THERAPISTS' PATIENT PREFERENCES: AN INTERVIEW STUDY

by

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Abstract

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The present investigation is an interview study of four therapists' patient preferences. Prominent in the literature on therapists' patient preferences is the notion that therapists uniformly prefer patients showing stereotypically "attractive" characteristics. The Yavis syndrome of Schofield (1964) summarizes this point of view in proposing that therapists prefer to work with patients who are Youthful, Attractive, Verbal, Intelligent, and Successful. The Yavis syndrome propositions have been elaborated in the literature such that the preferred patient of therapists is described as an individual who is highly motivated for therapy, possesses psychological-mindedness, collaborates actively with the therapist in psychodynamic self-exploration, shows little psychological disturbance, and makes the greatest therapeutic progress.

The four therapists interviewed in this study comprise the senior staff of the counseling service of an American university. They represent a relatively homogeneous group with respect to their level of experience and their psychoanalytic theoretical orientation. The student population that the staff serves is also a relatively homogeneous group. Overall, this student patient population meets the requirements of the stereotypically "attractive" psychotherapy patient.

In the interviews, each therapist gave anecdotal accounts of his therapy work with three most preferred patients and three least preferred patients. In addition to gathering the therapists' impressions of their patients in whatever manner they chose to present them, the interviewer also posed structured rating questions to which the therapists responded during the course of the interviews.

The results of the present study suggest that the assumption that therapists uniformly prefer stereotypically "attractive" patients is simplistic and inaccurate. This study finds individual differences among therapists in their patient preferences reflecting each therapist's personal attitudes, values, and needs. Each of the therapists viewed different factors in the patients and in the therapy relationship as central to his feelings of preference, and the interviews comprise four distinctly different portraits.

In the interviews the therapists provided examples of most preferred patients who were not viewed as stereo-

typically "attractive." Among the most preferred patients described were individuals perceived to show serious psychopathology, little psychological-mindedness, and high resistance to collaborating with the therapist in the therapy process. Some of the most preferred patients were also felt to attain only a limited degree of insight and behavioral improvement. Among the least preferred patients described by the therapists were individuals viewed as psychologically-minded, highly motivated for therapy, and lacking in serious psychological disturbance. Some of the least preferred patients were seen as showing active involvement in the therapy process resulting in attainment of a substantial degree of insight and behavioral improvement.

Most studies in the area of therapists' patient preferences, including those supporting the propositions of the Yavis syndrome, employ simple rating scales to assess therapists' patient preferences. In the present study, the combined use of the anecdotal interview method and structured rating questions yielded data that were clinically richer, more complex, and more valid than those obtained through the use of simple rating scales alone. Through the use of these combined methods, therapists' preferences for patients could be examined in detail on a case-by-case basis, revealing individual differences among the therapists in their patient preferences.

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CHAPTER I

INTRODUCTION: THE EVOLUTION OF THE PRESENT STUDY FROM AN INITIAL PILOT STUDY

This is an interview study of four therapists' individual patient preferences. During the course of the interviews the therapists described their therapy work with three most preferred patients and three least preferred patients. The four therapists comprise the senior staff of the counseling service of an American university. The therapists represent a relatively homogeneous group since they all describe themselves as primarily psychoanalytic in theoretical orientation.

The student population that the staff serves is also a relatively homogeneous group. The students tend to be articulate and psychologically-minded, intelligent, highly motivated and lacking in serious psychological disturbance. Overall this patient population meets the requirements of the stereotypically "attractive" psychotherapy patient which have been documented in the literature. These stereotypically "attractive" patient characteristics are summarized in the postulates of the Yavis syndrome proposed by Schofield (1964). According to the Yavis syndrome there is uniformity among therapists in their preference for work with patients who are

Youthful, Attractive, Verbal, Intelligent and Successful. The Yavis syndrome propositions subsequently have been elaborated in the literature such that the preferred patient of therapists is described as an individual who is highly motivated for therapy, possesses psychological-mindedness, collaborates actively with the therapist in psychodynamic self-exploration, shows little psychological disturbance, and makes the greatest therapeutic progress. The literature supporting the Yavis syndrome assumptions that therapists uniformly prefer to work with stereotypically "attractive" patients will be discussed in the following chapter. Also to be described in the next chapter is the body of literature that reveals individual differences among therapists in their patient preferences reflecting the therapist's personal attitudes, values and needs.

This study approaches the topic of patient preferences of therapists by examining in detail the views of four therapists about their therapy work with most and least preferred patients.[1] During a portion of the interview time the therapists gave anecdotal accounts of their therapy work with three most preferred and three least preferred patients. In addition to gathering the therapists' impressions of their patients in whatever manner they chose to present them, I also had the therapists respond to structured rating questions which I asked during the course of the interviews.

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[1] In this study all treatment will be referred to as therapy, and all students treated will be referred to as patients.

The following is an account of the evolution of this investigation from an initial pilot study to its present form. My interest in studying therapists' patient preferences emanated from my own experiences as a beginning therapist. I had worked as a therapist-in-training over the course of several years in a variety of treatment settings which served diverse patient populations. I had therapy contact with in-patients and out-patients who ranged broadly in their severity of disturbance, socio-economic background and general life style and outlook. I was beginning work in my second post-training therapy position, which involved making a new adjustment to learning how to establish a therapy relationship with a particular patient population. My involvement in this process brought to my mind the issue of how therapists learn to select the types of patients with whom they will work most effectively and who will bring them the greatest satisfaction.

My new position was on the therapy staff of a university counseling service. Patients were assigned to work with therapists on a rotational basis, depending upon which staff member had time available in his schedule. The assignment process was therefore an arbitrary one in which neither selection of patients by therapists nor procedures for matching patients with therapists were used. The working premise was that all therapists on the staff were potentially equally well-suited to treat any given patient.

I decided to conduct a pilot study in which I would

ask therapists about their perceptions of whether their therapeutic effectiveness varied with different types of patients. Only after I had completed two phases of the pilot study did I realize that my definition of the topic I was investigating was imprecise and needed redefinition. It became clear to me that although I was asking therapists about their perceptions of their therapeutic effectiveness, they were telling me about their patient preferences.

I realized that since the format of the study did not include independent objective measures of effectiveness of therapy outcome, the findings did not pertain to therapeutic effectiveness per se. Moreover, in discussing their subjective perceptions of effective and ineffective therapy work the therapists did not focus exclusively upon factors relevant to the outcome of therapy. Instead they emphasized a variety of features of the therapy relationship with particular patients which brought them feelings of satisfaction or dissatisfaction. For these reasons I asked therapists to focus specifically on their preferences for patients rather than on their views of their effectiveness with patients, in the present study.

In the first phase of the pilot study I asked my new work colleagues to participate in interviews, since I had the most direct access to them. I interviewed six of them about their therapy work, which included contact with patients at the university counseling service, in private practice, and in other institutional settings. In the interview I

asked the following questions:

1. Are you aware of differences in your therapeutic effectiveness with different groups of patients?

2. Could you describe the sorts of patients you feel you treat particularly effectively, moderately effectively, somewhat effectively, clearly ineffectively?

3. How do you account for these differences? What about you and what about the patient contribute to the degree of therapy effectiveness?

All of the therapists stated that they were aware of differences in their degree of effectiveness with different groups of patients. Yet they tended to describe only the two categories of patients with whom they worked most effectively and patients with whom they worked least effectively. There were individual differences in emphasis upon factors each therapist associated with most and least effective therapy cases, but all of the therapists tended to describe feeling most effective with patients who were introspective and psychologically-minded, who showed little psychopathology, and who came to therapy highly motivated to participate actively in psychodynamic self-exploration. The therapists stated that they developed a high degree of understanding of such individuals and felt personally engaged and empathic with them.

The therapists claimed to feel least effective with patients who were lacking in psychological-mindedness and who were not motivated to play an active role in striving to attain insight into their problems. Such patients were seen as needy and as wanting the therapist to cure them while

they remained closed and passive. Although the therapists said that they did not prefer to describe patients in terms of diagnostic categories, there was general consensus that they felt least effective with patients who were more seriously disturbed, suicidal, depressed and uncommunicative.

Some examples of the variety of responses among the therapists will now be given. Therapist A stated that he feels most effective with patients who conceive of the therapy process as he does. He emphasized the willingness of such patients to take responsibility for exercising their own authority in attempting to learn more about themselves in collaboration with the therapist. He feels that he is least effective with less mature, less reflective, less introspective patients. Such patients fear using their own authority and competence and come to therapy with strong expectations that the therapist will do something for them or to them.

Therapist B explained that he works most effectively with patients who can work in the transference. He feels more engaged and motivated in his work with such patients because he can understand their psychodynamics from inside of himself. He described such patients as psychologically-oriented and willing to talk about their feelings, fantasies and dreams. He claimed to feel least effective with patients who are more obsessional, guarded and intellectualized, because they don't allow him to develop a psychodynamic understanding of them. The patients with whom he feels least

effective are full of dependent rage. They look to him for solutions to their problems and lack the motivation to struggle to understand themselves. He adds that he is not effective with patients who need primarily supportive help.

Therapist C stated that he feels most effective with patients who are introspective, thoughtful, modest, genuine, and open. He feels that such patients are more easily engaged in therapy because they come with curiosity and readiness to think about themselves in a psychological way. He explains that he tends to like, respect, and value such individuals and consequently feels more highly engaged and connected with them. He emphasized the importance of feeling that he and the patient complement each other such that there is a sense of mutual flow and connectedness in a joint effort. He stated that he feels least effective with patients who are manipulative, narcissistic, exhibitionistic, and action-oriented. He feels that such patients are closed and unreflective and that they tend to yank and pull on the therapist for attention rather than joining with the therapist to explore themselves psychologically.

Therapist D asserted that he feels most effective with patients whom he likes in the intangible way that is also the basis for friendship. He stated that he is by nature active in the therapy work and feels most effective with patients who engage in an active exchange with him. He tends to carry the ball for patients who are non-verbal, but he feels that this is not useful therapeutically. He

expressed a greater feeling of optimism about working with basically healthy, intelligent, young patients. With those who are more seriously disturbed he holds back more and feels that he is walking on eggshells. He finds it more satisfying to be more direct and frank with healthier patients whose fragility is not of concern to him.

After examining the results of the initial pilot study I felt that the therapists' perceptions of their differential effectiveness with patients might become more detailed and focussed if I asked them to select and discuss a specific most effective therapy case and a specific least effective therapy case. I also hoped to clarify further the extent to which the therapists would tend to agree on factors associated with effective and ineffective therapy cases and the extent to which there would be individual differences among therapists. For these reasons I conducted a second phase of the pilot study in which the six therapists participated in hour-long interviews about their perceptions of one most effective and one least effective therapy case.

The interviews began with the therapist's anecdotal impressions of the therapy cases. I had prepared a list of salient factors that the therapists as a group mentioned in their initial pilot study descriptions of most effective and least effective therapy work. I consulted this list as the therapists spoke. In an unsystematic manner I introjected questions from this list when they seemed relevant to what the therapist was saying. I did not ask each therapist

about all of the factors on the list. The list contained questions about the patient's characteristics and background, his reason for seeking therapy, his degree of pathology, his behavior and attitudes in therapy, and the degree of insight and improvement he attained. The list also included questions about the therapist's experience of the quality of the therapeutic relationship, his feelings about the patient, the degree to which he attained understanding of the patient, the degree of personal identification he felt with the patient, and the extent to which he found the case challenging.

The greater specificity entailed in asking therapists to describe an actual most effective and least effective therapy case did result in more detailed and focussed responses from the therapists. My informal introduction into the interviews of a number of structured questions contributed to the therapists' greater specificity as well.

The findings concerning specific most effective therapy cases provided some new and contrasting information from that obtained in the first phase of the pilot study, while providing confirmation of other aspects of the initial study. The therapists described specific most effective therapy cases in which some of the patients were felt to show serious psychopathology, while other patients were seen as mildly or moderately disturbed. This finding was discrepant with the initial pilot study finding that the therapists viewed themselves as most effective with mildly dis-

turbed patients. It also ran counter to the Yavis syndrome proposition that therapists prefer to work with patients who have stereotypically "attractive" characteristics.

Another finding discrepant with the Yavis syndrome postulates and with the results of the initial pilot study was that among the most effective therapy cases were patients viewed as lacking in psychological-mindedness, lacking in initial motivation for therapy, ignorant of how the therapy process works, and highly resistant, defensive and intellectualized. The therapists' initial reactions to these most effective therapy cases included feelings of initial pessimism, frustration, and annoyance. One therapist stated that his feelings of satisfaction were based on the difficulty of the case, and another therapist similarly described the difficulty of overcoming the patient's resistance to therapy. The therapists tended to state that they felt highly challenged by the patient's initial resistance, lack of psychological thinking or complex psychodynamics.

In a specific most effective case, the therapists felt that there was mutual collaboration in the therapy work. They experienced the patients as highly engaged in the therapy process, and the therapists tended to feel highly engaged in the work as well. The therapists felt that they developed a high level of understanding of the patients. They expressed feelings of competence, satisfaction, warmth, and personal liking for patients in most effective therapy cases. There was also some expression of feelings of positive identifica-

tion with the patients and some sense that the therapist and patient shared a similar personal background. The therapists felt that the patients developed a high degree of insight and showed extensive improvement.

The findings concerning specific least effective therapy cases were generally consistent with the results of the initial pilot study. The least effective therapy cases involved patients who tended to be seen as more seriously psychologically disturbed than the patients described in most effective therapy cases. Yet the therapists did not focus on the patients' pathology as their primary reason for finding the work least effective. They emphasized instead that the cases were least effective because they were not able to overcome the patients' strong resistance to collaborating with them in psychodynamic exploration of their problems. The patients in least effective therapy cases were variously described as externalizing their difficulties, as terrified of insight, as negative and provocative, and as passively wanting to be changed by the therapist. The therapists felt that they lacked a sense of emotional engagement with the patients and viewed the level of exchange as superficial and intellectualized. The therapists tended to claim that they did not develop a high degree of understanding of the least effective therapy cases. They felt that the patients developed little insight into their problems, although some of them were felt to show behavioral improvement. The therapists did not express feelings of personal identi-

fication with the patients, and positive feelings were generally absent. The therapists described themselves as feeling frustrated, dissatisfied, and helpless at their inability to engage the patients in psychodynamically-oriented therapy. They expressed feelings of anger, irritation and annoyance at the patients as well.

Despite the consensus among therapists in their views of specific most and least effective therapy cases, individual differences in attitude about the salience of factors each therapist associated with most and least effective therapy patients remained striking in the second phase of the pilot study. After reviewing these findings I realized that I could not draw valid conclusions about the degree of similarity or disparity in perceptions and attitudes among the therapists because of limitations in the design of the study.

The most and least effective therapy cases the therapists chose to describe included patients seen at the university counseling service, in private practice, and in other institutional settings. The patients treated in each setting had broadly different characteristics and therefore constituted a heterogeneous patient population. The design of the pilot study made it unclear whether the variation observed was a function of the therapists' attitudes or a function of the real heterogeneity of the patients. With this limitation in mind, I required the therapists to discuss only patients whom they treated at the university

counseling service in the present study. This change increased the likelihood that any variations observed could be attributed to individual differences in attitudes among the therapists, since the patients at the counseling service comprise a relatively homogeneous population.

The design of the pilot study imposed a second limitation upon the validity of comparing the therapists' perceptions of their effectiveness with patients. I did not require the therapists to select patients for discussion who were currently or recently in treatment with them. Although some of the patients discussed were currently being treated by the therapists, others had not been seen in therapy for several years. One of the therapists spontaneously mentioned that he thought the "recency effect" contributed to his selection of cases to discuss in the interviews. It is noteworthy that four of the six most effective cases discussed involved patients who were currently being treated by the therapists, while there was only one current least effective case. The therapy of three of the six least effective cases had ended several years prior to the time of the interviews. Taking into account this design limitation, I required the therapists to discuss patients whom they had treated during the work year just ending in the present study.

Another limitation of the pilot study design was that I did not specify that the therapists should discuss patients with whom they had a prescribed minimum or maximum

number of therapy contacts. As a result there were variations in the degree of development of a therapy relationship over time among the cases. With this limitation in mind, I reviewed the attendance records for all patients seen by the therapists during that work year. I determined that it was pragmatic and feasible to ask that the therapists select for discussion in the present study patients who were seen for a minimum of 13 therapy sessions. It seemed overly restrictive, however, to introduce a criterion for the maximum number of therapy sessions into the selection process.

My review of the results of the second phase of the pilot study also indicated the need to control for the experience level of the therapists. In their discussions of least effective therapy cases several of the therapists explained that they felt relatively inexperienced and anxious about their competence at the time they treated the patients. In the present study I therefore interviewed only the four senior staff members of the counseling service because they shared similar levels of experience and competence. The senior staff was also a relatively homogeneous group with respect to the members' theoretical orientation to therapy. The four senior staff members had completed a background information sheet on which they indicated that they were primarily psychoanalytic in viewpoint.

A limitation of the pilot study that remains in the present study emanates from the need to maintain confidentiality concerning the identity of the therapists and their

patients. For this reason all personally revealing details including gender, race, personal characteristics and background, and specifics of the patient-therapist relationship and course of therapy were deleted in the present study. As a consequence, some of the data gathered will not be analyzed and discussed.

I learned from comparing the results of the two phases of the pilot study that the therapists' comments became more focussed and detailed when I asked them to discuss their work with specific patients. For this reason I specified in the present study that the therapists select for discussion three most preferred and three least preferred patients.

On the basis of the results of the second phase of the pilot study I incorporated a number of structured rating questions into the format of the interview in the present study. I found that the material that emerged when I asked the therapists to speak freely became more detailed and precise through the inclusion of structured questions in the interviews. In addition, the use of questions provided a degree of uniform structure to the interviews across therapists. I derived the rating questions used in the present study from the therapists' pilot study responses. I decided to introduce a five point rating scale in the present study to increase the standardization of the therapists' responses to the questions.

The central change which evolved from the pilot

study to the present one entailed redefining the interview topic to that of patient preferences of therapists. In the pilot study the therapists responded to my question about perceptions of differential therapy effectiveness by discussing the factors that brought them feelings of satisfaction or dissatisfaction in their work with particular patients. Their responses to my original question helped me to define more accurately the topic I could properly investigate within the anecdotal interview format.

CHAPTER II

REVIEW OF THE LITERATURE

In this review of the literature on therapists' patient preferences, the literature has been divided into two broad categories representing differing points of view. According to one viewpoint there is uniformity among therapists in their preference for work with stereotypically "attractive" patients. The Yavis syndrome of Schofield (1964) is a prominent formulation of the proposition that therapists uniformly prefer patients who are Youthful, Attractive, Verbal, Intelligent and Successful. Research based on the postulates of the Yavis syndrome and studies relevant to it will be discussed.

The other major viewpoint emphasizes that there are individual differences among therapists in their patient preferences reflecting the therapist's personal attitudes, values, and needs. Those studies based upon this point of view will be described as well.

Another issue in the literature on therapist preferences involves the methods used to assess therapists' patient preferences. The way in which preference is defined is pertinent here because the most common way of assessing preference has been for therapists to indicate

their degree of "liking" for a patient on a simple rating scale. In a review of the literature on liking for patients which is still timely, Meltzoff and Kornreich (1970) comment that liking and preference are often used as interchangeable terms and that "most studies do not attempt to do more than operationally define liking as a point along a rating scale" (p. 327). In some of the studies to be reviewed here the therapist is asked to rate his "personal liking" or his "social liking" for the patient. In other studies therapists are asked to rate their degree of "interest" in patients or their "willingness to treat" them. Therapist ratings of "patient attractiveness" or "patient likeability" are included in still other studies which will be mentioned.

The few empirical studies that examine therapists' patient preferences through the use of open-ended responses more closely resembling those of therapists in the therapy situation will be discussed. The literature to be reviewed last bears most directly upon the way therapists' patient preferences have been defined and examined in the present study. In this literature therapists' anecdotal accounts of patients they actually treat form the basis for studying their preferences.

Before examining the literature dealing directly with therapists' patient preferences, the impact of the psychoanalytic tradition upon the ways in which this subject has been considered in the literature will be reviewed.

Impact of the psychoanalytic tradition upon study of the therapist's feelings and attitudes

In a recent book entitled The Human Dimension in Psychoanalytic Practice, Frank (1977) states that "the fiction of the anonymous technician-analyst has prevailed in the literature for all too long" (p. 4). He believes that the paucity of material in the literature about the personal, subjective experience and attitudes of the therapist in his work is the result of a phobic attitude toward the therapist's inner life in his professional role. He cites misunderstanding of some of Freud's technical concepts such as "the surgeon's attitude" and "the mirror" as the origin of what he feels is a misleading description of the therapist in the literature.

Menninger (1958) and Stone (1961) quote Freud's 1912 recommendation that analysts "'model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible'" (Stone, 1961, p. 24). In support of Freud, Menninger asserts that Freud's advice to therapists on the role of warmth and sympathy is rarely quoted in full. Stone points out that in urging the putting aside of sympathetic feelings, Freud implies that sympathetic attitudes exist. Stone also cites the mirror image used by Freud in the same 1912 paper: "'The doctor should be opaque to his patients and, like a mirror, should show them nothing but

what is shown to him'" (p. 25). Stone concludes that the early development of psychoanalysis moved toward an extreme version of the concept of the therapist's cold aloofness and noninvolvement, and that the impact of this has been lasting.

Impact of the concept of countertransference

Several writers state that discussion in the literature of the therapist's personal reactions to patients has been limited largely to the concept of countertransference because of the classical psychoanalytic emphasis on the therapist's neutrality and anonymity. Strupp (1977) explains that when Freud articulated the concept of countertransference he was acknowledging that the therapist does in fact develop feelings and attitudes toward the patient which may influence the process and outcome of therapy. Strupp adds that Freud primarily addresses himself to the ways in which the therapist's feelings and attitudes were sources of interference and negative influence in the therapy relationship which needed to be eliminated. Strupp explains that Freud's interest in the technical factors in psychotherapy precluded emphasis upon the "'good human relationship'" the therapist provides the patient, which has significant curative aspects (p. 10).

In a similar vein Frank (1977) asserts that the primary disclosures in the literature of the therapist's personal responses to patients are limited to examples of countertransference which have been viewed in a pejorative

way. He summarizes changes which have evolved in the concept of countertransference that have been outlined in the literature (Singer and Luborsky, 1977; Wolberg, 1977; Menninger, 1958). The classicist view is that the presence of countertransference in the therapy is a source of interference. Its origins may be in the unconscious response of the therapist to the patient's transference. The therapist may also experience transference to the patient as a figure from the therapist's early life. The totalists or modernists define countertransference as the therapist's total emotional response to the patient including both conscious and unconscious reactions. These responses may be to the real qualities of the patient, as well as to his transference, and may emanate from the therapist's realistic needs in addition to his neurotic ones. Frank states that the two views overlap but that the classicists minimize the usefulness of countertransference and stress the need to resolve it, while the modernists believe that although resolution must occur, the countertransference is very useful in understanding the patient. Frank concludes that the modernist view legitimizes the therapist's subjective reactions to patients and frees the therapist to experience them fully and use them constructively. He feels that the classicist view of countertransference as problematic and detrimental to the therapy has resulted in suppression of personal disclosures of the therapist's feelings in the literature.

Frank mentions that there have been contributions

to the psychoanalytic literature which are notable exceptions to the norms proscribing disclosure of the therapist's personal reactions. Winnicott (1949) claims that countertransference includes the analyst's love and hate reactions to the actual personality and behavior of the patient. He believes that in order to work successfully with psychotic patients in particular, the analyst needs to be free to hate the patient objectively.

Searles (1959) states that psychoanalytic norms caused him to feel troubled by his experience of strong positive feelings toward patients. He proposes that for successful termination of analysis the analyst must have experienced and resolved his countertransference to the patient as a deeply cherished and desired figure on an oedipal-genital level. Frank cites Racker's (1968) assertion that Freud's case notes about some of his actual work with patients suggests that he felt free to be active and expressive with his patients. According to Frank, this observation led Racker to postulate the need for a positive countertransference in successful therapy.

In their empirical investigation of attitudinal factors within the therapist in the therapy situation, Strupp and Wallach (1965) note that their findings are inadequately described by the concept of countertransference. Investigators Howard, Orlinsky, and Hill (1969) state that the feelings of the therapist in the therapy situation have been relatively unexamined in empirical studies because of the

psychoanalytic tradition of labelling such feelings as harmful countertransference intrusions into the therapy of elements of the therapist's own neurosis. They state that the proscription of all feelings imposed by the psychoanalytic tradition has been more recently replaced by the prescription of positive feelings toward the patient by proponents of the client-centered approach. More recently Orlinsky and Howard (1977) begin a discussion of their studies of the therapist's experience of psychotherapy by describing the misleading bias in the literature that the therapist does not participate as a person in the therapy and that he has no subjective experiences worthy of study. They explain that this bias reflects the ambivalence of therapists about their personal involvement in therapy.

Literature emphasizing the existence of the therapist's personal reactions in the therapy situation

In addition to those who address the ways in which the concept of countertransference has limited discussion of the therapist's feelings and attitudes, there is a large body of literature devoted to counterbalancing the classical psychoanalytic image of the impersonal, anonymous therapist. Analytic theorists as well as those who study the nature and impact of all forms of therapy have pointed out that the therapist does in fact experience a wide range of feelings in the therapy situation which are influenced by his personal attitudes. Moreover, there is general consensus that the therapist's personal feelings and attitudes have an

important impact upon the process and outcome of therapy.

Fromm-Reichmann (1950) cautions against neglecting the significance of the dynamics of the actual doctor-patient relationship as opposed to its transference aspects. Anna Freud (1954) states that the analyst and the patient are two real people in a real personal relationship to each other. Menninger (1958) asserts that psychoanalysis is not something which happens to one person but that it is a "two-party transactional relationship" in which the therapist must be both the "surgeon" who sets aside his feelings and also a warm, human, friendly, and helpful physician (p. 85). Stone (1961) proposes that there is a "real and actual integrated personal relationship" which exists between analyst and patient in addition to the transference-countertransference relationship (p. 55). He claims that the analyst's own personality is involved in his work to a far greater degree than exists in other branches of medicine. Greenson (1967) also discusses the realistic and genuine relationship between patient and analyst and claims that the analytic relationship is a "complicated and fragile human predicament for both parties" which involves more than intellectual and theoretical considerations (p. 378). Greenson and Wexler (1969) state that the real relationship between patient and therapist supports the patient's tolerance for and endurance of the analytic situation. They feel that failures of humanness on the therapist's part are much more difficult to remedy than are technical errors.

More recently Marmor (1973) states that the real personalities of both patient and therapist significantly affect the process by which new learning occurs in psychoanalytic therapy. Dickes (1975) points out that the International Psychoanalytic Congress (1969) devoted an entire panel to the relationship between patient and therapist. He says that the spontaneous real reaction which both parties in therapy have to one another influences the course of therapy and the development of the working and therapeutic alliances. Guntrip (1977) states that psychoanalytic therapy is a process of interaction of the personalities of two real people in all its complex possibilities. Strupp (1977) postulates that all forms of psychotherapy are sustained by nonspecific interpersonal factors and that therapy is a significant human experience in which the therapist provides the patient with a good human relationship.

Kiesler's (1966) discussion of myths prevailing in therapy research is often mentioned in empirical studies of therapy. Kiesler describes the therapist uniformity myth which he feels ignores the growing body of evidence that therapists are quite heterogeneous along dimensions of attitude and personality. He asserts that these differences seem to influence therapy outcome. In a comprehensive article reviewing the empirical research literature on values and psychotherapy Kessel and McBrearty (1967) state that contrary to the traditional concept of the therapist's neutrality, their review indicates that the therapist does not

function outside of his own value system. They conclude that the interaction of therapist-patient value orientations affects therapy outcome and that similarity of values is an important antecedent of interpersonal attraction. There have been numerous subsequent empirical investigations which draw mixed conclusions about the effects upon therapy outcome of therapist-patient similarity in values and personality. Reviews of this research appear in Meltzoff and Kornreich (1970), Luborsky et al. (1971), Howard and Orlinsky (1972), Bergin and Strupp (1972), and Berzins (1977).

One of the lines of inquiry about therapist-patient matching and similarity involves the A-B variable first discussed in 1954 by Whitehorn and Betz (see Razin, 1977). They found that therapists with different vocational interest patterns were differentially effective with schizophrenic patients. Later work suggested that differential effectiveness with outpatient neurotics also correlated with differences in vocational interest patterns. Razin (1977) comprehensively reviews the research in this area and concludes that the A-B variable is not a powerful predictor of any important process or outcome parameters in real, ongoing psychotherapy.

In an empirical study of therapists' values and attitudes about their patients, Goldman and Mendelsohn (1969) assert that their own work is based on the growing recognition that the therapist's attitudes and personality importantly affect the therapy process. In their 1970 book on

research in therapy Meltzoff and Kornreich describe therapy as a two-way interpersonal relationship which can arouse personal feelings of varying intensity in the therapist. In another book reviewing psychotherapy research Bergin and Strupp (1972) conclude that the therapist's personal reactions to patients influence the course and outcome of therapy. The therapist's personality dispositions, interests, cultural background, and areas of conflict and anxiety influence the therapeutic interaction as well. They describe the therapist as "a person exerting personal influence rather than simply an expert applying techniques" (p. 18). They reiterate that "therapists cannot be regarded as interchangeable units" and that depending on variables in their personality, training, and experience, different therapists exert different effects (p. 8).

Literature stressing importance of positive therapist feelings to therapy outcome

Not only do theorists and empirical researchers concur that the therapist does have feelings in the therapy situation which affect therapeutic process and outcome, but some go further to postulate that in order to produce successful therapy outcome, the therapist's attitudes and feelings should be positive, warm, and involved. In order to establish a good therapy relationship it is felt that the therapist must create an atmosphere of trust, respect, acceptance, understanding, and empathy. The therapist's

experience of positive feelings of involvement with the patient in the therapy work has been heralded by some as an absolute prerequisite of therapeutic movement. The absence of such positive feelings or the presence of negative feelings about the patient have been associated with outcomes in which patients are made worse as a result of therapy.

Stone (1961) states that the analyst behaves as "both the mother of bodily intimacy and the mother of relative separation" (p. 110). He claims that the therapist should feel a kindly, helpful, tolerant and friendly interest in his patient and that a "failure of a palpable human relationship" will result in spurious qualities in the transference (p. 62). Greenson (1967) states that the analyst's role entails motherly aspects and that a certain degree of compassion, friendliness, warmth and respect for the patient is "indispensable" and "an absolute requirement" (pp. 379 and 391). He believes that to understand a patient fully, more than intellectual or theoretical considerations apply. The therapist must like the patient and must be able to become emotionally involved and committed to him. Greenson asserts that "generalized emotional withdrawal and uninvolvement with the patient" make the therapist unable to do the analytic work (p. 400). In a more recent article Greenson (1977) reiterates that empathy is a special variety of intimacy and that the therapist cannot empathize coldly but must be willing to become emotionally involved with the patient. He refers to the therapist's ability to empathize

in this fashion as an "absolute prerequisite" for psychoanalytic practice (p. 101). Guntrip (1977) asserts his belief that the personal relationship is the therapeutic factor in analysis and that to find a genuinely good object in one's analyst is a real life experience like that of having a good parent. Frank (1977) states that analytic techniques are optimally effective only when they are used in the context of a real, caring, human relationship.

In both theoretical writings and empirical studies Strupp and his collaborators refer to the therapist's creation of a good therapy relationship in which he himself experiences warm, positive feelings toward the patient as the "sine qua non" of therapeutic improvement (Strupp, 1958; Strupp, Wallach, Wogan and Jenkins, 1963; Strupp, Wallach and Wogan, 1964; Bergin and Strupp, 1972; Strupp, 1974; Strupp, 1977). Orlinsky and Howard (1975, 1977), who have developed the Therapy Session Report to investigate the therapist's experience as it occurs in the therapy hour, conclude that the therapist's feelings of warm, positive, personal involvement with the patient are associated with positive therapeutic movement. They state that the passive-receptive, detached and neutral attitudes of the therapist characterized by classical psychoanalysis are correlates of poor therapy sessions. In contrast, good therapy sessions are associated with genuine warmth, affective expressiveness, and interested, involved, intimate feelings on the part of therapists.

Rogerian client-centered therapy researchers comprise another group of investigators whose findings relate therapist positive feelings to good therapy outcome. Meltzoff and Kornreich (1970) trace the development of this group's work. In 1957 Rogers posited that the most important necessary and sufficient conditions for therapeutic change are the conditions of nonpossessive warmth, accurate empathy, and genuineness, which the therapist offers the client. Truax and Carkhuff (1967) developed a five point scale to measure the degree of these therapist-offered conditions present in the therapy hour, and a large body of research has been devoted to studying the relationship between these factors and therapy outcome. Among those who propose that high levels of these therapist offered conditions are associated with a high degree of therapy improvement or that low levels are related to patient deterioration are Traux and Mitchell (1971) and Lambert, Collins, and Bergin (1977). Other researchers who have not found the presence of these therapist offered conditions to correlate with successful therapy outcome or who question the validity of positive findings are Meltzoff and Kornreich (1970), Garfield and Bergin (1971), Sloane et al. (1975), Staples et al. (1976) and Mitchell et al. (1977). Mitchell et al. review studies in this area and state that conclusions about the relationship between these interpersonal therapist skills and client outcome have not been investigated adequately. Sloane et al. and Garfield and Bergin assert that the Truax group factors

may not relate to non-client-centered therapies and that the findings of this group are probably not replicable in therapy situations which are not client-centered.

Therapist negative attitudes and deterioration in therapy

Bergin (1971) reviews 23 studies showing deterioration effects in which some patients were made worse as a result of therapy. He indicates that personality variables in the therapist are related to deterioration. Truax and Mitchell (1971) state that there is evidence that low levels of therapist empathy, warmth, and genuineness are important factors leading to patient deterioration. Ricks (1974) examines the therapy notes of two therapists who treated virtually identical groups of child patients. One therapist's patients were felt to show unsuccessful outcome when adult adjustment was measured. This therapist seemed frightened by the patients' serious pathology. He tended to spend less time with them and became caught up in the patients' sense of hopelessness.

Hadley and Strupp (1976) sent open-ended letters to a sample of expert clinicians, theorists, and researchers, asking what factors might be associated with negative effects in therapy. Therapist variables which the respondents associated with negative outcome were the therapist's coldness, excessive unconscious hostility, pessimism, and absence of genuineness. The respondents also felt that negative outcome could result from the therapist's lack of respect for

the patient's pain, a disappointed attitude toward the patient and his progress, and countertransference feelings which prevented the establishment of a working alliance. Lambert, Collins and Bergin (1977) review the literature on deterioration effects in therapy and give examples in which the therapist's negative attitudes and feelings were associated with patient deterioration.

Therapist preferences: the Yavis syndrome

Since the therapist is affected by conscious and unconscious feelings and attitudes he experiences in the therapy situation, his relationship with the patient entails the unique interaction of two real personalities. The topic of therapist preferences for work with particular patients arises in this context. The notion that the therapist must establish a good working relationship with the patient in order to do effective therapy work also relates to the concept of preference, if it is assumed that as a unique individual, the therapist will not be able to form an equally good relationship with all patients.

The Yavis syndrome is prominent in the literature on therapist preferences. William Schofield first proposed the concept of the Yavis syndrome in Psychotherapy: the Purchase of Friendship (1964) which combines empirical research with social criticism of the role of therapists in American society. Schofield states:

> . . . there are pressures toward a systematic selection of patients, pressures that are perhaps subtle

> and unconscious in part and that, in part reflect theoretical biases common to all psychotherapists. These selective forces tend to restrict the efforts of the bulk of social workers, psychologists, and psychiatrists to clients who present the "Yavis" syndrome--clients who are youthful, attractive, verbal, intelligent, and successful (p. 133).

Schofield claims that Yavis patients are the preferred patients of the three major professional groups of psychotherapists. Considerable research literature has been based upon the assumption of the validity of the Yavis syndrome. Although other studies refute its validity, the data on which it is based have not generally been examined. For this reason the data gathered by Schofield as the basis for his proposition of the Yavis syndrome will now be reviewed.

Schofield sent questionnaires to a randomly selected subsample of each of the three professional groups of therapists. Each therapist was asked to describe his "'Typical Psychotherapy Case'" (p. 129). The "expressed preferences" of therapists were also sampled by asking each therapist to "indicate the characteristics of his 'ideal' patient, that is, 'the kind of patient with whom you feel you are efficient and effective in your therapy'" (p. 130). The major limitation to the validity of the Yavis syndrome is that Schofield draws conclusions about therapists' attitudes without studying their attitudes. His data do not measure therapist attitudes but consist instead of therapist ratings of six demographic-socio-economic characteristics of "typical" and "ideal" patients. Furthermore, Schofield does not specify to what degree the Yavis syndrome is based upon his findings

for "ideal" patients and to what degree it reflects his findings for "typical" patients. This is an important source of confusion because he concludes that therapists actually limit their practice to treating Yavis patients. Yet if the Yavis patient is based on an "ideal" composite fiction, it seems groundless to indict therapists for their actual practices.

If the Yavis patient is based upon findings for "ideal" patients, Schofield draws the erroneous conclusion that if an individual between the ages of 20-40 has some degree of education beyond the high school level and works in a professional-managerial job, then that individual is Youthful, Attractive, Verbal, Intelligent and Successful.

If the Yavis patient is based on findings for the "typical" patient, the data show that social workers' typical patients have an eighth grade-high school education and work as unskilled or skilled laborers. The typical patients of psychiatrists have a college education or additional advanced degree and do professional-managerial work. The characteristics of psychologists' patients fall in between these two extremes. These data do not support Schofield's claim that the three major professional groups of therapists restrict their efforts to work with a homogeneous group of patients showing stereotypically "attractive" characteristics.

Schofield's description of the "non-preferred patient," whom therapists "do not expect to be able to reach effectively" is also based on therapists' ratings of demographic-socio-economic characteristics (p. 133). He claims

that the non-preferred patient may be too young or too old (under age 15 or over age 50), may be widowed or divorced, may have less than a high school education or post-graduate training, and may be employed in services, agriculture, fishery, forestry, semi-skilled or skilled labor.

Studies suggesting that therapists prefer Yavis patients

Goldstein (1971) states that his research efforts focus upon the type of therapist-patient dyad suggested in the Yavis syndrome of Schofield. Goldstein asserts that "Mr. Yavis is apparently the type of patient with whom we all like to work" (pp. 6-7). Goldstein claims that Mr. Yavis is a patient who tends to be introspective and psychologically-minded or who at minimum can be trained in these behaviors by the therapist. He states that Mr. Yavis typically comes to therapy with the expectation of participating actively in the process and that his in-therapy behavior is characterized by high rates of verbalization and self-exploration. He explains that Mr. Yavis displays "a full array of the 'good patient behaviors' which clinical lore has taught us is likely to lead to a favorable therapeutic outcome" (pp. 6-7).

Goldstein's comments illustrate the way in which the Yavis syndrome has been interpreted and perpetuated in the literature. Goldstein redefines the Yavis syndrome concept as if it were based upon therapists' evaluations of patient role-related qualities and in-therapy behaviors

rather than upon demographic-socio-economic data. He perpetuates the assumption that "all" therapists prefer patients whom they perceive to have those qualities which are traditionally associated with successful outcome of psychodynamically-oriented therapy. The limitation of the validity of this assumption is that it overlooks the contribution of the individual therapist's personality to the shaping of preference, in focussing exclusively upon patient characteristics as the determinants of therapist preference.

In an empirical study of the effectiveness of psychotherapy versus behavior therapy, Sloane et al. (1975) state that there is considerable evidence that therapists prefer Yavis patients. Sloane et al. further elaborate the definition of the Yavis syndrome in claiming that not only do therapists assume that such patients have good prognostic qualities but that "these patients apparently have better outcomes" (p. 43).

They conclude from their own study that the results confirm clinical traditions and support the Yavis syndrome. At the end of four months of therapy the therapists in their study completed 10-point rating scales measuring the therapist's degree of liking for the patient, how interesting he found the patient, and how often he felt uncomfortable. In describing their results they provide their own operational definitions for the Yavis characteristics. They state that the patients showing most improvement in therapy were "more attractive (considered more likeable by the therapist),

more verbal (spoke more during therapy and in longer speech units, and gave faster reaction times when they spoke), and more 'successful' (higher income, less clinical pathology)" (p. 209). This specification that the Yavis patient exhibits little psychopathology is a further elaboration of the original meaning of the concept.

Despite the limitations to its validity the perpetuation of the Yavis syndrome in the literature suggests that the Yavis syndrome stereotypes address concerns of socially and politically-minded therapists. The Yavis syndrome is invoked to indict the profession of therapists for limiting their practice to patients of higher socio-economic status. Schofield relates the Yavis syndrome to Hollingshead and Redlich's earlier study (1958) which documented therapist preference for work with patients of higher socio-economic status and showed that lower class patients were excluded from receiving therapy. Socio-economic factors in therapist preference will not be examined in this study because of the limitation imposed by the need to maintain the anonymity of the individuals involved. Aside from specific considerations of social class, the Yavis syndrome concept is invoked to criticize therapists for not making greater efforts to develop new techniques for working with patients lacking the psychological sophistication and interpersonal skills appropriate to patients in psychodynamically-oriented therapy.

Goldstein and Simonson (1971) address some of these concerns in relation to the Yavis syndrome. They state that

Schofield called attention to the major degree to which therapists prefer to work with Yavis patients. Their research program focusses upon the HOUND patient who is homely, old, unattractive, nonverbal, and dumb. The thrust of their attraction enhancement research has been on developing techniques for making psychotherapy more attractive to such patients and for making the patients more attractive to the therapist. They state that such patients have been rejected from therapy for too long and have prematurely been judged unsuitable for treatment.

In addition to the work of Goldstein and collaborators on attraction enhancing techniques in therapy, there have been a number of related studies which use role induction interviews, role induction films, or preparatory socialization interviews in the attempt to enhance patient attractiveness to therapists. These studies constitute a major area in which simple rating scales are used to measure therapists' attitudes about patients. Yet the scales are not interpreted as reflecting therapist attitudes, but rather are felt to measure patient variables of "likeability" or "attractiveness." These studies are predicated on the assumption that therapists uniformly prefer working with patients who possess stereotypically "attractive" characteristics. Among such studies are those of Nash et al. (1965), Sloane et al. (1970), Heitler (1973), Strupp and Bloxom (1973), and Jennings and Davis (1977).

Other investigators who measure patient "likeability"

on a simple rating scale and who suggest that it is a personality variable in the patient are Stoler (1963) and Tomlinson and Stoler (1967). In their studies outside raters assessed patient "likeability" from tape recordings of therapy sessions. In a comprehensive review of quantitative research on factors influencing the outcome of therapy Luborsky et al. (1971) list "likeability" as a patient factor associated with patient attractiveness for therapy. In another review of the literature, Wills (1978) states that among the perceptual dimensions used by professional helpers to describe clients is the factor of client "likeability" or "attractiveness."

Several additional studies provide support for the notion that therapists prefer to work with Yavis-type patients. The Yavis syndrome is not specifically mentioned in these studies, however. In a study of therapist values and attitudes about patients, Goldman and Mendelsohn (1969) asked therapists to describe by means of Gough's Adjective Check List "the type of patient with whom they work best," which they also refer to as the "preferred patient" (p. 164). They found that the adjectives most frequently checked describe the preferred patient as an intelligent, imaginative, sensitive, curious, well-motivated, but anxious individual. The authors conclude that "therapists have found that patients who benefit most from therapy are those with the least amount of manifest pathology" (p. 167).

Kadushin (1969) examines the sociological aspects of

applying for therapy and being accepted for treatment in various types of therapy clinics in a large city. He states that there have been many studies of the characteristics of patients selected by psychiatric clinics and that almost all show that clinics prefer young, non-psychotic, highly motivated, better educated applicants. He claims that preferred patients are able to communicate their feelings to middle-class therapists and that therapists judge them to have a good prognosis for improvement. He claims his research indicates that such patients have the psychological sophistication which makes them acceptable for treatment according to the psychoanalytic model. Yet in contrast to the stereotype that good therapy patient characteristics are associated with higher social class position, Kadushin proposes that individuals from all social classes who have personal contact with what he calls the Friends and Supporters of Psychotherapy, develop the role requirements appropriate to being a patient in psychoanalytically-oriented therapy.

In an article reviewing the empirical research on the relationship of client variables in therapy to external outcome criteria, Garfield (1971) comments about the preference of therapists for patients possessing Yavis-type characteristics. He states that lower class, relatively non-verbal, more severely disturbed clients are often rejected by therapy clinics and are not well received by many therapists. Garfield concludes from his review that in the past the best therapy results have been achieved with clients who are the

least disturbed and who perhaps need therapy the least. Wills (1978) makes a similar comment to that of Garfield about the negative consequences of therapist preference for patients presenting the Yavis syndrome. He asserts that this preference for successful clients works against the interests of those most in need of psychological help. Other investigators who state that therapists prefer to work with patients having Yavis-type characteristics are Rabkin (1977) and Lambert et al. (1977).

Stein et al. (1972) conducted a study in which residents at a psychoanalytically-oriented hospital were presented with four case history vignettes. Represented in the vignettes were a middle class neurotic patient, a middle class schizophrenic, a lower class neurotic and a lower class schizophrenic patient. The therapists completed rating scales assessing the patients' likeability, prognosis, and the respondent's interest in treating the patient with therapy. In comparison to the schizophrenics, the neurotics were preferred by the residents, who regarded them as having a more favorable prognosis. It is noteworthy that in their conclusion the authors urge that increased specificity is needed in the conceptualization and operationalization of "likeability."

Del Gaudio et al.(1976) did a similar study based on research findings that therapists have more favorable attitudes toward patients who are middle class, insightful, and neurotic. They state that the degree to which such attitudes

reflect bias as opposed to accumulated wisdom based on actual clinical differences among patients is unclear. They presented 33 therapists with five years' or less experience treating outpatients, with 8 case histories. The variables of patient diagnosis, insight level, and social class were systematically varied. In the case histories the neurotic patients suffered from anxiety, depression, tension, or worry. The schizophrenic patients had symptoms including hallucinations, delusions, and incoherent speech. High insight patients had at least above average intelligence and ability to articulate emotional and/or relationship problems. The low insight patients had average intelligence and used defenses such as denial, projection, and somatization.

The therapists completed rating scales for each case history. They rated the degree to which they found the patient a likeable person, the degree of initial comfort they thought they would feel with the patient, their degree of interest in treating the patient, and the patient's prognosis, among other factors. The authors found that therapists clearly held more favorable attitudes toward neurotic, high insight patients, but that social class was not a salient determinant of therapist attitudes.

These two studies are examples of the most simplistic way in which therapist preferences have been examined in the research literature. By presenting therapists with only two extreme choices on the dimensions of pathology and psychological-mindedness, little new can be learned of value about

therapist attitudes toward real patients. The finding that therapists prefer to treat anxious, intelligent, insightful individuals over hallucinating or delusional schizophrenics serves only to reinforce stereotypes. The use of simple rating scales unsupplemented by other methods of assessment also seems an inadequate way to examine therapist preferences. Berzins (1977) comments upon the negative impact of the "widespread assumption" that therapists prefer Yavis patients and reject non-Yavis patients for treatment (p. 232). He claims that therapists' continued belief that non-Yavis patients lack the proper attitudes, expectancies, or motives toward therapy could serve as a source of incompatibility between patient and therapist. He feels that therapists' belief that Yavis patients are the preferred candidates for therapy may constitute a self-fulfilling prophecy when therapists encounter non-Yavis patients as therapy applicants.

Studies showing individual differences among therapists in their patient preferences

The studies to be discussed here emphasize that characteristics ranging from patient attractiveness to degree of patient pathology may be perceived and evaluated differently by different therapists.

The studies provide evidence that the Yavis syndrome is a stereotype about therapists' attitudes which has only limited validity, despite the serious questions it raises about the social-political aspects of therapists' values and practices. The studies to be reviewed here also indicate

that the method of investigation of a problem influences the results obtained. These studies tend to focus in detail on the individual therapist's attitudes about particular patients and the results show variation among therapists in their patient preferences.

Several studies by Strupp, Wallach, and collaborators examine individual differences among therapists in their patient preferences. Strupp (1958) employed a 30 minute sound film of an initial interview between a patient and therapist. The film served as a constant stimulus to which therapists were asked to respond as vicarious interviewers, in order to study individual differences among them. There were stopping points in the film in which the therapists wrote their responses to the question, "What would you do?" After viewing the film, each of the 237 therapists completed a questionnaire including ratings of his diagnostic impressions, treatment plans, goals, and attitudes toward the patient. Strupp describes the film patient as a very aggressive, demanding, manipulative individual who was likely to evoke emotional reactions in the therapists.

Strupp found that the therapist's conscious attitude toward the patient was positively correlated with his clinical evaluation, his treatment plans, goals, and proposed techniques. He states that there were impressive differences among therapists in their attitudes toward the patient, in their degree of willingness to engage in a therapy relationship with him, and in their degree of empathy for him. In

order to convey the wide range of therapist responses, the study included quotations from several therapists in response to particular points in the tape. The therapists' responses ranged from empathic remarks to moral judgements and condemnations. Concerning the variation among therapists in their degree of preference for the patient, 30% had somewhat positive attitudes toward him, 20% were neutral, 38% were somewhat negative and 10% were ambivalent. Thirty-six percent of the therapists commented on the patient's unpleasant personality characteristics and almost the same percentage stressed his personality assets.

There was a clear positive correlation between therapist attitude and prognosis. Therapists having a negative attitude toward the patient were likely to choose an unfavorable diagnosis such as psychopath, character disorder, or paranoid character. These therapists saw the patient as having a significantly poorer prognosis than those with positive attitudes. Negative therapist attitudes were also associated with perceiving that the patient was less insightful, less capable of self-observation, more emotionally immature, more poorly socially adjusted, and less anxious. A very high proportion of therapists with negative attitudes anticipated that therapy would produce very little change in comparison with therapists holding positive views about the patient. Those with positive attitudes advocated more intensive therapy for the patient, while those with negative attitudes prescribed more limited supportive treatment.

Of the group of therapists who had moralistic and harsh attitudes and approaches in reaction to the patient's demanding and manipulative qualities, Strupp says that culturally determined stereotypes may have a pervasive influence upon therapists' views that certain behavior disorders are untreatable. Strupp concludes that his findings suggest clinical impressions and therapeutic planning are influenced by attitudinal variables within the therapist.

Strupp and Williams (1960) asked a famous British psychoanalyst and a young American psychiatrist to independently interview the same 22 psychiatric inpatients. The therapists rated 14 variables on a five-point scale including their liking for the patient as a person and their willingness to treat the patient. Although the two therapists agreed in their preference for patients who were non-defensive, insightful, and well-motivated, there were idiosyncratic factors in the therapists that affected their evaluations and preferences. The authors state that aspects of the two therapists' needs, values, and methods of perceiving the world are reflected in their responses. One of the therapists saw the patients as more defensive and more seriously disturbed in comparison with the other therapist. This therapist liked the patients more, felt that they were more emotionally mature, and advocated less supportive treatment relative to the other therapist.

Wallach (1962) measured therapists' patient preferences on a seven-point scale which assessed the therapist's

degree of willingness to see the patient in therapy. Therapists also rated the patient's degree of disturbance. Wallach then separately compared only those patients rated most seriously disturbed with those rated least seriously disturbed. Only when the two groups representing extremes of disturbance were compared did therapists prefer to work with the least disturbed patients. This methodological distinction is important in relation to those studies which present therapists with only two extreme alternatives of patient pathology and conclude that therapists prefer Yavis-type patients.

Strupp and Wallach (1965) elaborated upon the 1958 Strupp study, using two sound films showing interviews with two different patients to whom therapists responded on paper as vicarious interviewers. They found that there was a positive correlation between therapists' positive attitudes toward the patients and their favorable clinical assessment. The authors assert that the therapist's personal responses and his clinical judgements are confounded such that the direction of causation is indeterminate. Strupp and Wallach state that the therapist responds simultaneously as both an objective clinician and as a person. He appraises and judges in the context of his clinical experience, while at the same time responding as a human being to another human being.

A paradoxical aspect of the study is that the therapists as a group preferred one of the patients to the other. The preferred patient was in several respects one who would

be non-preferred according to the Yavis syndrome. The preferred patient was rated more seriously disturbed, was given a poorer prognosis without treatment, was seen as having more severe reality problems, and was considered more likely to become psychotic than the non-preferred patient. The non-preferred patient was perceived as manipulative and as glibly glossing over his exploitative characteristics. Strupp and Wallach comment that widely and popularly held negative attitudes about the psychopathic behavior of this patient seem to have influenced the therapists' assessments. They suggest that the next task for investigation would be to study more intensively the fit between a particular patient and therapist. They advocate investigating the therapist's reaction to a single case rather than studying group trends. They state that although group trends are more reliable on statistical grounds, they tend to obscure what might be demonstrated more clearly in a single case.

Although these findings are an important contribution to the literature, they are limited by the fact that therapists' attitudes about actual patients in an on-going therapy relationship were not studied. The measurement of attitudes only in the initial interview, in combination with the vicarious nature of the therapists' interaction with the patient, may have resulted in emphasis on the degree to which the patient's presenting characteristics influenced the therapists' feelings of preference.

Two additional studies by Strupp et al. (1963 and

1964) also suggest that the therapist's clinical judgements and personal preferences and attitudes are confounded. Highly experienced therapists completed rating scales indicating their degree of liking for former patients they had treated for a considerable length of time. Therapist preferences were found to correlate with therapist perceptions of the degree to which therapy was successful. The examination of therapist preferences for patients in their naturally occurring caseloads with whom they had extensive contact is an unusual feature of these studies.

Another unusual approach to the examination of therapist preferences was undertaken by Wallach and Strupp (1964) in a study of therapist preferences for and attitudes toward therapeutic practices hypothesized to be fairly basic in therapy. This study focusses upon individual differences in the ways in which therapists prefer to act in the role of therapist. On the basis of their own clinical experience and the results of other studies, Wallach and Strupp developed a 17 item rating questionnaire which therapists completed.

Factor analyses of the results yielded several factors. The strongest factor involved therapist preference for personal involvement in the therapy relationship versus maintenance of personal distance. Another factor involved variations in therapist preferences for expectantly allowing transference feelings to develop versus actively manipulating the transference. The authors suggest their findings may

reflect basic temperamental differences among therapists in their preference for indirection and restraint versus active direction in solving life problems. They feel that these differences are relevant to preference for doing psychoanalytic therapy versus other forms of therapy.

Garfield and Affleck (1961) asked 20 therapists to complete rating scales evaluating patients on the basis of intake reports read at staff meetings in which cases were considered for outpatient therapy. They found that ratings of patient prognosis were highly correlated with feelings of the therapist about the patient and with interest in taking the patient into treatment. Like the Strupp group, they state that it cannot be said whether therapists like patients with good prognosis or whether a good prognostic rating is given to patients to whom therapists respond in a personally positive fashion. Each therapist was also asked to list in an open-ended way the therapeutic assets for each patient. Garfield and Affleck state that although there was some agreement among the therapists concerning desirable features in a therapy patient, there was also variation among therapists concerning the frequency with which they considered certain features to be patient assets. For example, they explain that one therapist listed intelligence as an asset of patients in 12.5% of the cases, while another therapist listed intelligence as a patient asset in 50% of the cases. Raskin (1961) and Brown (1970) also conducted studies in which therapist ratings of initial liking for patients were positively

correlated with perceptions of the patient as showing favorable prognosis.

Lowinger and Dobie (1966) studied the attitudes and emotions of 16 psychiatrists in the initial interview with patients whose diagnoses included schizophrenia, depression, neurosis, brain syndrome, and character disorder. Following the interview the therapists completed five-point rating scales assessing patient characteristics. The therapist's liking for the patient and his willingness to treat the patient were rated as well. They found that therapist attitudes varied as a function of the therapist's personality and were unrelated to patient diagnosis. The authors conclude that therapist attitudes reflect factors in the therapist rather than factors in the patient. This conclusion was supported by the finding that there were no significant correlations between the ratings of two interviewers who inadvertantly assessed the same patients. Other studies in which therapist ratings of liking for patients or preference for work with them were found to reflect individual personality factors in the therapist are Gottschalk et al. (1967), Gassner (1970) and Goodwin et al. (1978).

Literature in which patient preferences of therapists are examined on the basis of therapists' anecdotal accounts

The literature which bears most directly upon the way in which therapists' patient preferences are examined in this study will now be described. In the literature on

the selection of patients for therapy the topic of therapists' patient preferences is addressed. It is asserted that a given therapist will tend to work better with some patients than with others. The way in which the therapist's values and attitudes interact with the personality of the patient is discussed as a determinant of more effective or less effective therapist-patient combinations. It is noteworthy that writers tend to address the issue of whether therapists should reject for treatment those patients whom they least prefer, rather than focussing on the process whereby a therapist might strive to select those patients who would be most preferred by him.

Fromm-Reichmann (1950) discusses the psychiatrist's like or dislike of a patient as an interpersonal problem facing him in the establishment of the therapy relationship. She states that it is the therapist's privilege to reject for treatment a patient whom the therapist dislikes as a person. She adds that if a therapist likes or dislikes a patient he is treating, the reasons for this generally do not reside in the patient's personality. She states that a patient is often liked because of the satisfactory progress he is making in treatment. She asserts that the therapist may feel grateful to the patient for making his work life more meaningful by responding well to his therapeutic efforts. In contrast she states that if a therapist dislikes a patient, it is often because the therapy has become stagnant. This may result in the therapist's experience of doubts about his thera-

peutic skills or about the purposefulness of his career. She finds countertransference feelings of unresolved anxiety in the therapist in reaction to a patient an even more significant reason why a therapist may dislike a patient. Fromm-Reichmann advises that once a therapist decides to accept a patient for treatment, the categories of liking and disliking should become void of meaning in the therapy work. Fromm-Reichmann states that her views do not suggest that "every therapist should expect to be capable of treating persons suffering from any type of personality disorder" (p. 40). She believes that the contrary is true and that during the course of his career the therapist should "learn to find out what type of patients respond best to his personality as it colors his type of therapeutic approach" (p. 40).

Leo Stone (1961) states that the therapist's personal reactions to patients are as varied as those occurring in any other situation. He claims that the therapist cannot react to all patients in an enthusiastically positive way. The therapist's value system, interests, and general outlook on life may differ widely from those of many patients. Nonetheless he claims that a conscientious therapist can treat effectively an individual with whom he feels little in common "from the point of view of his everyday interests and preferences," as long as he doesn't find the patient "actually and insuperably repugnant" in some way (p. 44). If he does, Stone feels that the therapist may not be able to meet his professional commitment to the patient, since his

own personality is involved in the work. Stone's viewpoint is that a therapist may be able to work effectively with a patient whom he does not particularly prefer as a person, but that he may not be able to work effectively with a patient whom he "least prefers" as a person.

Greenson (1967) expresses a similar view to that of Stone. He states that if the therapist experiences strong negative reactions to a patient, it may be that the therapist cannot work well with the patient. He claims that his personal experience has taught him he cannot work effectively with some patients who are very reactionary in their political or social views. He says that the therapist must be outspoken when he feels that he and the patient are in basic disagreement on a social or political issue important to each of them. He explains that depending upon the intensity of his own feelings and the degree to which he finds the patient's other qualities likeable, he either suggests or insists that the patient seek treatment elsewhere.

In a discussion of therapist-patient matching Berzins (1977) states that in the clinic setting, patients are typically assigned to therapists either using a rotation system or on the basis of the secretary's intuition. Matching procedures in which therapists select patients are not generally employed. He comments that although most therapists readily admit that they perform better with some patients than with others, their training regimen has inculcated them with the notion of universalizing themselves and behaving as

though they could be of decisive benefit to almost all patients. He feels that therapists are not trained to pay special attention to the conditions under which their skills wax and wane relative to the types of patients they encounter. He describes problem cases all therapists face and asserts that such patients are perplexing, make their therapists squirm, and call attention to therapists' blind spots. It seems likely that such patients constitute "least preferred" patients of therapists.

Michael Stone (1971) provides a study of what he describes as "favorite" patients of therapists, involving specific real patients in therapists' naturally occurring caseloads. The study consisted of extensive retrospective interviews with ten therapists about their work with one particular schizophrenic patient. The therapist-patient combinations were selected by Stone on the basis that each patient had attained an unexpected degree of success in therapy relative to his initial prognosis. That the data for the study consist of direct interviews with therapists about their feelings for actual patients is unusual in the literature.

Stone found that among the ten patients, four evoked special feelings of attraction and sympathy from the therapist and were considered by the therapist to be his "favorite" patient. Stone concluded that in the work with all ten patients, each therapist had an object-specific countertransference reaction in which the patient was identified with

some past person in the therapist's life. Stone asserts that the object-specific countertransference allowed the therapist both to enjoy the patient and to work effectively with him. Stone states that the therapists' personal reactions to the patients enabled them to enjoy patients whom others found unlikeable. He claims that if the therapists had not enjoyed the patients they would not have been likely to commit themselves to the demanding, long, and uncertain task of working in therapy with schizophrenics.

An investigation by Ricks (1974) includes specific clinical illustrations relevant to the topic of therapists' patient preferences. Ricks studied the effects of two therapists' methods upon therapy outcome. He examined the therapy notes of two therapists who had treated virtually identical seriously disturbed child patients in a child guidance clinic. Using adult adjustment of the former patients as the therapy outcome criterion, he found that the patients of the two therapists showed markedly different outcomes.

Ricks explains that the successful therapist showed attitudes and approaches which were quite different from those of the unsuccessful therapist. The successful therapist responded to the seriously disturbed patients by becoming more involved with them and attempting to develop a strong therapy relationship to help anchor the child in reality. Ricks suggests that the successful therapist seemed to be unusually open and unthreatened by feelings of extreme love or hostility. In contrast, the unsuccessful therapist

had a distant, cognitive attitude toward feelings and appeared to be frightened by the patients' pathology. He tended to respond only to feelings of anxiety and depression in the patients and got personally caught up in such feelings. The result was that he seemed to reinforce the patients' depression and hopelessness. The unsuccessful therapist also responded to his perception that these patients were more disturbed than others by withdrawing and spending less time working with them. Although Ricks' focus is on the relation of therapist methods to differential outcome, the patients described seem to constitute "least preferred" patients of the unsuccessful therapist from what Ricks infers about his attitudes toward them. It may be that for the successful therapist the patients were examples of "most preferred" patients. Yet it is possible that his reasons for becoming closely involved with the patients did not include personal preference for them. It is also possible that his particular effectiveness in working with such patients was independent of his personal feelings about them.

The Human Dimension in Psychoanalytic Practice edited by Frank (1977), is a collection of articles by psychoanalysts about their personal feelings and attitudes in their work. Several of the contributors comment about their personal preferences for work with particular kinds of patients and provide anecdotal descriptions of such patients. In an article describing his own personal analysis with Fairburn and Winnicott, Harry Guntrip comments that the unpredictable

factor of natural fit enters into the relationship between patient and therapist, because all individuals can form a relationship more easily with some people than with others. He explains that when he was a patient of Winnicott, the analyst told him, "'I'm good for you but you're good for me. Doing your analysis is almost the most reassuring thing that happens to me. The chap before you makes me feel I'm no good at all'" (p. 62). In this comment by Winnicott which Guntrip reports, Winnicott seems to be saying that Guntrip is among his "most preferred" patients.

In an article about his personal experiences treating psychotic patients, Rosenfeld states that not all therapists are able or want to treat psychotic patients. He explains that his success in treating psychotic patients is due to his capacity to make sufficient contact with them. He feels that his empathy and insight in working with such patients depend on his capacity to identify himself with aspects of the patient's self.

It seems that Rosenfeld's "most preferred" patients, to whom he has devoted his primary efforts, are those suffering from psychosis. Such patients do not possess the characteristics of preferred patients outlined in the Yavis syndrome, and Rosenberg acknowledges that many therapists do not prefer to work with psychotics. That many therapists have chosen to devote their professional careers to working with and writing about seriously disturbed patients highlights the limited validity of the notion that therapists

uniformly prefer to work with patients possessing stereotypically "attractive" characteristics.

Hilde Bruch's discussion of her ability to work well with anorexic patients whom many therapists cannot treat successfully, provides another example of a therapist's preference for work with non-Yavis-type patients. Bruch states that "the theoretical formulation one prefers as meaningful is closely related to his personality and experiences" (p. 95). She illustrates this by explaining that certain features of her own development have to do with her preference for being active and self-assertive, which she communicates to anorexic patients with therapeutic results. She describes some of the personal antecedents of her refusal to be intimidated by anorexics, which she believes is a reason for her success in treating them.

David Shainberg describes certain peak experiences of personal transformation he has shared with patients in his work with them. He states that there are times when he and a patient are "able to pull together, working for each other's growth and expansion . . . this kind of unity occurred within . . . the mystery of the relationship we came to share" (p. 126). He says that the therapist-patient relationship is like a team coming to the edge of a forest and making its way through each thicket to a clearing through which they can walk together. His use of this imagery is noteworthy because one of the therapists in the present study described his work with most preferred patients

as being like taking a tandem walk through forest and meadows. Although Shainberg does not say explicitly that the patients with whom he has had such experiences are "most preferred" patients, it seems likely that individuals with whom he has shared a special sense of unity and personal growth are among his most preferred.

Conclusions: limitations upon the ways in which therapists' patient preferences have been studied in the literature

This review of the literature suggests that there has been little investigation of therapists' preferences for patients in their naturally occurring caseloads. Acceptance of the Yavis syndrome assumption that therapists uniformly prefer patients having stereotypically "attractive" characteristics may be one reason for the insufficient study of the individual therapist's attitudes toward specific patients he treats. The prevalent method of obtaining simple ratings of therapist attitudes and of reporting findings about the preferences of a statistical majority of a group of therapists, tends to obscure individual differences among therapists in their personal preferences.

Even in the cases in which therapists provide direct anecdotal accounts of patients they most prefer or least prefer, the focus is seldom upon the therapist's attitudes about their patients per se. Although therapists' attitudes about particular patients are examined in such studies as those of Stone (1971) and Ricks (1974), the focus is on

determining why certain therapists are able to achieve successful outcome with difficult patients. Therapist perceptions of what factors in their work with patients are associated with personal satisfaction or dissatisfaction are not generally studied independent of therapy outcome.

The linkage of the concept of therapist preference with effectiveness of therapy is common in the literature. For example, when Schofield (1964) asked therapists about their preferred patients, he defined the preferred patient as one with whom the therapist feels he is efficient and effective. It seems that this linkage fosters the often untested assumption that therapists most prefer those patients with whom they feel they are most successful.

A related limitation to what has been learned about therapists' patient preferences is that researchers tend to prescribe certain variables to be rated by therapists which the researcher hypothesizes to be correlated with therapist preference. Since therapists are not asked in an open-ended way about the factors they associate with their patient preferences, the information obtained in this manner is limited to those variables prescribed by the researcher. Schofield pursued this method in describing the preferred patient of therapists in terms of several demographic-socioeconomic variables which he asked therapists to rate.

The predominant use of simple rating scales to measure therapist liking for patients, interest in treating patients, perception of patient attractiveness, etc., seems

a global and inadequate way of assessing therapist preferences, as several investigators have pointed out. Exactly what is being rated by therapists on such scales is often poorly defined. The terms liking and preference are often used interchangeably in rating studies of therapist attitudes toward patients. It may be argued that the terms are not interchangeable since a therapist may feel a social, personal liking for many patients without feeling that he would prefer to work with them in a therapy relationship. The reaction of the therapist in his work role to qualities in the patient related to the way in which he fills the patient work role, may be a basis for therapist feelings of preference.

In those studies in which therapists are asked to describe an "ideal" patient or are asked to rate their feelings of preference for contrived patients presented in written case histories, little is learned about therapist attitudes about actual patients. The lack of opportunity for therapists to interact with a real patient also limits the usefulness of such studies. In many studies of therapists' patient preferences, the therapist's rating of his preferences is based upon only an initial contact with a real or contrived patient. Those studies in which the therapist's experience of the process and outcome of therapy with a patient form the basis for his preference rating have broader application to clinical practice. A final limitation of many studies of therapists' patient preferences is that the participants tend to be inexperienced therapists-in-

training rather than highly experienced therapists.

CHAPTER III

METHOD

Initial procedures preceding the interviews

I reviewed the attendance records of all counseling service patients of the four therapists participating in the study for the work year just ending. My purpose was to examine the range of number of therapy contacts the therapists had with patients. My aim was to study therapists' preference for patients with whom they had regular therapy contact over a reasonable period of time. I did not feel it would be useful to include in the study discussion of patients with whom the therapists had very minimal contact. I hoped to exclude from the study the influences of patients' very early dropping out of therapy or of attending sessions erratically upon therapists' patient preferences.

It seemed reasonable that a therapist could adequately evaluate his feelings of preference for work with a patient with whom he had a therapy relationship over a three month period. At the university counseling service a therapist would generally have approximately 13 weekly therapy sessions with a patient over the course of three months. The attendance records showed that each therapist saw between 11 and 21 patients for at least 13 sessions, and I estab-

lished that as the criterion for inclusion of patients in the study. It did not seem feasible to establish a maximum number of sessions without restricting further the number of patients from which the therapists were to select three most preferred and three least preferred cases.

On an individual basis I met with each therapist and asked him to complete a background information sheet on which he described his theoretical orientation to therapy and listed his number of years of experience at the counseling service and elsewhere. I also presented each therapist with two rating sheets. On both sheets were listed the names of all patients the therapist had seen for 13 or more sessions during the work year just ending. On one sheet the therapist was asked to rate on a scale from 1-5 the degree to which he "Enjoyed" the work with each patient. (On the scale 1 = most and 5 = least.) On the other sheet the therapist was asked to rate the degree to which "Therapy Helped" each patient. I retained these sheets as an additional source of information about the therapists' views of the patients they later selected to discuss in the interviews.

The interviews

For each therapist the interviews took place during a period of about one week. The length of time spent discussing each patient varied between twenty minutes and one hour. Some therapists discussed two or three patients in one interview session, while others discussed one patient per session. I tape recorded all interviews and took notes

as well.

At the beginning of the first interview I again presented the therapist with a list of all patients he had seen at the counseling service for at least 13 sessions that year. I asked the therapist to select three most preferred patients and three least preferred patients from this list for discussion in the interviews. During those interview sessions in which the therapist discussed more than one patient, I asked that he alternate between describing his work with a most preferred patient and a least preferred patient.

A structured interview format was used. I began the discussion of each patient by asking the therapist why he most or least preferred the patient. I asked him why he enjoyed working with each patient to the extent that he did and how he assessed the degree to which he felt the therapy helped the patient. Within this framework I encouraged the therapists to give spontaneous anecdotal accounts of their work with the patients. If the therapists did not offer information about the patient's age, sex, educational rank, dates of therapy, and frequency of appointments, I asked about these factors. I also inquired about the patient's reason for seeking therapy, how the therapy ended, and whether the patient had previous therapy, if the therapist did not provide this information in his discussion (see Appendix). During a portion of each interview I asked the therapist to reply orally to 20 rating questions which I posed. I developed the questions from the therapists'

responses in the pilot study by categorizing themes the therapists emphasized in common. The rating questions involved the four categories of the patient's characteristics and feelings, the therapist's characteristics and feelings, therapy characteristics and therapy outcome.

The therapist was asked to rate each item on a scale from 1-5. I provided the instructions that anchor point one equals "most" and that anchor point 5 equals "least," and I recorded the responses on a form containing the 20 rating questions (see Appendix). I did not introduce all 20 rating questions at a fixed point in each interview. I used the rating questions for the purpose of focussing the therapist's comments. For this reason, if the therapist brought up an issue which was the topic of a rating question, I interrupted his comments and asked him to rate the question.

Methods of data analysis

The interview material was analyzed by listening to the tape recordings and by consulting the notes I had taken. The tapes were not transcribed verbatim, but several pages of typed quotations were prepared from the taped interview about each patient. The analysis of the interview material was then based upon the resulting profile of quotations for each patient. In order to maintain confidentiality concerning the identity of the therapists and their patients, the interview results were written in a form which deleted all personally revealing details. The therapists are referred to as Therapists A, B, C, and D. For each therapist

the most preferred patients are referred to as MP1, MP2, and MP3, and the least preferred patients are referred to as LP1, LP2, and LP3. In order to maintain anonymity I also resort to the convention of referring to all therapists and to all patients as "he." In order to assess the reliability and validity of my presentation and analysis of the interviews, I asked the four participating therapists to review what I had written about their patient preferences. Each therapist approved of my analysis of the interviews and thought that the contents were reliable and valid.

The rating results provide an additional way of examining and evaluating the interview material. There was no attempt made to generate statistically significant data based on the observations of four therapists. The therapists were not trained to use each point on the 5 point scale in a standardized way. The therapists used the scale according to their personal perceptions, and the ratings constitute their subjective evaluations. For this reason the ratings are not reliable across therapists and the ratings of the four therapists cannot be compared.

The rating results are presented in their original form as separate ratings of three individual patients. In addition, the three individual ratings of most or least preferred patients were summed for each of the 20 questions, yielding summed rating scores for the most or least preferred patient group. Since anchor point 1 on the rating scale represents "most," the summed score of 3 is the most

favorable rating and the summed score of 15 is the least favorable rating. In order to reduce the confusion this rating system may create, the range of summed scores for each therapist has been divided into thirds. The lowest, or most favorable scores, are referred to as the High summed scores. The middle scores are referred to as Moderate summed scores. The highest, or least favorable scores, are referred to as Low summed scores. However, two questions among the 20 were phrased such that higher scores represent more favorable ratings and lower scores represent less favorable ratings. These questions assess the degree of psychopathology shown by the patient and the degree of initial resistance to therapy exhibited by the patient. In their summed score form, the ratings of these items have been converted so that they may be interpreted in the same way as all other scores.

CHAPTER IV

RESULTS

Therapist A: Most Preferred and Least Preferred Patients

Patient caseload from which cases were selected

During the working year at the university therapist A saw a total of 11 patients for 13 or more sessions, the criterion for inclusion in the study.

Description of patients selected by therapist A

After rating the 11 patients on the therapist's Enjoyment of the work and the Helpfulness of the therapy, Therapist A selected three most preferred and three least preferred patients he wished to describe in the interviews. He gave all three most preferred patients a rating of 2 on both Enjoyment and Helpfulness dimensions. Two of the least preferred patients were rated 4 on both Enjoyment and Helpfulness dimensions. The third was rated 5 on the Enjoyment dimension and 4 on the Helpfulness dimension.

The most preferred patient group was comprised of undergraduates, while there were both undergraduates and graduate students in the least preferred patient group. The mean age of most preferred patients was 19.3 and the mean age of least preferred patients was 21. The most preferred

group was seen for an average of 22.6 sessions and the least preferred group was seen for an average of 22 sessions. For both groups the patients had weekly meetings with therapist A. There were instances in both most preferred and least preferred patient groups of interruption of the therapy work followed by resumption of the therapy later in the year. The patients in both groups were seen up to the end of the working year. Two most preferred patients and one least preferred patient had previously been in therapy with therapist A.

There were no striking differences between most and least preferred groups with respect to therapist A's descriptions of the patients' presenting problems. He described a combination of social and academic difficulties for both most and least preferred patients.

Therapist A interviews: most preferred patients

Therapist A indicates that his most preferred patients do not fit the model of attractive candidates for psychodynamically-oriented therapy. When asked why the patients he selected were most preferred, his initial response is to describe their relatively serious psychological disturbance, lack of psychological-mindedness and high resistance to becoming engaged in the therapy process. He also stresses their socially unsophisticated, isolated, waif-like qualities. Therapist A states that there were "more psychological cases" in his caseload, but feels they were not as satisfying

because they were less challenging and difficult. After discussing the last of his most preferred patients, he summarizes his views of them as follows:

> Like the others, he was very difficult. There are some students who take right to this work and sort of breeze right along, and I don't think any of the three were in that category. All three of them came in with a certain degree of skepticism. . . . When it starts out like that and it works, somehow the other is nice . . . but it's not as remarkable as when there's skepticism, resistance, and a lack of fit with the model.

Therapist A developed a primarily supportive therapy relationship with his most preferred patients in which he adopted a benevolent, protective, nurturant, parental role. He states that a major therapeutic factor in his work with most preferred patients is their incorporation of him as a reassuring, uncritical, parental figure. He adds that he does not work interpretively with the patients' positive transference feelings for this reason. A primary source of therapist A's satisfaction in the work with most preferred patients seems to lie in his view that he provided them with an accepting, supportive relationship which was unique in their lives:

> The relationship has to be incorporated and becomes part of the treatment; . . . transference is an inevitable part of that set up. . . . If you work with it you take it away ultimately, one way or another. . . . To try and take that away is taking away a major ingredient in the therapy. . . . To have a relationship with somebody in the adult community . . . who in a relatively uncritical way listens and reassures by just his presence, or sometimes more directly than that. . . . So I've tried to be as benign an omnipotent, omniscient figure as I could. . . . I encourage them to take their own responsibility wherever I felt they could. . . . I

> often feel that a tremendous amount is being taken out of me. . . . I often feel glad I stuck it out, that the student got alot that he needed. . . . When I look it over, while nothing spectacular happened, little things have happened which are big things.

Therapist A feels that his most preferred patients had serious psychological problems and were socially isolated. He describes MP2 as follows:

> He was like a waif for a long time--thin, fogged over, lost. . . . He was socially backward, extremely shy, introverted, very unsavvy about people and feelings. . . . He was very isolated and ill-equipped; . . . descriptively I would say he was mildly schizoid.

Therapist A also describes MP1 as a socially isolated individual with serious interpersonal difficulties:

> His manner suggested that other people weren't important and didn't matter. . . . Nobody was really very important, everybody could be taken or left; . . . there was a whole kind of turning off.

Therapist A feels that his most preferred patients showed a marked absence of ability to think about their difficulties in a psychological manner. He describes them as frightened of confronting the psychodynamic meanings of their problems. In addition to finding them highly resistant to developing insight into their problems, Therapist A feels that they feared and resisted developing an open and trusting therapeutic alliance with him. He says of one most preferred patient:

> He came very reluctantly, very suspiciously; . . . he was always asking why. It took a long time to get him to ask himself why. . . . I saw him at the beginning as being terrified of insight. . . . He didn't know how to talk about himself and he wouldn't talk about himself in a way that would lead me to understand him. . . . He was ready to stop many times

> early on, feeling that he was boring me, that he couldn't talk, didn't know what to say, didn't know how to do this.

Therapist A states that another most preferred patient maintained his resistance to engaging in an open and trusting therapeutic alliance with the therapist throughout their work together:

> He entered the relationship with some degree of skepticism that it would do any good, and some resistance to a relationship doing him any good . . . because on intellectual grounds he didn't have very much faith in human relationships. . . . I thought there was a good possibility that he was withholding any signs of progress because he didn't want me to feel that the relationship was doing anything for him. . . . It was still part of his resistance to me which remained throughout. . . . He never really let down, in the sense of a fully mutual, cooperative, acknowledged, relationship.

Therapist A explains that the third least preferred patient's resistance to thinking psychologically about his problems reflected his fear of confronting painful feelings about himself:

> He's an impulsive kid, and he might very well have up and left. . . . He was looking for magical solutions and running away from something in the thought to leave. . . . Just getting him to stand still, I thought, was an accomplishment. . . . He didn't think psychologically at all. . . . It amazed me how resistant he was; . . . indications all over the place that he's frightened . . . and yet he didn't see it for quite a while.

Therapist A identifies a conflict with a parent as a central source of difficulty in the lives of his most preferred patients. He describes his own supportive behavior and positive influence upon the patients in contrast to the destructive effects of the patients' experience with their parents. He seems to view himself as acting in the

role of the benevolent parent his most preferred patients needed but never had. He describes each relationship as though he were the first person with whom the patient became open and trusting, and he sees the establishment of this supportive rapport as the primary therapeutic factor in the therapy work.

Therapist A attributes one most preferred patient's hypersensitivity, mistrust of people, and history of destructive relationships to his conflicts with one of his parents. He describes the evolution of an open and trusting relationship with this patient, and reports that much of the therapy work consisted of giving the patient practical help and guidance of the sort a parent might give:

> He was very caught up in a relationship with his parent; . . . the parent is very critical of him. They fight a great deal. . . . I don't think he trusted anybody very much. . . . Every relationship he talked about was one in which he was inviting, it seemed to me, angry, destructive behavior. He was attracted to people who would diminish him . . . very much like his parent. . . . I guess what I enjoyed most about him was that he really emerged as a person over the course of time I spent with him. And got to the point where he trusted me quite a bit. And considering where he started, that in itself was very satisfying. . . . He became more open because I stayed with him and encouraged him. . . . I believed in him as somebody who could do it here. . . . I sort of set some standards for what was reasonable for him. . . . I was on the side of not getting embroiled in those kinds of destructive relationships. . . . I would be a superego figure; . . . that was very much me standing behind him in that way. . . . We would talk about . . . what kinds of things might happen, and he would come back and report that he was able to hold his ground.

Therapist A explains that feelings of inadequacy in relation to competition with a parent were a central source

of another most preferred patient's difficulties. He responded to this patient with very protective feelings and acted in the role of an accepting, supportive parent by whom the patient didn't need to feel threatened. When asked what feelings the patient evoked in him he replies as follows:

> The psychological equivalent of putting my arm around him and patting him on the shoulder, and reassuring him. . . . I felt protective . . . supporting him, believing in him, urging him to take it easy, not to get carried away. . . . It was largely a supportive therapy . . . ; he couldn't do more. He hadn't separated from his parents . . . ; I had the impression that he never sat down and talked with anybody about these things who wasn't as caught up in them as he was, and that a minimum of clear thinking made a big impression on him. . . . That hooked him with me.

Therapist A also attributes the third most preferred patient's difficulties to his relationship with a parent. His protective feelings toward the patient were reflected in his worries that the patient wasn't getting enough to eat and wasn't wearing a coat in cold weather. He feels that he provided this patient with his first opportunity to have an open and trusting relationship with another person, and that this was the essence of the therapy work:

> He had an extremely painful, hidden relationship with his parent. . . . He had been deeply hurt in that relationship, very early on, and had never come out again. . . . I think he needed the kind of figure I became to him. He never had, was terrified to enter into it, and slowly did, to his benefit. . . . I think the process of opening up and just establishing a relationship with me was very helpful. . . . It was an unusual kind of therapy in the sense of the content. I don't know what he would say if he was asked what he learned. . . . I think the most important thing for him was having a relationship.

Therapist A stresses that he helps maintain equilibrium in the daily lives of his most preferred patients, and

their real dependence upon him is emphasized. He provides his most preferred patients with concrete problem solving help of the sort a parent might give. Therapist A feels that moderate behavioral improvement is the major benefit his most preferred patients derive from his supportive therapy relationship with them. He views them as developing only a limited degree of insight, but he feels that the insight they attained was crucially important to their development and welfare. Therapist A also tends to feel that his own psychodynamic understanding of his most preferred patients was limited.

At the time when he was working on termination with one of his most preferred patients, he experienced the patient as very dependent upon him for everyday functioning. He seemed to feel that the patient needed a push to help him individuate from the therapist, as though he were a parent helping a child with separation. He expresses the view that the primary therapeutic aspect of the therapy was that he served as the benevolent parent whom the patient could encorporate:

> I felt he needed some time on his own. . . . I felt he was taking me with him and I was very much a presence and a force in his life here, and that considering where he started . . . he'd gone as far as he could go right now. And that he was becoming too dependent on the relationship.

He feels that this patient attained only limited, but crucial insight into his difficulties, and that his own understanding of the patient was incomplete as well:

> [His insight] . . . wasn't very much in terms of

> quantity, but the quality was very important. . . . It's very limited, but also very crucial. . . . I understand him as a type, but whether I understood his particular dynamics and genetic aspects of them, I don't think so. I know where he is. I don't know how he got there.

Therapist A feels that another most preferred patient depended upon him for help in sustaining his well-being in interpersonal relationships. He explains that the patient responded to his supportive help by trying to please him as though he were a parent. He ascribes the improvement the patient achieved to his coming to behave in a way he felt the therapist would approve, rather than to the attainment of insight:

> It became difficult for him to lead that kind of life . . . which he knew we had come to identify as not being in his best interest. So that in that way he wanted to please me. . . . I wasn't always sure whether that [behavioral progress] was coming from inside of him or whether that was coming from a wish to preserve his relationship with me. . . . He never really understood that he was repeating something; . . . instead, what he did was he stopped having the relationships. . . . I think he behaved alot better, functioned better, but I don't think he had all that much better insight. He was still flying by the seat of his pants.

Therapist A also feels that his third most preferred patient attained only a limited degree of insight, and that the patient allowed therapist A to develop only a partial understanding of him. Therapist A believes that the patient benefitted primarily from the parental support he provided to help him cope with basic aspects of his daily life and social interactions:

> He's the kind of kid who could miss meals and not have a warm coat if somebody wasn't reminding him that he needed these things. . . . By the end I felt he

> was much more able to make his way. . . . A big part of the therapy was getting him into situations where he would have interactions, and he did O.K. but he was absolutely mystified in terms of how to pursue them. . . . His social life was much improved [at the end of therapy]. . . . I'd say one of the more effective contacts I've had with students, but not in the traditional way. He didn't have all that many insights. . . . There's always the feeling throughout with him that there was still stuff I didn't know about. He was really quite a closed, mysterious, strange person.

Therapist A concludes that he enjoyed "overcoming the odds" in engaging these patients who did not "fit with the model" in a therapy relationship from which they derived benefit.

Therapist A interviews: least preferred patients

Therapist A describes his least preferred patients as having similar characteristics to those of his most preferred patients. He views them as relatively seriously psychologically disturbed, lacking in psychological-mindedness, socially isolated and unsophisticated, and highly resistant to becoming engaged in the therapy process. An important correlate of his satisfaction in the work with most preferred patients was that they responded positively to his adoption of the role of the supportive, benevolent, parental figure he felt was lacking in their lives. He feels that least preferred patients had similar needs for support and he attempted to fill that role with them, but they rebuffed him. Therapist A was unable to overcome their fear and resistance to developing a trusting, open, therapeutic alliance with him. As a result, therapist A feels

that he developed little psychodynamic understanding of the patients and that they developed little insight into their difficulties, although some behavioral improvement occurred. He experienced feelings of incompetence, confusion, and frustration about the work with his least preferred patients, which interfered with his ability to like the patients.

Therapist A feels that one of his least preferred patients was "schizoid," and showed extreme social isolation and mistrust of other people:

> How sealed off he was; . . . so insensitive to social organization and society. . . . He saw himself as socially inept, unappealing, unattractive, unlikeable. . . . He's a very angry person. . . . He was very suspicious . . . and very alienated; . . . he was very suspicious of people who extended themselves to him.

Therapist A also describes another least preferred patient as seriously psychologically disturbed. Therapist A emphasizes that this patient was socially isolated, lacked interpersonal skills, and was mistrustful and fearful of rejection:

> I felt he was borderline. . . . He would get caught up in paranoid fantasies, I'm sure, and only give me little tips. . . . I could see him sort of retreating and caught up in his own fantasies. . . . He was very isolated, was going to his classes, going to his room, frequently not going to meals . . . wasn't talking to anybody and was convinced that nobody wanted to talk to him. . . . He's very wary of being rejected; . . . he's very wary of people. . . . He was terrified that people wouldn't like him and also convinced that they wouldn't.

Therapist A states that at the beginning of therapy with the third least preferred patient, he was optimistic that the work would be helpful because he viewed the patient as less seriously psychologically disturbed. His optimism

diminished quickly as the patient's defensive style of denying his difficulties pervaded their interaction. Therapist A feels that all three least preferred patients showed little ability to understand their difficulties in a psychodynamic way. He describes the last mentioned patient's defensive style and resistance to psychological thinking. He explains that the major way this patient blocked psychological exploration of his problems was to remove himself from social involvement with others, which was a central area of difficulty for him:

> No difficulty is going to stop him, it's not going to affect him even, is what his modus operandi was. . . . The problems . . . don't really matter, they're just minimized, they don't affect him really. . . . It was an acknowledgement of certain problems in his life, but no connection with the things that I thought were connected with his problems . . . his family background, his sense of himself. . . . When he came he was involved in difficult and upsetting relationships . . . and what he did was he seemed to get out of that arena. . . . So for most of the time I saw him . . . he wasn't active, and that's one way in which he protected himself. . . . Things got better for him but I think they got better in the way that they went underground.

Therapist A gently attempted to talk with another least preferred patient about his family in a psychological way, hoping to ease the patient into considering his problems from a psychodynamic viewpoint. The patient reacted by feeling that therapist A was being insulting and closed the door to working psychologically such that therapist A developed little understanding of him:

> I felt he was closing the door to working psychologically. . . . He shared one secret with me . . . he very reluctantly told me. . . . I was very encouraged by that. I thought, here we go, getting into his

> fantasies, and was very accepting of it, but it dried up, never went anywhere. . . . I had very little understanding of him, . . . he's a very angry person, and I don't know what he's angry about.

Therapist A was never certain whether the third least preferred patient was unable to think psychologically or whether he was deliberately concealing aspects of his life from the therapist. He could not make a clear assessment of this patient's capacity for psychological thinking because he remained confused about the extent to which apparent naivete was being used to resist becoming engaged in a therapeutic alliance:

> One of the things which unsettled me was, here we were dealing with very basic things, almost as if he were a very young adolescent; . . . on the other hand it would occur to me that this was a very sophisticated person in many respects. . . . I didn't know sometimes whether he was putting me on, whether he was really as primitive in his social relationships and as unsophisticated and naive as he seemed to be. . . . Lots of things would come out almost like he wasn't aware he was talking about something significant. . . . I would almost by accident, it seemed to me, pick them up.

When asked why he did not enjoy working with his least preferred patients, therapist A's initial response is to describe his sense that the patients strongly resisted developing an alliance with him in which he could offer support and help them gain an understanding of their difficulties. His feelings of dissatisfaction with the therapy work were based primarily on his perception of being shut out and pushed away by his least preferred patients.

Therapist A's first comments about his work with the patient whose apparent naivete confused him reflect his sense of lacking any firm footing in dealing with him. He felt

that the patient would not allow him to develop a clear understanding of his behavior and psychological functioning. He had a constant concern that this patient was concealing aspects of his actual behavior as well as his inner experience. He feels he never developed any genuine contact and exchange with the patient in which he had some control as a participant in a dialogue:

> [I didn't enjoy the work because of] . . . my confusion about him and the uncertainty that I felt all the way through about whether he was going to decompensate. Never developed any sense of, I'd say certainty, that I knew what was going on and that something crazy wasn't going to happen. And I never felt sure that I would know about it either, until it was pretty late. . . . He kept a great distance from me; . . . I had a lingering doubt all the time about whether . . . I was getting the whole picture from him. . . . I wasn't sure that he was telling me the truth about what he was doing. . . . It was a matter of trust and embarrassment; . . . I didn't know to what extent he had a hidden life.

In his first words about another least preferred patient, therapist A describes the patient's enduring fear and resistance to trusting him and exploring his difficulties with him:

> I didn't like working with him because I didn't feel very much of a relationship got established. He never trusted me, and I don't think I did very much for him. . . . He was virtually hand-delivered here; . . . he had not been talking to anybody . . . so he came with very little motivation. . . . We never really got engaged . . . he would push me away . . . he volunteered very little. I would have to pump him for everything.

These two least preferred patients exhibited their resistance to becoming engaged with therapist A in a specific concrete way. Therapist A states that they erected a barrier to communicating with him openly by mumbling when they spoke. He explains the way one least preferred patient shut him out by mumbling as follows:

> There were large patches of it that were so mumbled, so obscure that I would have to let it go. Because if I stopped him and made him say the words in a way that I could understand them . . . he would get annoyed. . . . I would just have to stay very alert. I would often sit on the edge of my chair, practically with my ear in his mouth.

The second least preferred patient kept therapist A perpetually confused and frustrated by mumbling when he spoke:

> About the first five minutes of every session was spent with him sort of smiling in a strange way, grunting, giving me half sentences. They were the strangest hours. . . . I felt like every session was the first session. . . . He mumbled, spoke very fast, spoke with his hand in front of his mouth. No amount of interpretation could really alter that.

The third least preferred patient was not as mistrustful of therapist A, but the therapy relationship remained superficial and distant. The patient resisted thinking about his difficulties in a psychodynamic way, because he was frightened of giving up his defensive posture of being "normal." Therapist A states that he could not accurately assess the patient's feelings about him because he felt held at a distance. His initial observations of his feelings of least preference for the patient are as follows:

> I have to say I didn't enjoy working with him because I never found out what was going on. I never got on track with him. My overall evaluation of it is that he was very invested in being normal and in order to get into a working relationship that position would have to be threatened. And as I was conscious of that I tried very hard to get him involved in the work in a way that wouldn't threaten that position, but I couldn't do it. . . . I don't think I became anybody for him, nor he for me. . . . I kept waiting for him to become engaged. . . . They were problems that lacked the stuff, they lack the juice that I think was there but never came into the relationship.

Despite his least preferred patients' resistance to

engaging in a therapeutic alliance with him, therapist A expended great effort to support the patients' self-esteem and to help them function in their daily lives. Therapist A feels that the patients showed some behavioral gains in response to his protective, supportive parental interaction with them, but their lack of reciprocity led him to feel frustrated and dissatisfied with the work. It seems that therapist A felt that one least preferred patient needed a surrogate parent to intervene in the world for him. He assumed a very protective, nurturant role with this patient that included "going out of role" of the therapist at times. After feeling buoyed by progress made by the patient in his daily functioning, he experienced painful personal disappointment when the patient suddenly left school. It appears that he felt this was an ultimate rejection of his offer of support and sustenance:

> I felt a warm kind of concern, a wish to step in and sort of join him and go through his life with him for a few weeks--guide him around, supplement him. . . . The next step would have been for me to have gotten into a relationship with his instructors and to sort of shepherd him through every course. . . . The leaving school came out of nowhere; . . . he rejected my offer of help in the relationship. . . . I felt that I tried hard and that he didn't even appreciate any of the efforts. . . . His fear of exposing himself . . . was so great, and that nothing I could do . . . was able to diminish that sufficiently for him to take advantage of help that was available. . . . I felt frustrated, angry, resentful, sorry for him, humbled . . . I was depressed.

Therapist A provided another least preferred patient with supportive help in his daily functioning that resulted in some behavioral improvement, although there were frequent

regressions. Toward the end of their work together therapist A felt that the patient was in a decline in which he began withdrawing in anticipation of ending therapy. Therapist A's experience of serving in a parental role with this patient is revealed when he speaks of finding it hard to like him because he felt responsible for his welfare:

> I found myself liking him at times, but it was very much interfered with by my sense that if he went bad, I knew I was going to feel very responsible, because I was the only potential, that I could see, source of intruding on that. . . . It was as if he was a potential source of alot of pain for me; . . . I'm very worried about him now.

Therapist A also feels that the third least preferred patient derived some supportive help in dealing with concrete issues in his life. He acted in the role of the benevolent parent he felt this patient needed but lacked. Nonetheless he felt dissatisfied, frustrated, and bored by his interaction with this patient because of the patient's unwillingness to explore his difficulties in a psychological way:

> A good part of the time was spent in figuring out . . . how to free himself from his family, how to conduct himself . . . with his friends . . . where to live. . . . He's somebody I felt dissatisfied working with, and yet also felt got something out of it. . . . I felt bored alot of the time . . . it didn't come alive and that was frustrating until I settled down and just allowed it to be largely an intellectual process. . . . I still felt not all that interested in his problems as they were presented and talked about.

Therapist A describes a dilemma in which he felt trapped in the work with each least preferred patient. He had the wish to confront the patients with their resistance to becoming engaged with him in a more trusting and psychologically open way. He refrained from doing so because he

feared that the patients were too fragile and would have fled from therapy if he challenged them to make the therapy relationship a more open, psychologically intense experience. Therapist A describes the therapeutic strategy he wished he could use with one least preferred patient:

> If I had it to do over again, I would do alot of very direct interpretation. . . . I would talk about the degree to which he's angry and how he comes in in a fight stance. . . . I wouldn't try to hold him, help him through, hold the line. . . . I would have taken that shot . . . he might have run. . . . I think he would have been terrified of the positive feelings much more so than the fight.

In describing the dilemma he faced over whether to confront another least preferred patient with his resistance to engaging in a therapeutic alliance, therapist A expresses his fear that a confrontation would drive the patient away:

> The question I always had . . . was should I really let him know just how unsure I was that I knew what was going on, and possibly drive him away. In other words, demand alot more from him--or hang in there, ride it out, do the best I could. . . . I made little efforts here and there and watched his reaction, and never felt that he was about to open up.

Therapist A felt that if he interpreted the third least preferred patient's avoidance of certain situations in which he experienced difficulties as resistance, he would be advocating the reactivation of painful feelings produced by these situations. He found that an untenable position to take because the patient viewed his own behavior as progress and improvement:

> His becoming less desperate was a desirable thing, so I was in the untenable position of advocating the return of something he saw as desirable to let go. . . . I couldn't work with it; . . . the avoidance behavior

couldn't be interpreted as a defense against the work.

Some of therapist A's frustrations about his work with least preferred patients resulted from his sense that he could not implement a confrontation which might have produced a more meaningful therapeutic engagement. In order to avoid risking that the patients would flee from therapy, he chose to work with them in a way which brought him little satisfaction about the quality of the therapy relationship and its outcome.

Therapist A rating results: most preferred patients

Therapist A's range of summed scores for most preferred patients was 3-14 and his range for least preferred patients was 4-14 (see tables 1 and 2). His full range of 3-14 has been divided into three parts. Summed scores from 3-6 are his High summed scores. Scores from 7-10 are Moderate summed scores and scores from 11-14 are Low summed scores. Therapist A's modal group for most preferred patients is the Moderate one containing 10 items (see table 1). There are 6 High items and 4 Low items. Since the modal group for the other three therapists was the High one for most preferred patients, therapist A assessed his patients in a less favorable manner.

Therapist A's summed scores indicate that his most preferred patients were felt to be seriously psychologically disturbed and were felt to show High initial resistance to therapy and Low initial psychological thinking. They were

TABLE 1

THERAPIST A: SUMMED RATING SCORES
FOR MOST PREFERRED PATIENTS

Rating questions	Scores
<u>High scores (3-6)</u>	
Patient attitudes	5
Therapist empathy	5
Challenge felt	4
Liking for patient	3
Therapist competence	5
Behavioral improvement	6
<u>Moderate scores (7-10)</u>	
Patient involvement	7
Therapist understanding	7
Personal identification	9
Therapist involvement	7
Initial optimism	9
Therapist effort	8
Mutual collaboration	8
Feelings emphasized	7
Understanding emphasized	10
Insight attained	8
<u>Low scores (11-14)</u>	
Psychopathology	11
Psychological thinking	14
Initial resistance	13
Similar backgrounds	12

TABLE 2

THERAPIST A: SUMMED RATING SCORES
FOR LEAST PREFERRED PATIENTS

Rating questions	Scores
High scores (3-6)	
Challenge felt	4
Therapist effort	6
Moderate scores (7-10)	
Patient attitudes	10
Therapist empathy	10
Liking for patient	8
Initial optimism	8
Therapist competence	10
Understanding emphasized	8
Behavioral improvement	10
Low scores (11-14)	
Psychopathology	12
Psychological thinking	14
Initial resistance	13
Patient involvement	11
Therapist understanding	11
Personal identification	12
Similar backgrounds	12
Therapist involvement	11
Mutual collaboration	11
Feelings emphasized	13
Insight attained	13

felt to develop a Moderate degree of involvement in the therapy process and a Moderate degree of insight into their difficulties. Therapist A feels that they exhibited Highly positive attitudes toward him and that they showed a High degree of behavioral improvement. The ratings suggest that the therapy with these patients was not primarily psychodynamically-oriented, since the patients were viewed as developing less insight than behavioral improvement, and since there was felt to be only Moderate collaboration between patient and therapist in examining feelings and striving for intellectual understanding of difficulties.

Therapist A felt Highly empathic with the patients, liked them to a High degree, felt Highly challenged by the work, and felt Highly competent. At the same time he experienced only Moderate involvement in the therapy and Moderate initial optimism about its outcome. He expended a Moderate degree of effort in the work, felt Moderately personally identified with the patients, and felt that he developed a Moderate degree of understanding of them. He feels that his own background was Low in similarity to that of his most preferred patients.

Therapist A rating results:
least preferred patients

Therapist A's modal group for least preferred patients is the Low one containing 11 items (see table 2). There were 7 Moderate items and 2 High items. The rating data suggest that as was the case with most preferred

patients, the therapy work with least preferred patients was not psychodynamically-oriented. Although there was a Moderate degree of emphasis upon intellectual understanding, there was Low emphasis upon examining feelings. Least preferred patients were felt to show a Low degree of collaboration in the therapy work, were felt to develop a Low level of insight, and were viewed as showing only Moderate behavioral improvement. The patients were seen as seriously psychologically disturbed and as exhibiting a Low degree of initial psychological thinking, High initial resistance to therapy, and Low involvement in the therapy process, despite their Moderately positive attitudes toward the therapist. Therapist A also felt a Low degree of involvement in the therapy work with these patients, felt a Low degree of identification with them, saw his background as dissimilar to that of the patients, and felt that his degree of understanding of them was Low as well. Nonetheless therapist A felt Moderate liking and empathy for least preferred patients, experienced a Moderate sense of competence in the work, and was Moderately initially optimistic about its outcome. He also found the therapy with least preferred patients Highly challenging, and he expended a High degree of effort in the work.

Areas of inconsistency between ratings and interview material

When therapist A's ratings are compared with the interview material, several areas of inconsistency emerge. One area of discrepancy resulted from combining rating scores

for individual patients into a summed score for the most preferred or least preferred patient group. Certain individual differences among patients that are clear in the interview descriptions and in the individual ratings were obscured by summing the ratings. In the interviews therapist A characterizes one least preferred patient as only Moderately psychologically disturbed in comparison with the other patients. The individual rating score for the patient shows this difference as well (see table 3). Yet the summed score for the least preferred patient group indicates that the group showed a High degree of psychological disturbance.

On two other items therapist A's Moderate summed scores also seem inconsistent with his interview comments. He rates his understanding of most preferred patients as Moderate, but in the interviews he tends to elaborate upon the limitations of his understanding. He also rates most preferred patients as developing a Moderate degree of insight, but his interview observations indicate that two of the patients attained little insight into their problems.

Another area of discrepancy involves therapist A's Low rating of his degree of involvement in the therapy with least preferred patients. This rating appears inconsistent with other ratings in which he indicates he felt Highly challenged and expended a High level of effort in the work with the patients. The Low involvement rating is also inconsistent with therapist A's interview comments that he felt frustration, anger, resentment, and depression in the

TABLE 3

THERAPIST A: INDIVIDUAL RATING SCORES FOR MOST PREFERRED AND LEAST PREFERRED PATIENTS

Rating questions	MP1	MP2	MP3	LP1	LP2	LP3
Psychopathology	2	2	3	1	4	1
Psychological thinking .	5	4	5	5	4	5
Initial resistance . . .	1	2	2	1	2	2
Patient attitudes	1	2	2	4	3	3
Patient involvement . . .	3	2	2	4	4	3
Therapist empathy	2	2	1	3	3	4
Therapist understanding .	2	2	3	5	2	4
Challenge felt	1	2	1	1	2	1
Personal identification .	4	3	2	5	3	4
Similar backgrounds . . .	4	4	4	5	3	4
Liking for patient . . .	1	1	1	3	2	3
Therapist involvement . .	3	2	2	3	4	4
Initial optimism	4	3	2	2	2	4
Therapist competence . .	2	2	1	3	3	4
Therapist effort	3	2	3	1	3	2
Mutual collaboration . .	3	3	2	5	3	3
Feelings emphasized . . .	2	2	3	5	4	4
Understanding emphasized	3	3	4	4	2	2
Insight attained	3	3	2	5	4	4
Behavioral improvement .	1	2	3	4	3	3

work with the patients, and that he went out of his therapist role in his attempts to help them. These comments suggest his high degree of emotional involvement with the patients. There is also evidence in the interview material that the rating item assessing patients' initial resistance to therapy is inadequately defined. Therapist A uses two different interpretations of the term, and his ratings seem of limited value for this reason. In the interviews he indicates that some patients were initially resistant in the sense of feeling mistrustful of the therapist and of being reluctant to talk candidly with him about their problems. Other patients were felt to show greater trust in therapist A, but they were initially resistant to thinking about their problems psychodynamically because they feared the painful feelings they might experience as a result.

Therapist B: Most Preferred and Least Preferred Patients

Patient caseload from which cases were selected

During the working year at the university, therapist B saw a total of 11 patients for 13 or more sessions, the criterion for inclusion in the study.

Description of patients selected by therapist B

After rating the 11 patients on the degree to which the therapist Enjoyed the work and felt that the therapy was Helpful, therapist B selected 3 most preferred and 3 least preferred patients he wished to discuss in the interviews.

He rated 2 most preferred patients 1 on both Enjoyment and Helpfulness dimensions. The third patient was rated 3 on the Enjoyment dimension and 2 on the Helpfulness dimension. One least preferred patient was rated 5 on both Enjoyment and Helpfulness scales, and another was rated 4 on both scales. The third least preferred patient was rated 4 on the Enjoyment scale and 2 on the Helpfulness scale.

The mean age for most preferred patients was 23.3 and the mean age for least preferred patients was 21.6. Undergraduates and graduate students were represented in both most and least preferred groups. During the year of the study the mean number of therapy sessions was 17 for the most preferred group and 18.6 for the least preferred group. One most preferred patient and two least preferred patients had been seen previously by therapist B. Two most preferred patients had previous therapy with another therapist. Therapist B viewed one patient's previous therapy experience positively and the other's negatively. One least preferred patient had a previous negative therapy experience.

Therapist B characterized the reasons for seeking therapy differently for most preferred and least preferred groups. The most preferred patients were described as seeking therapy for personal identity conflicts or for conflicts involving relationships with loved ones. The least preferred patients were seen as coming for therapy because they had difficulties forming social relationships and felt socially isolated, or because they were generally seriously

disturbed. Therapist B tended to characterize both groups as having symptoms of depression.

There were important differences between the two groups with respect to therapist B's description of how the therapy ended. The most preferred patients were planning to continue therapy privately elsewhere as a result of their positive therapy experience working with therapist B. The therapy with two least preferred patients ended when the patients failed to appear for appointments without discussing with therapist B their intention to discontinue therapy. Therapist B felt that the third least preferred patient would need to continue therapy with him the following year.

Therapist B interviews:
most preferred patients

When he was asked why he found the therapy work with MP3 particularly satisfying, therapist B said, "What you have to offer is what the person can use . . . giving me a feeling that he felt this was a useful process for him. . . ." In describing why he was not satisfied with the work with LP2 he referred to "the fascinating dilemma of patient expectations and therapist expectations." The key to understanding what makes certain patients most preferred by therapist B lies in his definition of his own preferred role and that of the patient in the therapy relationship. The interview material and rating results indicate that therapist B prefers psychoanalytically-oriented therapy work. He places the

highest premium on coming to understand the patient in a psychodynamic way and on the patient's development of insight into his thoughts, feelings, and behavior.

Within the general definition of most preferring patients whom he can engage in an insight-oriented therapy relationship, therapist B's descriptions of most preferred patients reveal aspects of his preferences which are particular to him in a personal way. Therapist B conceives of therapy as an active, strenuous, productive process. He habitually uses the word "work" to describe the therapy process with most preferred patients. He also tends to employ the word "struggle" to describe most preferred patients' involvement in therapy and their strivings to achieve insight.

Therapist B's primary role requirement for most preferred patients is that they show high motivation and ability to think about their difficulties in a psychodynamic way. His sense of engagement and empathy with most preferred patients involves viewing them as hard workers who have the courage to struggle to understand themselves and to implement their understanding productively. He says of MP2:

> I had alot of empathy for him because I felt that he was a man in pain, who has developed a characteristic defensive style to ward off some of it, and who at the same time had, I felt, a certain courage and willingness to uncover his own self-deceptions as best he could. And I could empathize with some of his dilemmas and some of his struggles. . . . I admired his work ability . . . I admired his spunkiness, in a way, and his tenacity in the face of alot of sadness . . . but worked hard . . . I admired that.

When asked why he found the therapy work with MP3 particularly satisfying, therapist B replies:

> His thinking psychologically, his willingness to push and get in touch with his feelings . . . trying to make sense of things. . . . So that I think he made progress and certainly sees therapy as a very useful tool for him and can use it productively. . . . It's his working capacity, it was his bringing in dreams and his working with dreams.

Therapist B also describes his enjoyment of the work with MP1:

> He was very psychologically oriented. He was highly motivated, was able to work, to bring in dreams, fantasies. He worked in the transference . . . he was highly motivated.

In defining the nature of the therapy relationship with most preferred patients, therapist B emphasizes that he and the patient are co-equals who share the work task of psychological exploration of thoughts, feelings, dreams, and behavior. He stresses the active self-sufficiency of most preferred patients in their work relationship with him. In the pilot study therapist B stated that he did not prefer acting as a supportive therapist because "you have to use more of your person." In his descriptions of most preferred patients he reiterates that he has an aversion to working with patients who are passive, needy, and dependent upon him. He feels that his work competence entails his freedom to work creatively at understanding the patients' psychodynamics, unhampered by demands that he sustain them in a supportive way. He refers to "our work" and "our commitment" in discussing his relationship with most preferred patients. His use of the plural reflects therapist B's sense of comradeship with these patients as they struggle together as self-reliant co-equals sharing the therapy work task. He articulates

these issues in discussing his reasons for enjoying the work with one of his most preferred patients:

> . . . I think I understand something about him, which helps. I mean I don't have enormous feelings of being helpless and overwhelmed and confused when I'm working with him. . . . There's a good feeling, an unspoken feeling that exists between the two of us, in terms of our commitment, and he takes it seriously and I take it seriously. . . . I have felt my own competence in working with him and he has felt his own competence in a way. . . . He sees it pretty much as a work relationship; . . . he's a very self-reliant person. . . . There's a mutuality in the work together, that he does his bit and I do mine; . . . so that he's holding up his end in a way and that I feel freer to work and more creative. I don't feel that I've got to do something for him. That's relevant to me, I think, as a therapist.

He compares his feeling of competence in sharing the psychological work with this self-reliant patient to his reaction to patients who are passive, needy, and dependent. Such patients' expectations that he provide them with solutions to their difficulties arouse unrealistic rescue fantasies in him, accompanied by feelings of incompetence:

> . . . he doesn't drag at me for the answers, he doesn't make me feel like I have to do something miraculous to save him. . . . [These issues] say something about me as a therapist. . . . There's something about him in which he doesn't lay back and expect that the answers will come from me . . . which doesn't make me feel useless and helpless and arousing rescue wishes that I've got to do something to save this guy. Which I know I can't do, which always throws me into conflict about work with somebody.

Therapist B describes most preferred patients as individuals who are able to internalize the process of psychological self-exploration and work with the transference feelings the therapist's role evokes rather than needing him to sustain them in a supportive way. He emphasizes that these self-reliant patients become highly involved in

the therapy process and find the analytic process useful. He downplays the patients' dependence upon him in reiterating that they are engaged in the analytic process in their on-going lives outside of the therapy relationship with him. He comments about this in discussing why he enjoyed working with MP1:

> He was trying to make use of what he learned in therapy, outside, in order to try and change some things. So it was as if something was happening inside that he was trying to make use of outside. . . . The work became not only sort of in the hour, but it moved him to begin to open up his relationship with X.

Therapist B describes the evolution of his relationship with MP3 from passive dependence upon the therapist to active self-sufficient collaboration as follows:

> I do have trouble in that area in which someone comes in and says, "Hi, I don't know--things are messed up. What can you do for me?" He did that initially. . . . He shifted at that point from someone who was just in a morass that he couldn't understand to someone who began to try to understand what was going on; . . . that made me feel then that I was working with somebody rather than someone simply presenting himself to me and saying, "Do something. . . ." So that therapy became a central part of his life. Even if he was only coming once a week he was using it during the week. I think I find that a rewarding personal experience. . . . His really thinking about things between sessions that made me feel he was really engaged in the process and that we were having a meaningful relationship. . . . He'd go deeper into his own images and his own thoughts and his own feelings outside of the hour to see where it would take him . . . and then he would come in with the feeling, and there'd be alot of work around the feeling.

Therapist B spends much of the interview time talking about the insights he and most preferred patients developed into the psychodynamic meaning of the patients' difficulties and the ways in which the patients implemented these insights

in beginning to make changes in their lives. From his vivid and detailed descriptions of the psychological material it seems that an important aspect of his preference for these patients was that their difficulties were rich, complex, and highly psychodynamically interesting to him.

He explains that in the work with MP2 the development of insight involved both intellectual understanding and exploring feelings:

> . . . there was a combination of how he felt about things, how he experienced things, and at the same time an attempt to figure out and to link and to understand. I mean I think that's what made it good, that it wasn't purely intellect and it wasn't purely catharsis. . . . There's been an engagement, a kind of direct engagement, and I find myself absorbed in the hours, and involved in what he's telling me, and listening intensively.

Therapist B devotes most of the interview on MP1 to describing the understanding he formulated about the patient's family dynamics and the way in which the patient's developing insight helped him to change his family relationships in significant ways:

> . . . what surfaced around that situation was the enormous anger that he had never experienced before about X keeping him away from Y. . . . In a sense he discovered his relationship with Y. . . . He began to see that he had alot of rage at X and was also terribly frightened. . . . He was able to integrate both X and Y into his life in a much more meaningful way.

Therapist B also feels that MP3 made important strides in improving his family relationships as a result of the insight he developed into ambivalent feelings and distant feelings he experienced about his family. Therapist B ascribes the patient's recovery from serious feelings of

depression to his success at working through these issues:

> . . . we made alot of progress on his relationship with X . . . and then got into his feelings about X. . . . And then also began to get into feelings about Y . . . some ambivalent feelings. . . . He began to have dreams . . . and all in all his depression and despair lifted. He was much more active and vital and alive.

Therapist B feels that he did not develop a high degree of psychodynamic understanding of all of his most preferred patients' conflicts, but he felt highly challenged to grapple with the psychological puzzles they presented. It seems that therapist B may have been particularly attracted to and involved with these patients because they so strongly stimulated his psychological curiosity and wish to understand their difficulties. His high motivation is evident in his reply to a question about the degree of effort he expended in the work with one of them:

> . . . [I worked] hard in the sense of trying always as much as I can to be there, to listen carefully, to listen for nuances, to raise issues that were difficult, to stretch myself hard in that way.

In relation to another most preferred patient, he states that he felt highly challenged to understand the patient's conflicts but that he achieved only a limited degree of psychodynamic understanding:

> I thought he was a challenge, particularly in that area--I was working hard to try to get to what was going on around the . . . identity issue. . . . I never really got to the point where I felt I had a firm grasp; . . . that was the one area where my understanding was intellectual and textbookish, rather than having come from him.

Therapist B also found it highly challenging to grapple with the psychological meanings of a third most

preferred patient's difficulties:

> I felt challenged by the situation, and challenged by trying to get him to get in touch with more feelings and to broaden his understanding of what was going on. He activated my interest. . . . The thing that puzzles me most about him is his [core conflict]. . . . I was never clear about his own development [with respect to that]. . . . Dynamically, I couldn't see it quite clearly.

Therapist B views the psychological problems of his most preferred patients as moderately serious in nature. He feels that despite their moderate psychopathology they were able to function well in areas of their lives which did not involve their focal problems. He describes the degree of psychopathology shown by one most preferred patient as follows:

> . . . developmentally he was retarded; . . . there was like a split off part of himself . . . but outside of that he functioned quite well.

He views the psychological difficulties of another most preferred patient in a similar manner:

> . . . he really has much more of a characterological problem, but he's able to work effectively and he's able to love moderately effectively and he is symptomatic on occasion.

Therapist B feels that in relation to the high degree of insight into their difficulties which his most preferred patients developed, they made only moderate behavioral gains. He did not view his therapy work as complete with any of the most preferred patients. Each patient was described as becoming highly involved in the analytic process during the course of his work with therapist B and as demonstrating his commitment to therapy by making plans to continue therapy

privately. Therapist B expresses feelings of satisfaction that his work with these patients culminated in their decisions to pursue further therapy in other settings.

Therapist B interviews: least preferred patients

Therapist B felt satisfied in the therapy work with most preferred patients because they found what he had to offer them useful. His least preferred patients reject the kind of therapy relationship he offers them, wanting something more or something different. These least preferred patients do not find helpful and useful the kind of therapy relationship which he prefers to establish with patients. In the interviews therapist B describes the "fascinating dilemmas" which emanate from the discrepancies between least preferred patients' expectations of therapy and his own.

In his discussion of most preferred patients therapist B outlines the model of the kind of therapy work relationship he prefers. The interview material and rating results for least preferred patients are discrepant with this model. One major way in which least preferred patients differ from the most preferred model is that therapist B viewed them as showing little ability to think about their difficulties in a psychological way. Although one least preferred patient developed some degree of psychological-mindedness during the course of therapy, the other two patients were felt to continue to show a lack of psychological thinking ability. Therapist B describes one of these patients as

lacking the basic understanding that therapy involves psychological self-examination on the patient's part:

> My initial reaction to him is I didn't think that he was a good candidate for insight therapy; . . . he wasn't psychologically oriented, he wanted somebody to help him. . . . He had the feeling that if he came long enough, I'd give him the answers. . . . He couldn't get really far into his feelings; . . . I may have had more insight into him than he had into himself. . . . I figured things out and told them to him. And he sort of nodded his head, but I don't think that he really was figuring anything out.

Therapist B feels that another least preferred patient had profound developmental difficulties which placed his diagnosis in the borderline category. He viewed the patient's serious psychopathology as greatly limiting his ability to think psychologically:

> He knows very little about his own wants. He can't really perceive his own inner states. He can't tell what his likes and dislikes are, and he's very diffuse and amorphous. . . . His feeling states--they're a jumble; . . . I try to get him to clarify what he is saying. And he gets more frustrated and feels he's disappointing me.

Therapist B viewed the psychological difficulties of his least preferred patients as more serious in nature than those of his most preferred patients. He feels that the borderline patient was among the most disturbed individuals with whom he has worked. He found the general functioning of another least preferred patient to be impaired, although he was not as seriously disturbed:

> At first I thought he might be borderline; . . . the intensity of his feelings . . . depression . . . made me worry. . . . I thought he might be schizoid, and I think as time went on I felt that he was not as seriously disturbed. . . . I'd say he was a kind of mixed neurotic character with hysterical and obses-

sional characteristics.

He assesses the third least preferred patient's psychological difficulties as follows:

> I think he was a terribly anal, insecure person who was very passive-aggressive--very very angry . . . and couldn't act on any of it. Would hold everything in; . . . he got depressed. . . . He was primarily socially inadequate.

Therapist B describes his least preferred patients as unable to function as self-sufficient, independent co-equals in a psychological work relationship. He emphasizes that these patients brought to the therapy relationship intense needy-dependent and/or angry-demanding feelings. His descriptions of these patients contain oral images which make clear that he was personally affected by his perception of the intensity of the dependent longings and angry demands of the patients. Rather than viewing the patients as motivated to collaborate with him in a psychological work relationship, he tended to experience them as wanting to merge personal boundaries by eating him or being fed by him.

At the very beginning of the interview about each least preferred patient, therapist B describes feeling in conflict with the patient because the kind of therapy relationship he was prepared to offer was not what the patient wanted. He experienced each least preferred patient as either demanding or needing to become dependent upon him in ways that violated the boundaries of his preferred analytic role and his once-a-week therapy work schedule. He consequently expresses the wish not to work with each least

preferred patient from the very outset.

Therapist B viewed one least preferred patient as a passive-aggressive individual who expected the psychological work to be done for him by the therapist. Therapist B feels that this patient wanted him to become a supportive and directive therapist rather than a therapist who engages the patient in psychodynamic exploration of his problems. He said that he "tried to get rid of" the patient early in the relationship:

> Working with him made me feel as if I were a dentist. He's a very passive-aggressive person who . . . had very few social relationships. . . . Sort of sat himself down, could hardly speak. . . . His notion of therapy is that he would sit quietly waiting for me to feed him . . . and no matter what I'd give him, he'd spit it out. . . . And so I'd be energizing myself trying to fill him up; . . . I'm no good at that kind of stuff.

Therapist B explains that he tried to persuade another least preferred patient to pursue private therapy because he felt he was too disturbed to be seen in a university setting on a weekly basis. The patient did not want to follow this recommendation and therapist B backed down, sensing that the patient would feel rejected if he refused to work with him. It seems that he experienced the patient's refusal to pursue private therapy as an indirect demand that he take care of him. Therapist B felt that the therapy work would have to be mainly supportive because of the patient's degree of disturbance:

> He came to have his needs met and his dependency needs met. . . . We've worked on his passive approach to things; . . . he won't do it for himself--I have to do

> it. He'll talk, but it will just go all over the place. He won't make any effort to focus. . . . I should not have seen him initially . . . my own inability to reject him. . . . It feels like a rejection and a pushing out . . . and I think I'm probably very conflicted, knowing I should see him two or three times a week and not wanting to. . . . I'm not prepared in this setting to get into that kind of total involvement with him.

Therapist B states that the third least preferred patient wanted to be seen two or three times a week in a sort of "total therapy experience" and was enraged that the therapist would only see him once weekly. Therapist B was unwilling to become deeply involved with the patient because he wasn't clear about his degree of disturbance. His angry demandingness suggested that he might regress, making once a week therapy inadequate treatment and raising the possibility that supportive intervention might be needed:

> He came in really depressed and down, crying. . . . He would weep and sob during the hours at the beginning. And scream at me for being so dispassionate. I did keep him at a distance, partly out of my own anxiety. . . . I was afraid that he would regress and get very much involved with me and have no other relationships, and it would become a very intensive therapy, that I'd have to see him more than once a week. . . . At the beginning I felt that he was going to gobble me up. He had no contact with anybody for a long time. . . . I used to feel used up at the end of the hour. I had to fill up so much for him, and I was trying. . . . There was a very quick transference to me as a kind of ungiving, unyielding parent.

In discussing his most preferred patients therapist B states that he experiences unrealistic, conflictual rescue fantasies in response to patients who expect him to provide solutions to their problems. He describes rescue fantasies which two of his least preferred patients aroused in him,

throwing him into conflict about whether to succumb to the patients' demands. In contrast to his description of most preferred patients' internal struggles to understand themselves, is his reiteration of the "struggle" and "conflict" which least preferred patients stimulated in him. He succumbed to his rescue fantasies and attempted to meet the patients' expectations in ways which deviated from his preferred analytic role. Therapist B feels dissatisfied with the therapy work as it proceeded, because he was not able to overcome the patients' resistance to collaborating with him in psychodynamic exploration of their difficulties. He describes his attempt to "feed" LP1 the answers to his problems as falling into a trap:

> There was a certain threat for me in that it touches off in me my wish to save him and rescue him, and at the same time knowing that's foolhardy. . . . And of course when you fall into the trap of telling him what to do, it wasn't any good, and it wasn't useful. . . . He never really saw much value to the whole thing, . . . he really blocked me and himself at every turn. Nothing was good enough; . . . no matter what I'd give him he'd spit it out. . . . Even though he said he wanted to change, there really wasn't very much he was going to do about it. So I found it very, very frustrating. . . . I felt I understood him, but I didn't feel competent in being able to get him in a working alliance with me.

Therapist B was in conflict about his work with LP2 because he struggled to overcome the patient's resistance to exploring his difficulties psychodynamically, and at the same time he resisted intense psychological engagement with the patient because he feared his regressive potential. Therapist B felt that if he encouraged intensive psychological engagement with the patient, LP2 would become too needy

and dependent upon him. His two conflicting modes of action resulted from therapist B's decision to work with LP2, whom he viewed as inappropriate to treat within the boundaries of his preferred analytic role:

> I tried to get him to go into private therapy, which he didn't want to do, and I led into one of my rescue fantasies, unfortunately. . . . He holds back a great deal, and tells me that; . . . he was always struggling not to get into therapy. . . . I'm in conflict about knowing that more intensive treatment could be useful and yet being fearful myself of wading in all that deeply. . . . I think I have been burdened by my own anxiety in this situation in not wanting to invite that regressive potential. . . . I think probably a much more intensive transference relationship has to develop, which on a once a week basis can't, and which I don't invite. . . . If only I could be satisfied with acting as an anchor for him . . . if I could come to that position I probably could be happier with the treatment because I think I am a stabilizing force in his life. But I'm very critical of myself in my work with him.

The third least preferred patient emphatically demanded that therapist B engage with him in intensive psychological exploration of his problems. Therapist B felt conflicted because he thought the patient could benefit from intensive therapy, but he also feared that the patient might regress to a state of extreme neediness and dependency upon him. He did not give in to the patient's demands to be seen more than once a week, but he felt dissatisfied with the therapy work. He viewed his own resistance to intense psychological engagement with the patient as limiting the extent to which the patient was able to make therapeutic progress:

> He was very demanding that he needed something much more intensive than I felt I was willing to give. . . . There were alot of conflicts in me--feeling

> I should see him as often as possible; . . . at times I thought maybe I felt guilty because he really needed more therapy and I wasn't giving it to him. . . . He wanted a much more volatile kind of psychotherapy. . . . I think I was dissatisfied because I was aware that alot of intensity had been drained off the therapy and that I had been involved with that; . . . I did keep him at a distance.

During the course of his discussion of this patient, therapist B mentions several times that his primary source of dissatisfaction with the work was that the patient abruptly stopped coming without discussing his decision to terminate therapy. It seems that therapist B felt that the patient's abrupt termination indicated his resistance to collaborating with the therapist in the kind of therapy relationship he was offering.

Therapist B feels that his least preferred patients attained little insight because he was unsuccessful in overcoming their resistance to collaborating with him in psychological exploration of their difficulties. In addition, he views them as showing limited behavioral improvement. He states that LP1 made no improvement of which he was aware. He explains that although LP2 seemed less depressed in a global way, little real growth and change occurred in the therapy. He feels that LP3's depression lifted in reaction to disengagement from the therapy because the relationship with the therapist was not gratifying. Therapist B viewed this change as indicating that the patient was acting out a character issue. Therapist B concludes that his work with least preferred patients was "very challenging and

extremely frustrating." He states that he worked "the hardest" with these patients and that his efforts had a "Sisyphus" quality to them.

Therapist B rating results: most preferred patients

Therapist B's range of summed scores for most preferred patients was 3-11 and his range for least preferred patients was 3-12 (see tables 4 and 5). His full range of 3-12 has been divided into three parts. Summed scores from 3-5 are his High summed scores. Scores from 6-9 are Moderate summed scores and scores from 10-12 are Low scores. Therapist B's modal group for most preferred patients is the High one containing 11 items (see table 4). There are 8 Moderate items and only one Low item.

The ratings reveal that in the therapy with most preferred patients there was a High degree of mutual collaboration between patient and therapist resulting in attainment of High levels of intellectual understanding and insight about feelings. Therapist B experienced himself and most preferred patients as Highly involved in the therapy process. He found the work Highly challenging, expended a High degree of effort, felt Highly competent, and felt a High degree of empathy and liking for the patients.

Therapist B felt that most preferred patients showed a Moderate degree of behavioral improvement. He viewed the patients as showing Moderately positive attitudes toward the therapist, Moderate initial psychological thinking, as well as a Moderate degree of psychopathology and initial

TABLE 4

THERAPIST B: SUMMED RATING SCORES
FOR MOST PREFERRED PATIENTS

Rating questions	Scores
High scores (3-5)	
Patient involvement	4
Therapist empathy	5
Challenge felt	5
Liking for patient	4
Therapist involvement	5
Therapist competence	5
Therapist effort	5
Mutual collaboration	3
Feelings emphasized	4
Understanding emphasized	5
Insight attained	3
Moderate scores (6-9)	
Psychopathology	8
Psychological thinking	6
Initial resistance	7
Patient attitudes	6
Therapist understanding	6
Personal identification	8
Initial optimism	8
Behavioral improvement	6
Low scores (10-12)	
Similar backgrounds	11

TABLE 5

THERAPIST B: SUMMED RATING SCORES FOR LEAST PREFERRED PATIENTS

Rating questions	Scores
High scores (3-5)	
Challenge felt	3
Therapist effort	3
Moderate scores (6-9)	
Patient attitudes	7
Patient involvement	9
Therapist empathy	9
Therapist understanding	9
Liking for patient	7
Therapist involvement	7
Low scores (10-12)	
Psychopathology	12
Psychological thinking	11
Initial resistance	11
Personal identification	11
Similar backgrounds	11
Initial optimism	10
Therapist competence	12
Mutual collaboration	12
Feelings emphasized	10
Understanding emphasized	11
Insight attained	10
Behavioral improvement	11

resistance to therapy. He felt Moderately initially optimistic about the outcome of therapy, attained a Moderate degree of understanding of the patients, and felt Moderately personally identified with them. Therapist B viewed his own background as Low in similarity to that of most preferred patients.

Therapist B rating results:
least preferred patients

Therapist B's modal group for least preferred patients is the Low one containing 12 items (see table 5). There were 6 Moderate items and 2 High ones. The two High scores indicate that therapist B felt Highly challenged and expended a High degree of effort in the work with least preferred patients. He viewed them as showing serious psychopathology, Low initial psychological thinking, and a High level of initial resistance to therapy. He feels that least preferred patients exhibited a Low degree of collaboration in the work and showed a Low degree of attainment of insight and behavioral improvement. He feels that there was Low emphasis upon feelings and intellectual understanding in the therapy work. He experienced a Low degree of competence, felt Low initial optimism about the outcome of therapy, felt a Low degree of personal identification with the patients, and viewed his own background as Low in similarity to that of the patients.

Therapist B viewed least preferred patients as Moderately involved in the therapy process and as holding Moderately positive attitudes toward the therapist. He also felt Moderate emotional involvement in the work, liked the

patients to a Moderate extent, and felt a Moderate degree of empathy and understanding of the patients.

Areas of inconsistency between ratings and interview material

Several Moderate summed scores seem inconsistent with therapist B's interview statements. He rates his understanding of most preferred patients as Moderate but he devoted a major portion of the interviews to describing the insights he and the patients developed about the patients' difficulties. When the interviewer challenged his Moderate rating of a particular patient he explained that it would be presumptuous of him to assign a High rating to his understanding of the patient. He adds that the longer he works with a patient, the clearer the limitations of his understanding become to him. Therapist B rates his most preferred patients as showing Moderate behavioral improvement. The interviews indicate that their behavioral gains were greater than the ratings indicate. Therapist B feels that most preferred patients showed Moderate psychopathology according to his rating, but his interview comments explain the meaning of this rating much more precisely. He states that the patients were able to function quite well despite their considerable psychological problems.

Therapist B also rates himself as Moderately emotionally involved in the therapy with least preferred patients. This rating is inconsistent with other ratings in which he indicates he exerted a High level of effort and

felt Highly challenged by the work with least preferred patients. In the interviews he also expresses feelings of fear, anxiety, frustration, and irritation which suggest strong negative affective involvement in the therapy.

Therapist B's ratings of individual patients did not tend to be inconsistent with his summed ratings, although such inconsistencies appear in the other three therapists' ratings. Therapist B's ratings of individual most preferred and least preferred patients are shown in table 6.

Therapist C: Most Preferred and Least Preferred Patients

Patient caseload from which cases were selected

During the working year at the university, therapist C saw a total of 21 patients for 13 or more sessions, the criterion for inclusion in the study.

Description of patients selected by therapist C

After rating the 21 patients on the degree to which the therapist Enjoyed the work and felt that the therapy was Helpful, therapist C selected three most preferred and three least preferred patients he wished to describe in the interviews. He rated two most preferred patients 1 on both Helpfulness and Enjoyment dimensions. He rated the third most preferred patient 2 on the Helpfulness dimension and 1 on the Enjoyment dimension. Two of the least preferred patients were rated 5 on both the Enjoyment and Helpfulness dimensions. The third least preferred patient was rated 4 on the Enjoyment

TABLE 6

THERAPIST B: INDIVIDUAL RATING SCORES FOR MOST PREFERRED AND LEAST PREFERRED PATIENTS

Rating questions	MP1	MP2	MP3	LP1	LP2	LP3
Psychopathology	4	3	3	3	1	2
Psychological thinking .	2	2	2	4	4	3
Initial resistance . . .	4	5	2	1	4	2
Patient attitudes	2	2	2	2	2	3
Patient involvement . . .	2	1	1	4	2	3
Therapist empathy	2	1	2	3	3	3
Therapist understanding .	3	1	2	2	4	3
Challenge felt	1	3	1	1	1	1
Personal identification .	3	1	4	5	3	3
Similar backgrounds . . .	2	4	5	4	3	4
Liking for patient . . .	2	1	1	2	2	3
Therapist involvement . .	2	1	2	3	2	2
Initial optimism	3	1	4	5	3	2
Therapist competence . .	2	1	2	5	4	3
Therapist effort	3	1	1	1	1	1
Mutual collaboration . .	1	1	1	5	4	3
Feelings emphasized . . .	2	1	1	5	4	1
Understanding emphasized	2	1	2	5	3	3
Insight attained	1	1	1	4	4	2
Behavioral improvement .	2	2	2	5	3	3

dimension and 1 on the Helpfulness dimension. Since there were no other ratings for therapist C which indicated that a patient was felt to be helped to the highest extent but enjoyed to a low extent, this patient is of interest.

The most preferred patients tended to be older than the least preferred patients. The mean age for most preferred patients was 24 and the mean age for least preferred patients was 21. There were undergraduates and graduate students in both groups. There was a difference in the number of times per week that therapist C had sessions with the most and least preferred groups. At the university counseling service, patients are generally seen on a once a week basis, but therapists have the choice to see patients more or less frequently, depending on their perception of patients' needs, the degree to which their schedules are full, and personal preference. Two most preferred patients were seen on a twice weekly basis, although one of them was initially seen once a week. The third most preferred patient was seen primarily once every two weeks. This patient had previously been in therapy with therapist C, and the every other week schedule was therapist C's way of continuing to meet with the patient as an alternative to having to terminate the therapy. None of the least preferred patients were seen on a twice weekly basis. One least preferred patient was seen once a week. Another was seen weekly at first and later was moved to an every other week schedule, when his presenting symptoms abated. The third least preferred

patient had previously been in therapy with therapist C. During the year of the study he was seen on an every other week basis. As a result of these scheduling differences, the average number of sessions for most preferred patients was 35 and the average number of sessions for least preferred patients was 17.

None of the most preferred patients had previously been in therapy with another therapist, but two of the least preferred patients had been. Therapist C states that one least preferred patient had several prior therapy experiences but that the therapy "never made any difference." The other least preferred patient had prior therapy experiences which therapist C characterizes as both positive and negative.

Therapist C describes the most preferred patients as seeking therapy because of conflict or depression involving the patient's relationship with family members. Therapist C describes two least preferred patients as coming to therapy because of anxiety and depression about academic concerns. One of them was also concerned about feelings of social isolation. The third least preferred patient was described as coming to therapy because of difficulties with social isolation as well.

Therapy with most preferred patients continued up to the end of the work year. One least preferred patient's therapy continued through the end of the work year, but the two other least preferred patients ended therapy several months earlier. In both cases there was mutual agreement

between the patients and therapist C about ending treatment.

Therapist C interviews:
most preferred patients

In describing his work with most preferred patients therapist C emphasizes that the quality of the personal interaction between the patient and himself is of central importance to his feelings of preference. He feels that his most preferred patients possess "sterling character" because they have high integrity, are modest, and show sensitivity and responsiveness to the needs of others. In addition to valuing these unique personal characteristics therapist C also views most preferred patients as unusually intelligent, perceptive, and quick to develop the ability and motivation to understand themselves psychodynamically, which makes the therapy work particularly interesting for him. The therapy relationship with these patients involves mutual giving, caring, and appreciation, as well as hard psychodynamically-oriented work.

Therapist C begins each interview with a description of the unique personal qualities his most preferred patients possess. He next describes their quick development of psychological-mindedness and interest in understanding themselves psychodynamically, which makes the work enjoyable to him. He also states that he feels personally gratified by the mutual giving and appreciation in the relationship with these patients. He says of MP1:

> He's preferred, one, because of his uniqueness as a person. He's, I think, extraordinarily gifted in

> terms of his intuition and perceptiveness and sensitivity. . . . Tremendous fairness and openness. His enormous capacity to see all sides of a question both from his own vantage point and from his understanding of the people he talked about . . . that's why personally he's preferred. Then you might say therapeutically or psychologically . . . it's so marvelous to find someone who was so engaged and worked so hard and struggled so with himself, and was so honest and searching and trying so hard to really understand himself and work things through. I thought he gave me alot; . . . that sort of ineffable interaction where you just feel so engaged with someone. . . . I learned alot about psychological dynamics from sharing his feelings and his perceptions.

Therapist C's initial description of MP3 is as follows:

> He is mature, extremely intelligent, extremely eager and responsive, and committed, and he really made me feel as if I were giving him alot. . . . Full of integrity, trust, terribly terribly nice human being. A person with a great deal of strength and resources, gifts, charm, in a very unassuming way, you know, a sterling character. . . . I think he quickly became very psychologically-minded and very interested in himself. Not just in working on the problem which brought him to therapy, but understanding himself in all sorts of ways. And I think he learned quite a bit about himself, and that meant alot to him and made him see how much he wanted to change.

Therapist C also gives his initial impressions of MP2:

> He's just, to me, very likeable. He's extremely intelligent and yet modest about it and very competent; . . . he's very fair, very open, very honest, very genuine, a very decent person. You have the feeling that he's motivated by very good principles, alot of integrity. He obviously gratifies me alot because he likes therapy. He feels it's been helping him alot, and I must say . . . it's so clear in this case, and it's very gratifying. . . . I look forward to the hours.

In the pilot study therapist C states that in the kind of therapy relationship that makes him feel most engaged and effective, it is as if he and the patient are "arm in arm walking . . . there is this willingness to embark on

this walk together." Therapist C again uses this same image to describe the therapy relationship with one of his most preferred patients. He states that the mutual collaboration in the work was like taking a "tandem walk." His use of this imagery underscores the importance to him of the personal interaction between himself and his most preferred patients:

> It was almost like leading someone through a path in the woods where you know the way and you just say, "You can turn here or turn there," and in that sense helping him from going too far afield. . . . He was such a great companion, you might say--so stimulating. Offered so much.

Therapist C articulates a feeling of personal identification with the conflicts with which his most preferred patients were dealing. He states that he has experienced similar struggles in his own life. It appears that his personal identification with most preferred patients contributed to his feeling of preference and special rapport with them.

Therapist C's sense that mutual giving, caring, and appreciation characterized his relationship with most preferred patients is evident in his decisions regarding how frequently to meet with the patients. Although therapy sessions are normally held on a weekly basis, it was therapist C's choice to meet with two most preferred patients on a twice weekly basis. He chose to work with the third most preferred patient once every other week. He explains that this was a way to continue to see him on a long-term basis rather than terminating when there was great demand for service on the part of new patients. It is apparent that

therapist C expressed his commitment and involvement with his most preferred patients in the giving of his time. He explains that the patients responded to the time commitment he made to them by showing appreciation and high motivation to work on their difficulties. He states that the patient he saw on an every other week schedule was "very grateful" that he was able to continue in therapy and he explains the mutual commitment to the therapy work he shared with the patient:

> I was very motivated to keep him because he was so motivated and working so hard and I thought so well and getting so far.

In discussing his decision to meet with another most preferred patient twice a week, he describes his eagerness to give as much effort as he could to the patient. He states that the patient responded with strong commitment to the therapy process and explains that he was deeply moved that the patient became much more open about himself when they began to have more frequent sessions:

> Those were very moving sessions when he certainly opened up much more about himself and his early memories. . . . I felt it was important to really hang in there; . . . how needful he was both of help and support, and how much there needed to be done, and how much he wanted to work on things . . . plus my willingness, liking him and wanting to give as much as I could.

He states that he initially began to meet twice a week with the third most preferred patient because he seemed to need it. He continued this schedule because of his personal interest in the patient and the pleasure he felt at the patient's responsiveness to his efforts:

> I saw him twice a week when I could, and then I continued to because he was working so hard and so well and was such a joy and a pleasure and I was so interested.

Therapist C's description of his high degree of effort, commitment, and involvement in the therapy work with most preferred patients includes his personal response to the patient. His personal motivation to help the patients impelled him to go beyond the work requirements inherent in the role of therapist. When he speaks of his own efforts he simultaneously describes the patient's efforts as well, so that he and the patient seem to be responding to each other's behavior in their mutual commitment to the therapy work. Therapist C experiences most preferred patients' exploration of their innermost thoughts and feelings with him as a personal kind of sharing that makes him feel appreciated, helpful, and competent. He describes his sense that one most preferred patient was giving him a great deal in sharing his inner experience with the therapist, and he explains his own high level of dedication to the therapy work:

> He talked very freely and shared so much, and I thought I was giving him the message that I had alot of compassion for what he was going through and appreciated his opening up and letting me in and sharing. . . . I always felt he was giving me so much by letting me in, by letting me see what he was really like because I think he was remarkable. . . . I guess I never worked with someone who engrossed me quite so much, both intellectually and emotionally. And every hour was a remarkable experience in terms of my total dedication . . . my total responsiveness, my total working hard and concentrating, and my feeling that I learned so much from him.

He describes taking personal pleasure in expending a very high degree of effort in the work with another most preferred

patient and feeling that the patient reciprocated with hard work and appreciation:

> I felt alot of press to try to help him. . . . I worked with great pleasure and joy, involvement, energy; . . . he did make me feel very competent. . . . He was just so responsive to his insights, and carrying them further, and being so positive and appreciative. It just was great--everybody should have that once a year.

Therapist C also discusses the mutual liking and acceptance he felt in the work with the third most preferred patient in addition to describing their mutual commitment to the therapy work:

> It was challenging in that I wanted very much to do it; . . . it was easier to work with him--it didn't feel so hard, but I certainly worked hard. . . . A breakthrough recently and we really are working on that; . . . he was very moved . . . it was very touching . . . I felt very rewarded. . . . It's so obvious that he trusts me and feels that I help him. He likes me, is comfortable. . . . I'm so genuinely aware of my liking of him and my acceptance of him. It's not ambivalent, it's not complicated.

Therapist C feels that his most preferred patients developed a high degree of insight into their difficulties. He believes that helping patients to "get in touch with" their feelings is the key to their development of insight, and he stresses that the therapy work was not an intellectualized process. Therapist C assesses the improvement shown by the patients in terms of their becoming more able to understand and express their feelings in formerly conflicted areas of their lives. Therapist C contrasts the earlier phase of therapy with one of his most preferred patients in which the patient was more intellectualized in his manner, with the later development of greater freedom

on the patient's part to express his feelings directly. Therapist C explains that he directed his efforts toward helping this patient to explore his feelings and that he made few interpretive or explanatory interventions:

> The therapy hours were so bland compared to what it became; . . . it got to be much more feeling and internal experience as opposed to . . . that descriptive way. . . . I wanted to help him to get in touch with his feelings and understand things. . . . I tried to ground him and hold him with things and help him look rather than . . . offering him many explanations or interpretations. . . . It was much more asking him questions, helping him to get into his feelings . . . trying to be really with him on his wavelength. . . . That was a real change; . . . to be in touch with his own feelings and thoughts, and furthermore to hold onto them and even express them. This happened a few times, which was really impossible before.

Therapist C describes the improvement shown by another most preferred patient with similar emphasis upon the patient's greater ability to be in touch with and express his feelings:

> He also made tremendous strides vis-a-vis [conflicts with his family];getting in touch with his anger and being able to express it more to X; . . . really got to the point of talking to X very directly . . . and just in general, self-acceptance.

Therapist C also refers to the third most preferred patient's development of insight based upon greater awareness of his feelings in his description of the progress made by the patient:

> He certainly became more expressive with X, and got in touch with his anger and what he wanted, and was able to give voice to that alot more. And the appreciation of himself and how he behaves, . . . that tremendous awareness of what he was doing and what the effects were. . . . The pressure he felt and what it did to him, and how it affected his personality . . . and his contribution to things. He became very introspective and very curious.

Therapist C views his most preferred patients as

showing only a moderate degree of behavioral improvement relative to the high level of insight he feels they achieved. He relates their limited ability to translate insight into behavioral change to the relatively serious nature of their psychological difficulties. He explains that one of the patients was among the most disturbed individuals with whom he has ever worked. He expresses pessimism about the small degree of progress this patient was able to make, and mentions that the patient was also discouraged by his inability to make substantial changes in his behavior:

> He could function so well even though there was tremendous pathology underneath. . . . I think his problems are on a very primitive level, . . . tremendous anxiety all the time about an awful lot of things. . . . I think he had alot of understanding, but it was so hard for him to feel that he could use it and could change. And the few steps he could take that were different, I'd applaud. He would often not be so encouraged, . . . alot of the time he was very hopeless about ever being able to be different and get along better by changing his behavior. . . . At times I thought he was less depressed . . . but I didn't trust that. I felt he could move back to the earlier position. . . . I still think [serious depression is] an active possibility for the future for him.

Therapist C also feels that another most preferred patient had serious psychological difficulties. He mentions that despite the progress made by this patient in certain areas of his functioning, there was not much progress in other areas:

> He's really a very obsessive-compulsive person with a lot of rigidity, a lot of doubts about himself. . . . When he first came I didn't have the hope, confidence . . . that therapy would help. . . . I just didn't know that he could loosen up very much; . . . he was very, very perfectionistic . . . has alot of ups and downs. . . . He felt progress . . . but he did want to talk more about . . . his conflicts. . . . Some

> progress has been made there, but not really as much; . . . I'd really like to take him further on that issue.

Therapist C explains that the third most preferred patient had less serious psychological problems than the other two but faced difficult situational problems which caused him to be depressed. He feels that this patient also developed greater insight into his difficulties than ability to change his behavior:

> The presenting thing was so much to get over. The depression and how to understand that. . . . How he behaved, at times, disappointed him, . . . how he wanted to be different! Even if he didn't actually effect it, that tremendous awareness of what he was doing and what the effects were.

Therapist C interviews: least preferred patients

Therapist C feels that the therapy relationship with his least preferred patients was characterized by psychological and emotional distance. He describes his interaction with each least preferred patient as dominated by "pushing," "pulling," and "tugging." Therapist C views his least preferred patients as individuals with whom he could not identify and whom he could not value and respect. He feels that these patients lacked both the personal qualities of sensitivity and responsiveness to the needs of others and the high motivation and ability to explore their problems in a psychological way, which he valued in his most preferred patients. He characterizes his least preferred patients as needy, demanding, and dependent and he feels that they pulled and tugged on him for attention, for gratification of dependency

needs, and for magical solutions to their problems. He explains that he pushed and tugged in the attempt to overcome the patients' resistance to collaborating with him in psychodynamic exploration of their problems. He expresses feelings of frustration and dissatisfaction about the therapy with these patients because he experienced a lack of personal reciprocity and mutual collaboration to do psychodynamically-oriented work.

Therapist C states that one of his least preferred patients developed substantial insight into his difficulties and made behavioral progress as well. He explains that this patient was least preferred because of "his personality, his style." He feels that this patient's extreme narcissism represented the opposite of the qualities of responsiveness to the needs of others and eagerness to engage with the therapist in a collaborative psychodynamic exploration of problems, which therapist C valued in his most preferred patients. Therapist C feels that this patient tugged at him for attention rather than valuing him as a collaborator in a psychological work relationship. He adds that the patient wanted him to do all the giving in the therapy relationship without giving anything himself:

> I didn't rate him high because I found him one of these very needful people who just pulls from me. I have the feeling he can never get enough attention, never get enough time. . . . He seems extremely narcissistic, extremely self-centered; . . . a feeling that I can never make up for the lacks he feels he apparently experienced. . . . Always pulling on you and wanting your attention. It's almost physical, as if, you know, tugging. . . . No matter how much

> you give him he'd want more. . . . I always felt really he couldn't care a whit about anybody else; . . . inability to give at all and just wanting to get . . . I want to say, "Let me be. Go away."

Another least preferred patient is also characterized as an individual whose personal qualities therapist C could not respect or value. He feels that this patient was extremely bland, naive, simplistic in his thinking, and passive-aggressive. Therapist C states that this patient lacked the motivation and ability to engage in psychological exploration of his problems, and the patient's lack of psychological-mindedness made the therapy work unenjoyable for therapist C. Therapist C describes this patient as needy and dependent and feels that the patient made covert demands for the therapist to transform his life without giving any of his own efforts to the therapy process. Personal reciprocity and mutual collaboration in the therapy relationship between patient and therapist hence were lacking in his work with this passive-aggressive patient:

> His immense passivity and blandness. I would try to get him somewhat engaged, somewhat more lively, but it was hard . . . not psychologically-minded, not introspective. Needy, you know, dependent. If I could just [do X for him] then everything would be fine, he seemed to think. . . . He was also terribly naive and terribly simplistic. I think that's another reason why I didn't like working with him. And I tried very hard to make him . . . see that things were more complicated. . . . My hunch is . . . that he was not only passive but passive-aggressive. . . . He didn't make those demands overtly, but underneath . . . he hoped that by some magic it would happen.

Therapist C explains that the third least preferred patient was a very inadequate person who had no "personhood" with which he could identify. He feels that the patient had

very serious psychological problems that prevented him from developing psychologically during the course of his life. Therapist C describes the patient as refusing to cooperate in a collaborative effort with the therapist to consider his problems from a psychological vantage point:

> He has always caused me no end of grief; . . . he's impossible to work with. . . . As soon as we would begin to really talk about something psychological and really would get close to the core of things, he wouldn't want to cooperate. . . . Psychologically, that he never sort of had a chance to develop. . . . He has had so many psychological problems and is so tied up in knots . . . so repressed. . . . I feel he must be so closed to himself; . . . how inadequate a person I feel he is. . . . He's probably very intelligent. It's even hard for me to really feel that and experience that when I'm with him; . . . there's no personhood there.

In the interviews therapist C devotes much time to describing his persistent efforts to overcome the strong resistance of the patients to becoming "open" and "engaged" with him in a psychological work relationship. He repeatedly employs the images of "pushing" and "pulling," which emphasize the psychological and emotional distance and opposition characterizing his therapy relationship with least preferred patients. Therapist C states that LP2 was "an implacable block" he was trying to penetrate in describing his attempts to engage the patient in psychodynamic exploration of his problems. This image gives concreteness to therapist C's sense that the patient was shutting him out from psychological collaboration and closeness. He believes that the patient remained highly resistant because his serious psychological problems made him fearful of becoming more open

both to himself and the therapist:

> It was sort of like this implacable block--no way to get in--you try and try. . . . I felt I just couldn't get in and make any difference, into all this morass. . . . So much resistance; . . . I try to pull things out of him or get him to see things. . . . His usual answer is that he doesn't have a clue. . . . I just felt I was dealing with someone who was so unable to help himself at all. And I was so unable to reach him. . . . He didn't want to go too deeply into things . . . because he was afraid. . . . He realized that he'd never committed himself to therapy.

In therapist C's description of his efforts to overcome LP1's resistance to collaborating in a psychological work relationship, the therapist's active giving and the patient's passive lack of reciprocation is clear:

> It was very hard to find out very much; . . . he wasn't a very open person. . . . If you would try and confront him with expectations or what did he think he would accomplish here . . . you wouldn't get much. . . . It was very hard to get at [his feelings]; . . . pulling teeth, a challenge to engage him. I did try to do alot of digging about his background; . . . in terms of making connections like that I would try and pull and stretch and point, and still, you know, he would just sort of sit there. And I thought I'd been doing sort of interesting work, suggesting possibilities, and trying to be engaged myself.

Therapist C feels that at the beginning of his relationship with LP3 the patient was closed to him and resisted his efforts to engage him in psychodynamic exploration of his problems. He explains that the patient eventually began to consider his problems from a psychodynamic viewpoint and that he ultimately attained substantial insight. Therapist C experienced the patient's development of interest in psychological exploration of himself as a change the patient made on his own, rather than viewing it as the product of a col-

laborative effort with the therapist:

> I think he was resistant alot early on and wasn't as open as he became. . . . Even though I might suggest things he usually had to reject them. . . . So it was very hard to get in; . . . there was no way to get in with him . . . I never felt I could get in. . . . I guess I hung in there, and what happened was that he began to work on his own; . . . he began to see connections on his own.

Therapist C's feelings about the quality of the personal interaction between patient and therapist and the outcome of therapy with least preferred patients contrast sharply with his sense of feeling engaged, helpful, competent, and appreciated in his work with most preferred patients. He expresses feelings of restlessness, disinterest, frustration, and irritation about least preferred patients' lack of personal reciprocity and mutual collaboration to do psychodynamically-oriented work. He feels that two of the patients neither developed insight nor made behavioral progress. He was also dissatisfied with the therapy with the third least preferred patient despite the insight and improvement he achieved, because of the patient's lack of genuine engagement and collaboration with the therapist.

Therapist C states that he felt despairing about his inability to help one of the least preferred patients make therapeutic progress. He viewed this patient as a deeply disturbed individual for whom he provided a much needed supportive and educational experience. Therapist C found the absence of psychological engagement and exploration in his work with this patient frustrating and unsatisfying:

I really see him as a very crippled person psycho-

> logically . . . all his life from childhood on. . . . I was very despairing that I felt I couldn't get in and make any difference; . . . I can't see that our working together made any difference except that he certainly seemed to want to touch base and come. . . . It was to give him support and help him review things, be interested. . . . He was so needy and so out of contact with people that someone he could talk to was important. . . . I thought it was supportive and education . . . but to me that's not therapy and I think I would feel very frustrated . . . irritated. . . . I could never really come to terms with that.

Therapist C views the passive-aggressive patient as less seriously disturbed, but feels that his naive and simplistic manner suggested immaturity. He explains that the patient viewed therapy as a place to come and tell stories about himself without making any effort to understand their psychological importance to him. Therapist C asserts that since no psychological work was being done, he was relieved when the patient decided to stop coming:

> When there were events that he wanted to report . . . then he would come in and tell a story . . . without any thought as to looking at how come it happened, or what does it mean or what does it say about him. . . . We weren't doing anything or getting anywhere and I did find the hours a terrible drag, so in that sense it was a relief, but I just felt professionally it shouldn't have happened. . . . Nothing was happening . . . nothing would take.

Despite the third least preferred patient's attainment of insight and behavioral improvement therapist C expresses negative feelings about the quality of the interaction between the patient and himself. Therapist C found the patient's narcissism a barrier to mutual engagement and reciprocity in the work. He feels that the patient viewed him as a source of gratification of needs for attention and admiration, rather than as a collaborator in a psychological

work relationship. Hence therapist C believes that his own therapeutic contribution was never really appreciated by the patient. He also feels that the patient's narcissism represented serious psychopathology, which frustrated him because he viewed the progress made as only a modest beginning in the process of change for the patient:

> I didn't enjoy working with him; . . . he is so self-absorbed and so delighted with himself and his own productions, and I often didn't find them that interesting. . . . I really didn't look forward to those hours. I would get restless before they were over. . . . His whole style; . . . sort of this pleading, "Admire me," . . . "gratify me!" . . . I guess it's also the infinite quality about it; . . . that no matter how much you give him he'd want more. . . . Another thing that made it so frustrating to work with him--even though he was beginning to open up and beginning to see some patterns, it was just such a beginning. How far down he needed to go; . . . his very profound conflicts were on a very primitive level.

Therapist C rating results:
most preferred patients

Therapist C's range of summed scores for most preferred patients was 3-9 and his range for least preferred patients was 3-14 (see tables 7 and 8). His full range of 3-14 has been divided into three parts. Summed scores from 3-6 are his High summed scores. Scores from 7-10 are Moderate summed scores, and scores from 11-14 are Low summed scores. Therapist C's modal group for most preferred patients is the High one containing 16 items (see table 7). There are 4 Moderate items and no Low items. Relative to the other therapists, therapist C's summed scores for most preferred patients are heavily concentrated in the High end of the range.

Therapist C feels that in the therapy with most

TABLE 7

THERAPIST C: SUMMED RATING SCORES
MOST PREFERRED PATIENTS

Rating questions	Scores
High scores (3-6)	
Psychological thinking	5
Initial resistance	5
Patient attitudes	4
Patient involvement	3
Therapist empathy	3
Therapist understanding	3
Challenge felt	4
Personal identification	4
Liking for patient	3
Therapist involvement	4
Therapist competence	3
Therapist effort	3
Mutual collaboration	3
Feelings emphasized	3
Understanding emphasized	4
Insight attained	3
Moderate scores (7-10)	
Psychopathology	9
Similar backgrounds	8
Initial optimism	9
Behavioral improvement	7

TABLE 8

THERAPIST C: SUMMED RATING SCORES FOR LEAST PREFERRED PATIENTS

Rating questions	Scores
High scores (3-6)	
Patient attitudes	5
Patient involvement	6
Therapist empathy	4
Challenge felt	3
Therapist involvement	5
Therapist effort	5
Moderate scores (7-10)	
Initial resistance	9
Therapist understanding	7
Mutual collaboration	9
Feelings emphasized	8
Understanding emphasized	8
Behavioral improvement	10
Low scores (11-14)	
Psychopathology	13
Psychological thinking	14
Personal identification	14
Similar backgrounds	12
Liking for patient	12
Initial optimism	12
Therapist competence	11
Insight attained	12

preferred patients there was a High degree of collaboration with the therapist in emphasizing both feelings and intellectual understanding, resulting in a High degree of attainment of insight on the patients' part. Therapist C views most preferred patients as High in initial psychological thinking, positive attitudes toward the therapist, and involvement in the therapy process. He feels that they showed little initial resistance to therapy. He feels that he was Highly involved in the therapy work, that he expended a High degree of effort, and that he felt Highly competent. He gives High ratings to his liking of the patients, his sense of empathy and personal identification with them, his degree of understanding of them, and the degree to which he found the work challenging. He felt Moderately initially optimistic about the outcome of therapy and viewed his own background as Moderately similar to that of his most preferred patients. He views the patients as showing a Moderate degree of psychopathology and as developing a Moderate degree of behavioral improvement.

Therapist C rating results:
least preferred patients

Therapist C's modal group for least preferred patients is the Low one containing 8 items (see table 8). There were 6 items in both the Moderate and High categories. Relative to the other therapists, therapist C assigned more High scores to rating items for least preferred patients.

He views least preferred patients as High in positive

attitudes toward the therapist and in their involvement in the therapy process. He feels that he was also Highly involved in the therapy and that he expended a High degree of effort in the work. He found the therapy work Highly challenging and was Highly empathic with the patients. He feels that he developed a Moderate degree of understanding of least preferred patients and that they showed Moderate collaboration with him in emphasizing exploration of feelings and intellectual understanding. He found them Moderately initially resistant to therapy and feels that they showed a Moderate degree of behavioral improvement. He feels that least preferred patients were Low in initial psychological thinking and that they developed a Low degree of insight into their problems. Therapist C viewed them as High in psychopathology. He feels that he had a Low degree of liking for least preferred patients and that his sense of personal identification with them was Low as well. His degree of competence about the work with them was Low, as was his initial optimism about the outcome of therapy. He views his own background as Low in similarity to that of his least preferred patients.

Areas of inconsistency between ratings and interview material

Therapist C's summed scores for most preferred patients do not describe this patient group in an articulated way because the ratings are globally positive. The interview comments provide details necessary to understand his percep-

tions of most preferred patients.

There are several inconsistencies between therapist C's ratings and his interview impressions of patients, resulting from the use of summed ratings which obscured individual differences among patients shown in the individual ratings and in the interview material. Therapist C rates most preferred patients as showing Moderate psychopathology, but the interviews and individual ratings show considerable variation among patients (see table 9). In the interviews therapist C states that one patient was among the most disturbed he had ever treated. Another most preferred patient was felt to be moderately characterologically disturbed, while the third patient was seen as having less serious psychological difficulties. In the interviews therapist C emphasizes both the behavioral gains made by most preferred patients and the limitations upon the behavioral progress made. These distinctions are not reflected in the Moderate rating of behavioral improvement. Therapist C's least preferred patients are also rated as showing Moderate improvement. The individual ratings and interview impressions of patients reveal that therapist C viewed two patients as showing Low improvement while the third patient showed Moderate improvement. This same patient was also described and rated as developing a High degree of insight. Yet the least preferred patient group was rated as attaining a Low degree of insight. Therapist C also rated the degree of initial resistance to therapy shown by least preferred

TABLE 9

THERAPIST C: INDIVIDUAL RATING SCORES FOR MOST PREFERRED AND LEAST PREFERRED PATIENTS

Rating questions	MP1	MP2	MP3	LP1	LP2	LP3
Psychopathology	2	3	4	3	1	1
Psychological thinking .	1	1	3	5	5	4
Initial resistance . . .	3	5	5	5	1	3
Patient attitudes	2	1	1	2	1	2
Patient involvement . . .	1	1	1	3	2	1
Therapist empathy	1	1	1	1	2	1
Therapist understanding .	1	1	1	3	3	1
Challenge felt	1	2	1	1	1	1
Personal identification .	2	1	1	4	5	5
Similar backgrounds . . .	4	2	2	5	5	2
Liking for patient . . .	1	1	1	4	4	4
Therapist involvement . .	1	2	1	3	1	1
Initial optimism	2	4	3	3	4	5
Therapist competence . .	1	1	1	4	5	2
Therapist effort	1	1	1	2	2	1
Mutual collaboration . .	1	1	1	5	3	1
Feelings emphasized . . .	1	1	1	4	2	2
Understanding emphasized	2	1	1	3	3	2
Insight attained	1	1	1	5	5	2
Behavioral improvement .	4	1	2	4	4	2

patients as Moderate, but his interview comments convey his sense that the patients were Highly initially resistant to therapy.

Therapist D: Most Preferred and Least Preferred Patients

Patient caseload from which cases were selected

During the working year at the university, therapist D saw a total of 14 patients for 13 or more sessions, the criterion for inclusion in the study.

Description of patients selected by therapist D

Therapist D rated the 14 patients on the degree to which the therapist Enjoyed the work and felt that the therapy was Helpful. All three most preferred patients were rated 1 on the Enjoyment dimension and 2 on the Helpfulness dimension. Therapist D assigned no ratings of 1 to the Helpfulness dimension. One least preferred patient was rated 3 on both the Enjoyment and Helpfulness dimensions, and a second was rated 5 on the Enjoyment dimension and 4 on the Helpfulness dimension. The third least preferred patient is of interest because he received a negative Enjoyment rating but a positive Helpfulness rating. He was rated 4 on the Enjoyment scale and 2 on the Helpfulness scale.

The most preferred patients tended to be slightly younger than the least preferred patients. The mean age for the most preferred group was 20.3 and the mean age for the least preferred group was 22.3. There were undergraduates and graduate students in both groups. The average

number of therapy sessions with most preferred patients was 22, while least preferred patients had an average of 14 therapy sessions with therapist D. In both the most preferred and least preferred groups, the patients began meeting with therapist D on a weekly basis. One most preferred patient and two least preferred patients were moved to an every other week schedule as therapist D's workload became heavier. Two most preferred patients and two least preferred patients had previous therapy contact with therapist D.

Therapist D describes the most preferred patients as having diverse reasons for seeking therapy. Each was engaged in a kind of identity conflict involving struggles with the beginnings of his adult development. The least preferred patients were described as coming for therapy because they had general interpersonal problems as well as difficulties in the area of feeling sufficiently mobilized to function well on a daily basis. Therapy with both most and least preferred patient groups continued up to the end of the working year, although the therapy with one least preferred patient ended slightly before this time on the basis of mutual agreement between patient and therapist.

Therapist D interviews:
most preferred patients

Therapist D's interview comments and rating results indicate that his patient preferences are not determined by the degree of psychological-mindedness, attainment of insight, or level of behavioral improvement shown by his most

preferred patients. He feels that the patients ranged from developing little insight and showing little improvement to achieving substantial insight and change. In the pilot study therapist D explains that he views himself as being most effective with patients for whom he feels greater empathy and liking. He states that his feelings of preference for patients develop in an intangible way and are "like friendships" in that sense.

Therapist D's feelings of preference for patients primarily seem to be a response to the "person" of the patient rather than a reaction to characteristics which relate to fulfilling the role of a therapy patient. The interviews about his most preferred patients begin with his observation that he found the patients "likeable" and "appealing," and experienced a sense of "empathy" or "identification" with them.

Therapist D describes MP1 as the most seriously psychologically-disturbed patient with whom he worked on a regular basis. His initial comments about why he preferred working with the patient are as follows:

> Basically because I found him a very appealing, likeable person. I could empathize with some of the things he was going through. . . . Probably of the students whom I've been seeing on a regular basis . . . the most disturbed student, which generally would be a reason why I wouldn't enjoy working with someone like him, but I found him likeable, and also, I found that I could get into his world. . . . That despite the degree of loss of touch with reality . . . he and I were communicating on some wavelength; . . . the rapport transcended just sitting there and talking.

In his initial observations about his preference for

work with MP2, therapist D mentions that in addition to feeling that he liked and identified with the patient, his response to the patient is atypical for him. This was also true for MP1 whom he preferred despite the patient's serious psychopathology, a factor he normally does not associate with preferred patients. It seems that therapist D's view that his response to these patients is unusual for him contributes to his feelings of preference:

> What made him stand out . . . in very atypical style for me, I told him he was crazy if he was even thinking of doing it [suddenly leaving school]. . . . It was certainly a departure from the way I respond to people. . . . I probably in some way was identifying with him, not in terms of his personal identity, but almost like a parent to a child. . . . It was definitely a sort of parental kind of role. . . . The therapy was quite relaxed and I had a feeling of, again, liking him, and that he felt that way too.

Therapist D also describes his positive feelings about MP3 as a person, in his first comments about his work with the patient:

> I found that it was easy to relate to him. I felt to some extent some identification with him, . . . just a certain basic rapport that made things seem easy. . . . Some degree of warmth and more identification . . . in terms of his personal background. . . . I enjoyed him as a person so that it was a pleasant hour.

Therapist D explains that he trusted his most preferred patients to communicate with him openly and turn to the therapy relationship as a source of help rather than fleeing from therapy at a time of crisis. Their welfare was not a source of worry and burdensome concern for therapist D for this reason. Hence, he comments repeatedly that he felt a sense of "comfortable," "relaxed" "rapport" in the

therapy work with his most preferred patients. Therapist D describes the feeling of comfortable rapport he shared with MP1, whom he trusted to contact the therapist when his serious psychological difficulties were overwhelming to him. He adds that the patient also felt sufficiently comfortable and trusting of the therapist that he was able to express negative feelings about him without needing to flee from the relationship:

> I felt comfortable with what was happening, and that somehow or other he would sooner be in touch with me than taking self-destructive action. . . . Collaboration evolved and became pretty important. . . . He was able to be comfortable being rejecting and harsh at times; . . . he would just stand up and say, "I really can't talk any more." . . . I felt completely comfortable with that. I didn't feel I had to go chasing him. I knew that he would come back for our next appointment.

Therapist D explains that he felt comfortable and relaxed in his therapy relationship with another most preferred patient. They shared good rapport and the patient's psychological difficulties were not so severe as to be a taxing burden for the therapist:

> The therapy sessions were relaxed. I guess that I didn't feel that his problems were of that kind of nature that they were so severe that I didn't feel they were taxing or a great burden; . . . that contributed to the relaxed feeling. . . . The relationship was very relaxed, very comfortable.

In the pilot study therapist D states that he feels a sense of identification with creative individuals and enjoys working with them in therapy. He describes each of his most preferred patients as questioning the conventional patterns of behavior they have been following and as strug-

gling to find a personal identity which lay off the beaten track. It seems that therapist D's feelings of preference for the patients were enhanced by his view that they were engaged in a creative process of building a personally meaningful identity. He states that one of his most preferred patients "had grown away from . . . the usual run of the mill kind of ambition" and that he found the patient's choice a "refreshing" one. He expresses feelings of identification with the patient in his struggle to find a personal identity which was not conventional. He also explains that the patient who was on the verge of suddenly leaving school was mechanically following a conventional pattern of behavior without examining the personal meanings of it. During the course of his therapy work with therapist D the patient did question the meaning of his behavior and identity. He also describes the third most preferred patient's development of awareness that the conventional behavioral path he had been pursuing seemed hollow to him:

> He had never before really asked himself why . . . he was mechanically going on and on a given path, and now at least he was stopping and looking at it and asking himself about it. . . . It was different, and in that sense I thought important. . . . We got more into . . . why he in a sense had these expectations of himself. As it became less and less clear to him why he had them he began to in a sense doubt their import. Which wasn't necessarily a very pleasant thing for him because in the long run he didn't know where he was at then; . . . it had a much hollower sound to it.

It seems that therapist D's patient preferences are not determined by his perception that his most preferred patients attained substantial insight into their difficulties

and achieved significant behavioral gains. He views the nature of his therapeutic collaboration with one most preferred patient as a primarily supportive, stabilizing operation. He feels that this patient resisted thinking about his difficulties in a psychological way and feared developing insight into them. Therapist D was not certain of his own understanding of the patient, and he feels that the patient made little behavioral progress in therapy:

> The level . . . which essentially we were dealing with things was very superficial most of the time, and certainly supportive rather than any kind of in-depth work. . . . Having me as an anchor; . . . there was not very much change really. I saw it from the very beginning as at best a stabilizing or holding operation. . . . He came motivated by desperation . . . with a lot of hesitation. A lot of questions and doubts about therapy. . . . Very difficult to get into his own feelings and thoughts. . . . I'm not sure that I really understand him at the end; . . . it might be that really the understanding was rather complete, but didn't particularly generate too much in the way of change.

Therapist D's initial comment about another most preferred patient is that nothing very much happened in the therapy but that he liked the patient and could relate to him with ease. He feels that the patient achieved some significant insights about his difficulties but that they were not translated into behavioral change to a notable extent:

> Nothing really that much happened; . . . I don't really think it changed much frankly. I think the only thing that really changed was his looking at things; . . . his having stopped and taken a look and questioned. . . . He may just cover it all up again. . . . We got more into his past history and his background . . . to stir up some things and make some connections. All this was really pretty tentative.

Therapist D feels that the third most preferred patient

attained a substantial degree of insight and behavioral improvement. Yet he expresses some doubt about whether this might have occurred because of the patient's general development over the course of time, rather than as a result of therapy:

> We did get into some basic dynamics; . . . he was able to work on them quite well, both on a feeling level as well as intellectually. . . . There was a sufficient degree of improvement that . . . his relationships . . . had changed significantly--was certainly one of the sources of his problems. . . . I'm not sure that it wouldn't have all happened anyway, just in the course of getting through school.

Therapist D's feelings of preference seem influenced by his perception that his most preferred patients initially showed a kind of special selection of him as the therapist to whom they chose to commit themselves. He explains that he initially felt he should not work with one most preferred patient and that he recommended that the patient seek private therapy. He states that he continued to work with the patient because the patient felt comfortable with him and requested to remain in therapy with him:

> I really felt I couldn't give him the time he needed. . . . He felt very comfortable working with me. . . . Finally he was the one that decided; . . . I compromised and decided to work with him, basically on his request. . . . [His feelings about me] were very positive; . . . I think they developed very strongly after a while.

Therapist D states that another most preferred patient asked to work with him again after having previous therapy contact with him in the past. He feels that the patient maintained a fantasy that the previous contact had been even more positive and helpful than therapist D believed

was realistic. As long as the patient was working well with him, though, he felt it was unnecessary to examine the patient's assumptions:

> I had seen him once before; . . . coming back to see me in a sense, sort of again going on with his fantasy of how wonderful this relationship was. . . . It was paradise seeing me; . . . he seemed quite involved in the therapy process.

Therapist D also views the third most preferred patient as selecting him as the therapist to whom he chose to commit himself. He explains that the patient accepted his advice to stay in school and work with him in therapy. The patient became highly involved in the therapy process and his feelings about the therapist seemed quite positive. Therapist D comments that the patient "would have come two or three times a week if given the opportunity."

Therapist D interviews: least preferred patients

Therapist D does not describe his feelings about the "person" of his least preferred patients in positive terms. The comfortable, relaxed rapport he felt with most preferred patients is lacking in his relationship with least preferred patients. He does not mention that least preferred patients evoked in him feelings of empathy and personal identification, and when asked about these factors he replied that he felt little empathy and identification with the patients. Therapist D states that his least preferred patients seemed more highly involved in the therapy process than he was. He either felt bored, worried, and irritated by the work with

least preferred patients or felt personally removed from the therapy relationship. His attitude of least preference was based upon a sense of personal dislike in some cases and a feeling of burdensome worry and responsibility in others.

Therapist D's first words about one of his least preferred patients express his personal dislike of the patient. He comments that the patient was so boring and dull that he could understand why he had no real friends. Although he found him a bland, affectless, uninteresting person, therapist D did not feel that he had serious psychological difficulties:

> He was the most boring, dull person that I've ever seen. It was, you know, pulling teeth to get him to converse, to get him to talk. He wasn't really that disturbed. . . . In terms of . . . relationships with people . . . I really felt I could empathize with why no one really was very interested in him because there was so little that he seemed to offer in a relationship. . . . Very bland, affectless, uninteresting . . . no outside interests . . . had formed very few friendships. . . . He had some acquaintances but no real friends. In fact, that was consistent in the past.

Therapist D's initial description of another least preferred patient emphasizes his sense of personal dislike for the patient, despite his overall evaluation that the patient developed substantial insight into his difficulties and made significant behavioral gains. He comments that although the patient was not seriously disturbed, he had difficulty forming relationships with people. It seems that therapist D viewed his own negative personal reaction to the patient as one other people probably shared:

> I just didn't like him as a person particularly. . . . I didn't really care for him as a person; . . .

> he just rubbed me the wrong way. . . . His presenting complaints about difficulties in forming relationships, difficulty in trusting people, difficulty in maintaining relationships and friendships.

Therapist D claims that he liked the third least preferred patient as a person but that the patient would not collaborate with him in making a regular commitment to attend therapy sessions. The patient became seriously depressed from time to time and would come to therapy appointments only when he was depressed. Therapist D feels that the patient used the making and breaking of appointments in a manipulative way. His periods of depression were unpredictable to therapist D and he found the responsibility of dealing with them a taxing, exhausting source of concern:

> I found the pressure of his from time to time becoming depressed . . . in a sense wearing. . . . It was very unpredictable when he would be depressed; . . . there were all kinds of little manipulations. . . . When he wasn't terribly depressed . . . he was a rather likeable, down to earth person. Had a certain amount of humor. . . . I saw him sporadically. He would come and go. . . . When he wasn't depressed he'd stop coming. . . . When he was very depressed . . . I was concerned about his well-being and trying to be on top of where he is at . . . which was always very taxing, exhausting, a source of concern. . . . A question of feeling a sense of responsibility, and not particularly by choice.

Therapist D states that he experienced boredom and lack of involvement in the therapy work with one least preferred patient. Despite his efforts to throw himself into the work, he was only able to feel engaged with the patient in a half-hearted way. He believes that the patient contributed more to the work collaboration than he himself did:

> He was a big challenge but I wasn't really that

> involved to take up the challenge . . . my depth of involvement was pretty near nothing. I felt that it was a drag. And certainly when I would see that he was on my schedule for that day I didn't look forward to it. So there was really a negative component. . . . I think there was probably more collaboration emanating from him than from me. . . . I'd try to throw myself into it but I don't think I was very successful. I'd try at least to make the hour pass, get involved. . . . We tried to deal, sort of half-heartedly on my part at least, with the social adjustment.

Therapist D observes that another least preferred patient was more highly engaged in the therapy process than he was and that the patient seemed to feel quite positively about the therapist. He states that despite the good therapeutic progress made by the patient, his personal aversion to him left him feeling uninvolved in the therapy:

> He was more involved than I was. . . . He was very positive about the work; . . . I think his attitudes about me were very positive also. . . . My involvement was not very profound; . . . he didn't grow on me.

Although therapist D liked the third least preferred patient and feels that the patient viewed him positively, he states that the mutual collaboration was limited and that he himself did not feel highly engaged in the therapy work. Therapist D explains that it was difficult for him to feel involved in the therapy process when the patient was depressed, aside from being concerned about the patient's welfare:

> His attitude toward me was quite positive. In need he would come, but it had to really be pressing. . . . The mutual collaboration was limited, not that great. . . . My involvement depended a great deal on what he was bringing to the hour, frankly. When he was very depressed it was difficult to become that involved other than to be concerned about

his well-being.

Therapist D mentions that each least preferred patient showed a different sort of resistance to therapy. He says of LP1 that although he became more open about discussing his difficulties and thinking about them in a psychological way, he remained resistant in the area of examining his feelings. Therapist D was dissatisfied with the outcome of therapy in this area, despite feeling that other gains were made:

> Resistance was a big stumbling block in the beginning; . . . he would very much block out feelings. . . . Attempts were made, but it wasn't very successful. . . . There was a change, but much too little really, for the amount of time and effort that went into trying to elicit the feelings.

Therapist D relates the resistance shown by LP2 to the patient's lack of development of psychological-mindedness:

> He didn't show psychological insight or ability to think in those terms about himself. If you take that as a measure of resistance it was really very consistent.

In relation to LP3, therapist D states that his resistance consisted of not coming to appointments:

> There was alot of resistance. Right to the end he often would cancel appointments . . . and not come over for weeks.

Therapist D gives a negative assessment to the outcome of therapy with LP2 and LP3. He appears more dissatisfied about the therapy with these patients than he was with the therapy outcome with most preferred patients, even though he did not feel that most preferred patients made particularly substantial progress either. Therapist D

states about the degree of improvement shown by LP2 that the patient made "none." Nevertheless he reports that the patient became mobilized and began to function again after therapy began. It appears that part of therapist D's dissatisfaction with the therapy with LP2 is that he could not perceive a connection between the therapy work and the changes the patient was able to make. He refers to this several times in the course of the interview:

> He got working pretty soon after we started seeing each other. . . . I don't have any idea why. . . . He did start working, but I don't know that that had anything to do with our work, because it started relatively soon after he came to see me and it sort of became a side issue. . . . I asked him on many occasions why he kept coming and he seemed in some way to find it helpful, but I could never fathom why. . . . We tried to deal with [certain issues] . . . and never really got very far with it.

Therapist D feels that LP3 developed very little insight and that the therapy was effective only to the degree that it served a supportive function. He states that supportive therapy is not his preferred mode of working:

> It wasn't really that effective. It was supportive, and I think that the rapport established between the two of us was helpful to him. I don't think the therapy itself was. I don't think we really got very far. . . . [Supportive work] isn't my favorite thing, but it's a role here I've come to accept.

Therapist D feels more positively about the therapy outcome with LP1, in terms of his development of insight and progress he made in relationships with people close to him:

> Being able to open up and trust me. . . . He had a very strained relationship with X, which he was

> able to change. . . . He was also able to have a much more open relationship with X. To get in touch with some of his feelings. . . . In that sense he became a more insightful person; . . . was in that sense more psychological-minded. And I think was able to connect at least in my work with him . . . certain areas of his life which had been presenting problems when he came. They were at least working better. . . . Intellectual understanding was the level that he could work with most. It was more the area that was helpful to him.

Therapist D states that LP1 "didn't grow on me" and indicates that despite the gains the patient made, he had a feeling of least preference for him. It seems that the special feelings of personal liking, empathy, and rapport which were central to his preference for the patients selected as most preferred, were missing in his reaction to this patient.

Therapist D rating results:
most preferred patients

Therapist D's range of summed scores for most preferred patients was 4-12 and his range for least preferred patients was 5-13 (see tables 10 and 11). His full range of 4-13 has been divided into three parts. Summed scores from 4-6 are his High summed scores. Scores from 7-10 are Moderate summed scores and scores from 11-13 are Low summed scores. Therapist D's modal group for most preferred patients is the High one containing 11 items (see table 10). There are 8 Moderate items and 1 Low item. Since individual items were rated on a scale from 1-5, the highest possible summed score on any item is 3. That the highest summed score in therapist D's range is 4 indicates that he

TABLE 10

THERAPIST D: SUMMED RATING SCORES
FOR MOST PREFERRED PATIENTS

Rating questions	Scores
High scores (4-6)	
Patient attitudes	4
Patient involvement	5
Therapist understanding	6
Challenge felt	6
Personal identification	6
Liking for patient	4
Therapist competence	5
Therapist effort	6
Mutual collaboration	5
Feelings emphasized	5
Understanding emphasized	5
Moderate scores (7-10)	
Psychopathology	8
Psychological thinking	9
Initial resistance	8
Similar backgrounds	8
Therapist involvement	7
Initial optimism	8
Insight attained	7
Behavioral improvement	10
Low scores (11-13)	
Therapist empathy	12

TABLE 11

THERAPIST D: SUMMED RATING SCORES FOR LEAST PREFERRED PATIENTS

Rating questions	Scores
High scores (4-6)	
Patient involvement	5
Moderate scores (7-10)	
Psychopathology	7
Patient attitudes	7
Therapist understanding	10
Challenge felt	7
Liking for patient	10
Therapist competence	8
Therapist effort	9
Understanding emphasized	9
Low scores (11-13)	
Psychological thinking	11
Initial resistance	11
Therapist empathy	11
Personal identification	13
Similar backgrounds	12
Therapist involvement	13
Mutual collaboration	12
Feelings emphasized	11
Insight attained	11
Behavioral improvement	11

did not assign the highest possible rating to all three patients on any of the rating items.

Therapist D views his most preferred patients as showing Highly positive attitudes toward the therapist and as Highly involved in the therapy process. He feels that they showed a High degree of collaboration with the therapist in emphasizing feelings and intellectual understanding in the therapy work. Therapist D liked most preferred patients to a High degree, felt Highly challenged by the work with them, and viewed himself as expending a High degree of effort. He felt Highly competent, and experienced a High degree of personal identification with the patients, whom he felt he understood to a High degree.

Therapist D feels that most preferred patients showed Moderate psychopathology, initial psychological thinking, and initial resistance to therapy. He views them as developing a Moderate degree of insight into their problems and as achieving a Moderate degree of behavioral improvement. He experienced a Moderate degree of initial optimism about the outcome of therapy with the patients and felt Moderately involved in the therapy work with them. He feels that his own background is Moderately similar to that of his most preferred patients. He rates his degree of empathy with most preferred patients as Low.

Therapist D rating results:
least preferred patients

Therapist D's modal group for least preferred pa-

tients is the Low one containing 10 items (see table 11). There were 8 Moderate items and only 1 High item. There was no entry for the rating item assessing the therapist's initial optimism about the outcome of therapy with least preferred patients, so that 19 items were rated in all.

Therapist D views least preferred patients as Highly involved in the therapy process and as showing Moderately positive attitudes toward the therapist. He feels that they showed a Moderate degree of psychopathology but that they were Low in initial psychological thinking and High in initial resistance to therapy. Therapist D believes that intellectual understanding was emphasized in the therapy work to a Moderate degree, but that there was a Low degree of emphasis upon feelings and a Low degree of collaboration with the therapist in the work. Consequently he views the patients as attaining a Low degree of insight into their problems and as showing a Low level of behavioral improvement.

Therapist D gave Low ratings to his feelings of empathy, personal identification, and involvement in the work with least preferred patients. He views his own background as Low in similarity to that of the patients. He feels that he liked the patients to a Moderate degree, that he felt Moderately challenged by the work with them, and that he expended a Moderate degree of effort in the therapy work. He felt Moderately competent and viewed the degree of understanding he developed of least preferred

patients as Moderate as well.

Areas of inconsistency between ratings and interview material

In addition to several inconsistencies between ratings and interview material, two ratings seem inconsistent with ratings of a related item. Therapist D gives a High rating to the degree of emphasis upon examining feelings and a High rating to the degree of emphasis upon intellectual understanding in the therapy with most preferred patients. Such ratings suggest that most preferred patients developed a High degree of insight into their difficulties, but therapist D rates the most preferred group as showing only Moderate insight. Moreover, according to therapist D's interview impressions and individual ratings, one most preferred patient developed little insight while the other two achieved substantial insight (see table 12).

Therapist D's Low rating of his sense of empathy with most preferred patients is discrepant with his repeated interview assertions that he felt highly empathic with the problems of most preferred patients. One least preferred patient was felt to develop substantial insight and behavioral change according to the individual ratings and the interview discussion, but these individual differences were not reflected in the Low insight and change ratings assigned to the least preferred patient group.

Therapist D assesses most preferred patients as showing a Moderate degree of behavioral improvement, but the

TABLE 12

THERAPIST D: INDIVIDUAL RATING SCORES FOR MOST PREFERRED AND LEAST PREFERRED PATIENTS

Rating questions	MP1	MP2	MP3	LP1	LP2	LP3
Psychopathology	2	4	4	5	4	2
Psychological thinking	3	4	2	2	5	4
Initial resistance	2	3	5	2	4	1
Patient attitudes	1	1	2	2	3	2
Patient involvenent	2	1	2	1	2	2
Therapist empathy	4	4	4	4	5	2
Therapist understanding	3	1	2	2	4	4
Challenge felt	1	1	4	4	1	2
Personal identification	1	1	4	4	5	4
Similar backgrounds	5	1	2	2	5	5
Liking for patient	2	1	1	4	5	1
Therapist involvement	1	3	3	4	5	4
Initial optimism	2	4	2			
Therapist competence	3	1	1	1	5	2
Therapist effort	1	2	3	4	4	1
Mutual collaboration	1	2	2	3	5	4
Feelings emphasized	1	1	3	4	4	3
Understanding emphasized	3	1	1	2	4	3
Insight attained	3	2	2	2	5	4
Behavioral improvement	4	2	4	2	5	4

individual ratings and interview comments convey that therapist D viewed one patient as achieving substantial gains while the other two patients were felt to show little improvement. One most preferred patient was described as seriously psychologically disturbed, while the other two patients were felt to show less serious disturbance. The individual ratings reflect these judgements but the summed score shows that therapist D viewed most preferred patients as Moderately psychologically disturbed. According to the summed score therapist D felt Moderate liking for the least preferred patients, but the individual ratings and interviews comments indicate that he disliked two patients and liked the third one.

Therapist D rated least preferred patients as Highly initially resistant to therapy. Yet in the interviews he describes each patient as showing a different sort of resistance. The summed rating does not reflect these detailed differences among the patients.

CHAPTER V

DISCUSSION

The findings

Prominent in the literature on therapists' patient preferences is the notion that there is uniformity among therapists in their patient preferences. It is held that therapists prefer patients showing stereotypically "attractive" characteristics and that "attractive" patient characteristics are the primary determinants of therapist preferences. The Yavis syndrome of Schofield (1964) summarizes this point of view in proposing that therapists prefer to work with patients who are Youthful, Attractive, Verbal, Intelligent, and Successful. Studies based on the propositions of the Yavis syndrome find that the preferred patient of therapists is an individual who is highly motivated for therapy, possesses psychological-mindedness, collaborates actively with the therapist in striving to attain insight into his difficulties, shows little psychological disturbance, and makes the greatest therapeutic progress.

The results of this study suggest that the assumption that therapists uniformly prefer stereotypically "attractive" patients is simplistic and inaccurate. This study finds individual differences among therapists in their patient preferences reflecting each therapist's

personal attitudes, values, and needs. Despite the fact that the therapists in this study serve a relatively homogeneous "attractive" patient population, the therapists provide examples of most preferred patients who were not viewed as stereotypically "attractive." Among the most preferred patients described are individuals who were perceived to show serious psychopathology, little psychological-mindedness, and high resistance to collaborating with the therapist in the therapy process. Some of the most preferred patients were also felt to attain only a limited degree of insight and behavioral improvement.

The therapists in this study describe themselves as psychoanalytic in theoretical orientation. For this reason their selection of certain most preferred patients who were perceived as deficient in characteristics necessary for successful fulfillment of the role of an "attractive" psychodynamically-oriented therapy patient is strong evidence that personal predilections influence therapist preferences. Moreover, among the least preferred patients described by the therapists are individuals who were felt to show high motivation for therapy, psychological-mindedness, and active involvement in the therapy process resulting in attainment of a substantial degree of insight and behavioral change. Not all least preferred patients were viewed as seriously psychologically disturbed and the therapists did not focus upon their degree of disturbance as the central reason for least preferring them.

In other cases therapists felt that most preferred patients did possess stereotypically "attractive" characteristics. Yet even these patients were described as departing from the "attractive" stereotype with respect to the moderately serious nature of their difficulties or the limited degree to which they were able to use their insight to change their behavior. Their "attractive" characteristics were included in the therapists' reasons for preferring such patients but were not the primary or sufficient reasons for preferring them. Similarly, certain of the least preferred patients were viewed as stereotypically "unattractive," but the therapists' feelings of least preference reflected more than their perception of the patients' "unattractive" characteristics.

The interviews with the therapists comprise four distinctly different portraits revealing clear individual differences among therapists in their patient preferences. Each therapist viewed different factors in the patients and in the therapy relationship as central to his feelings of preference. That each therapist's personal attitudes, needs, and values are reflected in his feelings of preference can be seen most clearly when the therapists' views are presented in juxtaposition. The following are summary sketches of the interviews with each therapist.

Therapist A indicates that his most preferred patients do not fit the model of "attractive" candidates for psychodynamically-oriented therapy. He describes them as

"difficult" cases who were relatively seriously psychologically disturbed, lacking in psychological thinking and highly resistant to becoming engaged in the therapy process. He feels that they were socially unsophisticated, isolated, and waif-like as well. Therapist A developed a primarily supportive therapy relationship with his most preferred patients in which he adopted the role of a benevolent, protective, nurturant parent who provides concrete problem-solving help. He describes each relationship as though he were the first person with whom the patient became open and trusting, and he contrasts his positive influence upon the patients with the negative effects of conflictual relationships with their parents. He feels that the therapy relationship he established with most preferred patients was a vital sustaining force in their lives and he emphasizes the patients' real dependence upon him. Therapist A describes his most preferred patients as developing only a limited degree of insight, but he feels that the insight attained was crucially important to their development and welfare. He perceives that the moderate degree of behavioral change and improvement shown by most preferred patients was greater than the degree of insight they achieved.

Therapist A also feels that his least preferred patients were relatively seriously disturbed, socially isolated, resistant, and lacking in psychological thinking. Like most preferred patients, he saw them as in need of a kind of parental support but he was unable to overcome their

fear and resistance to developing a trusting and open relationship with him. Some of his frustration about the work related to his sense that least preferred patients were fragile and would have fled from therapy if he openly confronted them with their resistance and challenged them to make the therapeutic relationship a more open, psychologically intense experience.

Therapist B prefers to do psychoanalytically-oriented therapy with patients who develop the ability to think in a psychodynamic way and who are motivated to become highly engaged in the therapy process. Therapist B conceives of therapy as active, strenuous, productive "work." He feels a sense of comradeship and empathy with most preferred patients because he views them as hard workers who have the courage to "struggle" as self-reliant co-equals with him in examining their feelings, dreams, thoughts, and behavior. Such patients are able to internalize the process of psychological self-exploration and work with the transference feelings the therapist's role evokes rather than needing him to sustain them in a supportive way. Therapist B feels freer to work creatively at understanding the patients' psychodynamics because he doesn't feel compelled to provide them with solutions to their difficulties. Therapist B describes his most preferred patients' problems as moderately serious, rich, complex, and highly psychodynamically interesting. It seems that he felt particularly challenged by and involved with the patients

because they so strongly stimulated his psychological curiosity and because their mutual effort resulted in the patients' attainment of a high degree of insight.

Therapist B describes his least preferred patients as unable to function as self-sufficient co-equals with him in a collaborative psychoanalytically-oriented therapy relationship. He feels that they had intense needy-dependent and/or angry-demanding feelings. The oral images he uses to describe his least preferred patients suggest that he was personally affected by them and experienced them as either wanting to be fed by him or as wanting to eat him. He feels that the patients tended to resist engaging in psychological self-exploration or that he resisted intense psychological engagement with them because he feared their regressive potential. The unrealistic rescue fantasies the patients aroused in him created internal conflicts and his perceptions of their demands resulted in external conflicts over how much involvement, support, or direction to offer them. He feels dissatisfied working outside of his preferred analytic role and views least preferred patients as showing little development of insight and little behavioral improvement.

Therapist C feels that the quality of the personal interaction between the patient and himself is of central importance to his feelings of preference. He states that his most preferred patients possess "sterling character" because they have high integrity, are modest, and show

sensitivity and responsiveness to the needs of others. In addition to valuing these unique personal characteristics therapist C states that most preferred patients are unusually intelligent, perceptive, and quick to develop the ability and motivation to understand themselves psychodynamically, making the therapy work particularly interesting for him. The therapy relationship with his most preferred patients involves mutual giving, caring, and appreciation between patient and therapist as well as hard psychodynamically-oriented work. Therapist C employs the image of feeling that there is mutual willingness to embark arm in arm on an exploratory walk together, to describe his relationship with the patients. His feeling of personal identification with the struggles of most preferred patients contributed to his sense of being highly engaged in an "ineffable interaction" with them.

His strong commitment and involvement in the therapy work is expressed in his choice to meet with most preferred patients on a more frequent basis or over a longer time period than he normally does. He also perceives most preferred patients as strongly committed to striving to attain insight, and he experiences the patients' exploration of their innermost thoughts and feelings with him as a personal kind of sharing which makes him feel appreciated, helpful, and competent. In his work with most preferred patients the focus is on helping them to understand and express feelings, and the process is not an intellectualized one.

In comparison to the high level of insight they achieved by "getting in touch" with their feelings, he feels that they showed only a moderate degree of behavioral improvement because of the relatively serious nature of their difficulties.

In contrast, therapist C feels that the therapy relationship with least preferred patients was characterized by psychological and emotional distance. He perceives that he and the patients engaged in "pushing," "pulling," and "tugging" at each other. He pushed and tugged in the attempt to overcome the patients' resistance to collaborating with him in a psychodynamic exploration of their problems. He characterizes least preferred patients as needy, demanding, and dependent and he feels that they pulled and tugged on him for attention, for gratification of dependency needs, and for magical solutions to their problems. Therapist C views his least preferred patients as individuals with whom he could not identify and whom he could not value and respect. He felt frustrated and dissatisfied about the therapy with these patients because he experienced a lack of personal reciprocity and mutual collaboration to do psychodynamically-oriented work.

Therapist D's patient preferences are not determined by the degree of psychological-mindedness, attainment of insight, or level of behavioral improvement shown by his most preferred patients. He feels that the patients ranged from developing little insight and showing little improvement to

achieving substantial insight and change. Therapist D's feelings of preference for patients seem to be primarily a response to the "person" of the patient rather than a reaction to characteristics which relate to fulfilling the role of a therapy patient. He states that his feelings of preference involve finding the patients personally "likeable" and "appealing." He trusted that his most preferred patients would communicate with him openly and would turn to the therapy relationship as a source of help rather than fleeing from therapy at a time of crisis. Their welfare was not a source of worry and burdensome concern for therapist D for this reason, and he therefore felt a sense of comfortable, relaxed rapport in the work with most preferred patients. His feelings of preference seem influenced by his perception that his most preferred patients initially showed a kind of special selection of therapist D as the therapist to whom they chose to commit themselves.

Therapist D states that his least preferred patients seemed more highly involved in the therapy process than he was. He either felt bored, worried, and irritated by the work with least preferred patients or felt personally removed from the therapy relationship. His attitude of least preference was based upon a sense of personal dislike in some cases, and a feeling of burdensome worry and responsibility in others. Among his least preferred patients were individuals who were "boring and dull" and who "just rubbed me the wrong way."

Methodological considerations: strengths and limitations of the study

The methods employed in this study allowed individual differences among therapists in their patient preferences to emerge. The review of the literature indicates that most studies in this area, including those supporting the propositions of the Yavis syndrome, employ simple rating scales to assess therapists' patient preferences. The researchers prescribe a limited number of patient variables for rating which they hypothesize to be correlated with therapist preferences. Findings about the preferences of a statistical majority of therapists are generally reported, so that individual differences among therapists tend to be obscured. The therapists are frequently asked to rate their preferences for "ideal" patients or for contrived patients depicted in written case histories or on film. The findings are seldom based upon therapists' attitudes about actual patients they have treated over a period of time.

In this study the anecdotal interview method was combined with the use of structured rating questions. Interviews were conducted with only four therapists who were relatively homogeneous with respect to theoretical orientation and experience level, and the very small sample size allowed for intensive scrutiny of their views. They provided anecdotal accounts of their therapy work with several most preferred and least preferred patients, and gave oral responses to rating questions posed by the interviewer.

Through the use of these combined methods therapists' preferences for specific individual patients were able to be examined in detail on a case by case basis, revealing individual differences in patient preferences among the therapists.

Since it was up to the therapists to structure the discussion of patients in whatever manner seemed most appropriate to them, they provided their own observations of the factors they each associated with most preferred and least preferred patients. Their responses are therefore clinically richer, more complex, and more valid than those obtained through the use of simple rating scales alone. The therapists' anecdotal impressions of their work with real current patients with whom they had contact over time also have greater validity and meaningfulness than therapists' preference ratings of contrived patients, "ideal" patients or patients in the initial interview.

The use of structured rating questions within the interview format helped to capture fine details in the therapists' responses. The rating scores provided a way of evaluating the reliability and consistency of the interview observations. The scores also served as a standard basis for comparing the therapist's views of each of the six patients he described. In addition, the use of rating questions provided a degree of uniform structure to the interviews across therapists. At times the posing of rating questions served as a catalyst for further anecdotal

observations about patients on the part of therapists as well.

Despite the usefulness of the rating questions there was a methodological drawback to introducing them into the interview format. By asking rating questions during the course of an interview, the interviewer imposed priorities upon the therapists which inevitably influenced their thoughts and comments about their patient preferences to some extent. That the posing of a rating question served at times as a catalyst for further anecdotal observations about patients is evidence of this influence. Nonetheless the interview results indicate that each therapist was able to assert his own personal priorities in his discussion of factors he associated with most preferred and least preferred patients. In fact the rating results and the interview contents for each therapist comprise two somewhat discrete and unintegrated sets of data. If the interviewer had waited to ask rating questions until after the therapists gave their anecdotal impressions of all six patients, the rating questions would not have been a confounding influence upon the interview contents.

Other limitations of the rating method were apparent in the rating results for the four therapists. In most cases the rating scores for each individual patient were reliable and consistent with the therapists' interview observations. The combining of rating scores for three individual patients into a summed score for the most preferred

or least preferred patient group provided an overview of factors each therapist associated with most preferred or least preferred patients. However, for each therapist there were several cases in which individual differences among patients reflected in the individual ratings and in the interview descriptions were obscured by summing the rating scores. In particular, the grouping of ratings of three individual patients in to a Moderate summed score category was not a useful way of organizing the rating scores. The Moderate summed scores tended to be ambiguous in meaning and often misrepresented the interview findings and individual ratings of patients. The therapists' responses to several rating questions suggested that the questions were not clearly defined. The therapists interpreted the meaning of these rating questions in more than one way and misunderstood the intended meaning.

Several other features of the design of this study imposed limitations upon the meaning and scope of its findings. Among the most preferred patients of the therapists were individuals who were <u>perceived</u> not to show stereotypically "attractive" patient characteristics. This finding refutes the Yavis syndrome notion that therapists uniformly hold prejudicial <u>attitudes</u> about the undesirability of treating "unattractive" patients. The meaning of this finding is limited, however, by the fact that there were no objective assessments made by independent observers of the characteristics of the patients described. For this

reason, whether certain of the most preferred patients of the therapists would be considered seriously psychologically disturbed, lacking in psychological-mindedness, etc., according to objective assessments cannot be ascertained within the scope of this study.

It might be that a patient viewed as seriously psychologically disturbed in the context of a relatively attractive student patient population would be considered only mildly disturbed in the context of the patient population of a metropolitan psychiatric clinic. Furthermore, it might be that a patient showing serious psychopathology would be considered a preferred patient in a university counseling service setting for the reason that he would be viewed as an unusually difficult and challenging case. In a setting in which seriously disturbed individuals constitute the majority of the patient population, the same person might be considered a least preferred patient. The university counseling service setting of this study therefore must be considered a source of limitation upon the findings.

A limiting procedural feature of this study is that the interviewer was also a work colleague of the therapists participating in the study. It could be argued that for this reason I could not serve as an objective interviewer and my analysis of the interviews could not be impartial and unbiased. In order to assess the reliability and validity of my presentation and analysis of the interviews, I asked the four therapists to review what I had written

about their patient preferences. Each therapist approved of my analysis of the interviews and thought that the contents were reliable and valid.

The degree to which the therapists felt free to speak candidly about themselves and their work with someone with whom they shared a work relationship is debatable. It may be that they were more willing to speak openly with me because they knew me, but it is also possible that an interviewer who was not known to them may have evoked more candid responses. Since an interview situation is an interpersonal event, the interviewee will inevitably react personally to the interviewer's personality in ways that affect the course of the interview to some extent, regardless of whether or not the interviewer is known to him. Moreover, since personal considerations are inherent in the topic of therapists' patient preferences, I believe that there will generally be individual differences among therapists in the degree to which they are willing and able to be self-disclosing in the interviews, irrespective of the interviewer's personality.

That this study is based upon interviews with only four therapists limits the scope of its findings, although the very small sample size allowed for intensive scrutiny of the views of a relatively homogeneous therapist group. It was methodologically advantageous that the therapists interviewed were all psychoanalytic in viewpoint, but the fact that only one theoretical orientation is represented

limits the extent to which the findings are generalizable. Another limitation of the findings emanates from the need to maintain confidentiality concerning the identity of the therapists and their patients. For this reason all personally revealing details including gender, race, personal characteristics and background, and specifics of the patient-therapist relationship and course of therapy were deleted. As a consequence, some of the data gathered were not analyzed and discussed.

The ultimate goal of research on the attitudes of therapists about their patients is to determine whether the therapist's feelings of personal preference for patients significantly influence the outcome of therapy. Since no independent objective outcome measures were employed in the present study, conclusions cannot be drawn about whether therapists are able to achieve most successful therapy outcomes with patients they most prefer or whether therapists cannot successfully treat patients whom they least prefer. The subjective impressions of the therapists in this study do not reveal that most preferred patients were felt to make the most therapeutic progress or that least preferred patients were felt to make the least progress. Certain of the least preferred patients were viewed as showing successful therapy outcomes while certain of the most preferred patients were felt to make little therapeutic progress.

In order to determine whether there is a significant correlation between therapist feelings of preference for

patients and therapy outcome, assessments of outcome by independent observers are needed in addition to therapists' evaluations. It would be most useful to interview both patients and therapists about their perceptions of personal preference in the therapy relationship and its influence upon the course and outcome of therapy.

Whether a causal relationship exists between therapists' patient preferences and therapy outcome could only be investigated by studying the therapy relationship from its beginning to its conclusion. The findings of the present study are limited in scope by its retrospective nature, although the therapists' impressions were based on therapy with patients which took place during the same year in which the study was made.

Conclusions: the therapists views of the strengths and limitations of the study

Since this study is based upon interviews with four therapists, it seems appropriate to conclude by describing their reactions to participating in it and their views of the strengths and limitations of its findings. The reaction of one therapist to reading the analysis of his patient preferences was that the views he presented in the interviews were accurately summarized. During the interviews, however, he was aware of describing a kind of therapy relationship with patients which only partially represented his preferred mode of working. He said that at the time he felt stuck in this mode and unable to break out of

this vein of thinking. He thought it might be that his observations represented his most salient feelings about patient preferences at one point in time. He emphasized that the kinds of relationships with patients that bring a therapist feelings of satisfaction may change as the therapist's perspective on himself and his work changes. For this reason, the method of assessing patient preferences of therapists at only one point in time was a limiting feature of the study.

Another therapist expressed feelings of surprise about the primary correlates of his feelings of preference for patients revealed in the analysis of his interview comments. He was startled to find that what seemed to him at the time like somewhat disparate observations about the theapy with specific patients formed a unified picture of the factors relevant to his preferences. After reading about his patient preferences he felt impelled to think about his feelings of preference for patients in his current caseload. He concluded that the correlates of his preferences outlined in the study accurately applied to his feelings of preference for patients he is now treating.

This therapist pointed out that although the university counseling service setting was a limiting feature of the study, it also provided a basis for examining patient preferences of therapists that was free of certain confounding factors present in other treatment settings. He explained that the conditions affecting therapists'

patient preferences in private practice are more complex. In private practice the patient population is more heterogeneous with respect to the "attractiveness" of the individuals treated, and such factors as whether a patient pays his bill may influence the therapist's feelings of preference.

A third therapist felt that the interview method used in the study constituted a useful projective technique. He explained that through the process of talking about most preferred and least preferred patients, the therapist was describing his own attitudes, needs, and values as they operated in his therapy work. He said that although he brought to the interviews an awareness of many of the salient factors shaping his feelings of preference, others became clearer to him when he read his comments about the work with the six patients in juxtaposition.

Reading about the interviews reminded him that during the course of the interviews he was aware that he censored certain observations about the correlates of his feelings of preference. He explained that these observations were of a personal nature and might be more appropriately disclosed in a therapy supervision discussion of countertransference feelings. This therapist thought that the technique of describing particular most and least preferred patients could be applied in therapy supervision to enhance the therapist's understanding of himself in relation to his work. He speculated that if this technique

were to be implemented by the staff members at the university counseling service, the results might suggest a matching procedure for assigning therapists to work with particular patients.

The fourth therapist also felt that the interview method used in this study served as a projective technique, but he described his reaction in different terms. He explained that in the interviews about most and least preferred patients, the therapists were talking about themselves and their relationship to their work. In discussing the patients they prefer and don't prefer, he felt that the therapists described the needs they seek to fill through their work and the factors that bring them feelings of satisfaction or dissatisfaction.

His view of the Yavis syndrome assumptions was that "attractive" patient characteristics may be necessary to therapists' feelings of preference, but that the Yavis syndrome does not provide a sufficient, comprehensive explanation of the correlates of preference. He thought a strength of the anecdotal interview method employed in the present study was that it allowed the therapists to provide information about their preferences differing from the postulates of the Yavis syndrome, because they were asked questions in a new and different way. He found that his participation in the study provided him with a useful perspective from which to think about his therapy relationships with patients in general.

The views of the therapists who experienced the process of being interviewed about their patient preferences broaden and enhance the critical perspective of the research-interviewer. The therapists' reactions to the findings of this study and to their participation in it suggest new directions for future research and practical application of the anecdotal interview method.

APPENDIX

FORM USED IN INTERVIEWS TO RECORD PATIENT BACKGROUND INFORMATION AND THERAPISTS' RESPONSES TO TWENTY RATING QUESTIONS

Therapist:
Patient initials:
Patient age:
Patient sex:
Educational rank:

Dates of therapy:
Frequency of appointments:
Reason for seeking therapy:
How therapy ended:
Previous therapy:

Patient characteristics and feelings

Degree of psychopathology
Degree of initial psychological thinking
Degree of initial resistance
Degree of positive attitudes toward therapist
Degree of involvement in therapy

Therapist characteristics and feelings

Degree of empathy with patient
Degree of overall understanding of patient
Degree of challenge the case represents
Degree of personal identification with patient
Similarity of therapist-patient backgrounds
Degree of liking for patient
Degree of involvement in therapy process
Degree of initial optimism about therapy outcome
Degree of competence experienced
Degree of effort expended

Characteristics of therapy

Degree of mutual collaboration in the work
Degree of emphasis on feelings
Degree of emphasis on intellectual understanding

Outcome of therapy

Degree of insight patient attained
Degree of behavioral improvement of patient

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