistemic Style on Ratings of Therapy Approach

Main and interactive effects of locus of control and dominant epistemic style were examined to test hypotheses three and four, whether differences in dominant epistemic style and locus of control influenced ratings of the three therapy videos. No effects were found. Similar findings were obtained using a sub-clinical eating disturbed sample.

Effect of Locus of Control and Epistemic Style on Ratings of Therapist

Main and interactive effects of locus of control and dominant epistemic style were examined to test hypothesis five, whether differences in dominant

epistemic style and locus of control influenced ratings of the therapist in each of the three videos. A significant between-subjects main effect of locus of control was found for ratings of therapists $F(1, 387) = 3.80$, $MSe = 120.02$, $p = .05$.

Table 3

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Post-hoc comparisons were conducted using the Least Square Means procedure. As Table 3 illustrates, there was a trend for externals to rate therapists less positively than internals, especially for ratings of the constructivist therapist. This was corroborated by a negative correlation between locus of control score and ratings of the constructivist therapist $r(396) = -.12$, $p = .02$. Increasing externality was associated with less favourable ratings of the constructivist therapist. Similar findings were obtained using a sub-clinical sample.

To examine whether locus of control and epistemic style influenced ratings of therapists' expertness, trustworthiness, and attractiveness, three 3 X 3 X 2 ANOVAS (Therapy approach X Epistemic Style X Locus of Control) were conducted. A between-subjects main effect

of locus of control was found for ratings of therapist's trustworthiness $F(1, 388) = 4.91$, $MSe = 46.97$, $p = .03$ and expertness $F(1, 388) = 4.14$, $MSe = 48.26$, $p = .04$. The Least Square Means procedure revealed that externals found the therapist in each of the vignettes significantly less trustworthy and expert than did internals. Locus of control and epistemic style did not influence assessments of therapists' attractiveness. Findings were similar for a sub-clinical sample.

Secondary Analyses

After the principle hypotheses were investigated, several post-hoc analyses were conducted. Of interest was the role of self-esteem and body-image dissatisfaction on ratings of therapy approaches and therapist characteristics. Based on past research findings, it was anticipated that individual differences in self-esteem and body-image dissatisfaction might disguise a relationship between dominant epistemic style/locus of control and ratings of therapists and therapies. The analysis of covariance procedure (ANCOVA) was employed to probe these suspicions. Assumptions of the ANCOVA model (reliability, linearity, normality, and

homoscedasticity) were met for both the self-esteem and body-image dissatisfaction covariates. However, the assumption of homogeneity of regression was not met for the body-image dissatisfaction covariate. Nevertheless, several researchers have commented that effects of heterogeneity of regression are typically small and in a conservative direction (Maxwell & DeLaney, 1990). Consequently, the ANCOVA procedure was considered robust to this violation. Due to non-random assignment of subjects to treatment conditions, it was impossible to know with absolute certainty whether differences in the dependent measures were due to effects of the independent variables or to variables correlated with the independent variables (ie., anxiety, social desirability).

Self-Esteem as Covariate. Self-esteem was used as a covariate in a 3 X 3 X 2 ANCOVA (Therapy approach X Dominant Epistemic Style X Locus of Control). Main and interactive effects were assessed. No main or interactive effect of locus of control or dominant epistemic style on ratings of therapists were found as a result of partialling out effects due to self-esteem. However, there was a trend towards a (Self-esteem X Therapy Approach) interaction for ratings of therapists

$F(2, 756) = 2.68$, $MSe = 119.60$, $p = .07$. Analysis of plotted data revealed a tendency for those with low self-esteem to rate the cognitive therapists (rational and constructivist) less positively and the behavioural therapist more positively compared to those with high self-esteem. In contrast, results from an analysis of correlational data showed an association between low self-esteem and elevated ratings of both the behavioural and rational therapists. Hence, results were discrepant concerning the effects of self-esteem on ratings of cognitive-rational therapists. Analysis of plotted data revealed that external-rationalists with low self-esteem rated the rational therapist more favourably than external-rationalists with high self-esteem, but that empiricists (internals and externals) and external metaphorists with low self-esteem rated this therapist less favourably than their high self-esteem counterparts. There was no apparent relationship between self-esteem and ratings of the cognitive-constructivist therapist. When self-esteem scores were covaried, no significant main or interactive effects of locus of control and epistemic style were found using a sub-clinical sample.

Body-Image Dissatisfaction as Covariate. It was

suspected that subjects' concern with weight and body image might lead to differential identification with the client in the vignettes and in so doing influence ratings of therapy approaches. Body-image dissatisfaction was measured by responses from a demographic question "How dissatisfied are you with the way that your body is proportioned?" Possible responses ranged from 'extremely dissatisfied'(1) to 'not at all dissatisfied'(5) on a 5-point Likert scale. A 3 X 3 X 2 (Therapy approach X Epistemology X Locus of Control) ANCOVA was conducted with body-image dissatisfaction serving as the covariate. Main and interactive effects of locus of control and dominant epistemic style were examined. As Table 4 reveals, there was a significant

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Table 4

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between-subjects main effect of epistemic style $F(2, 377) = 3.31$, $MSe = 35.71$, $p = .04$ for satisfaction ratings given to therapy approaches. Post-hoc comparisons using the Least square means procedure were not significant but revealed a trend for metaphorists to report less satisfaction with each of the therapy approaches than rationalists or empiricists. Similar

findings were obtained with a sub-clinical sample.

When effects of body-image dissatisfaction were partialled out, a significant within subjects (Therapy X Locus of Control X Epistemic Style) interaction emerged $F(4, 754) = 2.67$, $MSe = 79.72$, $p = .03$. Planned comparisons between groups were not significant, although there was a trend for external empiricists to rate cognitive-rational therapy more favourably (M = 24.61) than internal empiricists (M = 23.08); p = .07.

Body image dissatisfaction was also used as a covariate in a 3 X 3 X 2 ANCOVA (Therapy X Epistemology X Locus of Control) to determine whether extent of dissatisfaction with body shape would influence ratings of the therapist in each of the vignettes. A significant interaction (Therapy X Locus of Control X Body-image Dissatisfaction) was found $F(2, 762) = 3.11$, $MSe = 371.22$, $p = .05$. Analysis of plotted data showed that as degree of dissatisfaction with body shape increased, externals rated the directive therapists (ie., behavioural, rational) more favourably whereas internals rated these therapists less positively. In contrast, internals rated the non-directive therapist (ie., constructivist) more favourably whereas externals rated this therapist less positively.

Table 5

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Table 5 describes mean therapist ratings as a function of epistemic style and locus of control. Rationalists were found to assign the most favourable ratings to the cognitive-rational and behavioral therapist, and internal metaphorists to give the most favourable ratings to the constructivist therapist. A similar pattern was found for a sub-clinical sample.

Overall, Friedman's nonparametric analysis of variance procedure revealed that the mean rankings given to each of the three vignettes differed significantly $F(2, 1143) = 32$, $MSe = .64$, $p > .0001$. Planned contrasts using the Least Square means procedure revealed that the cognitive-constructivist video was ranked significantly higher than the cognitive-rational video which was ranked significantly higher than the behavioral video. Similarly, subjects mean satisfaction ratings of each therapy approach differed significantly. T-tests revealed that the constructivist approach ($M = 26.77$) was rated more favourably than both the rational ($M = 23.58$) and the behavioral approach ($M = 23.86$); $t(396) = 7.96$, $p =$

.0001 for treatment of a body-image disturbance problem. Subjects also rated the constructivist therapist (M = 57.06) significantly better than either the behavioral therapist (M = 52.85) or the rational therapist (M = 51.44); $t(396) = 5.53$, $p = .0001$. No significant differences were found between mean ratings of therapist attractiveness, trustworthiness, or expertness.

Residual Findings

The influence of previous successful and non-successful experience with different types of therapy on ratings of therapies and therapists was examined. Results indicated no relationship between previous therapy experience (judged successful or non-successful, recent or old, different types of approach) and reported satisfaction with one or more approaches or therapist characteristics.

Discussion

Two limiting aspects of this research include the analogue design and non-clinical sample. Both of these features place limitations on the external validity of research findings. Hence, conclusions derived from such research should be viewed as tentative, pending clinical trials.

<u>Locus of Control Interaction</u>

Bellack's (1975) Locus of Control Theory posits that externals will prefer and be more satisfied with directive treatments due to perceived deficits in self-reinforcement capabilities. Results from this investigation only partially support Bellack's formulation.

No main effect of locus of control was found for ratings of therapy approaches. This finding is contrary to results obtained by some researchers (Friedman & Dies, 1974; Killman & Sotile, 1976; Jacobson, 1970) but consistent with results from other investigations (Killmann, 1974; Kinder & Kilmann, 1976; Stuehm, Cashen, & Johnson, 1977). When effects due to body-image dissatisfaction were removed, external empiricists tended to rate rational therapy and to a lesser extent behaviour therapy more favourably than did their internal counterparts. External rationalists rated both cognitive-rational and behavioural therapy more favourably than internal rationalists, however these effects were not statistically significant. In contrast, external metaphorists assigned less favourable ratings to the directive approaches (behavioural and cognitive-rational) compared to those

with an internal locus of control, which is opposite to what Bellack would predict. Thus, results of this study suggest the conclusion that Bellack's theoretical propositions are weak and only tenable for individuals with empirical epistemic styles. This may explain some of the divergent findings from previous studies examining matching clients' locus of control orientation to directive/non-directive treatments.

Locus of control orientation influenced assessments of therapists. There was an inverse association between externality and ratings of the non-directive therapist (cognitive-constructivist). Those with an external locus of control gave less favourable ratings to the constructivist therapist. This effect was magnified as the extent of body-image dissatisfaction increased. Internals with elevated body-image dissatisfaction were more likely to rate the non-directive therapist (ie., constructivist) more favourably, whereas externals with elevated body-image dissatisfaction were more likely to rate the directive therapists (cognitive-rational, behavioural) more positively. Thus, it appears that externals may prefer directive therapists and internals may prefer non-directive therapists, but only under certain conditions

(ie., severe distress). Also of interest, individuals with an external locus of control found the therapists overall to be less trustworthy and less expert compared to those with an internal locus of control. This was especially significant for evaluations of the constructivist therapist. Several investigators have noted that individuals with clinical eating disorders present with an external locus of control orientation. Thus, it may be useful for therapists to communicate to clients about their knowledge of the problem (expertness) as well as their honesty and sincerity (trustworthiness) as caregivers to compensate for the perceived deficit in these qualities.

Matching Thesis

The matching thesis formulation was not supported by the results of this study. Recall that according to the 'Matching thesis', individuals will report greater preferences for therapeutic approaches which are similar to their own cognitive styles (Fry & Charron, 1980). Based on this theory, it was anticipated that rationalists would most prefer cognitive-rational therapy, empiricists would find behavioural therapy most promising, and that metaphorists would assign the most favourable ratings to cognitive-constructivist

therapy. Results of the study do not support a 'matching thesis' formulation. Contrary to predictions, empiricists did not find behaviour therapy significantly more satisfactory than the other two approaches, nor did rationalists rate cognitive-rational therapy significantly better than behavioural or cognitive-constructivist therapy, nor did metaphorists rate constructivist therapy more favourably than behavioural or rational approaches. Thus, the matching thesis is not supported by the results of this study.

This finding is contrary to results obtained by Lyddon (1989). Lyddon's (1989) investigation of personal epistemology and therapy preference found evidence of a matching thesis. Recall that this study required subjects to read three general, one-page, written descriptions of a behavioral, cognitive-rational, and cognitive-constructivist approach to therapy (no specific target problem identified). Lyddon found that those with rational, empirical, and metaphoric epistemologies preferred rational, behavioral, and constructivist therapies, respectively. The results of this study run contrary to Lyddon's findings, possibly for several reasons. These reasons

are as follows: a more tangible introduction to the three therapeutic approaches via (1) audiovisual medium (2) the identification of a target problem suspected to be relevant to subjects (3) longer intervention time (approximately 15 minutes). Thus, the lack of congruence between Lyddon's results and the results of this investigation may be a result of differences in the duration and quality of the presented therapy approaches.

Partial support for the matching thesis was obtained by examining the trend towards a relationship between ratings of therapists as a function of epistemological styles. For example, rationalists (internals) most preferred the cognitive-rational therapist and metaphorists (internals) most preferred the cognitive-constructivist therapist. In contrast, neither external nor internal empiricists most preferred the behavioural therapist. Thus, these findings lend partial support to the idea that matching individuals to therapists on dimensions of epistemic style and locus of control may be predictive of client satisfaction with therapist for those with rational or metaphoric epistemic styles.

Effect of Self-Esteem on Ratings of Therapists

Results of this study indicated an association between self-esteem and assessments of therapists. Those with impoverished self-esteem tended to rate the behavioural therapist more favourably than those with high self-esteem. Since many eating disordered clients initially present with low self-esteem, it may be advantageous for a therapist to display an action-oriented, directive personality style typical of behavioural therapists. This might serve to maximize clients' satisfaction with their service provider.

Factors Influencing Therapy Preference and Acceptability

Previous studies have found that prior experience with therapy (Hensley, Cashen, & Lewis, 1984) and degree of subject identification with the target problem (Glidden & Tracey, 1989) influence ratings of therapy approach. Also, the latter authors speculated that approaches would be viewed more positively if perceived as novel.

Findings of this study indicate that previous experience with therapy does not influence satisfaction ratings of therapy approaches, rankings of therapeutic preference, or assessments of therapist qualities. Hensley, Cashen, and Lewis (1984) found that

individuals with prior therapy experience exhibited greater preferences for a behavioural as opposed to a client-centred approach for both a vocational-education and personal-concern target problem. These authors found that subjects without previous therapy experience did not report a preference between the two different interventions. Results from this investigation do not support the idea that previous therapy experience influences ratings of therapy approaches/therapists.

Another finding from this study which conflicts with previous research is the failure to find that identification with the target problem produces elevated ratings of all types of therapy. This contradicts findings from Glidden and Tracey's (1989) investigation. Results from this investigation show that the presence of a personally relevant target problem does not produce more hopefulness, enthusiasm, or stronger preferences for therapy approaches in general.

Some researchers have speculated that individuals will be more satisfied/prefer an approach to a problem which is novel to them. For example, one study found a strong correlation between perceived novelty of approach and satisfaction with that approach (Glidden &

Tracey, 1989). In this study, there was no relationship between novelty of approach and ratings of that approach. This suggests that preference/satisfaction for therapy/therapist type is guided by features or qualities other than originality.

Finally, Wollersheim, McFall, Hamilton, Hickey, and Bordevick (1980) note that certain treatments are consistently preferred over others for particular types of problems. These authors comment that behavioural treatments are frequently preferred over both client-centred and psychoanalytic therapeutic approaches in analogue studies for target problems such as recurrent headaches and test anxiety. Also, analogue subjects tend to prefer cognitive-rational interventions for problems relating to snake phobia, depression, and paranoid schizophrenia. Results of this study suggest that constructivist treatment is judged most satisfactory for a body-image disturbance problem.

Conclusions

Conclusions of this research are as follows: (1) Matching individuals of a particular epistemic style to a corresponding therapeutic modality does not produce elevated ratings of that approach; (2) Matching individuals of a particular epistemic style to a

corresponding therapist does not necessarily produce elevated ratings of that therapist's trustworthiness, attractiveness, or expertness; (3) Individuals with an external locus of control orientation tend to prefer more directive therapists than those with an internal locus of control if they have elevated body-image dissatisfaction; (4) Overall, those with an external locus of control report less confidence in therapists' expertness and trustworthiness than do those with an internal locus of control; (5) Cognitive-constructivist therapy is attractive to a female university sample and perhaps more importantly to a sub-sample of university women with eating and weight-related concerns; (6) Therapists may desire to maximize the exploratory, meaning-making, non-directive aspects of a proposed treatment plan in the intake interview to maximize likelihood of client satisfaction with treatment in the early stages of therapy.

Future Directions

Future research should examine matching individuals on locus of control to directive/non-directive treatments, paying special attention to the roles of level of disturbance and self-esteem in influencing therapeutic satisfaction and preference.

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Appendix A

DSM-III-R Criteria for anorexia nervosa and bulimia nervosa(American Psychiatric Association, 1987)

Anorexia nervosa

1. Refusal to maintain body weight over a minimal normal weight for age and height

2. Intense fear of gaining weight or becoming fat even though underweight

3. Disturbance in the way in which ones body weight, size, or shape is experienced

4. Absence of at least three consecutive menstrual cycles when otherwise expected to occur

Bulimia nervosa

1. Recurrent episodes of binge eating (at least twice per week for a minimum period of 3 months)

2. Feeling out of control during a binge

3. Overconcern with body shape and weight

4. Excessive exercising, vomiting, and/or the use of laxatives or diuretics for weight loss purposes

Appendix B

Current Psychiatric Treatments for Eating Disorders

Modality	Authors
Family Therapy	Madanes (1981); Rosman, Minuchin, & Liebman, (1976); Vandereychken (1987)
Psychoanalytic	Bruch (1976); Wilson, Hogan & Mintz (1983)
Group	Barth & Wurman (1986); Schneider & Agras (1985)
Behavioural	Cooper, Cooper, & Hill (1989); Johnson, Schlundt, Kelly, & Ruggiero, (1984); Nutzinger & Zwaan (1990); Rosen & Leitenberg (1982)
Cognitive-rational	Garner (1986a 1986b); Garner & Bemis (1985); Wilson, Rossiter, Leifield, & Lindholm (1985)
Cognitive-Constructivist	Blanco, Guidano, Mahoney, Reda (1986); Guidano & Liotti (1983); Hatfield & Sprecher (1986); Mahoney (1991)
Nutritional	Yates (1990)
Pharmacologic	Wilkard, Anding, & Winstead (1983)
Multi-Modal	Garfinkel & Garner (1982); Strober & Yager (1985)

Appendix C

Contrasting Therapeutic Approaches (Mahoney, 1991)

Issue	Behavioural	Rational	Constructivist
Epist-emology (theories of knowing)	knowing is based in sense experience, careful observation, accurate measurement	knowledge is author-ized as valid by logic or reason; reality is revealed via the senses	knowing is behavioral and emotional as well as cognitive; the validity of knowledge is less important than its viability; sensation is proactive
Pathology	maladaptive patterns of emotional behavior that are result of skill deficiencies or pathogenic conditioning histories	negative emotions are result of negative, irrational, and incorrect patterns of thinking	dysfunctional and distressing patterns of emotional experience are individual's imperfect attempts to adapt and develop
Causal processes (theories of change)	association-ism:linear chained events or classical and operant conditioning	association-ism:learning and change are linear chains of discrete causes and effects	structural differen-tiation: learning and development involve refinements and transformation of self-organizing processes

table continues

Appendix C contd.

	Behavioural	Rational	Constructivist
Intervention emphasis	a)historical b)problem-focused c)control-focused d)teleological	a)a-historical b)problem-focused c)control focused d)teleo-logical	a)historical b)process-focused c)development focused d)teleonomic
General treatment plan	emphasis on counter-conditioning undesired emotional responses, with de-sensitization, extinction(in-vivo exposure), massed practice (implosion or flooding) techniques aimed at eliminating or controlling such responses	emphasis on controlling or replacing intense negative affect by identifying and altering irrational thought patterns(via disputation or rehearsal of alternate thoughts	emphasis on the experience and appropriate expression of emotions, as well as on the exploration of their development, functions (past and present), and possible roles in emerging life developments. Within the limits of each person, periods of emotional dis-organization
Resistance	a)motivation deficit b)lack of learning c)ambivalence of choice	a)lack of motivation b)ambiv-alence c)motivated avoidance	a)natural self-protective processes that guard systemic integrity and resist rapid or substantial "core"change

Table continues

Appendix C contd.

	Behavioural	Rational	Constructivist
			may afford and reflect opportunities for change
Therapeutic relationship	guidance and instruction in learning to comply with environmental and self-regulated contingencies	entails technical instruction and guidance to correct irrational thought processes	entails a safe, caring, and intense context in and from which the client can explore and develop different relationships with self and world
Insight and meta-cognition	unnecessary, and possibly represents a diversion which may be responsible for much of our failure to solve problems, not compatible with therapeutic change	insight into irrational and unrealistic beliefs is necessary and (almost) sufficient for therapeutic change	insight may help to transform personal meanings and scaffold change, but emotional and behavioural enactments are also very important
Eating Disorders	presence of learned maladaptive behaviours (ie., binge eating, fasting, purging)	presence of disordered beliefs and values about weight and shape	tendency to rely on external factors to help regulate emotional organization

Appendix D

Epistemic Styles

Epistemic Style	Cognitive Processes	Epistemological Justifiability
Rationalism	logical analysis/ synthesis of information; deductive approach to knowledge; coherent and consistent knowledge structure; conceptualization emphasized	beliefs justified if consistent and logical
Empiricism	perception of sensory data; inductive approach to knowledge; highly confirmed or consensually validated knowledge structure; perceptual processes emphasized	beliefs justified if reliably linked to physical observation
Metaphorism	creation of symbolic forms and generation of meaning; analogical approach to knowledge; knowledge structure based on information which is related in some way (ie., rhymes, synonyms, analogies, or metaphors); symbolic processes emphasized	beliefs justified if they seem intuitively correct and lead to a universal rather than idiosyncratic awareness; includes beliefs which imply something more than that which is obvious

Appendix E

Eating Disorder Survey (EDS)

Please circle the appropriate oval on the IBM sheet or specify where indicated

Age______

Ethnic Group
- a = white
- b = black
- c = asian
- d = east indian
- e = west indian
- f = north american indian
- g = other

Marital Status
- a = presently in first marriage
- b = divorced and remarried
- c = divorced, not remarried
- d = widowed, remarried
- e = widowed, never remarried
- f = never married
- g = cohabiting

Educational Background
- a = graduate degree
- b = some graduate school
- c = university graduate
- d = some university
- e = trade school or community college
- f = high school graduate

Occupation
- a = unemployed
- b = part time student
- c = full time student
- d = part time employment
- e = full time employment
- f = full time homemaker
- g = retired

Appendix E contd.

Parent's Income
a = less than 10 000
b = 10 000 - 20 000

c = 20 000 - 30 000
d = 30 000 - 40 000
e = 40 000 - 50 000
f = 50 000 +

Height
________ft.________inches

Weight_______lbs.
Desired weight______lbs.

Please use the following scale to answer the next two questions, and fill in the appropriate oval on the IBM sheet, starting where you left off. Thank-you

Scale:
1 = never
2 = once a month or less
3 = several times a month
4 = several times a week
5 = once a day
6 = more than once a day

1)How often do you exercise regularly to prevent weight gain?
2)In the last 3 months, what is the average frequency of binge eating you have engaged in? (a binge is the rapid consumption of high calorie foods)

Now please use the following scale to answer the next two questions. Again, please fill in the appropriate oval on the IBM sheet, starting where you left off. Thank-you

Scale:
1 = extremely
2 = very much
3 = moderate
4 = slightly
5 = not at all

1)How much does a two pound weight gain affect your feelings about yourself?

Appendix E contd.

2)How disatisfied are you with the way your body is proportioned?

The next questions can be answered directly on the page

1)Have you ever refused to maintain your body weight over some particular weight? yes____ no____ If so, what was that weight?______

2)Currently, do you feel fat?______

3)Have you ever missed three consecutive menstrual cycles, when normally expected to occur (ie., not due

to pregnancy or the birth control pill?)

The following questions can also be answered directly on this page and pertain to any personal experiences with therapy that you might have had or are currently having. All responses will be completely anoynomous.

4)Have you ever been in therapy for a personal problem?
Yes_______ No______
If so, what was the
problem?____________________________
When were you in therapy for this
problem?________________________
How many sessions did you go to?____________
For how long?_________________
What treatment approach did the therapist use to help you with your problem?_________________
In your opinion, was treatment successful?____________

Appendix F

Eating Attitudes Test (EAT)

Below are a list of questions pertaining to your attitudes and beliefs about eating and food. Please answer all questions as honestly as possible, and remember that all responses will be kept confidential. Shade in the appropriate oval on the IBM sheet starting where you left off.

Answer key: 1 = always
2 = very often
3 = often
4 = sometimes
5 = rarely
6 = never

1)I like eating with other people
2)I prepare foods for others but do not eat
3)I become anxious prior to eating
4)I am terrified about being overweight
5)I avoid eating when I am hungry
6)I find myself preoccupied with food
7)I have gone on eating binges where I feel that I may not be able to stop
8)I cut my food into small pieces
9)I am aware of the caloric content of foods that I eat
10)I particularly avoid foods with a high carbohydrate content
11)I feel bloated after meals
12)I feel that others would prefer if I ate more
13)I vomit after I have eaten
14)I feel extremely guilty after eating
15)I am preoccupied with a desire to be thinner
16)I exercise strenuously to burn off calories
17)I weigh myself several times a day
18)I like my clothes to fit tightly
19)I enjoy eating meat
20)I wake up early in the morning
21)I eat the same foods day after day
22)I think about burning up calories when I exercise
23)I have regular menstrual periods
24)I feel that other people think I am too thin
25)I am preoccupied with the thought of having fat on my body

Appendix F contd.

26)I take longer than others to eat my meals
27)I enjoy eating at restaurants
28)I take laxatives
29)I avoid foods with sugar in them
30)I eat diet foods
31)I feel that food controls my life
32)I display self-control around food
33)I feel that others pressure me to eat
34)I give too much time and thought to food
35)I suffer from constipation
36)I feel uncomfortable after eating sweets
37)I engage in dieting behaviour
38)I like my stomach to be empty
39)I enjoy trying new rich foods
40)I have the impulse to vomit after meals

Table F-1

Description of EAT

The EAT is a 40-item multiple choice questionnaire. Responses may range from always (1) to never (6) on a variety of questions concerning attitudes and beliefs about food and weight. Scores can range from 0 to 120, with scores above 30 indicating attitudes and beliefs characteristic of anorexia nervosa, scores between 10 and 30 indicating sub-clinical anorexia nervosa, and scores less than 10 indicating no eating pathology. Several investigators have suggested using cut-offs of 10 and 25 to identify sub-clinical anorexic-like subjects to avoid the possibility of contaminating a sub-clinical group with clinical subjects.

Appendix G

The Bulimia Test (BULIT)

Below are questions relating to your eating behaviours and activities. Please answer all questions as honestly as possible, keeping in mind that all responses are completely confidential. Please begin where you left off on the IBM sheet. Thank you very much.

1)Do you ever eat uncontrollably to the point of stuffing yourself (ie., going on eating binges?)
    a)once a month or less (or never)
    b)2-3 times a month
    c)once or twice a week
    d)3-6 times a week
    e)once a day or more
2)I am satisfied with my eating patterns
    a)agree
    b)neutral
    c)disagree a litte
    d)disagree strongly
3)Have you ever kept eating until you thought you'd explode?
    a)practically every time I eat
    b)very frequently
    c)often
    d)sometimes
    e)seldom or never
4)Would you presently call yourself a "binge eater"?
    a)yes, absolutely
    b)yes
    c)yes, probably
    d)yes, possibly
    e)no, probably not
5)I prefer to eat:
    a)at home alone
    b)at home with others
    c)in a public restaurant
    d)at a firend's house
    e)doesn't matter
6)Do you feel you have control over the amount of food you consume?
    a)most or all of the time
    b)a lot of the time
    c)occasionally
    d)rarely

Appendix G contd.

e)never

7)I use laxatives or suppositories to help control my weight

a)once a day or more
b)3-6 times a week
c)once or twice a week
d)2-3 times a month
e)once a month or less (or never)

8)I eat until I feel too tired to continue

a)at least once a day
b)3-6 times a week
c)once or twice a week
d)2-3 times a month
e)once a month or less (or never)

9)How often do you prefer eating ice cream, mild shakes, or puddings during a binge?

a)always
b)frequently
c)sometimes
d)seldom or never
e)I don't binge

10)How much are you concerned about your eating binges?

a)I don't binge
b)bothers me a little
c)moderate concern
d)major concern
e)probably, the biggest concern in my life

11)Most people I know would be amazed if they knew how much food I can consume at one sitting

a)without a doubt
b)very probably
c)probably
d)possibly
e)no

12)Do you ever eat to the point of feeling sick?

a)very frequently
b)frequently
c)fairly often
d)occasionally
e)rarely or never

13)I am afraid to eat anything for fear that I won't be able to stop

a)always
b)almost always
c)frequently
d)sometimes
e)seldom or never

Appendix G contd.

14)I don't like myself after I eat too much
- a)always
- b)frequently
- c)sometimes
- d)seldom or never
- e)I don't eat too much

15)How often do you intentionally vomit after eating?
- a)2 or more times a week
- b)once a week
- c)2-3 times a month
- d)once a month
- e)less than once a month (or never)

16)Which of the following describes your feelings after binge eating?
- a)I don't binge eat
- b)I feel o.k.
- c)I feel mildly upset with myself
- d)I feel quite upset with myself
- e)I hate myself

17)I eat a lot of food when I'm not even hungry
- a)very frequently
- b)frequently
- c)occasionally
- d)sometimes
- e)seldom or never

18)My eating patterns are different from eating patterns of most people
- a)always
- b)almost always
- c)frequently
- d)sometimes
- e)seldom or never

19)I have tried to lose weight by fasting or going on "crash" diets
- a)not in the past year
- b)once in the past year
- c)2-3 times in the past year
- d)4-5 times in the past year
- e)more than 5 times in the past year

20)I feel sad or blue after eating more than I'd planned to eat
- a)always
- b)almost always
- c)frequently
- d)sometimes
- e)seldom, never, or not applicable

Appendix G contd.

21)When engaged in an eating binge, I tend to eat foods that are high in carbohydrates (sweets and starches)
a)always
b)almost always
c)frequently
d)sometimes
e)seldom

22)Compared to most people, my ability to control my eating behaviour seems to be:
a)greater than others' ability
b)about the same
c)less
d)much less
e)I have absolutely no control

23)One of your best friends suddently suggests that you both eat at a new restaurant buffet that night. Although you'd planned on eating something light at home, you go ahead and eat out, eating quite a lot and feelings uncomfortably full. How would you feel about yourself on the ride home?
a)fine, glad I'd tried that new restaurant
b)a little regretful that I'd eaten so much
c)somewhat disappointed in myself
d)upset with myself
e)totally disgusted with myself

24)I would presently label myself a "compulsive eater"(one who engages in episodes of uncontrolled eating)
a)absolutely
b)yes
c)yes, probably
d)yes, possibly
e)no, probably not

25)What is the most weight you've ever lost in 1 month?
a)over 20 pounds
b)12-20 pounds
c)8-11 pounds
d)4-7 pounds
e)less than 4 pounds

26)If I eat too much at night I feel depressed the next morning
a)always
b)frequently
c)sometimes
d)seldom or never
e)I don't eat too much at night

Appendix G contd.

27)Do you believe that it is easier for you to vomit than it is for most people?
a)yes, it's no problem at all for me
b)yes, it's easier
c)yes, it's a little easier
d)no, it's less easy
28)I feel that food controls my life
a)always
b)almost always
c)frequently
d)sometimes
e)seldom or never
29)I feel depressed immediately after I eat too much
a)always
b)frequently
c)sometimes
d)seldom or never
e)I don't eat too much
30)How often do you vomit after eating in order to lose weight?
a)less than once a month (or never)
b)once a month
c)2-3 times a month
d)once a week
e)2 or more times a week
31)When consuming a large quantity of food, at what rate of speed do you usually eat?
a)more rapidly than most people have ever eaten intheir lives
b)a lot more rapidly than most people
c)a little more rapidly than most people
d)about the same rate as most people
e)more slowly than most people (or not applicable)
32)What is the most weight you've ever gained in 1 month?
a)over 20 pounds
b)12-20 pounds
c)8-11 pounds
d)4-7 pounds
e)less than 4 pounds
33)I use diuretics (water pills) to help control my weight
a)once a day or more
b)3-6 times a week
c)once or twice a week
d)2-3 times a month

Appendix G contd.

e)once a month or less (or never)

34)How do you think your appetite compares with that of most people you know?

a)many times larger than most
b)much larger
c)a little larger
d)about the same
e)smaller than most

Table G-1

Description of BULIT

The BULIT is a 32-item multiple choice questionnaire. Possible responses vary from most symptomatic to least symptomatic along a 5 point continuum. Scores can range from 0 to 180, with scores above 102 indicating attitudes, beliefs, and behaviours characteristic of bulimia nervosa, scores between 53 and 102 indicating bulimic-like weight preoccupation, and scores less than 53 indicating no weight preoccupation. Several researchers have suggested upper and lower limit scores of 53 and 85 to identify sub-clinical bulimic-like subjects and to avoid the possibility of contaminating a sub-clinical group with a clinical group (Krueger & Bornstein, 1987; Turcotte, 1991).

Appendix H

The Psycho-Epistemological Profile (PEP)

This is a measure of how you feel about a variey of things which are important to you. Try to answer the questions as honestly as possible, and shade in the appropriate oval on the IBM sheet starting where you left off. Thank you.

Scale: 1 = completely disagree
2 = moderate disagreement
3 = neutral
4 = moderate agreement
5 = complete agreement

1)A good teacher is primarily one who has a sparkling entertaining delivery
2)The thing most responsible for a child's fear of the dark is thinking of all sorts of things that could be "out there"
3)Most people who read a lot, know a lot because they come to know of the nature and function of the world around them
4)Higher education should place a greater emphasis on fine arts and literature
5)I would like to be a philosopher
6)A subject I would like to study is biology
7)In choosing a job I would look for one which offered opportunity for experimentation and observation
8)The Bible is still a best seller today because it provides meaningful accounts of several important eras in religious history
9)Our understanding of the meaning of life has been furthered most by art and literature
10)More people are in church today than ever before because they want to see and hear for themselves what ministers have to say
11)It is of primary importance for parents to be consistent in their ideas and plans regarding their children
12)I would choose the following topic for an essay: The artist in an age of science
13)I feel most at home in a culture in which people can freely discuss their philosophy of life
14)Responsibility among men requires an honest appraisal of situations where irresponsibility has

Appendix H contd.

transpired
15)A good driver is observant
16)When people are arguing a question from two different points of view, I would say that the argument should be resolved by actual observation of the debated situation
17)I would like to visit a library
18)If I were visiting India, I would be primarily interested in understanding the basis for their way of life
19)Human morality is molded primarily by an individual's conscious analysis of right and wrong
20)A good indicator of decay in a nation is a decline of interest in the arts
21)My intellect has been developed most by learning methods of observation and experimentation
22)The prime function of a university is to teach principles of research and discovery
23)A good driver is even tempered
24)If I am in a contest, I try to win by following a pre-determined plan
25)I would like to have been Shakespeare
26)Our understanding of the meaning of life has been furthered most by mathematics
27)I like to think of myself as a considerate person
28)I would very much like to have written Karwin's "The Origin of Species"
29)When visiting a new area, I first try to see as much as I possibly can
30)My intellect has been developed most by gaining insightful self knowledge
31)I would be very disturbed if accused of being insensitive to the needs of others
32)The kind of reading which interests me most is that which creates new insights
33)The greatest evil inherent in a totalitarian regime is alienation of human relationships
34)Most atheists are disturbed by the absence of factual proof of the existence of God
35)In choosing a job I would look for one which offered the opportunity to use imagination
36)In my leisure I would most often like to enjoy some form of art, music, or literature
37)The kind of reading which interests me most is that which stimulates critical thought

Appendix H contd.

38)I prefer to associate with people who arespontaneous
39)In my leisure I would like to play chess or bridge
40)Most people who read a lot, know a lot because they develop an awareness and sensitivity through their reading
41)When visiting a new area, I first pause to try to get a "feel" for the place
42)Many T.V. programs lack sensitivity
43)I like to think of myself as observant
44)Happiness is largely due to sensitivity
45)I would be very disturbed if accused of being inaccurate or biased in my observations
46)A good teacher is primarily one who helps his students develop their powers of reasoning
47)I would like to be a novelist
48)The greatest evil inherent in a totalitarian regime are restrictions of thought and criticism
49)Most people are in church today than ever before because theologicians are beginning to meet the minds of the educated people
50)The most valuable person on a scientific research team is one who is gifted at critical analysis
51)Many T.V. programs lack organization and coherence
52)I like country living because it gives you a chance to see nature first hand
53)Upon election to Congress I would endorse steps to encourage an interest in the arts
54)It is important for parents to be familiar with theories of child psychology
55)The prime function of a university is to train the minds of the capable
56)I would like to have written Hamlet
57)Higher education should place a greater emphasis on mathematics and logic
58)The kind of reading which intrerests me most is that which is essentially true to life
59)A subject I would like to study is art
60)I feel most at home in a culture in which realism and objectivity are highly valued
61)The prime function of a university is to develop a sensitivity to life
62)When playing bridge or similar games I try to think my strategy through before playing
63)If I were visiting India, I would be primarily interested in noting the actual evidence of cultural change

Appendix H contd.

64)When buying new clothes I look for the best possible buy
65)I would like to visit an art gallery
66)When a child is seriously ill, a good mother will remain calm and reasonable
67)I prefer to associate with people who stay in close contact with the facts of life
68)Many T.V. programs are based on inadequate background research
69)Higher education should place greater emphasis on natural science
70)I like to think of myself as logical
71)When people are arguing a question from two different points of view, I would say that each should endeavour to assess honestly his own attitude and bias before arguing further
72)When reading an historial novel, I am most interested in the factual accuracy found in the novel
73)The greatest evil inherent in a totalitarian regime is distortion of the facts
74)A good driver is considerate
75)Our understanding of the meaning of life has been furthered most by biology
76)I would like to have been Galileo
77)My children must possess the characteristics of sensitivity
78)I would like to be a Geologist
79)A good indicator of decay in a nation is an increase in the sale of movie magazines over news publications
80)I would be very disturbed if accused of being illogical in my beliefs
81)Most great scientific discoveries come about by thinking about a phenomenon in a new way
82)I feel most at home in a culture in which the expression of creative talent is encouraged
83)In choosing a job I would look for one which offered a specific intellectual challenge
84)When visiting a new area, I first plan a course of action to guide my visit
85)A good teacher is primarily one who is able to discover what works in class and is able to use it
86)Most great scientific discoveries comes about by careful observation of the phenomena in question
87)Most people who read a lot know a lot because they acquire an intellectual proficiency through the sifting of ideas

Appendix H contd.

88)I would like to viist a botanical garden or zoo
89)When reading an historical novel, I am most interested in the subtleties of the personalities described
90)When playing bridge or similar games I play the game by following spontaneous cues

Table H-1

Description of PEP

A person'a psycho-epistemological profile consists of scores on each of the 3 epistemic styles, with the highest assumed to indicate the dominant epistemology for that person. The PEP is a 90 item questionnaire with possible resonses ranging from complete disagreement (1) to complete agreement (5).

Appendix I

The Rosenbergy Self-Esteem Scale (RSE)

These questions refer to how you feel about yourself. Please answer them honestly, starting on the IBM sheet where you left off. Thank you.

Scale: 1 = strongly agree
2 = agree
3 = disagree
4 = strongly disagree

1)I feel that I'm a person of worth, at least on an equal plane with others
2)I feel that I have a number of good qualities
3)All in all, I am inclined to feel that I am a failure
4)I am able to do things as well as most other people
5)I feel I do not have much to be proud of
6)I have a positive attitude toward myself
7)On the whole, I am satisfied with myself
8)I wish I could have more respect for myself
9)I certainly feel useless at times
10)At times I think I am no good at all

Table I-1

Description of RSE

The RSE is a 10-item scale. Responses range from strongly agree (1) to strongly disagree (4). Scores may range from 10 to 40 with higher scores indicating lower self-esteem.

Appendix J

Locus of Control Scale(LOCS)

This questionnaire is designed to find out the way in which certain important events in our society affect different people. Please select the statements which you more strongly BELIEVE to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true. There are no right or wrong answers. In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be the case. Also try to respond to each item INDEPENDENTLY when making your choice; do not be influenced by your previous choices. Please fill in the appropriate oval on the IBM sheet beginning where you left off.

I MORE STRONGLY BELIEVE THAT:

1) a)children get into trouble because their parents punish them too much
b)the trouble with most children nowadays is that their parents are too easy with them

2) a)many of the unhappy things in people's lives are partly due to bad luck
b)people's misfortunes result from the mistakes they make

3) a)one of the major reasons why we have wars is because people don't take enough interest in politics
b)there will always be wars, no matter how people try to prevent them

4) a)in the long run people get the respect they deserve in this world
b)unfortunately, an individual's worth often passess unrecognized no matter how hard he tries

5) a)the idea that teachers are unfair to students is nonsense
b)most students don't realize the extent to which their grades are influenced by accidental happenings

6) a)without the right breaks one cannot be an

Appendix J contd.

effective leader
b)capable people who fail to become leaders have not taken advantage of their opportunities

7) a)no matter how hard you try some people just don't like you
b)people who can't get others to like them don't understand how to get along with others

8) a)heredity plays the major role in determining one's personality
b)it is one's experiences in life which determine what they're like

9) a)I have often found that what is going to happen will happen
b)trusting to fate has never turned out as well for me as making a decision to take a definite course of action

10) a)in the case of a well prepared student there is rarely if ever such a thing as an unfair test
b)many times exam questions tend to be so unrelated to course work that studying is really useless

11) a)becoming a success is a matter of hard work luck has little or nothing to do with it
b)getting a good job depends mainly on being in the right place at the right time

12) a)the average citizen can have an influence in government decisions
b)this world is run by the few people in power, and there is not much the little guy can do about it

13) a)when I make plans, I am almost certain that I can make them work
b)it is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow

14) a)there are certain people who are just no good
b)there is some good in everybody

15) a)in my case getting what I want has little or nothing to do with luck

Appendix J contd.

b)many times we might just as well decide what to do by flipping a coin

16) a)who gets to be the boss often depends on who was lucky enough to be in the right place first

b)getting people to do the right thing depends upon ability; luck has little or nothing to do with it

17) a)as far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control

b)by taking an active part in political and social affairs the people can control world events

18) a)most people can't realize the extent to which their lives are controlled by accidental happenings

b)there really is no such thing as "luck"

19) a)one should always be willing to admit his mistakes

b)it is usually best to cover up one's mistakes

20) a)it is hard to know whether or not a person really likes you

b)how many friends you have depends upon how nice a person you are

21) a)in the long run the bad things that happen to us are balanced by the good ones

b)most misfortunes are the result of lack of ability, ignorance, laziness, or all three

22) a)with enough effort we can wipe out political corruption

b)it is difficult for people to have much control over the things politicians do in office

23) a)sometimes I can't understand how teachers arrive at the grades they give

b)there is a direct connection between how hard I study and the grades I get

24) a)a good leader expects people to decide for themselves what they should do

b)a good leader makes it clear to everybody what their jobs are

Appendix J contd.

25) a)many times I feel that I have little influence over the things that happen to me
b)it is impossible for me to believe that chance or luck plays an important role in my life

26) a)people are lonely because they don't try to be friendly
b)there's not much use in trying too hard to please people, if they like you, they like you

27) a)there is too much emphasis on athletics in high school
b)team sports are an excellent way to build character

28) a)what happens to me is my own doing
b)sometimes I feel that I don't have enough control over the direction my life is taking

29) a)most of the time I can't understand why politicians behave the way they do
b)in the long run the people are responsible for bad government on a national as well as on a local level

Table J-1

Description of LOCS

The LOCS is a 23 item forced choice questionnaire with 6 filler items. Each question requires subjects to make a dichotomous choice between one internal and one external statement. It is scored in the external direction, with higher scores representing increased externality. Scores range from 0 to 23, with those above the median (12) indicating an external orientation and those below, an internal orientation.

Appendix K

The Counselor Rating Form-Short Version (CRF-S)

We would like you to rate several characteristics of the therapist you just watched in the video. For each characteristic, there is a seven-point scale that ranges from "not very"(1) to "very"(7). Please fill in the appropriate oval on the IBM sheet starting where you left off that corresponds to how you viewed the therapist. Though all of the following characteristics are desirable, therapists differ in their strengths. We are interested in knowing how you view these differences. Remeber, your responses are totally anonymous.

Scale: 1----2----3----4----5----6----7
not very ... very

1)friendly
2)experienced
3)honest
4)likeable
5)expert
6)reliable
7)sociable
8)prepared
9)sincere
10)warm
11)skillful
12)trustworthy

Table K-1

Description of CRF-S

The CRF-S is a 12 item questionnaire. The score range for each item is 1 (not very) to 7 (very), resulting in a total score range from 4 to 28 for each of the three dimensions (expertness, attractiveness, trustworthiness). Higher scores indicate greater satisfaction with therapist qualities.

Appendix L

Counseling Satisfaction Questionnaire (CSQ-8)

Please answer all of the questions below **as if you were the client you watched in the video.** Please answer all of the questions and fill in the appropriate oval on the IBM sheets. Thank you very much. **Remember you are answering as if you were the client in the video.**

1. If you were the client, how would you rate the quality of service you have received?

a) = excellent
b) = good
c) = fair
d) = poor

2. If you were the client, did you get the kind of service you wanted?

a) = no, definitely not
b) = no, not really
c) = yes, generally
d) = yes, definitely

3. If you were the client, to what extent did this program meet your needs?

a) = almost all of my needs have been met
b) = most of my needs have been met
c) = only a few of my needs have been met
d) = none of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to him or her?

a) = no, definitely not
b) = no, I don't think so
c) = Yes, I think so
d) = yes, definitely

5. If you were the client, how satisfied would you be with the amount of help you received?

a) = quite dissatisfied
b) = indifferent or mildly dissatisfied

Appendix L contd.

c) = mostly satisfied
d) = very satisfied

6. If you were the client, did the services you received help you to deal more effectively with your problems?

a) = yes, they helped a great deal
b) = yes, they helped somewhat
c) = no, they really didn't help
d) = no, they seemed to make things worse

7. If you were the client, in an overall, general sense, how satisfied would you be with the service you have received?

a) = very satisfied
b) = mostly satisfied
c) = indifferent or mildly dissatisfied
d) = quite dissatisfied

8. If you were the client, and were to seek help again, would you come back to our program?

a) = no, definitely not
b) = no, I don't think so
c) = yes, I think so
d) = yes, definitely

Table L-1

Description of CSQ-8

The CSQ-8 is an 8 item questionnaire. Scores can range from 8 to 32 with higher scores indicating greater satisfaction with therapy.

Appendix M

Structure Rating Scale (SRS)

Therapies differ in the amount of stucture they provide for the client. For example, a highly structured therapy is one in which the therapist exerted a lot of control over the client, that is, the therapist directs the flow of conversation and does so in a somewhat pre-determined fashion. Alternatively, a non-structured therapy is one in which the client is involved in the direction the discussion is headed and the client is encouraged to discover information for themselves.

Please rate the therapy session you just watched on the following dimensions. Please circle the appropriate oval on the IBM sheet where you left off

Scale: 1-----2-----3-----4-----5------6-----7
strongly agree ... strongly disagree

1)There was a high degree of counselor control over the therapy sessions
2)The interaction between the therapist and client was highly organized and pre-determined by the therapist
3)Clients were encouraged to discover for themselves what factors might contribute to their behaviour
4)The problems stated by the clients were dealt with in an exploratory, discovery manner
5)The responsiblity for the interview was shared by the counselor and client
6)The therapist assumed a "teaching" role in the treatment sessions

Table M-1

Description of SRS-Modified

The SRS consists of 6 items, 3 reflecting the presence of a minimally structured counselling environment, and 3 reflecting the presence of a highly structured counselling environment. Ratings are made on a 7 point scale ranging from "strongly agree" (1) to "strongly disagree" (7). Scores can range from 6 to 42 with high scores reflecting a low structure environemtn and low scores indicating a highly structured environment. Instructions for ratings of treatment structure are given to subjects prior to rating.

Appendix N

Counselling Scripts

CONSTRUCTIVIST

My approach to counselling is based on the idea that we all experience a unique history of development which leads us to view the world in a very personal way. For example, through interactions with significant people in our lives, each of us has learned to organize in a meaningful fashion our own internal experience of what we see, hear, and feel. In short, we have come to construct personal representations of our selves and of our world which serve as maps or guides for our everyday actions and decisions.

However, for many people that I see in counselling these representations of self and world are no longer fully effective in helping them cope with some new life challenge or crisis. In other words, your current view of self and world, while previously adaptive, now prevents you from generating new ways of coping effectively with the demands of some new developmental task--like moving away from home, or coping with a major crisis. Thus, in my view, various problems that people bring to counselling are a result of the growing gap between the demands of some particular life challenge, on one hand, and their current capacity to generate effective resolutions, on the other. In essence, it is an experience of being "stuck"--being unable to move beyond the present difficulty. As a result, your personal development is hampered. Thus, I view counselling as an opportunity for you to develop a novel way of viewing yourself and the world that allows you to begin "moving" in your life development once again.

In order for this process to unfold, it will be important for us both to understand the unique way you have come to symbolize and assign meaning to your own life experience. The analogy I often use to describe counselling is that of a sea voyage--one in which we embark together as shipmates. The picture here is of a relationship characterized by cooperation between two people who mutually respect each other and are attempting to understand each other. In this sea voyage analogy,the most important issue is the nature of the voyage itself, not specific destinations--it is your own process of self-exploration, rather than some

Appendix N contd.

particular goal, that I believe is fundamental to furthering your personal development.

It is my hope that we can create a relationship in which you feel safe to fully explore your feelings and the personal meanings associated with your present difficulties. Through this process of self-exploration I believe you can come to construct an alternative way of viewing the world--one that represents a more viable way of understanding your life experience.

VIDEOTAPE BEGINS

T: Hello. This approach to counselling is based on the idea that people coming to me with personal problems are stuck in their life development..or are faced with situations that they are not able to resolve or deal with in their normal way. Thus, I see people as constantly changing and adapting to meet their own life challenges. Counselling as a process then is directed towards personal growth and self-exploration. I view counselling as a mutual effort where my role is to assist the client, but not to tell the client my views of what's right or wrong, healthy or unhealthy. While I'm never sure where this process will lead us, it is up to the client to determine what we talk about and how quickly therapy moves. Now I'll give you an example of this approach.

CONSTRUCTIVIST SCRIPT

T: How can I help you?

C: I thought I should talk to someone. I think there is something wrong with me (pause)....I don't know, maybe I'm really screwed up (client takes a deep breath and clears her throat. She speaks in a low, somewhat monotonous tone).

T: Okay...let's talk

C: I guess I should start at the beginning... but I'm not ever sure when that was...Last week a friend of mine called, inviting me to a pool party and after I got off the phone, I started freaking out. I tried to get my mind off it by cleaning my apartment.

T: What did your friend say on the phone?

C: She said that she had just bought a new bikini and

Appendix N contd.

had invited practically all of our friends to this party plus some people I don't know to this pool party. I've been thinking about it a lot (therapist nods) and it's getting worse..I don't know, it's so stupid

T: Nothing is stupid about feeling anxious Jennifer...we all do.

C: But I don't like to feel that way

T: Ok, have you had bad experiences at pool parties before?

C: yah a while ago I went to one, it was awful

T: Do you feel comfortable telling me about it?

C: I guess. Last month, I went to this pool party and it was really bad. I went with my boyfriend and after I got there I started looking at all of those people and they all looked so skinny and I started feeling so fat and gross.. I couldn't bear the thought of walking around in front of these people (Client looks very solemn and speaking quietly) I thought I might freak out and they'd all laugh at me

T: So what did happen?

C: I had to leave...my boyfriend was really pissed off because he wanted to stay, but I just couldn't... so we left

T: And after you left, how did you feel then?

C: Relieved. Like I could breathe again

T: When are you the least likely to feel uptight or anxious, in other words, when do you feel most safe?

C: Safe, that's a good word...Umm, when I'm hanging around by myself in my sweats or with my boyfriend.

T: Oh, I see. When you're in this situation, are you likely to come into contact with people who judge you based on your weight and shape?

C: No, but that's what it is..people looking at me-at

Appendix N contd.

my body.....It's been getting worse and I'm really scared it's going to get out of control. Can this sort of thing be overcome?(client leans lightly in the direction of the therapist-eyes
wide, mouth drawn)

T: Well, we have a pretty good track record for people with this kind of problem, but first of course I'm going to need a lot more information. I'll bet you're feeling pretty tense.

C: Yah (sighs).

T: Ok, have you ever thought about developing a new way of looking at yourself and others, a way that would enable you to move forward in your personal development?

C: No, but I think that's something I might need, like getting to know myself better and accepting myself for who I really am?

T: Yes. I think it might be a start by exploring some of your feelings and meanings around what it means to be seen as fat, what is fat, and that kind of thing. This would be a process of you changing over time and taking small steps. We need to work together, you and I, to decide how big those steps should be and in what direction we should go, so that it's not just a matter of you coming in here and me telling you, "well, this is what we're going to do".

C; I think that would help me to handle things.

T: Ok, I can think of something that might help you understand and know yourself a bit better. It's sort of a personal work. It's called journalling. This is aporcess whereby every day you write down your thoughts, feelings, memories, dreams, and fantasies, and than a special space to the side for you to write reflective notes to yourself. I would be here to encourage you to reflect on what you're feeling and what you want to feel-umm..that might help you try to look at things and events in your life from a different perspective. Do you know what I mean by a different perspective?

C: Client nods no

T: Ok. imagine this, try to imagine yourself as someone else, someone who's not you, who doesn't know you, doesn't know anything about you. Now, this person is at the pool party. Now, put yourself back into you as you, and you arrive at this party. What happens?

C: Do you mean like my friends coming up and saying hi and chatting and stuff?

T: Exactly. This person who doesn't know you sees you coming up and sees other people coming up to you and greeting you warmly and talking with you affectionately

C: I see what you mean, while on the inside I'm thinking that everyone is looking at me and my body in a negative way, they may be actually looking at me in a good way

T: Exactly. There's another thing we could try, something called mirror time. That's where we have you standing in front of a mirror and you look at yourself and describe what you see and at the same time you'll answer questions that I may ask you. These will be questions like are there differences between what I see in the mirror and what I feel myself to be? Sometimes when we look into our own eyes and ask ourselves questions about what we see there, sometimes these questions get answered. The purpose of these exercises is to really explore and understand your development beyond what you might be able to tell me verbally.

C: I think I'd like that, sometimes I have a really hard time telling people how I feel...This all sounds really interesting but how will it help me to get through the party without freaking out?

T: Well, personal change doesn't occur overnight and only as quickly as you want it to.

C: So let me make sure I've got all this. I'm going to start journalling my thoughts and stuff and doing mirror exercises with you...

T: Yes, Through some of these exercises, we can explore and sort out what some of these anxieties are and where they come from and in the process determine where you are going so that by the end of treatment, you may find that what was your most anxiety-provoking situation, won't create any stress for you at all. From now on

when you come into therapy, that will be what will happen-I think this will really help you with your problem
--FADE OUT-

BEHAVIOURAL

My approach to counselling is based on the idea that all behaviour is lawful and can be explained through systematic observation and study. In other words, I believe problem behaviours are learned just like non-problem behaviours, and thus can be unlearned. As a result, my approach to counselling tends to rely upon a systematic method of examining your behaviour and your environment and then developing specific interventions or strategies designed to alter your behaviour and life circumstance.

There are some basic steps in my approach to counselling that I would use in working with you. First, I would try to obtain information about your problem in a systematic way. I will need to discover clear and precise information about your behaviour and actions. In other words, I believe in defining your problem through focusing on what you do and how you behave in certain situations. The goal of this first step, then, is to define your problem in terms of objective, observable actions--or what you actually do, because I believe it is easier to work with objective behaviour than with vague, nonspecific concepts such as depression or sadness. One way I define problems objectively is to ask the following simple, but fundamental question: "Can I see, hear, or touch the problem my client is describing?" For example, a young woman may express a desire to be less concerned about her weight and body shape-but because I cannot see, hear, or touch her word "concerned", I would encourage her to define this concept in more tangible and concrete terms and behaviour..something like, "I wish when I look at myself in a mirror that I wouldn't <u>think</u> and <u>say</u> the things I do to myself, and when I'm out at parties, I wish I wouldn't <u>leave</u> so soon".

I also believe that problem behaviour is related to certain events and stimuli in the environment. Thus, the second step of my approach involves the study of antecedent events, the resultant behaviour, and the consequences of that behaviour. In other words, I am interested in knowing what happened just prior to a specific behaviour, what the specific behaviour was, and what the result or consequence was for you. When

personal actions are followed by positive things they are much more likely to happen again. Similarly, if actions are followed by reduced anxiety, they are also more likely to happen again.Through this examination of cause and effect relationships, I can come to understand the sequence of events underlying your particular problem. From understanding these patterns, it is then possible for me to define specific and relevant goals for you to achieve through counselling. Once such goals are determined, it is possible for me to design and teach you ways to help you change your behaviour and attain your goals. That is, I will give you specific instructions on how to change your behaviour.

T: Hello. This approach to counselling is based on the idea that people coming to me with personal problems are doing things or behaving in ways that are causing them distress. Thus, I view people with personal problems as having learned a problem behaviour. As a process, then, counselling is directed towards reducing or eliminating this problem behaviour. I view counselling as a teacher-student relationship..my role is to teach the client how to change this problem behaviour. This is normally achieved by looking carefully at what is causing the behaviour and what is the result of the behaviour and then making a systematic plan for change. Now I'll give you an example of this approach.

-CLIENT ENTERS ROOM-

T: How can I help you?

C: I wanted to talk to someone. I think there is something really wrong with me (pause). I don't know, maybe I'm really screwed up (client takes a deep breath and clears her throat-she speaks in a low, somewhat monotonous tone).

T: Okay...let's talk about your problem

C: I guess I should start at the beginning...but I'm not sure when that was..Last week, a friend of mine called and invited me to a pool party and for no reason after I hung up, I started freaking out.

T: And what did you do then?

C: I tried to calm down by cleaning my apartment.

T: Can you recall anything that happened, right before or during the phone call?

C: (pause). She said she just bought a new bikini and she had invited practically all of our friends, plus some people I didn't know to this party.

T: Have you been thinking about it a lot since then?

C: Yah

T: How often?

C: All the time and it's getting worse. I don't know, it's so stupid

T: Nothing is stupid about feeling anxious..we all do.

C: But I don't want to feel that way

T: Have you had bad experiences at pool parties before?

C: Yeah, a while ago I went to a party...and it was awful

T: How awful? So bad you had to leave?

C: Yah

T: Ok, did you go to the party with someone?

C: Yah, I went with my boyfriend

T: And how did he react to you having to leave?

C: He was really pissed off..He wanted to stay but I just couldn't

T: What were other people doing at the party?

C: Just walking around

T: How did they look?

C: They looked good, so skinny

T: What were your thoughts?

Appendix N contd.

C: I don't know, I started thinking about how fat and gross I was..and I couldn't bear the thought of walking around in front of these people (Client looking very solemn and speaking quietly) I thought I might start to freak out and they'd laugh at me

T: So what did happen?

C: I had to leave

T: So when you got out of there, how did you feel?

C: Relieved..... Like I could breathe again

T: When are you the least likely to feel uptight? In other words, when do you most feel safe?

C: Safe. That's a good word for it...when I'm by myself hanging out in my sweats or with my boyfriend

T: And when you're in this situation, are you likely to come into contact with people who will judge you based on your weight and shape?

C: No, of course not, but that's what it is. People looking at me-at my body...I don't know, it's getting worse. Can..this sort of thing be overcome? (client leans lightly in the direction of the therapist, eyes wide, mouth drawn)

T: Well the track record for people with your kind of problem is quite good. Of course, I'm going to need some more information first, but right now, I bet you're feeling pretty tense just talking about all this?

C: Yah (sighs)

T: Ok, what I'm going to do is teach you a way to reduce that anxious feeling that develops when you are getting ready to go to a party or something like that by using a specific procedure

C: That's something I might need

T: At the beginning of treatment, I am going to train you to become really relaxed, through a technique called progressive relaxation. Do you know what progressive relaxation is?

Appendix N contd.

C: You mean like learning to stay calm.

T: Yes exactly

C: I think I'd like that

T: Ok, we'll start training for this here in this office each week. At the beginning, we'll concentrate on learning to relax while you're lying down. There is a series of exercises where you concentrate on relaxing a specific muscle by tightening that muscle and holding it really tight for awhile and then relaxing the same muscle. Then I'll direct your attention to the feelings associated with the relaxed state, so you can get used to how relaxed is supposed to feel, and also how tense muscles feel. Ok, now after you've mastered this, while you're lying down then we'll go through the same thing with you sitting up and standing and then moving around. Our goal will be to have you learn to stay relaxed and be aware of tension (if it's there) while you're walking or moving.

C;I think I'd like that

T: Now, once you can produce and maintain a moderate level of deep relaxation, then we'll start to expose you to things that make you fearful. It will be up to you to tell me what these things are because you're the only one who really knows how these things make you feel. After you have described these tension-provoking situations to me, I'll administer the treatment so to speak, and create the feared atmosphere for you. At the beginning, things we will expose you to will cause you just a little bit of anxiety.. like perhaps being here in my office with tight fitting clothes on. Then, after you have mastered this, I'll expose you to things that cause you a little more anxiety...perhaps like walking around campus with tight fitting clothes or maybe shorts. Then, we'll move on to role-playing in this office-I'll pretend I'm a friend phoning you up to invite you to a pool party. Now, here's how it works, because you will be relaxed, before long you will be able to encounter real situations like these and actually feel comfortable

C: This all sounds interesting but how will it help me to go to the party without feeling awful?

T: Well, I'll go at a slow easy pace. Starting here,

Appendix N contd.

perhaps moving outside and I won't proceed further until you've developed the skill to produce and maintain a moderately deep state of relaxation

C: So this is going to work by me teeling you situations that make me feel a little anxious, up to ones that make me really anxious. Then, you'll teach me how to stay calm...

T: Then we'll slowly start to expose you to those feared situations while you're in that relaxed state. Now, by the end of treatment, you may find out that what was previously your most anxiety-provoking situation won't be stressful for you at all. From now on when you come into therapy-this will be what will happen.I think this will really help you with your problem
-FADE OUT-

RATIONAL

My approach to counselling focuses on the way people think about certain life events and situations. In particular, it is my contention that most problems people experience stem from their own irrational and illogical thinking patterns. For example, one irrational belief that people hold is that one MUST have sincere love and approval almost all the time from all people whom one finds significant. Another common one, is the belief that people who harm you or commit misdeeds are generally bad, wicked individuals and that you should severely blame, damn, and punish them for their sins. As a result, the main task of counselling, as I see it is to correct certain thought patterns and rid people of their irrational ideas.

The most common way I help clients understand their present difficulty is by teaching them rational self-analysis. For example, most people tend to consider that when some event in their life occurs, this directly leads to some personal emotional consequence. In other words, people generally come to believe that their feelings are caused by some incident, some circumstance, or some person in their lives. However, they fail to consider that it is not the event that determines their emotional reaction or consequence, but instead it is their beliefs about the event. In short, it is what people think about an event that determines how they feel. Thus, the first step to my approach to counselling would be to help you identify the incorrect logic of your statements and

understand that your own beliefs play a major role in determining your feelings.

What I would typically do at this point would be to encourage you to talk about certain situations in your life so that we could begin to analyze what it is you believe about these situations that causes you to feel upset, confused, or depressed. Thus, the second step to my approach involves helping you identify the specific irrational beliefs that are maintaining your present emotional difficulties and encourage you to begin to replace these beliefs about certain events in your life with more rational interpretations. As you begin to change these beliefs you will find that your feelings will also begin to change in a positive way.

Thus my primary role as a counsellor is to show you how to analyze your own beliefs, identify your own particular pattern of irrational thinking, and learn how to change your thoughts so that your interpretations of various life events will be more rational and your emotional responses to life situations more adaptive.

T: Hello, (warm smile). This approach to counselling is based on the idea that people coming to me with personal problems have confused thinking..that they may simply not be thinking logically about their problem. Thus, I view people with personal problems as having certain irrational beliefs about the problem that are serving to maintain these problems. As a process, then, counselling is directed towards eliminating or reducing those irrational beliefs. I view counselling as a teacher-student
relationship..my role is to help the client identify those irrational beliefs and replace them with more rational ones. I encourage the client to talk with me about whatever in their life is bothering them, and then to systematically examine the nature of their beliefs. Now, here's an example of this approach.
-CLIENT ENTERS ROOM-

T: How can I help you?

C: I wanted to talk to somebody..I think there's something wrong with me (pause). I don't know, maybe I'm really screwed up (client takes a deep breath and clears her throat-she speaks in a low, somewhat monotonous voice)

T: Okay, let's talk about your problem

Appendix N contd.

C: Well I guess I should start at the beginning... but I'm not sure when that was. Last week a friend of mine called and invited me to this pool party and for no reason, after I hung up, I started really freaking out. I tried to get my mind off it by cleaning my apartment

T: Okay, what were you thinking?

C: Well, she had told me about this party and this new bikini she just got and all these people she invited and I was thinking about what it would be like to be around all those people. I've been thinking about it a lot lately, maybe it's really stupid

T: There is nothing stupid about feeling anxious..we all do

C: But I don't want to feel that way

T: Have you had bad experiences at pool parties before?

C: Yeah, a while ago I went to a party, it was awful

T: Can you describe it to me?

C: I guess. I went to this party with my boyfriend and after I got there I started seeing all these people walking around looking so skinny

T: And what were you thinking?

C: I started thinking about how fat and gross my body was, and I was afraid I'd freak out and everybody would laugh at me (client looks very solemn and speaking quietly)

T: So what did happen?

C: I had to leave..my boyfriend was really pissed off because he wanted to stay, but I just couldn't... so we left

T: Ok, so when you got out, what were you thinking then?

C: I was thinking about how getting out of that situation gave me so much relief.Like I could breath again

Appendix N contd.

T: When are you least likely to feel anxious or uptight, in other words, when do you most feel safe?

C: Safe, that's a good word for it..when I'm by myself hanging out in sweats or with my boyfriend

T: Ok, so when you're in this situation, are you likely to come into contact with people who would judge you based on your shape or your weight?

C: No, of course not, but that's what it is..people looking at me..at my body..I don't know, I'm afraid it's going to get out of control. Can..this sort of thing be overcome? (client leans lightly in the direction fo the therapist, eyes wide, mouth drawn)

T: Well, the track record for this kind of problem is quite good. I'm going to need more information of course, but right now, I bet you're pretty tense just talking about all this?

C: Yah (sighs)

T: Ok, well what we're going to do is try to teach you a way to reduce that anxious feeling you have, that develops when you are getting ready to go out, by teaching you to systematically analyze and change any beliefs that you have that are founded on irrational principles. You know what I mean?

C: I think that's something I might need

T: First, we will find out what your personal irrational beliefs are, and then we will begin to challenge them, and expose them for what they are...irrational

C: You mean like learning to think straight

T: Exactly

C: Yah, I think I'd like that. I'd like to be more rational. It might help me to handle things

T: We will begin to examine your beliefs about going to a pool party and I will show you how the consequences of going are very much dependent on your beliefs about going. Do you know what I mean by that?

Appendix N contd.

C: Client nods no

T: Well, one thing that's bothering you is that you feel you'll arrive and you'll be laughed at, people will be really mean, right?

C: yah

T: Well, you said that you weren't laughed at before, at the other party, and my guess is it wouldn't happen at this one either

C: Yah but it could happen

T: It could happen, but what if it did? Why would it be so terrible? Do you mean that you'd be hurt, or angry, or you wouldn't know how to react?

C: All of those things. I just, I don't like people looking at me, just staring

T: And what are those people thinking?

C: That I'm fat

T: Okay, it looks to me like you think the worst that could happen would be that people would look at you and laugh and be real mean. First, that is pretty unlikely isn't it?

C: Nods

T: Ok, so put yourself in the situation or suppose you are at a party and someone else comes in and this happens to them. People are really mean to these people that just cam in and are laughing at them. Now, how would you judge them?

C: Well, I'd feel sorry for them,..I'd try to help them. .I wouldn't think they were bad people. I guess maybe everybody wouldn't laugh at me

T: I wouldn't think they would. Ok, but suppose they did. Suppose they did, suppose you arrive and everyone is laughing at you and being really mean. How would you react?

C: I'd shrivel up and die.

Appendix N contd.

T: Now, you have to remember that events don't cause feelings, it's beliefs about those events that do. True, most people wouldn't enjoy this situation, it would be a bad experience, but exactly how bad it would be would depend on what you choose to say to yourself in a situation like that. And in your case, what would that be?

C: That I'm worthless and fat

T: Ok, here we get into the question of human worth. Now the last time I looked, human worth was not ratable or quantifiable, there's no measure for it. Thus, it follows that nothing that anyone does can lower your worth as a human being. Right?

C: But you seem to be saying that it's all right to have people laugh and make fun of you?

T: Well, no I can understand that it would be unpleasant and awkward but we agree that people not approving of you at a pool party can't have any bearing on your worth. So, it can't be that terrible. I mean thinking this way is self-defeating. The treatment strategy that I think will work best for you is one that rids you of these irrational beliefs and more importantly, I hope that you'll learn to discard your current illogical system of information processing in favour of more rational beliefs.

C: This sounds interesting. So how does this work again? I'm going to tell you about situations, that give me anxiety and then my beliefs about what is going to happen in those situations. Then, you're going to help me get rid of the irrational stuff and then..what?

T: Then, together, we will develop a system of beliefs based on rational premises, and by the end of treatment, you may find that what was your most anxiety provoking siuation won't be stressful at all. From now on when you come into therapy-this will be what will happen. I think this will really help you with your problem
--FADE OUT--

Table N-1

Mean Structure Scores Associated With Each Vignette

	Pilot	
	First	Second
Vignette		
Behavioral	9.33^{+}	19.83^{*}
Rational	12.08^{*}	20.62^{+}
Constructivist	18.58^{+*}	29.21^{*+}

Note. Higher scores indicate less therapeutic structure.
Means within a column with same superscript differ significantly at $p < .05$.
Omnibus F test from first pilot $F(2, 12) = 17.96$, $MSe = 9.96$, $p = .0002$.
Omnibus F test from second pilot $F(2, 56) = 20.31$, $MSe = 38.62$, $p = .0001$.

Table N-2

Matching Epistemological Phrases with Corresponding Vignettes

Vignette	Epistemic Phrases			
	Empirical	Rational	Metaphoric	F
Behavioural	25	3	3	37.41*
Rational	3	23	3	21.29*
Constructivist	4	2	24	27.86*

Note. Values represent number of subjects matching particular epistemic phrase to type of vignette.

* denotes $p < .0001$.

Appendix O

Graduate Validity Check

You are about to view 3 videotapes depicting 3 different approaches to psychotherapy treatment for a body-image disturbance problem. I would like you to rate these tapes on the following dimensions after you have viewed each one. Thank-you.

1. How neutral was the therapist's tone in this therapy approach?

    1 - | - | - | - 5
    not neutral — highly neutral

2. How would you rate the pace of therapy for this therapy approach?

    1 - | - | - | - 5
    very fast — very slow

3. How expert did the therapist seem to you in this therapy approach?

    1 - | - | - | - 5
    very expert — very non-expert

4. How attractive did the therapist seem to you (in a general, overall sense) in this therapy approach?

    1 - | - | - | - 5
    very attractive — very unattractive

5. How sincere did the therapist seem to you in this therapy approach?

    1 - | - | - | - 5
    very sincere — very insincere

6. How skilled did the therapist seem to you in this

Appendix O contd.

therapy approach?

1 - | - | - | - 5
very skilled — not at all skilled

7. How responsive was the client in this therapy approach?

1 - | - | - | - 5
very responsive — not at all responsive

8. How would you rate the level of the client's disturbance in this therapy approach?

1 - | - | - | - 5
very disturbed — not at all disturbed

9. In your opinion, how representative of an early stage of counselling was this vignette?

1 - | - | - | - 5
very representative — not at all representative

10. For this type of problem, how effective would you rate this counselling approach to be?

1 - | - | - | - 5
very effective — not at all effective

DO NOT COMPLETE THIS SECTION UNTIL YOU HAVE VIEWED ALL 3 VIDEOS

11. If you had to say that this therapy approach was representative of one of [(behavioural, cognitive-rational (ELLIS), cognitive-constructivist (MAHONEY)] approaches to psychotherapy, which would it be?

video x is representative of ________________
video y is representative of ________________
video z is representative of ________________

Appendix O contd.

Now, I would like you to match each of the phrases below with one of the therapy approaches you just watched. After you watch the first video, read each of the three phrases below, and decide which one "best" matches the therapy video. Follow the same procedure for the second and third videos. To help you with your decision, try to imagine what the therapist in each of the three videos would likely agree with.

Phrases

1. Most people who read a lot, know a lot because they come to know of the nature and function of the world around them.
THIS PHRASE SHOULD BE MATCHED WITH THERAPY #_____

2. Most people who read a lot, know a lot because they develop an awareness and sensitivity through their reading.
THIS PHRASE SHOULD BE MATCHED WITH THERAPY #___

3. Most people who read a lot know a lot because they acquire an intellectual proficiency (expertise) through the sifting of ideas._
THIS PHRASE SHOULD BE MATCHED WITH THERAPY #____
Treatment Acceptability

Appendix P

Consent Forms for University Subjects

We are from the University of Manitoba's Dept. of Psychology. We are conducting a study are interested in knowing your views and preferences on a variety of things in life as well as your attitudes towards food and eating. The sessions will last for 2 hours. We will be asking you to write down your name, address, and phone number, however, all responses will be kept completely confidential. We are asking for this information because we will be contacting a random sample of you sometime in February and asking you whether you would like to participate in another study. You are not obligated to participate in this other study, but only if you want to. All information pertaining to you name, address, and phone number will be recorded onto a master list, and will be kept locked and secure at all times until the studies are completed, at which time this information will be shredded. For the purposes of analysing the data, all subjects will be represented by a subject number, and so no one will know how each individual responded. We request that you answer all questions as honestly as possible. However, if you prefer not to answer a question, you are free to omit it. Similarly, you may withdraw from the study at any time without loss of experimental credit. After the study has been completed, we will describe it in greater detail and give you an opportunity to receive results of the study.

Consent

I, ________________________, have read the participant information and understand what is expected of me. I understand that I may decline to respond to questions and may withdraw from the study at any time without loss of experimental credit.

__________________ __________________

Signature Date

Appendix Q

Subject Feedback

Thank you for participating in the study entitled "An Evaluation of Counselling". I will now provide you with some feedback regarding the nature of the study. Please do not share this information with your friends or family members, since I am still collecting data, and subjects might respond differently if they knew what this study was about. Thanks for your consideration on this matter.

This study explored the relationship between various personality factors and personal preferences for therapeutic approaches. In psychotherapy research, many investigators are trying to determine what is the best client-therapy match to produce optimal client satisfaction, the best results, and fewer client drop-outs from therapy. Further, several individuals have suggested that clients will do better if they receive their most preferred from of therapy. This is becoming more of an issue becuse people now often shop around for a therapist and therapy. This study evaluated several personal values and beliefs about education, jobs, and people. I am predicting that based on your responses to these questions, you may be more inclined to prefer one of these therapies over the other two. If my predictions are confirmed, then it my be important for therapists to know about their clients with respoect to these personality variables before beginning therapy in order to maximize treatment success.

Unfortunately, this is all I can tell you about this study thus far, however, I anticipate being finished analysing the data in April of 1993 and would be pleased to discuss the study and the results with anyone who is interested. You can leave a message for me at the psychology general office (474-9338) and we can arrange a meeting time. Additionally, I will be posting the results outside my carol in the Duff Roblin Building, room P417, around April. Feel free to stop by and look things over.

For some of you, some of the quesitons I have asked you today may have left you feeling hurt or upset. Some of this material may have brought up feelings in you that were unexpected or perhaps were not. If you would like to further talk about some of

Appendix Q contd.

your feelings or would like some help in dealing with them, the following resources are available to you. These are the Psychological Services Centre on campus by the Greenhouse (474-9222), the University of Manitoba Counselling Centre (474-8592), Klinic crisis line (786-6836), the Fort Garry Women's Resource Centre (269-6836), or myself (474-9338) where you can leave a message and I'll get back to you as soon as possible. Please do not hesitate to use these facilities if you need them. Thank you again for participating in my sudy and have a great day.

Norah Vincent

Table 1

Means and standard deviations of PEP and LOCS scales

	Full sample[a]		Sub-clinical sample[b]	
Epistemic Style	M	SD	M	SD
metaphorism	101.89	11.47	101.60	11.10
empiricism	100.17	10.59	100.93	10.70
rationalism	100.52	9.56	100.51	9.71
Locus of Control	11.76	4.92	11.81	4.35

Note. The values represent mean scores on PEP and LOCS.

[a]N = 397

[b]n = 274

Table 2

Correlations between self-esteem and EAT, BULIT, LOCS, and CRF-S scores

	Sample	
	Full[a]	Sub-clinical[b]
	self-esteem	
1. EAT	.20**	.13*
2. BULIT	.27**	.19**
3. LOCS	.32**	.13*
4. CRF-S (rational therapist)	.45**	n.s.
5. CRF-S (behavioral therapist)	.45**	n.s.

Note. $*p < .05$. $**p < .001$.

Na = 397. nb = 274.

Table 3

Effect of Locus of Control on Ratings of Therapists

	Therapist		
Locus of Control	Behavioural	Rational	Constructivist
External	51.82	49.59	55.23
Internal	53.77	52.11	58.83

Note. Values represent mean scores on Counselor Rating Form (CRF-S).

Table 4

Effect of Dominant Epistemic Style on Satisfaction with Therapeutic Approaches

Epistemic		Therapy	
Style	Behavioural	Rational	Constructivist
Empiricism	23.91	23.73	26.79
Rationalism	24.20	23.87	26.81
Metaphorism	23.16	22.20	26.68

Note. Values represent mean scores on the Counselling Satisfaction Questionnaire (CSQ-8).

Table 5

Mean Ratings of Therapist as a Function of Epistemology and Locus of control

	Therapist		
Group	Rational	Behavioural	Constructivist
Internal Rationalist	54.36	56.19	59.83
External Rationalist	50.37	53.16	56.25
Internal Empiricist	51.09	52.30	56.86
External Empiricist	52.23	53.58	57.70
Internal Metaphorist	50.90	52.79	59.93
External Metaphorist	47.22	50.81	52.63

Note. Values are adjusted for body-image dissatisfaction and reflect mean scores on the Counselor Rating Form-Short Version (CRF-S).