The Evaluation of Beginning Therapist Effectiveness Using Karon's Thematic Apperception Test Pathogenesis Index: A Psychological Approach

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THE EVALUATION OF BEGINNING THERAPIST EFFECTIVENESS USING KARON'S
THEMATIC APPERCEPTION TEST PATHOGENESIS INDEX:
A PSYCHOLOGICAL APPROACH

by
Catherine Rae Miller

A Dissertation
Submitted to the
Faculty of The Graduate College
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requirements for the
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Western Michigan University
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The purpose of the study was to determine the applicability of Karon's Pathogenesis Index as a selection measure for persons entering graduate programs in the mental health field. The fundamental problem generating the research was the need for such selection indicators because of the present inadequacy of personality measures which adequately discriminate between those who have the capacity to become competent therapists and those who do not.

Analysis of the literature revealed many attempts to delineate those characteristics which defined a competent therapist. However, the results were mixed. Only one study, VandenBos and Karon (1971) clearly identified a personality variable which correlated positively with therapist effectiveness. This study showed that the Pathogenesis Index, when used with therapists of schizophrenics, could differentiate between those therapists whose clients got better and those therapists whose clients did not.

To determine if the Pathogenesis Index could also be used to distinguish between therapists in general, and, thus, provide a selection measure, a random sample of 20 beginning therapist trainees were selected from persons enrolled in the beginning phases of the Counseling and Personnel Master's Program who were enrolled in the Counseling Techniques Course during the Winter of 1981.
The trainees were administered a set of Thematic Apperception Test (TAT) cards. Their responses were tape-recorded, transcribed, and scored by two independent judges who determined the Pathogenesis Index for each subject according to Bertram Karon's "Pathogenesis Revised Scoring Criteria."

After the subjects had completed the first ten weeks of the Counseling Techniques Course, they were considered to have been exposed to comparable training. To ascertain therapist effectiveness, the subjects were then placed in a 30 to 40 minute therapy session with a coached client. Following the session both the therapist and coached client completed forms of the Barrett-Lennard Relationship Inventory (BLRI). The BLRI served as the measure of therapist effectiveness with $\alpha \leq .05$ as the a priori level of confidence.

T-tests of differences between client and therapist scores on the BLRI indicated that the five therapists with the lowest Pathogenesis Index scored significantly higher than the six therapists with the highest Pathogenesis Index on three of the four BLRI client scales: Regard, Empathy and Total Score. The Congruence score indicated a trend towards a significant difference. The therapist scales, however, were not significantly different. T-tests for therapist and client scored on the BLRI indicated that there was a significant difference on all four BLRI scales between client and therapist scores. A Pearson Product Moment Correlation Matrix revealed that, while significant differences were found when comparing "high" pathogenesis therapists with "low" pathogenesis
therapists, there was not a direct relationship between scores on the BLRI and the amount of pathogenesis as measured on the Pathogenesis Index. Finally, a Verimax Factor Analysis indicated that there were two factors involved in the data: one factor included client BLRI scores and Pathogenesis Index scores, and the second included BLRI therapist scores.

It was concluded that the Pathogenesis Index could discriminate between effective and ineffective therapists. In addition it was shown that client's perception of the therapeutic relationship differs significantly from the therapist's perception and is more accurate in reflecting the therapeutic relationship. Feasibility and ethical considerations for using the Pathogenesis Index were discussed. It was suggested that the measure may be more useful as an integral part of a graduate program than as a selection indicator.
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Catherine Rae Miller
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LIST OF TABLES

Table | Page
--- | ---
1 | T-tests for Pathogenesis on Barrett-Lennard Relationship Inventory (BLRI) Client and Therapist Scales 44
2 | T-tests for Therapist and Client Scores on the Barrett-Lennard Relationship Inventory (BLRI) 45
3 | Pearson Product Moment Correlation Matrix for the Barrett-Lennard Relationship Inventory (BLRI) and the Pathogenesis Index 47
4 | Principal Factors Verimax Analysis of Barrett-Lennard Relationship Inventory (BLRI) Variables and Pathogenesis Index (PI) 49

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CHAPTER I

THE PROBLEM

Introduction

The process of selection for those entering graduate programs in the mental health field has been varied. Generally, entrance requirements are a composite of academic credentials and grades, work experience, and recommendations from supervisors. The question that arises is whether these criteria accomplish their intended purposes. An increasing number of commentators believe that traditional selection procedures in the mental health field are inadequate (Lippett, Benne, Bradford & Gibb, 1975; Nelson, 1973; Taylor & Torrey, 1972; and Tempone, 1971).

In their review of the literature in the area, Truax and Mitchell (1971) offer a broad condemnation of selection procedures. They concluded that:

From existing data it would appear that only one out of three people entering professional training has the requisite interpersonal skill to prove helpful to patients... In short, current procedures for selection and training are indefensible. Out of habit we still cling to them and perpetuate them even when the evidence is clear (p. 337).

Hogan (1979) in his review of selection procedures found that the majority of empirical research supports the contention that current procedures are badly in need of overhaul. Traditional reliance on academic grades, written and oral examination, or years of experience have little empirical validation (Bergin & Solomon, 1979).
It is apparent that a different approach to the selection process in the mental health field needs to be found for several reasons. First, a different approach is important because of its impact on perspective clients. To select into a graduate program one who will be ineffective or harmful in dealing with clients is to, at best, invite continued suffering in that client and, at worst, prolong or increase the pain. Second, a new selection process is important for the profession of mental health. To select those who would be competent practitioners and reject those who do not have the interpersonal skills to be helpful would increase the credibility of the profession as a whole and allow the public to feel more confident that its mental health problems can be handled satisfactorily. Finally, a new selection process is important for the students wishing to enter a mental health graduate program. It would provide a method for objectively evaluating the potential therapists before they have invested years in training only to find that they are not very effective. A revised method of assessing the "fitness" of potential mental health professionals needs to be based on measures which predict the ability of that person to become an effective therapist.

An effective therapist is one who is able to bring about positive change in the client. Obviously, as has been shown, past selection procedures have not proven adequate. However, prediction of future behavior is difficult to ascertain in the field.
of mental health where so many human variables come into play.

One effective way of predicting behavior is to ascertain the desired outcome and determine the relevant antecedent variables which produce the outcome. By presenting those relevant antecedent variables in a new situation, the desired outcome can be predicted. In the problem of predicting which potential therapists will be successful, the desired outcome is effective therapy demonstrated by positive client change. The antecedent variables under examination are the personality characteristics of the therapist. By determining those relevant personality characteristics which have led to positive client change in the past, it may be ascertained which potential therapists will be effective with clients.

Results of studies relating specific therapist personality variables and therapeutic outcome, however, have been meager and mixed in defining the "ideal" personality profile of a therapist (Bergin & Solomon, 1970; Campbell, 1962; Durlak, 1971; Hoover, 1971; McGreevey, 1967; and Wasson, 1965). On the other hand, certain studies have demonstrated a strong relationship between therapist emotional adjustment and various measures of therapeutic effectiveness (Bergin, 1963; Bergin & Jasper, 1969; Luborsky, 1952; and Heikkinen & Wegner, 1973). The literature, then, does not suggest a particular personality type as the only type from which good therapy results. Rather, it suggests that therapists may, in fact, be very different in terms of personality characteristics and still get favorable results with clients. What appears to be more important is the absence of maladjustment—in a global sense--
in the therapist. A measure of maladjustment, then, may best be able to delineate between those who have the ability to become competent therapists and those who do not and may serve well as a selection measure.

Murstein (1965) argues that maladjustment characteristics are more apt to be measured by projective rather than nonprojective measures since projectives are seen as being able to detect unconscious motivations more adequately than nonprojectives. Unconscious motivations are seen as relatively enduring dispositions which cause the individual to strive for a particular kind of goal state or aim, e.g., power or dominance. The aim of a motive defines the kind of satisfaction that is sought, e.g., pride in accomplishment, a positive affective relationship with another person or a sense of being in control of the means of influencing the behavior of other persons. The attainment of a goal state is accompanied by feelings of satisfaction. Disruption of goal-directed activity or nonattainment of a desired goal state is accompanied by feelings of dissatisfaction. Because many of these motivations are not socially acceptable, Murstein contends that they have been repressed until the person is no longer aware of them. They still, however, actively influence behavior.

By presenting the person with a stimulus, Thematic Apperception Test (TAT) cards, and encouraging imaginative stories, it is possible not only to bypass conscious restrictions on material verbalized but also to gain useful information about the motive.
The imaginative story contains specific statements of aims and imagery related to the subtleties of feeling that are never directly observed in action. The story also defines the motive by describing the kind of circumstances which produce affective reactions in the characters of the stories.

VandenBos and Karon (1971) tested this hypothesis using the TAT. Karon theorizes that the unconscious motivation present in some therapists may be labeled "pathogenesis" if it interferes with effective behavior change. Karon defines pathogenesis as the unconscious utilization of a dependent person stemming from feelings of inadequacy. When therapists are strongly motivated by pathogenesis, they tend to take their own needs into consideration over those of their clients and, thus, are ineffective in their efforts to help clients.

In their study, VandenBos and Karon (1971) used a maladjustment rating scale called the Pathogenesis Index (Appendix B) which they used to score the TAT's. They hypothesized that by using this method of scoring TAT stories according to whether the dominant person in the story took the dependent person's needs into account when a conflict arose, the pathogenesis motivation could be directly measured.

Earlier research (Karon, 1963; Karon & Rosberg, 1958; Melnick & Hurley, 1969; Mitchell, 1968; and Mitchell, 1969) indicated that the Pathogenesis Index could distinguish between mothers of schizophrenics and mothers of normals, between child-abusing mothers and nonabusing mothers, and between parents of schizophrenics,
delinquents and normals. VandenBos and Karon (1971) tested ten therapists and found therapist scores correlated significantly with improvement in their schizophrenic client's level of functioning after six months of treatment. Clients of the better adjusted or "benign" therapists demonstrated greater foresight, less schizophrenic thought disorder, greater intellectual functioning, were rated healthier in a Clinical Status Interview (Johnson, 1968), and spent less time in the hospital than clients of the less adjusted "pathogenic" therapists. The results, then, suggest that maladjustment as measured on the TAT can predict therapist effectiveness.

Definition of Terms

To facilitate understanding of the terms used throughout this study, the following definitions were accepted for purposes of the research.

Therapist. Those who work with clients on a one-to-one basis for the purpose of resolving emotional conflicts. It includes all of the helping professions.

Therapist Effectiveness. The ability of a therapist to bring about positive change in the client. In this study therapist effectiveness is measured by the Barrett Lennard Relationship Inventory (BLRI).

Pathogenesis. The unconscious utilization of a dependent person. In this study pathogenesis is measured by the Pathogenesis Index.
The Purpose of the Study

Similar to the Karon experiment the study employed an outcome measure format. The outcome measure for the experiment was the Barrett-Lennard Relationship Inventory (BLRI). The BLRI measures the therapeutic conditions of regard, empathy, and congruence as proposed by Rogers (1957). Research has indicated that although these conditions have been questioned as to their relationship to client outcome, they are the most supported measures at the present time (Truax & Mitchell, 1971). Results of the BLRI should give an indication of the therapist's effectiveness with the client. This is especially true when the client's perceptions of the therapeutic conditions are taken into account (Gurman, 1977). The purposes of the present study, then, were to determine whether the Pathogenesis Index proposed by Karon could distinguish between effective and ineffective therapists as measured by the BLRI and to what extent it could be used as a selection measure for those entering graduate programs in the mental health field.

Hypotheses of the Study

The hypotheses tested to determine the ability of the Pathogenesis Index to discriminate between effective and ineffective therapists were:

\[ H_1: \text{ Therapists who score "low" on the Pathogenesis Index score significantly higher on the BLRI than therapists who score "high" on the Pathogenesis Index.} \]

\[ H_2: \text{ There is a significant difference between therapist BLRI scores and client BLRI scores.} \]
Review of the Related Literature

The review surveyed five areas of research. First, the literature on current selection procedures for admission to graduate programs in the mental health field were summarized. Second, outcome studies of the relationship between specific personality variables and therapist effectiveness were reviewed. Third, a summary of Karon's work on the Pathogenesis Index is given. To examine the literature on the use of the BLRI, two sections are included. One is a section on outcome studies of the therapeutic conditions of regard, empathy, and congruence; and a second section is on client perceptions of the therapeutic conditions.

Selection Processes

The idea that success in school is a useful predictor of professional performance has been strongly attacked by a number of researchers. McClelland (1973) contends that academic grades predict nothing but future grades. Heath (1977) examined the lives of 68 Haverford men over more than 10 years and found no significant link between college-level achievement and work competence. In addition, he uncovered a good deal of evidence indicating that high undergraduate achievement directly correlated with increasing interpersonal immaturity. Those graduates who were highly rated by their department faculty tended to have less stable identities and to be less well integrated and autonomous.
In the mental health field itself, evidence exists that academic credentials are inappropriate as a means of identifying those who would be competent practitioners. Carkhuff (1969) concludes that traditional academic criteria in psychology have a low ability to predict very much at all. Research bears this conclusion out. Kelly and Fiske (1951) found that academic and research competence could be reasonably well predicted by academic grades and other academic measures. On the other hand, assessment ratings, objective tests, and academic performance were not highly correlated with rated therapeutic competence. Empathic ability, generally seen as an important criterion for therapeutic competence, has been found to be unrelated to traditional graduate school selection and grading criteria. For example, Bergin and Solomon (1970) found no significant relationship between verbal empathic ability and verbal intelligence scores, the psychology subscale of the Graduate Record Examination (GRE), and grade-point averages—whether overall or restricted to practicum grades. A replication study by Bergin and Jasper (1971) also found no relationship between empathic ability and student grade-point averages.

Traditional written examinations fare no better. Again, McClelland's (1973) review of the literature concludes that most such tests can predict nothing but academic grades and scores on similar tests. As previously noted, Bergin and Solomon (1970) found no significant relationship between verbal GRE scores and empathic ability. Patterson (1968) argues that beyond a necessary minimum, academic ability and results of written examinations may
not be related to potential as a therapist. He cited research indicating a negative correlation between such potential and scores on the Miller Analogies Test (Miller, 1970) to support his contention.

The relationship between supervisor/teacher reports and therapeutic competence has been studied and considerable research indicates that such judgments have very little validity. Typical of the findings from clinical psychology are those of Kelly and Fiske (1951). In their five year project to assess and predict performance in clinical psychology, they found that assessment ratings by staff were not highly correlated with rated therapeutic competence. In a replication study (Kelly & Fiske, 1950) they found that the more confident staff members were in their predictions, the less valid was the prediction.

Melloh attempted to determine the relationship of accurate empathy ratings of therapists with a global criterion of effectiveness made by the therapist's supervisor. He found that accurate empathy as a characteristic of therapist behavior was not included among the criteria of therapist effectiveness by the practicum supervisor despite the fact that almost all of the supervisors adhere to the Client-Centered therapeutic orientations.

One study does indicate a relationship between supervisor or teacher report and other measures of therapeutic competence. Klein (1965) conducted a study in which supervisors evaluated psychoanalysts-in-training as "superior," "above average," or "below average." Sixty-three percent of the patients treated by
the superior students showed substantial improvement, while only 39% of those seen by below-average therapists were comparably improved. One confounding variable in this study, however, is that the same supervisor evaluated both student competence and patient improvement.

Carkhuff and his associates have provided some tentative explanations as to why global judgments of supervisors are suspect. They distinguish between the ability to discriminate and the ability to communicate. The former consists of the ability to discern and evaluate how a client is functioning and what type of treatment is advisable, while the latter consists of skill in facilitating movement toward deeper self-exploration and self-understanding (Carkhuff, 1969). Carkhuff cites a number of studies indicating that therapists rated low in the ability to communicate are apt to be poor discriminators, especially when evaluating themselves.

The idea that only certain types of supervisors are capable of accurately evaluating therapeutic ability is indicated by Holt and Luborsky's (1958) work at the Menninger Foundation. As part of their project they attempted to assess how well clinicians could predict whether psychiatric residents would be successful. On the average, when clinicians made free, predictive ratings, they did not achieve significantly high levels of accuracy. On the other hand, a few individual clinicians were able to predict accurately more than half the time.

In summary, then, it can be seen that current procedures for selection of those entering graduate programs in the mental
health field are inadequate. New methods are needed to increase the possibility that those chosen will become effective therapists.

**Personality Variables and Therapist Effectiveness**

Ten outcome studies were found in which the relationship between personality variables and therapist effectiveness was investigated. The major weakness of these studies is the lack of any consistent measure of therapist effectiveness. It is difficult, therefore, to determine whether the same kind of effectiveness is being measured by any two of the experiments.

The Minnesota Multiphasic Personality inventory (MMPI) (Hathaway & McKinley, 1967) was used in seven of the ten studies. Arbuckle (1956) conducted an experiment on 70 therapist trainees. Using peer selection of a potential therapist as the therapist effectiveness measure, he found that the six most preferred therapists scored significantly lower than trainees in general on seven of the ten clinical scores. The six rejected or least preferred therapists scored significantly higher than trainees in general on five of the clinical scales. Daane and Schmidt (1957) studied the relationship between the MMPI and empathy. Using five male and five female college therapists, they found that high empathy was significantly related to four of the MMPI clinical scales. Brams (1961) conducted a study using 22 male and five female practicum students. The experiment measured rapport between the therapists and clients and found no significant relationships between MMPI scales and rapport. Wasson (1965) studied the
relationship between staff and peer ratings of psychological closeness and MMPI scales. His subjects were 28 male and two female NDEA Institute enrollees. He found a negative correlation between the MMPI Schizophrenic Scale and psychological closeness. Watley (1966) chose the ability of therapists to predict freshman year GPA from first quarter grades and background data as his measure of therapist effectiveness. Using 12 male and 12 female experienced therapists he found that the most effectively predicting therapists scored significantly higher on the MMPI Psychothenia Scale than less effectively predicting therapists. In a study to determine the relationship between practicum grades as a therapist effectiveness measure, Johnson, Shertzer, Linden, and Stone (1967) used 68 male and 30 female therapist trainees. They found that the MMPI Schizophrenia Scale correlated negatively with practicum grades for females only. Hoover (1971) measured therapist effectiveness by scores obtained on administrator's and supervisor's ratings on a nine-point scale. Those deemed effective were above the median on the scale. Using 49 public school therapists he found no significant differences between effective and less effective therapists. Mendosa (1968) found no significant relationships between peer group ranking, supervisor ranking, the Rokeach Dogmatism Scale (Rokeach, 1973), the Strong Vocational Interest Blank (Strong & Campbell, 1971), and the MMPI.

It is evident, then, that the present research on the MMPI as a discriminator between effective and ineffective therapists shows meager results. In addition to the lack of careful
replication, the lack of standard definitions of effectiveness, and the small sample size of studies make it impossible to draw any positive conclusions about the relationship between the MMPI and therapist effectiveness.

Three other studies using different measures of personality were found in the research. Sievers (1970) conducted a study with 30 therapists from the NDEA Summer Counseling and Guidance Institute. Therapist effectiveness was judged by a Counselor Behavior Checklist filled out by a supervisor. Personality profiles were drawn from the 16 Personality Factors (16 PF) (Cattell, Eber & Tatsuoka, 1973). The 16 PF was not able to differentiate between effective and noneffective therapists. In a second study examining the 16 PF as a possible predictor of therapist effectiveness (Davis, 1972), nine therapist trainees were given the 16 PF and classed according to their effectiveness scores into three groups: High-effective (HE), Medium-effective (ME) and Low-effective (LE). Each therapist received three clients for 10 weeks of eclectic therapy. At the end of therapy, clients were given the Personality Orientation Inventory (POI) (Shostrom, 1968) to determine their degree of self-actualization. HE and ME therapists did not differ but HE and LE therapists differed significantly in the scores of their clients on the POI. Although the author concluded that the HE therapists were more able to move their clients towards self-actualization, the validity of this statement is in question. Because of the low number of therapists and because there were no pre-tests of clients, such a statement is not
merited. Cargill (1971) conducted a study in which the ratings of therapist's clients on the BLRI was used as an effectiveness measure. Thirty-nine therapists were given the Tennessee Self-Concept Scale (Fitts, 1965) and then rated by 10 of their clients. There was no support for the hypothesis that self-concept is related to therapist effectiveness.

In summary, the research on the relationship between personality variables and therapist effectiveness is not definitive. No single variable has been shown to adequately discriminate between the effective and ineffective therapist. Not only are there few studies in the area, but these studies have presented mixed or nonsignificant results. The lack of a consistent definition of effectiveness also is detrimental to any conclusions which might be drawn from the data.

Karon's Pathogenesis Index

The development of the Pathogenesis Index (PI) arose from Karon's years of work with schizophrenics and his concern over the etiology of the disorder. Karon (Karon, 1963; Karon & Rosberg, 1958) theorizes that schizophrenia is the result of a pattern of malevolent mothering from the earliest days of infancy onwards. It is not merely the result of isolated traumatic experiences but of a pattern of pressures which continues throughout childhood in somewhat changing form: the basic problems which begin in infancy are strengthened rather than reduced by the continuing interactions
between the pre-schizophrenic child, particularly its mother. The child is the victim of a series of subtle and obvious rejections, the effect of which, is to make the child feel worthless and unlovable. To the infant, to be worthless and unlovable means abandonment, pain and death. This is the infantile terror that lurks behind the schizophrenic system. The schizophrenic's whole life is organized around the need to defend the self psychologically against this danger.

The schizophrenic mother feels inadequate and compensates for her inadequacies by making demands on the child in terms of her own pathological needs without regard for the welfare of the child whenever her needs conflict with those of her child. Her relationship with the child is typically of a dominating dependence whereby she dominates the child in order to force the child to satisfy her dependency needs. The pathological pressures are not subtle but a casual observer may miss them since they are mainly to be found in the mother's unconscious and involuntary reactions to the child. Consciously, the mother in most cases manifests not only to others but to herself an attitude of apparent benevolence. In summary, then, the destructive or schizophrenogenic mother takes from her child to satisfy her own needs where the benign mother interacts for the most part in the actual best interests of her child.

From this theory, Meyer and Karon (1967) hypothesized that since psychodynamic concepts were being investigated, a projective test would be useful. The Thematic Apperception Test (TAT) was assumed to measure both conscious and unconscious motivations which
represented underlying and pervasive characteristics of the personality. If the mothers were "schizophrenogenic" as a result of a motivational pattern, conscious or unconscious, this should be reflected in their fantasies concerning the relationship between dominant and dependent people and, thus, it should be possible to derive a measure of schizophrenogenesis from TAT stories.

In an experiment to test this theory (Meyer & Karon, 1967), six mothers of schizophrenics and six mothers of normals were administered the entire female TAT. Each story was then typed on a separate sheet of paper with no identification clues. The stories of all subjects were then randomized and presented to two judges. The general criteria for scoring was in two stages: (1) Is there an interaction between a dominant and a dependent person, both with somewhat conflicting needs? If not the story cannot be scored. (2) If there is such an interaction, does the dominant person take the dependent person's needs into account. If not, the story is scored as "pathogenic." If the dominant person does take the dependent person's needs into account, the story is scored "benign."

The results indicated that mothers of schizophrenics can be significantly differentiated from mothers of normals. A second finding was that a list of themes began to emerge from the stories which were representative of the three categories of pathogenic, benign, and unscorable. Karon compiled this list and began devising a scoring criteria for the pathogenesis index.
Several further studies, discussed below, validated this concept and broadened its applicability to other populations.

Mitchell (1968) replicated Karon's original schizophrenogenic mother study using a larger sample. A second purpose of the experiment was to further delineate and refine the scoring themes. The subjects were 30 mothers of schizophrenic children and 20 mothers of normal children. Each subject was given the TAT and as in the previous study (Meyer & Karon, 1967) stories were typed on separate sheets of paper and scored pathogenic, benign, or unscorable. In this study, the list of themes was used to help determine which category was most appropriate. Results indicated that both judges were able to differentiate between experimental and control pairs of mothers at beyond the .001 level of significance.

Karon's measure of pathogenesis was used to differentiate child-abusing mothers from nonabusing mothers (Melnick & Hurley, 1969). Ten child-abusing mothers and 10 nonabusing mothers were given the TAT, among other measures. The pathogenesis index now updated and revised by the previous two studies was used to score the TAT stories. A significant difference between the two groups was found. The authors concluded that abusing mothers have a significantly lower capacity for empathizing with and administering to their children's needs.

Mitchell (1970) used the TAT to differentiate parents of schizophrenics, delinquents, and normals. He found that the parents of schizophrenics and parents of delinquents were strikingly similar in that they both scored high of the pathogenesis
measure. There was a significant difference between these two groups and the parents of the normal children.

A final study by VandenBos and Karon (1971) is the basis for the present experiment. In an article titled *Pathogenesis: A New Therapist Personality Dimension Related to Therapeutic Effectiveness*, VandenBos and Karon (1971) contend that psychotherapy, at least in the eyes of the client, is a relationship between two unequals, with the client being the dependent or exploring person and the therapist being the superior or giving person. Within this context, therapists who consciously or unconsciously utilize dependent individuals (in this case their clients) to satisfy their own needs will be less clinically effective than therapists who put the legitimate needs of the client first. Therefore, they predicted, therapists who receive higher pathogenesis scores, as measured by Karon's Pathogenesis Index, should be less effective therapists than those with lower pathogenesis scores and their clients should demonstrate lower levels of functioning than clients treated by more benign therapists.

The subjects in the study were ten therapists-in-training at Detroit Psychiatric Institute. The number of clients treated by each therapist ranged from one to three, totaling 15 patients. Treatment consisted of psychoanalytically-oriented therapy administered once a week for a period of six months.

Before treatment began, each therapist took the TAT (self-administered) responding to a complete 20 card set orally. The therapist's TAT's were tape-recorded and later transcribed a a
secretary with one story typed per page. These were randomized before being scored for pathogenesis by two experienced raters.

Two clinically-naive undergraduate students were trained in the use of the Karon system for rating TAT stories (Meyer & Karon, 1967) on the Pathogenic-Benign dimension. A battery of intellectual and projective tests were administered to each client before and after treatment. These outcome measures included the Thorndike-Gallop Vocabulary Scale (Thorndike, 1966), the Porteus Maze (a measure of "planfulness" found to improve with the successful treatment of schizophrenics) (Porteus, 1965), the Wechsler Adult Intelligence Scale (Wechsler, 1955), the Drasgow-Feldman Visual-Verbal Test (a concept formation task specifically designed to reflect schizophrenic thought disorder) (Feldman & Drascow, 1960) the TAT and the Rorschach (Rorschach, 1954). A Clinical Status Interview was conducted and length of hospitalization data was kept.

The clients of the more pathogenic therapists did significantly poorer than the clients of the more benign therapists on four of the eight outcome measures: the WAIS, the Porteus Maze, the Drasgow-Feldman Visual Verbal Test, and the Clinical Status Interview.

The authors concluded that the hypothesis had been supported; that is, the more "pathogenic" a therapist, the less effective that therapist is in producing therapeutic personality change in clients. The findings show the same relationship between therapist pathogenesis and client outcome regardless of whether the outcome
was measured by intellectual tests, clinical status interviews
or hospitalization data.

**Outcome Studies of Therapeutic Conditions**

From the work of Carl Rogers (1951, 1957 & 1962), a voluminous
amount of research had been generated by his students and others
during the 1960's which focused on the effect of therapeutic change
of levels of accurate empathy, nonpossessive warmth, and genuineness.
Truax and Mitchell (1971) in summarizing the literature conclude
that therapists who are accurately empathic, nonpossessively warm
in attitude and genuine, are, in fact, effective. Further, they
state, the evidence suggests that these findings hold in a variety
of therapeutic contexts and in both individual and group therapy.

There were, however, reservations about the validity of these
studies (Matarazzo, 1971; Weltzoff & Kornreich, 1970). It was
argued that in many cases the number of therapists was small and
often the therapists were not only aware of the hypotheses in
question but were associated with the research.

More recent outcome studies based on samples of therapists
of varying orientations seem to indicate that the conclusions of
Truax and Mitchell (1971) need to be qualified. Since outcome
studies examine the relationship among therapist orientations,
different client situations, and therapist settings in more and
more detail, it becomes clear that the research neither supports
nor rejects the importance of the influence of the therapeutic
conditions. Some studies continue to support the earlier findings
that one or more of the interpersonal skills are related directly to positive client change (Cairns, 1972; Truax, 1970; Truax & Wittmer, 1971; and Truax, Wittmer & Wargo, 1971). Others offer some support (Altmann, 1973; Mitchell, Truax, Bozarth & Krauft, 1973; and Truax, Altmann, Wright & Mitchell, 1973). However, numerous studies find little or no direct relationship between interpersonal skills and outcome (Beulter, Johnson, Nevill & Workman, 1972; Beutler, Johnson, Neville, Workman & Elkins, 1973; Garfield & Bergin, 1971; Furtz & Grumman, 1972; Minter, Luborsky & Auerbach, 1971; Mullen & Abeless, 1971; and Sloane, Staples, Cristol, Yorston & Whipple, 1975).

In summary, the work of Carl Rogers on therapeutic conditions generated a voluminous amount of research. Earlier studies suggested a direct relationship between possession of the therapeutic conditions and therapist effectiveness. Later studies, however, produced mixed results.

The Client's Perception of the Therapeutic Relationship

Gurman (1977) argues that much of the work done in the area of Roger's therapeutic conditions had been misguided on theoretical grounds. Roger (1957) stated that the mere presence of therapeutic conditions to a client is not sufficient for positive change. Rather these conditions, attitudes or styles of relating must be communicated to the client—the client must perceive them for change to occur. The majority of outcome studies to date, however, rely almost entirely on nonparticipant observer's ratings of the therapeutic relationship. This is the reason, Gurman feels, that so
much of the outcome research in the area of therapeutic conditions has obtained mixed results.

Studies implementing client perceptions of the therapeutic relationship appear to bear this out. The major instrument used in assessing the client's perceptions is the Barrett-Lennard Relationship Inventory (BLRI) and it has been used in most of the following studies.

The research related to the BLRI (Barrett-Lennard, 1962) begins with the author's dissertation done at the Counseling Center at the University of Chicago. Here the writer began to formulate an instrument based on the question of how observed personality changes are brought about through therapy and through what means does the association between client and therapist lead to constructive change in the personality of the client. The author considered Roger's work (1957, 1959) to be the theoretical underpinning for this study.

It was then postulated that each of five distinguishable aspects of dimensions of the therapist's attitudes and responses are influential in the process of therapeutic change. These dimensions are the therapist's level of regard for the client and (as a separate factor), the extent to which the regard is unconditional or unqualified, the degree of the therapist's empathic understanding, the therapist's congruence in the relationship, and the therapist's willingness to be known by the client. A basic general assumption of the investigation was that the client's experience of the therapist's response was the primary locus of therapeutic influence in their relationship. It follows from
this that the relationship as experienced by the client (rather than by the therapist) would be more crucially related to the outcome of therapy.

A questionnaire was designed to measure the five variables of therapist response, firstly (and most importantly), from the client's frame of reference, and secondly, from the therapist's own standpoint (Barrett-Lennard, 1962). The inventory itself, then, was prepared in parallel forms for the client and therapist respondents. There were separate groups of items for each variable composed of subgroups of positive and negative expressions of the variable. Items were rated on a Likert-type scale of six values ranging from +3 to -3. This was done to reflect how certain respondents felt about the item statement being correct or incorrect and how important it was to respondents that it was true or false. Concern was with subjects' feelings about their therapists' responses and not merely what they observed. The group of items representing each variable was then dispersed throughout the Inventory so as to obtain maximum independence of answers to them.

The internal consistency of the five individual scales was assessed by the split-half method. The investigator's judgment was matched as nearly as possible in content with the items on the other half. The reliability coefficients ranged from .82 to .96.

A formal content validation procedure was also carried out. Directions and definitions of the variables were given to five judges who were all therapists of varying levels of experience. The judges classified each item as either a positive or negative
indicator of the variable in question and gave a 0 to any item they considered ambiguous or irrelevant. There was perfect agreement between judges on all except four items. Three of these were eliminated, the one being retained having only a neutral rating by one judge.

Several studies have been conducted to test the relationship between client perceptions of therapeutic conditions as measured on the BLRI and client outcome. College counseling center clients were tested in 12 experiments (Barrett-Lennard, 1962; Brown, 1954; Cain, 1973; Carmichael, 1970; Grigg & Goldstein, 1957; Gross & DeRidder, 1966; Hill, 1974; Jones, 1968; Kurtz & Grummon, 1972; Lesser, 1961; McClanahan, 1974; and Strupp, Fox & Less, 1969). Seven studies examined outpatient-clinic client populations (Board, 1959; Feifel & Eells, 1963; Feitel, 1968; Fretz, 1966; Lorr, 1965; Feifel & Eells, 1963; Feitel, 1968; Fretz, 1966; Lorr, 1965; and Ryan & Gizynski, 1971). Clients hospitalized for psychiatric disorders were studied in three of the experiments (Kiesler, Klein & Mathieu, 1967; Libo, 1957; and Sapolsky, 1965). Two studies tested high school students (McNally, 1973; and Stanley, 1967).

Experienced and inexperienced therapists were about equally represented in these studies. The treatment modalities included a mixture of client-centered, psychoanalytically oriented, behavioral and eclectic therapist orientations. The studies were about equally divided between relatively brief (2 to 20 sessions) and more long-term (20 or more sessions) therapies. Outcome was
evaluated by independent judges in over half of the experiments.

Among the studies, 20 reported positive findings for the hypothesis that client ratings are related to outcome. Three reported mixed but supportive results and only three show results clearly failing to demonstrate a relationship. Of these, two utilized analog designs and in one "treatment" lasted only two sessions. Only one study, then, with actual help-seeking clients failed to confirm the hypothesis.

In summary, Gurman's contention that therapeutic conditions must be measured by the client in order to correlate with outcome appears to be substantiated. Of the 23 studies reported testing the relationship between BLRI ratings and client outcome, only one study using actual help-seeking clients failed to have significant results.

Summary of the Review of the Related Literature

As evidenced by the review of the preceding studies, there are, at present, no adequate means for selecting students into graduate programs in the mental health field. A solution posed to this problem was to find a measure of personality which discriminated between effective and noneffective therapists. By administering this measure to selectees, it could be determined whether they had the potential to become competent therapists.

The research on such a personality measure was meager and mixed. One study showed promise. VandenBos and Karon (1971) devised an experiment in which a "Pathogenesis Index" was determined.
This Index was shown to be able to discriminate between effective and ineffective therapists.

The present study was designed to determine whether this Pathogenesis Index would serve as a selection measure for students entering a graduate program in the mental health field. In order to examine this hypothesis, an outcome format was employed. Research indicated that the BLRI, especially the client form, was the best means for determining the present ability of the therapist to be effective. The BLRI, then, was used as the outcome measure.

Organization of the Study

The general format of the study was as follows: In Chapter II, the methods used in data collections and organization were stated and statistical techniques used in analyzations were explained. Chapter III contains the results of the analysis. The summary, conclusions and implications for future research were reported in Chapter IV.
CHAPTER II

METHODS

The study evaluated the impact of a selected personality variable, pathogenesis, on the therapeutic relationship. In the present study beginning therapists and their work with coached clients were used in contrast to the Karon study where experienced therapists and their schizophrenic clients were used.

Subjects

Twenty subjects were randomly selected from a pool of 48 beginning therapist trainees who had enrolled in a Master's level counseling techniques course at Western Michigan University during the winter semester of 1981. This course was designed to present the subjects with a beginning sampling of counseling techniques. The first 10 weeks of the course centered on the use of listening skills, empathic understanding of clients, and structuring of the therapeutic relationship. There was extensive practice of these techniques through role-playing. Later in the semester the trainees were introduced to a variety of therapy approaches including Rational-Emotive and Client-Centered techniques. It was determined that the subjects would have been exposed to the same training at the end of the initial 10 week period to participate in the present experiment. Subjects' ages ranged from 25 to 43 with a mean age of 28.
30. They consisted of six males and 14 females who were in the beginning one-third of their studies in the Counseling and Personnel Master's Program.

The randomization of subjects was accomplished by collecting all the names of the students, assigning a number to each one, and then choosing the 20 by referring to a list of random numbers (Edwards, 1961). All persons enrolled in the class were given a standardized introduction to the experiment in the classroom (Appendix A) and were told that about half of them would be telephoned and asked to participate in the experiment. After the first 20 were chosen by random, they were called. Five refused to be in the study. The list of random numbers was again used and five more subjects were chosen and called. All of these were willing to participate.

Instrumentation

Two instrumentations were used in the study. To obtain the pathogenesis score Karon's "Pathogenesis" Revised Scoring Criteria was used (Appendix B). To obtain the counselor effectiveness measures from both subject and coached client, forms of the revised version of the Barrett-Lennard Relationship Inventory (BLRI) were used (Appendices E and F).

The TAT and Karon's Pathogenesis Index

The Pathogenesis Index (PI) (see Appendix B) was devised by Karon (1967) as a means of measuring a person's pathogenic
qualities when relating to others. Karon defines pathogenesis as the unconscious utilization of another person. If a story from the TAT is told in which there is a conflict and a dependent person's needs are not taken into account, the story is scored "P" for pathogenic. If a story is told in which there is a conflict and a dependent person's needs are taken into account, the story is scored "B" for benign. If there is no conflict in the story, it is scored "NS" for nonscorable. The Pathogenesis Index is the number of pathogenic stories divided by the number of scorable stories.

In the present study 10 TAT Cards were used: Cards 1, 2, 3GF, 4, 6GF, 8GF, 9GF, 11, 12F, and 15. These were chosen in accordance with an experiment done by Meyer and Karon in 1967. In research using an experimental group of mothers of normals, the TAT responses were compared card for card. The study not only validated the Pathogenesis Index by differentiating between the two groups but also indicated which TAT cards most strongly showed this differentiation. The 10 cards mentioned above are those which do this most dramatically and, therefore, would be most likely in the present research to bring out differences should they exist.

Inter-judge reliability measures have been implemented in most of the pathogenesis studies (Melnick & Hurley, 1969; Meyer & Karon, 1967; Mitchell, 1968; Mitchell, 1970; VandenBos & Karon, 1971). In all of these studies inter-judge reliability was in excess of .89. Validity of the measure is shown by its ability to distinguish between mothers of schizophrenics and mothers of
normals (Meyer & Karon, 1967; and Mitchell, 1968), between child-abusing and nonabusing mothers (Melnick & Hurley, 1969), between parents of schizophrenics, delinquents and normals (Mitchell, 1970), and between effective and ineffective therapists (VandenBos & Karon, 1971).

The Barrett-Lennard Relationship Inventory (BLRI)

Barrett-Lennard (1962) originally postulated that each of five distinguishable aspects or dimensions of a therapist's attitudes were influential in the process of therapeutic change. These were (1) the therapist's level of regard for the client, (2) the extent to which the regard is unconditional or unqualified, (3) the degree of the therapist's empathic understanding, (4) the therapist's congruence in the relationship, and (5) the therapist's willingness to be known by the client. A basic assumption was that the client's experience of the therapist's response was the primary locus of therapeutic influence in the relationship.

Barrett-Lennard (1962) designed a questionnaire to measure the five variables of therapeutic response, firstly, and most importantly, from the client's frame of reference, and secondly, from the therapist's own standpoint. The original inventory, called the Barrett-Lennard Relationship Inventory (BLRI) was prepared in parallel forms for the client and therapist respondents. There were separate groups of items for each variable, each composed of subgroups of positive and negative expressions. The BLRI made provisions for three grades of "yes" response and three
grades of "no" response on a Likert-type scale construction. This system was used to reflect how certain the respondents felt about the item statement being correct or incorrect, and also how important it was to the respondent that it was true or false. The group of items representing each variable was then dispersed throughout the Inventory so as to obtain maximum independence.

The revised version of the BLRI used in the present study (see Appendices E and F) reflects further refinement of the Inventory. Barrett-Lennard (1962) found that results for the measure of "Willingness to be Known" did not reflect therapist effectiveness and so the items measuring this were dropped from the Inventory. In the rotated principal-components analyses studies of the factor structure of the BLRI by Mills and Zytowski (1967) and Lanning and Lemons (1974), the results made a strong case for eliminating the 16 items that make up the Unconditionality of Regard subscale and using a 48 item instrument to obtain a measure of overall satisfaction or dissatisfaction with the relationship. Here it was shown that the Unconditionality of Regard subscale items loaded almost exclusively on a second component in such a way as to be in opposition to the other aspects measured by the Inventory.

The revised 48 item BLRI was used in this study. Of the 48 items, 16 items each make up to empathy, regard, and congruence scales. A final scale was derived from the total score of the other three. The four scores from the therapist BLRI and four scores from the client BLRI gave each subject a total of eight scores,
The internal consistency of the individual scales was assessed by the split-half method (Barrett-Lennard, 1962). The investigator's judgment was matched as nearly as possible in content with items on the other half. The reliability coefficients ranged from .82 to .96. A formal content validation procedure was also carried out in the same study. Directions and definitions of the variables were given to five judges who were all therapists of varying levels of experience. The judges classified each item as either a positive or negative indicator of the variable in question and gave a 0 to any item they considered ambiguous or irrelevant. There was perfect agreement between judges on all except four items. Three of these were eliminated, the one being retained having only a neutral rating by one judge.

Procedure

TAT Administration

The 20 subjects, when called for the first appointment, were again given a standardized explanation of the experiment. They were told that it consisted of two parts. The first part, to be completed within the following two weeks, consisted of taking a portion of the TAT, and would involve about 30 to 60 minutes of their time. The second part, to take place eight to ten weeks later, consisted of a 30 to 40 minute counseling session in which they were to counsel with a coached client. After the session they were told that they would be asked to fill out a questionnaire
about the session, which would take an additional 30 minutes. Total time for both parts of the experiment would be approximately two hours; appointments were then set up for each subject.

When the subjects arrived for the first part of the experiment, the TAT administration, they were led to a small, well-lit room with a tape recorder in it. Before the actual experiment began each was given a Release of Information Form (see Appendix D) to read over and fill out. After they had signed their names the experimenter placed a sheet of instructions and began a three-minute standardized instruction tape (see Appendix C). The tape and instruction sheet said the same thing.

After the tape was over the subjects were asked if they had any questions. The experimenter was careful here not to say anything new about the experiment but only to reiterate the instructions. The few times the subjects wanted more information they were told that the experimenter would answer the questions after the TAT was given.

The experimenter then placed the blank tape into the machine and maneuvered it so the subject would only have to flip the "pause" switch to turn the recorder on and off. This was explained to each subject. After it was apparent that the subjects understood how to work the machine, they were told to begin and to bring the finished tape and cards to the experimenter who would be waiting in the front office. At this point the experimenter left the room.

The time it took subjects to finish the TAT ranged from 25 to 50 minutes with most averaging 40 minutes. The subjects were
cooperative and did not object to the TAT or the length of time it took to complete it.

At the end each subject turned off the tape recorder, removed the tape and brought the tape and cards to the experimenter waiting outside. At this point the subjects were thanked and any unanswered questions were addressed. The experimenter then told them that they would be contacted in the next five to six weeks to schedule for the second half of the experiment. This second half, they were told, consisted of a 30 to 40 minutes counseling session in which the subject would be the counselor and the client would be someone taught to bring a specific problem into the session. After the session a questionnaire would be given to the subject to fill out about the session.

Training of the TAT raters

Neither of the two raters was familiar with the research design or even why they needed to score the responses in a certain way. In this regard they were naive to the process. They were somewhat psychologically sophisticated both having a Master's degree in the social sciences and currently enrolled in further graduate study.

The training of the TAT raters followed instructions given by Karon in a personal interview (Karon, 1980). According to these instructions the TAT raters needed to be trained to read each response, rate it according to Karon's Pathogenesis Revised Scoring Criteria (see Appendix B), and record each score on a rating sheet.
Thus, it was necessary to take the original taped responses to the TAT, transcribe them and type each on a separate sheet of paper.

The training took two meetings. During the first one, each rater was given a copy of Karon's revised pathogenesis scale. Parts of the scale were read aloud by the trainer and there was discussion of the different categories and how to distinguish them. Special emphasis was placed on the last section of the Revised Scoring Criteria to further clarify the differences between categories. A few examples of TAT stories were read and raters asked to score these. Between meetings raters were asked to familiarize themselves with the Scoring Criteria. The second meeting, a week later, consisted of answering questions which raters had during the week and reading a number of stories aloud for them to rate. Finally a set of 10 stories was given to be rated. The raters scored these correctly and it was determined that they knew the categories well enough to score the responses accurately. The raters were then shown the scoring form and instructions were given on how to fill it out.

The 200 TAT responses, in the form of one response per sheet of paper, were given to one rater at a time. At the time of receiving the responses, the rater was told to score in the following way. She was told to read through each story and place the piece of paper in one of four piles: pathogenic (P), benign (B), unscorable (NS), and questionable. After the 200 responses were read, she was to go back to the questionable pile and put all of the responses into one of the other three piles. When this
was done the rater was to transpose this information onto the rating sheet. When both raters were finished, the rating sheets were compared by the experimenter. The raters disagreed on 24 of the 200 responses. When they disagreed, the experimenter reread the story and made a determination. Finally, each set of 10 scores for the 20 subjects was tallied to arrive at the Pathogenesis Index.

**Training of the Coached Clients**

The coached clients were asked to present a conflict in a therapy session explained in more detail later in this section. The purpose of the conflict was to determine how the therapists would respond: would they take their client's needs into consideration or their own? It was decided that a high conflict situation would involve clients and therapists of opposite sex discussing a sexual issue. Two coached clients, then, one male and one female, were chosen for the experiment. The coached clients were highly experienced and considered "pros" in the art of acting the part of the client. Each had had several previous coached client experiences and came highly recommended.

The training followed the steps considered by Betz (1980) to be necessary for the successful integration of the simulation technique. They are as follows:

1. **Orientation of the trainees (coached clients) to their use in the situation.** The coached clients were told that the sessions would last from 30 to 40 minutes and would center around
a sexual issue the client was dealing with in regards to a boyfriend or girlfriend. The coached client was to show ambivalent feelings about having sexual relations and at about the 15th minute of the session ask the therapist outright "Should I or should I not have intercourse with this person?" Presenting this question would bring out a conflict and it would be seen whether the therapists take their own needs into account over the needs of the client. If the therapist avoided the question, the coached client was to press once more and then drop the issue.

2. **Proximity of the contrived situation to the expected life-like behavior.** Both coached clients approximated the age of clients seen by therapists in this course. They were given freedom to develop the character they would play in whatever way felt most comfortable within the constraints of the instructions. The coached clients practiced the role with the experimenter until all felt at ease with the character. The male coached client portrayed himself as a young man whose sexual conflict centered around religious values versus "modern" morals. He told the story of feeling pressures to have intercourse with his girlfriend. The female coached client portrayed herself as a young woman who was living with a man. The relationship was rocky and she came to therapy to see if she should continue to have intercourse with her boyfriend while they were fighting. Both stories represented true-to-life situations while bringing the conflict fully into play.

3. **The necessity of feedback and debriefing following simulating exercises.** Care was taken not to reveal any aspects of
the study to the coached clients during the experiment. This provided another "blind" for the study and thus avoided the coached clients consciously or unconsciously "helping" the study in any way. After the study was completed, however, both coached clients and subjects were debriefed concerning the experiment.

Coached-Client Session and Administration of the BLRI

It had been determined that the subjects would have been offered comparable training around the 10th week in the semester. At the ninth week they were called for appointments. These appointments spread over a two-week period. Each subject was told to report to the office and again a short synopsis of the second half of the experiment was given.

The subjects upon arrival were again taken to the small counseling room. They were again briefed on their part in the experiment: that they were to conduct the counseling session the way they usually conducted sessions and that in the next few minutes a person trained to bring a certain problem into the session would be brought into the room. They were told that they would be asked to fill out a questionnaire afterwards. Any further questions which the subjects had were put off until the end of the session. At this point the coached client was brought in and the experimenter left the room.

Most of the counseling sessions ran over the 30 minutes limit. At 35 minutes the experimenter knocked on the door to indicate that the session would need to end. Most of the sessions
finished then or within the next five minutes. When the session ended the coached client left the room and the counselor was asked to remain. Although many had questions about the session at this point they were asked to forestall them until the questionnaire had been filled out.

The experimenter then presented the BLRI and gave a short description of it. The subject was told that this was a list of a number of statements about the counselor-client relationship just experienced. The subject's task was to rate each of the statements by placing a check in one of the columns.

The subjects were told that if they could not answer for some reason, to leave the column blank and this would be scored a "0." They were told that when they were finished to bring the questionnaire out to the experimenter. The subjects averaged 20 to 35 minutes on the BLRI. During the same period of time the coached clients were filling out their parallel form of the BLRI.

When they completed the form and brought it out, they were thanked by the experimenter. They were told that if they wanted the group results they could leave their name and address and the experimenter would send them.

At this point many of the subjects left. A few had questions and were taken back into the counseling room. Most of the questions concerned the coached client. Some wanted to know if the person was truly a coached client and remarked about what a "good job" he or she had done. Often, they stated, they had gotten totally immersed in the problem forgetting that it was contrived. Some
wanted further information explaining the experiment. The experimen­ter stated here that no further information could be given until all the subjects had been tested.

**Statistical Analyses**

The study was designed to compare the differences between a "high-pathogenesis" group and a "low pathogenesis" group. Campbell and Stanley (1963) termed this design a static-group comparison design. The independent variable, then, was the score obtained through the use of Karon's Pathogenesis Index in judging 10 Thematic Apperception Test (TAT) stories told by the subject. The dependent variables were the eight scores obtained by administering the revised version of the Barrett-Lennard Relationship Inventory (BLRI) to subjects as therapists and coached clients involved in a therapy session.

T-tests were used to measure differences between the "high" and "low" pathogenic groups and also to measure differences between client and therapist (BLRI scores. The probability of .05 was selected as the level of confidence. Probabilities between .05 and .10 were considered trends towards significant levels of confidence. The sample sizes for the first hypothesis includes an _n_ of six for the "high" pathogenesis group and an _n_ of five for the "low" pathogenesis group. For the second hypothesis, two groups of 20 were used. To facilitate understanding of the variables, a Pearson Product Moment Correlation Matrix and a Principal Factors Varimax Rotation Analysis were run.
Summary

Twenty subjects were randomly selected from a pool of 48 beginning counseling trainees. These subjects were administered the TAT. The protocols were scored according to Karon's Revised Scoring Criteria. From this the subject's Pathogenesis Index (PI) was determined.

After ten weeks of a course designed to teach basic counseling techniques, the subjects were considered to have been exposed to comparable training. Each was placed in a therapy situation with a coached-client. The coached clients had been trained to bring a problem into the session which would cause the therapists to be placed in a conflict situation. The sessions lasted 30 to 40 minutes after which both the coached-clients and therapists were given the BLRI.
CHAPTER III

RESULTS

In Chapter III an analysis of the data is presented based on the methodological approach and statistical treatment detailed in Chapter II. Results are reported in the following sequence:

1. Comparison of "high" pathogenesis and "low" pathogenesis groups.

2. Comparison of the client BLRI scores and therapist BLRI scores.

3. Factor analysis.

Differences between the "High" and "Low" Pathogenesis Groups

The null hypothesis tested was:

\[ H_0: \text{ Therapists who score "low" on the Pathogenesis Index do not score significantly higher on the BLRI than therapists who score "high" on the Pathogenesis Index.} \]

As evidenced in Table 1, the "low" pathogenesis group scored significantly higher than the "high" pathogenesis group on three of the four BLRI scales: Regard (\( p \leq .01 \)), Empathy (\( p \leq .02 \)), and Total (\( p \leq .07 \)). This was not the case, however, when the two groups were compared on the therapist form of the BLRI. When Regard, Empathy, Congruence, and Total Score were tallied for the therapists, there were no significant differences between "high" and "low" pathogenic groups.

The null hypothesis, that the "low" pathogenesis groups would not score significantly higher than the "high" pathogenesis group,
Table 1
T-tests for Pathogenesis on Barrett-Lennard Relationship Inventory (BLRI) Client and Therapist Scales

<table>
<thead>
<tr>
<th></th>
<th>&quot;low&quot; Pathogenesis Group Means</th>
<th>&quot;high&quot; Pathogenesis Group Means</th>
<th>df</th>
<th>T-value</th>
<th>Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regard</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Form</td>
<td>28.60</td>
<td>2.17</td>
<td>9</td>
<td>3.17</td>
<td>0.005*</td>
</tr>
<tr>
<td><strong>Empathy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Form</td>
<td>16.60</td>
<td>- 6.50</td>
<td>9</td>
<td>2.61</td>
<td>0.014**</td>
</tr>
<tr>
<td><strong>Congruence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Form</td>
<td>12.00</td>
<td>- 5.83</td>
<td>9</td>
<td>1.69</td>
<td>0.070</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Form</td>
<td>57.20</td>
<td>-10.16</td>
<td>9</td>
<td>2.26</td>
<td>0.024***</td>
</tr>
<tr>
<td><strong>Regard</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist Form</td>
<td>30.20</td>
<td>36.67</td>
<td>9</td>
<td>0.36</td>
<td>0.362</td>
</tr>
<tr>
<td><strong>Empathy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist Form</td>
<td>19.60</td>
<td>23.00</td>
<td>9</td>
<td>0.43</td>
<td>0.342</td>
</tr>
<tr>
<td><strong>Congruence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist Form</td>
<td>26.20</td>
<td>32.67</td>
<td>9</td>
<td>0.32</td>
<td>0.385</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist Form</td>
<td>76.00</td>
<td>91.33</td>
<td>9</td>
<td>0.41</td>
<td>0.356</td>
</tr>
</tbody>
</table>

* Significant at the .01 level for one-tailed test.
** Significant at the .02 level for one-tailed test.
*** Significant at the .03 level for one-tailed test.

was rejected for three of the four client BLRI scores but was accepted for the client Congruence scale and for all therapist scores. It was concluded that the "low" pathogenesis therapists were rated significantly higher on Regard, Empathy, and Total Score when rated by their clients but not when they rated themselves.
Differences Between Client and Therapist Scores on the BLRI

The null hypothesis tested was:

$H_0$: There are no differences on the BLRI scores between therapists and their coached clients.

Table 2

T-tests for Therapist and Client Scores on the Barrett-Lennard Relationship Inventory (BLRI)

<table>
<thead>
<tr>
<th></th>
<th>Therapist Mean</th>
<th>Client Mean</th>
<th>df</th>
<th>T-value</th>
<th>Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regard</td>
<td>32.09</td>
<td>14.18</td>
<td>38</td>
<td>2.70</td>
<td>0.013*</td>
</tr>
<tr>
<td>Empathy</td>
<td>21.45</td>
<td>4.00</td>
<td>38</td>
<td>2.53</td>
<td>0.022**</td>
</tr>
<tr>
<td>Congruence</td>
<td>28.09</td>
<td>13.18</td>
<td>38</td>
<td>2.29</td>
<td>0.035***</td>
</tr>
<tr>
<td>Total</td>
<td>81.63</td>
<td>31.36</td>
<td>38</td>
<td>2.57</td>
<td>0.027**</td>
</tr>
</tbody>
</table>

* Significant at the .02 level for two-tailed test.
** Significant at the .03 level for two-tailed test.
*** Significant at the .04 level for two-tailed test.

As evidenced in Table 2, there were significant differences at beyond the .05 level for the Regard, Empathy, Congruence and Total scales. The null hypothesis, then, of no difference was rejected for all four BLRI scales.

Factor Analysis

The T-tests used in testing Hypothesis I indicated that significant differences occurred between "high" and "low" pathogenesis groups. In order to determine the relationship among the variables for the entire sample, a Pearson Product Moment
Correlation Matrix and a Principal Factors Verimax Analysis is presented.

As evidenced in Table 3, a number of significant relationships are revealed when the entire sample is analyzed.

For the client variables it can be concluded:
1. There is a significant positive correlation ($p < .02$) between client-perceived regard and client perceived empathy.
2. There is a significant positive correlation ($p < .01$) between client perceived regard and client-perceived congruence.
3. There is a significant positive correlation ($p < .01$) between client-perceived regard and total client score.
4. There is a significant positive correlation ($p < .01$) between client-perceived empathy and client-perceived congruence.
5. There is a significant positive correlation ($p < .01$) between client-perceived empathy and total client score.
6. There is a significant positive correlation ($p < .01$) between client-perceived congruence and total client score.

For the therapist variables it can be concluded:
1. There is a significant positive correlation ($p < .01$) between therapist-perceived regard and therapist-perceived congruence.
2. There is a significant positive correlation ($p < .01$) between therapist-perceived regard and total therapist score.
3. There is a significant positive correlation ($p < .01$) between therapist-perceived empathy and therapist-perceived congruence.
Table 3
Pearson Product Moment Correlation Matrix for the Barrett-Lennard Relationship Inventory (BLRI) and the Pathogenesis Index

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
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<tbody>
<tr>
<td>Variable 1</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLRI-Client-Regard</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable 2</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLRI-Client-Empathy</td>
<td>.531**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Variable 3</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLRI-Client-Congruence</td>
<td>.572*</td>
<td>.612*</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Variable 4</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLRI-Client-Total</td>
<td>.772*</td>
<td>.789*</td>
<td>.831*</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Variable 5</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLRI-Therapist-Regard</td>
<td>.131</td>
<td>.089</td>
<td>.159</td>
<td>.137</td>
<td>1.000</td>
<td></td>
<td></td>
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<tr>
<td>Variable 6</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>BLRI-Therapist-Empathy</td>
<td>-.111</td>
<td>-.164</td>
<td>-.076</td>
<td>-.121</td>
<td>.363</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Variable 7</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>BLRI Therapist-Congruence</td>
<td>-.137</td>
<td>-.242</td>
<td>-.186</td>
<td>-.198</td>
<td>.595*</td>
<td>.581*</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable 8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLRI-Therapist-Total</td>
<td>-.059</td>
<td>-.138</td>
<td>-.059</td>
<td>-.086</td>
<td>.629*</td>
<td>.725*</td>
<td>.732*</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>Variable 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PI</td>
<td>-.381</td>
<td>-.425</td>
<td>-.416</td>
<td>-.401</td>
<td>-.169</td>
<td>-.095</td>
<td>-.083</td>
<td>-.018</td>
<td>1.000</td>
</tr>
</tbody>
</table>

*Significant at the .01 level

**Significant at the .02 level
4. There is a significant positive correlation (p < .01) between therapist-perceived empathy and total therapist score.

5. There is a significant positive correlation (p < .01) between therapist-perceived congruence and total therapist score.

To ascertain what factors were involved and which variables on those factors, a Principal Factors Verimax Analysis was performed.

As evidenced in Table 4, two factors are involved in the results. Factor one includes all the BLRI client-perceived therapeutic conditions and the PI score. Factor two includes all of the therapist-perceived therapeutic conditions. The factor analysis substantiates not only the lack of independence of the BLRI variables but also the significant loading of the PI variable on the BLRI client variables.

Summary

To examine the ability of the PI to discriminate between therapists scoring high on the BLRI and those scoring low, a group of 20 therapists were administered both measures. Eleven of the 20 were then placed in one of two groups. The "high" pathogenesis group included the six subjects who scored highest on the PI. The "low" pathogenesis group consisted of the five subjects who scored lowest on the PI. T-tests were performed to determine the extent to which the "high" pathogenesis group differed from the "low" pathogenesis group.

A significant difference was found between the two groups on
Table 4
Principal Factors Verimax Analysis of Barrett-Lennard Relationship Inventory (BLRI) Variables and Pathogenesis Index (PI)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Factors</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
<td>h²</td>
</tr>
<tr>
<td>Variable 1</td>
<td>0.78*</td>
<td>-0.11</td>
<td>.61</td>
</tr>
<tr>
<td>BLRI-Client Regard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable 2</td>
<td>0.85*</td>
<td>-0.10</td>
<td>.72</td>
</tr>
<tr>
<td>BLRI-Client Empathy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable 3</td>
<td>0.86*</td>
<td>-0.01</td>
<td>.73</td>
</tr>
<tr>
<td>BLRI-Client Congruence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable 4</td>
<td>0.89*</td>
<td>-0.04</td>
<td>.78</td>
</tr>
<tr>
<td>BLRI-Client Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable 5</td>
<td>0.20</td>
<td>0.75*</td>
<td>.60</td>
</tr>
<tr>
<td>BLRI-Counselor Regard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable 6</td>
<td>-0.11</td>
<td>0.61*</td>
<td>.65</td>
</tr>
<tr>
<td>BLRI-Counselor Empathy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable 7</td>
<td>-0.16</td>
<td>0.84*</td>
<td>.72</td>
</tr>
<tr>
<td>BLRI-Counselor Congruence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable 8</td>
<td>-0.05</td>
<td>0.90*</td>
<td>.80</td>
</tr>
<tr>
<td>BLRI-Counselor Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variable 9</td>
<td>-0.72*</td>
<td>-0.03</td>
<td>.50</td>
</tr>
<tr>
<td>PI Score</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Significant at the .01 level
the client-perceived regard scale, the client-perceived empathy scale, and on total client scores. A trend towards significance was found on the client-perceived congruence scale. No differences were found between the groups on any of the four therapist-perceived therapeutic condition scales.

A second hypothesis, that there would be differences between client and therapist scores on the BLRI, was proposed. T-tests revealed significant differences between scores for all four scales.

To aid in the understanding of the relationships between the one independent variable (PI) and the eight dependent variables (BLRI client and therapist perceptions) a correlation matrix was developed. Here a number of significant correlations were revealed. Finally, a rotated factor analysis was performed to identify the factors involved in the analysis. Two factors were identified. One included the client BLRI scales and the PI. The other included the therapist BLRI scales.
CHAPTER IV

DISCUSSION

Summary

The purpose of the study was to determine the applicability of Karon's Pathogenesis Index as a selection measure for those entering graduate programs in the mental health field. The fundamental problem generating the research was the need for such selection indicators due to the present lack of personality measures to adequately discriminate between those who have the capacity to become competent therapists and those who do not.

The literature presented many attempts to delineate those characteristics which defined a competent therapist but with mixed results. Only one study, VandenBos and Karon (1971), clearly suggested a personality variable which correlated positively with therapist effectiveness. This study showed that the Pathogenesis Index, when determined for therapists of schizophrenics, could differentiate between those therapists whose clients got better and those therapists whose clients did not get better.

To determine if this Pathogenesis Index could also be used to distinguish between therapists in general and, thus, provide a selection measure, a sample of 20 beginning therapist trainees who had just completed 10 weeks of counseling techniques were randomly selected. These trainees were given a battery of TAT cards. Their responses were tape-recorded, transcribed, and scored by two
independent judges who determined the Pathogenesis Index for each subject.

To ascertain therapist effectiveness the subjects were then placed in a 30 to 40 minute therapy session with a coached client. The coached client had been trained to bring up in the session a conflict of a sexual nature and a demand for an opinion from the therapist. This placed the therapist in a situation where they were forced to respond in accordance with their own needs or in accordance with the needs of their clients. After the session both the therapist and coached client filled out parallel forms of the BLRI.

Analysis of the data revealed the following. T-tests of differences between client and therapist scores on the BLRI indicated that "low" pathogenic therapists scored significantly higher than "high" pathogenic therapists on three of the four BLRI client scales: Regard, Empathy, and Total Score. The Congruence score showed a trend towards a significant difference. The therapist scales, however, were not significantly different. T-tests for therapist and client scores on the BLRI indicated that there was a significant difference on all four BLRI scales between client and therapist scores. A Pearson Product Moment Correlation Table revealed that, while significant differences are found when "high" pathogenic therapists are compared to "low" pathogenic therapists, there is not a direct relationship between scores on the BLRI and amount of pathogenesis as measured on the PI. Finally, a Factor Analysis indicated that there were two factors involved in the
data: one factor included client BLRI scores and Pathogenesis scores; the second factor included BLRI therapist scores.

Discussion

Hypothesis I indicated that the "low" pathogenic therapists scored significantly higher than the "high" pathogenic therapists on three of the four BLRI client scales. When effectiveness was measured by therapist BLRI scores, no difference was found. Since client perceptions of therapeutic conditions have been shown to accurately reflect outcome of therapy, it can be concluded that the Pathogenesis Index does discriminate between effective and ineffective therapists on the extreme ends of the PI scores.

The results of testing Hypothesis I also indicate that the Pathogenesis Index does not discriminate between effective and ineffective therapists when this effectiveness is measured by the therapist. This suggests that the beginning therapists were not accurate in reporting the therapeutic conditions which they were relating to the client. The results of testing Hypothesis II indicate the discrepancy between client and therapist measures of the therapeutic conditions of the therapist was significant.

There may be several factors involved. First the subject population must be considered. Beginning therapists were the subjects of the study. Although they had just been involved in a class designed to teach them the use of the therapeutic conditions of regard, empathy, and congruence, as well as other counseling techniques, most were relatively naive in their work with actual
clients. A few had not even experienced therapy with a real client. It is possible, then, that although they may have perceived the feelings of regard, empathy and congruence within themselves, they had not become skilled enough to communicate these skills to the client.

This does not account, however, for the clients of differentially pathogenic therapists reporting different levels of the conditions whereas the therapists rated themselves significantly higher. This could be explained by Karon's assertion that Pathogenesis is unconsciously motivated and usually not perceived by the person who has the characteristic. The pathogenic therapists may actually not be aware of the impact they have on clients. The clients, however, were able to perceive the pathogenic behaviors in their therapists. These findings may have been enhanced in the present study by using relatively naive therapists and coached clients who were very adept at discriminating between skilled and unskilled students. Both coached clients had been graduate assistants in classes similar to the one from which the subjects were chosen. Although actual clients may not be as adept, the effect the therapist has on the client may be the same.

Client perceptions as measured on the BLRI and the Pathogenesis Index, according to the Rotated factor analysis, appear to be measuring the same thing to a significant degree ($p < .01$). Although further research will have to be done to evaluate this factor, speculation is that it is the maladjustment factor.

Maladjustment could account for both the pathogenic themes picked
up on the TAT stories and for the lack of learning or use of appropriate therapeutic skills in the therapeutic relationship. Those therapists who use dependent people for their own benefit are those who do not show regard, empathy, or congruence in their relationships with clients. On the other hand, those therapists who take their clients' needs into consideration are those who exhibit the therapeutic conditions in their relationships with clients.

Correlations matrix results indicate that there is a significantly high correlation ($p < .01$) between the four therapeutic condition measures as reported by the client and between three of four therapeutic conditions as measured by the therapist. This supports the work of Mills and Zytowski (1967) and Lanning and Lemons (1974) who have found in their factor analytic studies indications that the BLRI is not measuring distinct therapeutic conditions but rather one factor: general satisfaction or dissatisfaction with the relationship. The rotated factor analysis further substantiates this finding in indicating that two factors, one derived from client and PI data, and the other derived from counselor data, are involved rather than all four measures of the therapeutic conditions being seen as separate factors.

The rotated factor analysis indicates a difference, however. That difference is that the client scores and therapist scores on the BLRI are not purported to be measuring the same thing to any significant degree. Speculation is that, rather than measuring satisfaction with the relationship, therapist perceptions may well
be a function of what the therapist thought was expected of them or what they perceived to be the ideal response. Perusal of the data shows that therapists rated themselves about a +2 on all responses. This indicates that they all reported to have a substantial amount of the therapeutic conditions but not the optimal amount.

Limitations of the Study

It is important to realize that the conclusions to this point have been based on only a little more than half the available data. It is necessary, then, to be careful about interpretation of the results. The T-tests indicated that the PI could discriminate, but only between those at the extreme ends of the sample. They indicate nothing about the relationship of the therapeutic conditions to PI as it related to the entire sample. The correlation matrix, however, indicated that there is only a trend (p<.10) towards a significant negative correlation between PI scores and client-perceived therapeutic conditions. When the entire sample is considered, then, the negative correlation between PI and client-perceived therapeutic conditions does not hold. It, therefore, cannot be concluded that as pathogenesis increases, the therapeutic conditions increase or conversely, as the PI decreases, so do regard, empathy, and congruence. No such relationship is indicated. It can only be concluded that those who score on the extreme ends of the PI can be distinguished from each other as to therapeutic conditions. In considering the PI as a selection measure, only those with extremely high PI scores could be questioned as to their
potential to become competent therapists. Further research would have to be done to determine what PI score would be high enough to consider the potential therapist pathogenic. In the meantime, caution would need to be implemented so that potentially effective therapists would not be mistakenly eliminated from graduate school programs.

Recommendations for Therapist Education Programs

The following recommendations, stemming from the findings of this study, may be helpful in devising or improving therapist education programs:

1. The Pathogenesis Index may well be a viable measure to determine the potential ability of those wishing to begin graduate studies in the mental health field. Although too little is known about the measure to determine how high a PI score a potential therapist would have to have to be considered pathogenic, it has been ascertained in the study that those with extremely high scores are ineffective as measured on the BLRI. Further research needs to be done on this measure to discover the exact parameters.

2. Do not rely on beginning therapists’ ability to recognize their own skill level. In this study, even nonpathogenic therapists rated themselves higher than their clients rated them. Be cognizant of the fact that there may be a vast difference between perceived skill level and actual delivery of that skill to the client.

3. Feedback to the therapist is of paramount importance. Beginning therapists are not sufficiently aware of their impact on
clients. Provide learning situations where the therapist may receive feedback not only from other therapists but from clients as well. Clients can provide much needed information about how and what the therapist is communicating in the relationship.

In considering the use of the Pathogenesis Index in selection processes, several issues concerning feasibility need to be addressed. In the present study a minimum of an hour was needed for administration of the instrument. An hour would also be needed during the selection process. Scoring includes transcription and rating of responses.

This procedure would take approximately two hours per selectee. It may be possible for a highly trained person to rate the responses without transcription but the time involved would still be a minimum of an hour. The total time, then, would be two to three hours per selectee. In programs where large numbers of potential candidates have applied for entry, the length of professional time needed to administer and score the Pathogenesis Index may make the use of the instrument untenable.

Whether or not a potential candidate is chosen to enter a graduate program can have a tremendous impact on the career endeavors of that person. As such the ethical implications of rejecting a viable candidate must be considered. Although it is hypothesized that the unconscious motivation of pathogenesis is a relatively enduring personality characteristic, too little research has been done to justify any stand. It may be, then, that with special training and/or extensive in-depth therapy, highly
pathogenic therapists would be able to be as effective with their clients as low pathogenic therapists.

A more practical and perhaps more ethical use for the Pathogenesis Index may be, then, to include it as a part of the therapist training program. As such, it may serve to identify those beginning therapists who are highly pathogenic. The trainees could then receive information and guidance on which they could themselves decide their professional careers. They could determine for themselves whether to continue in the training program and if they continued what measures to take to become effective therapists.

Implications for Further Research

Throughout this experiment, the need for further study of the variables involved became apparent. Following is a summary of that need.

1. Replication of the research is desirable to discover if the Pathogenesis Index used to discriminate between effective and ineffective therapists gets the same results with a different group. Replication could demonstrate that results were due to the relationship between the Pathogenesis Index and the outcome measure and not a product of the therapist's lack of skill, the coached client's expertise, or other concomitant variables.

2. Further study could be done to determine how extreme the PI would need to be for the therapist to be considered potentially ineffective.
3. The same basic study—examination of the relationship between the Pathogenesis Index and an outcome measure could be done using a different measure of outcome. One such measure, approximating the "true to life" situation more adequately, is the use of the BLRI with "real" clients who have been in therapy with the more advanced counselor for a number of sessions.

4. Further study of the pathogenic therapists could be done to determine if they can become more effective through personal psychotherapy, increased skill development, or other change procedure. This approach would require a longitudinal study.

5. Further study of the Pathogenesis Index could be done to determine if fewer than 10 cards could be used to determine the pathogenic qualities of the therapist. Computerization of the Revised Scoring Criteria could be implemented. Both of these suggestions would shorten the administration and scoring procedure for the Pathogenesis Index and make it more amenable to use by selection committees.

6. The Pathogenesis Index could be examined for use in other populations in which there are dependent people. For example, it could be used in selection of nurses, prison guards, group home workers, hospital aides and orderlies, and nursing home personnel.
APPENDIX A

PROTOCOL

Hi! My name is Cathy Miller and I am a doctoral candidate in this department in the Counseling Psychology option. I am presently doing my doctoral dissertation on counselor behaviors. This is why I am here.

As you know research on counselor behaviors is important in the field of counseling for several reasons ranging from understanding counseling theory to helping counselors learn more effective skills in their work with clients. The research I am doing uses Master's level students as subjects. They will be randomly selected from C-P Classes. This is done because it is felt that these particular people would fit best into the design of the study. I cannot tell you now about the design in detail because I don't want to bias the results. I can tell you that approximately half of you will be contacted by phone to participate in the study.

The study consists of two parts. In the first part the counselor will be given a portion of the Thematic Apperception Test (TAT), a well-known projective technique. This will take about an hour. Later in the semester the counselor will be given a client who has been trained before-hand to present a certain problem in the session. The session will last approximately 30 minutes, after which both the client and the counselor will be given a set of questions pertaining to the sessions.
All information gathered in this study will be held in strictest confidence. This means several things. First it means that all test results and information will be used for research purposes only. Secondly, no personal identifying information will be used in any report or published studies. Finally it means that university personnel or faculty will not have access to individual results.

At the end of the semester, when the study is finished, I will give you, upon request, a statement about the research. Are there any questions?
APPENDIX B

Karon's "Pathogenesis" Revised Scoring Criteria

Based on contributions of Gary R. VandenBos, Ph.D.,
Daniel Robbins, Ph.D., and Kevin Mitchell, Ph.D.

The PI consists of asking, of each story, "Is there an interaction between a dominant person and a dependent person, both of whom have conflicting or potentially conflicting needs, and does the dominant person take the dependent person's needs into account?" If the dominant person takes the dominant person's needs into account, the story is scored "benign" (B). If the dominant person does not take the dependent person's needs into account, the story is scored "pathogenic" (P). If it is not clear whether there is an interaction or whether the needs are taken into account, the story is scored "non-scorable" (NS). The PI is the number of stories scored P divided by the number of stories scored either P or B (expressed as a decimal). In other words, the PI is the percentage of scorable stories which are scored P.

Further copies may be obtained from:

Bertram P. Karon, Ph.D.
Department of Psychology
Michigan State University
East Lansing, MI 48824
APPENDIX C

WRITTEN INSTRUCTIONS

The task is simple. For each of the ten cards you are asked to make up a story. Look at the cards in order and for each card tell: what is going on, what the characters are feeling and thinking, what might have led up to it, and what the outcome is. In other words, just tell a good story.

You may want to refer to these four statements during the task so you don't leave anything out. They, again, are:

1. WHAT IS GOING ON?
2. WHAT ARE THE CHARACTERS FEELING AND THINKING?
3. WHAT MIGHT HAVE LED UP TO IT?
4. WHAT IS THE OUTCOME?

Work at your own pace. When you have finished with the ten cards return them with the tapes and tape recorder to the experimenter in the Counseling and Personnel Office (3109).

Thanks again for your involvement in this research! You may begin now by first removing the taped instructions and then putting in the blank tape placing it on RECORD.
Pathogenesis Index

Pathogenesis Scoring Criteria

Pathogenic Themes

1. Murder.
2. Boss driving workers hard.
3. Parents make boy study or practice when he doesn't want to.
4. Mother supposedly kind, but not meeting expressed needs of child.
5. Mother showing particularity for one daughter or son over another.
6. Any kind of talking to as a form of punishment.
7. Mother warning child on things that can harm him or her in growing up.
8. Mother telling child he or she hasn't worked up to ability.
9. Going to cemetery to scare people.
10. Husband give wife news he is leaving town (or her).
11. Spying on girlfriend, or being stood up.
12. Monster ready to attack child or smaller animal.
13. Happy old witch and pretty young woman.
14. Man telling wife something to hurt her, e.g., took secretary to lunch.
15. Mother reading to child from Bible to teach her a lesson.
16. Woman and evil conscience; devil behind her, etc.
17. Mother feels what she has said to daughter has done little good.
18. Husband interrupts something wife is interested in.
19. Nasty remarks to a subordinate, making him or her unhappy.
20. King or leader leading nation to ruin.
21. Mother doesn't like something about daughter or son (looks, makeup, attitudes, etc.), even though daughter or son likes it.
22. Refusal of marriage bid; one is interested, one is not.
23. Mother checking up on son or daughter (study, etc.).
24. Destructive witch themes.
25. Family ruled or dominated.
26. Husband or father jealous or forbidding.
27. Woman harming child by punishment.
28. Suicide attempt to frighten someone.
29. Man pulling out of extramarital affair and woman doesn't want to.
30. Losing interest in playing violin. (It is assumed that card 1 reveals parental relations even if the parent is not mentioned. The child playing the violin against his will is assumed to imply coercion).
31. Rape.
32. Physical assault.
33. Being fired from a job.
34. "Trying to find a job and can't." (Implies turning the hero down)
35. Accidental injuries due to human error, e.g., accidentally shooting someone, automobile accidents.
36. Unsuccessful rescues.
Pathogenesis Index

Benign Themes

1. Parents force child to do something; he is unhappy, they change.
2. Teacher consoling a problem child; helping a gifted child.
3. Guides leading animals across difficult areas, etc.
4. Reunion of two people--both people pleased.
5. Person springing a pleasant surprise on another one.
6. Parent interrupts punishment of child by another parent.
7. Stopping children from activity in which they would be likely to get hurt.
8. Woman trying to console man in trouble.
9. Father and daughter consoling each other after death of mother.
10. Helping people in a disaster.
11. Son or daughter interested in advice from parents (or stories).
12. Woman working hard for benefit of her children.
13. Mother thinking of children and is happy.
14. Accepted protestations of love, or evidence of mutual love.
15. Mother admiring work of children or making something they like.
16. Man heeds woman's wish not to leave.
17. Any attempts to help or console with no ulterior motive.
18. Prevention of disaster (suicide, murder, etc.).
19. Mother enlightening child about the birds and bees.
20. Mother caring for child.
21. On card 11, hero slaying bad dragon (because implies successful rescue).
22. Two people being happy together.
Non-scorable Themes

1. No interaction between two people, though somewhat conflicting needs.
2. One person enjoying himself.
3. No people or living things.
4. Two people, but no indication of interaction.
5. Conflict with person's own needs, not other people's.
6. Thinking about a mother who was kind to her. (It is assumed that this indicates such a fantasy--but it is at least as likely to be defensive as it is to be a reflection of reality.)
7. Wanting to join a dead person--an intrapsychic problem.
8. Nothing in the story speaks to a shared bond, conflicting needs, or interaction; nothing to indicate that the people know each other. Applies to all cards, including card 1. (In card 1, we assume the presence of a parental figure.)
9. No evidence of pathogenic or benign behavior.

Problematic Issues in Scoring

1. Question: Does it require an unequal status relationship to have a dependency--i.e., mother-daughter, mother-son, older-younger person? Answer: No. We can assume that in a friendship or peer relationship there is mutual dependency, that a relationship is meant to be mutually rewarding and nurturing. If the story is benign or pathogenic in either event, it is not
necessary to establish who is dominant.

2. Question: Is a son leaving an older parent pathogenic?
   Answer: The role of the parent is to help the son or daughter grow up and separate. If the parent doesn't do that, it is pathogenic.

3. The total package of behaviors is important—not just the final behavior. The emphasis is on behavior, intentions don't matter. It has to be acted. Taking the other person's needs into account has to be done actively.

4. Boredom—how to score.
   Answer: If people are bored with someone else doing something and it continues to occur, it's pathogenic. If it's a temporary situation where someone is bored and it's not an ongoing thing, it's not pathogenic. The issue is if the one person continues not to take the other's feeling into account or not.

5. Startle reaction—how to score.
   Answer: In and of itself this is not scored pathogenic.

6. Triangle love affair situation—how to score.
   Answer: Starting with a relationship that is basically pathogenic, is there anything in the card that indicates that the people are benignly handling it?
   Example: Relationship focuses on the two people on the card. There's some evidence that he's articulating his needs and feelings about duty, obligation, and family. She doesn't acknowledge these, she manipulates him. His behavior is influenced out of guilt. She uses his guilt. Nothing benign
in either's behavior.

7. Question: There seem to be a lot of cards where the story is told of people being unhappy and feeling badly, and yet nothing is resolved. How is this scored?
Answer: It is pathogenic when members of a family are silently unhappy and they don't interact to attempt to resolve it.
Example: Nobody is talking about what's going on. Both are thinking the action is going to occur. It's all going on inside their heads. Nobody has permission to say he or she is hurting. Both are silently hurting, and he's going to make an autonomous decision. When people are related and unhappy, when there's no communication, the question is, "Do they actively take each other's needs into account?"

8. Pathogenic situation followed by hope—how to score.
Answer: Possibilities—hope is not sufficient unless there is concrete evidence that the possibilities are based on some reality, that they might really occur. Just a wish or a hope is not sufficient.

9. Child trying to please parents by doing something he or she doesn't really want to do is pathogenic. Child not saying something out of fear of hurting parent's feelings is pathogenic.

10. Issue of persons succeeding, being benign to themselves, or taking care of their own needs:
Benign if:
A. Someone was encouraging and helpful.
B. Person overcame odds, and there is indication of logical assumption of some support.
Pathogenic if:
A. This person is able to help him/herself and no one else will.
B. No one else notices person struggling, and other people are in a position to notice.
C. Someone else could have helped and chose not to.
   Ambiguous: It is not stated that "nobody will help," but it is unclear. An assumption must be made as to whether or not someone will help.

11. Separation issues--how to score.
Look at what evidence there is in the story of being able to separate despite feelings of guilt. Benign if parent expresses concern and feelings, but allows child to separate in spite of fears. Pathogenic if parent says, "Don't go" and tries to talk child out of going whether he or she goes or not.

12. "Recasting" a pathogenic childhood event into positive terms in memory later in life is seen as a rationalization and not scored benign. The pathogenic childhood event is scored pathogenic unless there is evidence that the "victim" handles things differently (benignly) towards others as an adult or parent.

13. It is possible to give a story on card 1 which describes an internal struggle, and is thus non-scorable.

14. "Cruel world" is pathogenic if there is nothing more immediate and specific to score. The word "world" have to be used. Having a good relationship as a solution to a "cruel world" is benign.
15. "Story within a story" situations—how to score.
Answer: If the hero is wondering about what will happen to him or her (thinking, which is non-scorable intrapsychic phenomenon), and reports starting this process because of seeing a P or B event or relationship of some others, the "within" story is scored (but only when the hero's story is non-scorable).

16. Dungeon, jail, and arrest—how to score.
Answer: Dungeon and jail are P. Locking people up (even criminals) is P. Arresting themes are probably P. Arresting is not P if arresting person says it is so the person won't commit crime again.

17. Prostitution is scored P if needs are not being taken into account.

18. Suicide is mostly score P because suicide is interpreted as an unconscious or conscious expression of anger or wish to hurt someone else. An exception, for example, would be if a terminally ill man unplugged his life support system because of the emotional and financial burdens upon his family (scored B).

19. Deal with the events presented in the story, called on-stage events, first.

20. The card characteristics are largely irrelevant; it is the story which is scored.

21. Deal primarily with actions, not thoughts, for scoring.

22. Brief notes on arbitrary rules to use in sparse stories:
A. Sometimes consequences in others have to be considered.
B. Interaction need not be the central focus of the story as long as the interac
long as the interaction alluded to is pathogenic or benign.

C. Expectation based on earlier experience has greater weight than expectation based on hope.

D. Guilt production is not benign. Scoring is to be inferred from statements about guilt. Concern about someone, even with guilt, leading to appropriate behavior is not pathogenic.

E. If a parent wants a child to do or not to do something, and the child does not want to:
   1. Pathogenic, usually.
   2. Benign if there is a real and clear danger.
   3. Even if what parent wants is unreasonable, but parent adds basis of request, story is not scored pathogenic. It may be scored benign.
   4. If a helping relationship does not help, it is scored P.

F. On-stage events are more important than off-stage events. Therefore, overt actions are more important than expectations.

G. Someone "worried about," but not acting, is not B. It may be P.

H. Parent-child interactions take precedence over equals interacting in the same story.

I. Pseudo-helpful comments meant to taunt are P.

J. Score impact-effect, not intent-hope.

K. Conflict of needs does not have to be evident for story to be B.
APPENDIX D

INFORMATION RELEASE FORM

I hereby agree that test data gathered on me may be used for research purposes under the following conditions:

1. All test results and information will be used for research purposes only and will be held in confidence;
2. No personal identifying information will be used in any report or published studies;
3. University personnel and faculty will not have access to individual results.

Signature __________________________ Date ______________________

If you have any questions concerning how this information will be used, feel free to contact me.

Catherine Miller
Doctoral Candidate
3109 Sangren
Western Michigan University
APPENDIX E

Relationship Inventory--Therapist form (BLRI-Co)*

Number________

Below are listed a variety of ways that one person could feel or behave in relation to another person. Please consider each statement with respect to whether you think it is true or not true in your present relationship with your client. Place a checkmark in one of the spaces provided to represent your feelings about the item as indicated by the code.

<table>
<thead>
<tr>
<th>I feel strongly that it is true</th>
<th>I feel that it is probably true or more true than untrue</th>
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<th>I strongly feel that it is not true</th>
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<tbody>
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<td>-3</td>
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</tbody>
</table>

1. I respect him/her. ______  ______  ______  ______  ______  ______

2. I try to see things through his/her eyes. ______  ______  ______  ______  ______  ______

**3. I pretend that I like him/her or understand him/her more than I really do. ______  ______  ______  ______  ______  ______

**4. I disapprove of him/her. ______  ______  ______  ______  ______  ______

*A modified version of G. T. Barrett-Lennard's (1962) Relationship Inventory (BLRI).

**Denotes items scored in a negative direction.
**5.** I understand his/her words but not the way s/he feels.

**6.** What I say to him/her never conflicts with what I think or feel.

**7.** I am curious about "the way s/he ticks," but not really interested in him/her as a person.

**8.** I am interested in knowing what his/her experiences mean to him/her.

**9.** I am disturbed whenever s/he talks about or asks about certain things.
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<th>I strongly feel that it is not true</th>
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<tr>
<td>10.</td>
<td><strong>I like seeing him/her.</strong></td>
<td>+3</td>
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<tr>
<td>11.</td>
<td><strong>I nearly always know exactly what s/he means.</strong></td>
<td>+2</td>
<td>+2</td>
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<td>-1</td>
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<tr>
<td>**12.</td>
<td><strong>I feel that I have unspoken feelings or concerns that are getting in the way of our relationship.</strong></td>
<td>+3</td>
<td>+3</td>
<td>+3</td>
<td>-1</td>
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<tr>
<td>**13.</td>
<td><strong>I am indifferent to him/her.</strong></td>
<td>+3</td>
<td>+3</td>
<td>+3</td>
<td>-1</td>
</tr>
<tr>
<td>**14.</td>
<td><strong>At times I jump to the conclusion that s/he feels more strongly or more concerned about something than s/he actually does.</strong></td>
<td>+3</td>
<td>+3</td>
<td>+3</td>
<td>-1</td>
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Relationship Inventory--Therapist form (BLRI-Co)

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<th></th>
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<td>+3</td>
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<td>15.</td>
<td>I behave just the way I am, in our relationship.</td>
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<td>16.</td>
<td>I appreciate him/her.</td>
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<td><strong>17.</strong></td>
<td>Sometimes I think that s/he feels a certain way, because I feel that way.</td>
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<td>18.</td>
<td>I do not think that I hide anything from myself that I feel with him/her.</td>
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<td>19.</td>
<td>I am friendly and warm toward him/her.</td>
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<td>20.</td>
<td>I understand him/her.</td>
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<td>21.</td>
<td>I care about him/her.</td>
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</tbody>
</table>

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## Relationship Inventory--Therapist form (BLRI-Co)

<table>
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<tr>
<th></th>
<th>I strongly feel that</th>
<th>I feel that it is true</th>
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<tr>
<td></td>
<td>+3</td>
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</table>

**22.** My own attitudes toward some of the things s/he says, or does, stop me from really understanding him/her.

**23.** I do not avoid anything that is important to our relationship.

**24.** I feel that s/he is dull and uninteresting.

**25.** I understand what s/he says, from a detached, objective point of view.

**26.** S/he feels that s/he can trust me to be honest with him/her.

**27.** I am interested in him/her.
**Relationship Inventory--Therapist from (BLRI-Co)**

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<tr>
<th></th>
<th>+3</th>
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<td>I strongly feel that it is true</td>
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28. I appreciate what his/her experiences feel like to him/her.

29. I am secure and comfortable in our relationship.

**30. I just tolerate him/her.**

**31. I am playing a role with him/her.**

32. I do not really care what happens to him/her.

**33. I do not realize how strongly s/he feels about some of the things we discuss.**
**34.** There are times when I feel that my outward response is quite different from my inner reaction to him/her.

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<th>I strongly feel that it is true</th>
<th>I feel that it is probably true or more true than untrue</th>
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35. I seem to really value him/her.

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**36.** I respond to him/her mechanically.

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**37.** I don't think that I am being honest with myself about the way I feel toward him/her.

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**38.** I dislike him/her.

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39. I feel that I am being genuine with him/her.

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<tr>
<td><strong>40.</strong> I am impatient with him/her.</td>
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<td><strong>41.</strong> Sometimes I am not at all comfortable, but we go on, outwardly ignoring it.</td>
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<td>42. I feel deep affection for him/her.</td>
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<td>43. I usually understand all of what s/he says to me.</td>
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<td>44. I do not try to mislead him/her about my thoughts or feelings.</td>
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<td>45. When s/he does not say what s/he means at all clearly, I still understand him/her.</td>
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<tr>
<td><strong>46.</strong> I try to understand him/her from my point of view.</td>
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<td>I strongly feel that it is true</td>
<td>I feel that it is probably true</td>
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<td>+3</td>
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47. I can be deeply and fully aware of his/her most painful feelings without being distressed or burdened by them myself. 

48. What I say gives a false impression of my total reaction to him/her.
## APPENDIX F

**Relationship Inventory—Client's form (BLRI-C1)**

Number ___

Below are listed a variety of ways that one person could feel or behave in relation to another person. Please consider each statement with respect to whether you think it is true or not true in your present relationship with your therapist. Place a checkmark in one of the spaces provided to represent your feelings about the item as indicated by the code:

<table>
<thead>
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<td>I feel that it is probably untrue</td>
<td>I feel that it is untrue</td>
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</tr>
<tr>
<td>1. S/he respects me.</td>
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<tr>
<td>2. S/he tries to see things through my eyes.</td>
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<tr>
<td><strong>3. S/he pretends that s/he likes me more than s/he really does.</strong></td>
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<td><strong>4. S/he disapproves of me.</strong></td>
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* A modified version of G. T. Barrett-Lennard's (1962) Relationship Inventory (BLRI).
  ** Denotes items scored in a negative direction
### Relationship Inventory--Client's form (BLRI-Cl)*

<table>
<thead>
<tr>
<th></th>
<th>I strongly feel that it is true</th>
<th>I feel that it is true</th>
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<th>I strongly feel that it is not true</th>
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<td><strong>5.</strong></td>
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<td>S/he understands my words but not the way I feel.</td>
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<td><strong>6.</strong></td>
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<td>What s/he says to me never conflicts with what s/he thinks or feels.</td>
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<td><strong>7.</strong></td>
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<td>S/he is curious about &quot;the way I tick,&quot; but not really interested in me as a person.</td>
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<tr>
<td>S/he is interested in knowing what my experiences mean to me.</td>
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<tr>
<td><strong>9.</strong></td>
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<tr>
<td>S/he is disturbed whenever I talk about or ask about certain things.</td>
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*BLRI-Cl: Brief Locus for Relationship Inventory, Client's form.

**Note:** The table is rated on a scale of +3 to -3, where +3 indicates strong agreement and -3 indicates strong disagreement.
<table>
<thead>
<tr>
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<td>I feel that it is probably true or more true</td>
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<td>I feel that it is probably untrue or more</td>
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<td>10. S/he likes seeing me.</td>
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<td>**12. I feel that s/he has unspoken feelings or concerns that are getting in the way of our relationship.</td>
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<td>**13. S/he is indifferent to me.</td>
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<td>**14. At times s/he jumps to the conclusion that I feel more strongly or more concerned about something than I actually do.</td>
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<td>15. S/he behaves just the way that s/he is, in our relationship.</td>
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16. S/he appreciates me.  

**17. Sometimes s/he thinks that I feel a certain way, because s/he feels that way.**

18. I do not think that s/he hides anything from him/herself that s/he feels with me.

19. S/he is friendly and warm toward me.

20. S/he understands me.

21. S/he cares about me.

**22. His/her own attitudes toward some of the things I say, or do, stop him/her from really understanding me.**
<table>
<thead>
<tr>
<th></th>
<th>I feel strongly that it is true</th>
<th>I feel that it is probably true or more true than untrue</th>
<th>I feel that it is probably untrue or more untrue than true</th>
<th>I feel that it is not true</th>
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23. S/he does not avoid anything that is important to our relationship.

**24. S/he feels that I am dull and uninteresting.**

**25. S/he understands what I say, from a detached, objective point of view.**

26. I feel that I can trust him/her to be honest with me.

27. S/he is interested in me.

28. S/he appreciates what my experiences feel like to me.

29. S/he is secure and comfortable in our relationship.
**30.** S/he just tolerates me.  

**31.** S/he is playing a role with me.  

32. S/he does not really care what happens to me.  

**33.** S/he does not realize how strongly I feel about some of the things we discuss.  

**34.** There are times when I feel that his/her outward response is quite different from his/her inner reaction to me.  

35. S/he seems to really value me.
**36. S/he responds to me mechanically.**

<table>
<thead>
<tr>
<th>I feel that it is true</th>
<th>I feel that it is probably true or more true than true</th>
<th>I feel that it is not true or more untrue than untrue</th>
<th>I feel that it is not true</th>
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</table>
| **37. I don't think that s/he is being honest with him/herself about the way s/he feels toward me.**

<table>
<thead>
<tr>
<th>I feel that it is true</th>
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<th>I feel that it is not true or more untrue than untrue</th>
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</thead>
</table>
| **38. S/he dislikes me.**

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<tr>
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