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AN EXPLORATORY STUDY OF CHANGE OF INTERNAL-EXTERNAL  
LOCUS OF CONTROL AS A FUNCTION OF  
PSYCHOTHERAPY

by

PAUL H. FEINBERG

A dissertation submitted to the Graduate  
Faculty in Psychology in partial fulfillment  
of the requirements for the degree of  
Doctor of Philosophy, The City University  
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1977

This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

July 26, 1977  
date

Herbert Nechin  
Chairman of Examining Committee

July 26, 1977  
date

Flourence L. Denmark  
Executive Officer

Professor Herbert Nechin

Professor Laurence Gould

Professor William King  
Supervisory Committee

The City University of New York

"I didn't have no goals...I didn't like where I was, but I figured I was stuck. I felt I had no future, so I didn't give it no thought."

Connie Hawkins, Foul!: The Connie Hawkins Story by David Wolf. Holt, Rinehart and Winston of Canada, Limited, 1972.

Abstract

AN EXPLORATORY STUDY OF CHANGE OF INTERNAL-EXTERNAL  
LOCUS OF CONTROL AS A FUNCTION OF  
PSYCHOTHERAPY

by

Paul H. Feinberg

Adviser: Professor Herbert Nechin

This study was designed to explore the usefulness of psychotherapy in altering the internal-external control of reinforcement expectancies of patients. Internal-external control of reinforcement was defined as the tendency to perceive one's reinforcements as contingent on one's own behavior (internal) or as being not related to one's own behavior (external).

The internal-external (IE) locus of control construct had become important because it (being more external) had been empirically associated with being failure avoidant, less able to defer gratification, suicide and accident prone, and less able to confront their problems and engage in remedial behaviors. In addition, there were indications that externality was on the rise.

Attempts to change such an expectancy utilizing psychotherapy were reviewed. Hypotheses based on this research were elaborated. Cooperation from 42 patient-therapist pairs from various out-patient clinical facilities was obtained. Means, standard deviations, high and low scores, and intercorrelations of the variables were computed. A nominal significance level was used to decide upon interpretable correlations.

Hypothesis I stated that psychotherapy would lead to changes in external expectancy, as judged by patients' IE scores at the beginning of and again after 6-10 weeks of therapy. Similarly, the therapists' estimates of how the patient would respond at the beginning of and after 6-10 weeks of therapy were compared. The findings in both instances failed to confirm the hypothesis.

Hypothesis II stated that the patients' judgement of the success of therapy would be related to the degree of change in externality. This was not confirmed.

Hypothesis III stated that the patient's degree of change in externality would be related to the therapist's judgement of the successfulness of therapy. The findings did not confirm this.

Hypothesis IV stated that therapists' judgements of the success of psychotherapy would be related to their perceiving their patients as declining in externality. This was not confirmed.

Hypothesis V stated that the degree of change in a patient's externality would be related to the accuracy of initial assessment, defined as the extent of agreement between the patient's score on the Internal-External Locus of Control Scale at the beginning of therapy and the therapist's estimate of the patient's responses on the IE scale. Extent of initial agreement was further partitioned into directional and non-directional disagreement. And it was found that directional disagreement, that is, the tendency to see the patient as more internal than the patient sees himself, was significantly related to change in and decreases in externality.

Hypothesis VI stated that therapists' degree of experience, training, and personal therapy would be related to accuracy of initial assessment, defined in this study as directional and non-directional disagreement. The findings indicated that personal therapy and experience doing therapy were significantly correlated with the tendency to view patients as more internal than they viewed themselves.

Tentative conclusions were derived from findings that were based on a sample of therapist experience that was considered to be less than, and therefore not representative of, the entire range of practicing psychotherapists. Suggestions regarding further research in this area were mentioned.

## Acknowledgments

I want to take this opportunity to express my appreciation to some of the people who contributed to the successful completion of this study.

To Dr. Herbert Nechin, Chairman and Adviser, I am most deeply indebted for years of patience, advice, and encouragement. I would also like to thank the other members of my committee, Drs. Laurence Gould and William King, for being helpful and supportive in just the right way at the necessary times. A special note of thanks to Dr. Thad Harshbarger for his unstinting assistance in the statistical analysis of the data of this study.

To my wife Mary and my daughters Alexandra and Shaina, I am thankful for the encouragement and stimulus to go on when things were less than clear.

I am deeply indebted to Alan Grossman and Dr. Arno Gruen for believing in me when I doubted myself most. And also to Dr. David Glassman who helped me see more clearly what had to be done.

While there were many others who helped, encouraged, prodded, and provoked me towards completion, I would like to close now with a special note of thanks to those patients and therapists without whose cooperation this study would not have been possible.

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## CHAPTER I

### Introduction

Internal-external locus of control has been defined as the tendency to perceive one's own reinforcements (or lack thereof) as contingent upon one's own behavior (internal), or as being a function of luck, fate, chance, under the control of others, or unpredictable because of the complexity of things (external) (Rotter, 1966).

Lefcourt (1966), in an excellent review of the literature pertaining to the research and theory behind the internal-external locus of control construct, reports studies that show that Ss scoring highly on the external side (people who in effect see no causal relationship between their behavior and their rewards and/or punishments) tend to be failure avoidant (Crowne and Liverant, 1963), less able to defer gratification (Bailer, 1961), more prone to self-accusatory ruminations (Butterfield, 1964), withdrawal, apathy, etc. (Gore and Rotter, 1963; Lefcourt, 1966). In addition, Williams and Nickels (1969) found that Ss scoring highly on the I-E scale, externals, also scored highly on indices measuring suicide and accident proneness. It was Lefcourt's (1966) emphatic conclusion that research was sorely needed to determine what would

change such an orientation or expectancy. Indeed, Rotter (1971) states that there has been a marked increase in externality or in the expectancy of powerlessness in college students between 1962 and 1971. Rotter (1971) also concluded that research was vital to reversing this trend. And it is this writer's intention to study in a somewhat limited and exploratory fashion how psychotherapy may be useful in this regard.

#### Development of the construct of internal-external control

Rotter's interest in the notion of internal-external locus of control grew out of seemingly diverse areas. The theoretical background and related conceptions all have to deal with earlier social science endeavors relating to man's style of viewing himself in his world and how he sees himself related to the world. So, for example, Veblen (1899) drew attention to the notion that societies that hold to a belief in luck or fate tended to be inefficient and unproductive (Rotter, 1966). According to Rotter (1966), Marx, Weber, and Durkeim also were extremely concerned with man's sense of helplessness, powerlessness, and alienation. It was Rotter's contention that one construct, internal-external locus of control, would further empirical study of these vital concerns.

Lefcourt, who, as mentioned previously, wrote a major review of the literature pertaining to I-E locus of control,

cited two highly instructive animal behavior studies wherein the animals who were unable to escape (Richter, 1959) or unable to control a painful stimulus situation (Mowrer and Vieck, 1948) succumbed to death (Lefcourt, 1966). But by far the most important animal behavior study as relates to expectancies was the work of Harlow (1949) that showed that not only do we learn, but that we learn to learn. That is, that expectancies develop as a result of experience, and that these expectancies can and do generalize to other situations. And it is the development of such learning sets that allows us to live life in an adaptive, efficient manner as opposed to living by trial and error (Harlow, 1949). While it therefore has been amply shown that expectancies are facilitative of certain behaviors, problem-solving research has shown both the negative and positive effects that expectancies have. That is, while an expectancy facilitates certain behaviors, it also inhibits others. And it would appear that when the expectancy is one of powerlessness or lack of goal-striving then these are the tendencies and behaviors that will be facilitated while tendencies towards mastery or effectiveness are being inhibited. Herein lies the importance of this, but I am getting ahead of myself.

Now, in order to generalize this to human beings from monkeys, it would be important to show that a person's sense of control, his expectancy that his behavior would indeed be causally related to his rewards, had an important part to

play in determining his behavior. Phares (1957) showed that Ss performed differently on tasks labelled skill or chance. That is, when Ss were told that the task was skill determined they tended to use experience of past performances in formulating expectancies for future performances, whereas this was not the case with Ss who were told their tasks were chance determined. That is, when Ss were told that the success of the task was chance or luck determined they didn't use past experience in formulating future expectancies for performance. In this experiment the subjects' expectancy was induced and controlled by the experimenter.

While Phares (1957) was the first to attempt to measure individual differences in a generalized expectancy or belief in external control as a psychological variable, it was Rotter in conjunction with Seeman, Liverant, and Crowne (1961) who refined the I-E scale into its present form by item and factorial analysis and eliminating those items that correlated with the Marlowe-Crowne Social Desirability Scale (Rotter, 1966). The scale was developed to study the extent to which these expectancies exist, which in turn would allow them to relate I-E construct to different but predictable ways of behaving. Among the most pertinent are the studies by Seeman (1963) and Seeman and Evans (1962), which showed that there was a difference in learning styles, or a differential in learning, between internals and externals. For

example, hospitalized tuberculosis patients who scored as externals had less objective knowledge about their condition than did internals. While these differences are significant, it is also important to point out that the correlations between I-E and intelligence are negligible (Strickland, 1962; Ladwig, 1963; Rotter, 1966), indicating that we cannot attribute these differences to differences in intelligence. That is, the difference in objective information about their condition was significant and not a function of intelligence, but was a function of how they saw themselves relating to their world. To restate their finding: internals had more objective information about their condition than did externals.

Similarly, Phares, Ritchie, and David (1963) showed that while externals recalled more total and negative material about themselves, internals showed a significantly greater willingness to engage in remedial behaviors and confront their problems. Two experiments by Lefcourt and Wine (1969) demonstrated significant differences in attention deployment between internals and externals such that internals appeared more vigilant and observant. This difference between internals and externals was even greater as a function of the degree of uncertainty introduced into the experimental situation, and decreased when instructional cues made it clear that attention was the focus of the experimenter's interest. The results point to more active commerce with the environment on the part of internals.

Thus, it becomes apparent that providing information is not sufficient, the information is actually irrelevant if a person's expectancy is that his situation is totally beyond his control. Changing such an expectancy is thus a vital issue and the central issue of this exploratory study.

### Psychotherapy and internal-external locus of control

Many theories of therapy postulate that one of the products of therapy is greater self-direction (Rogers and Dymond, 1954), greater self-mastery (Freud, Sullivan, White, etc.). Singer (1965) notes that such a belief underlies all forms of psychotherapy, that man is capable of change, and capable of bringing this change about himself, provided he is aided in his search for such change (Singer, 1965, p. 16). Thus, it is the intent of this study to show that the accurate assessment of the internal-external locus of control expectancy is related to the successfulness of therapy, and that therapy is an operation that will lead to changes in this expectancy.

A word seems to be in order at this point about research in the field of psychotherapy. There is an enormous amount of research (Kiesler, 1966) regarding psychotherapy. I have tried to review the studies which were found to be most specifically pertinent to the issues at hand. To ask whether psychotherapy does any good, according to Sanford (1953) and Bergin and Garfield (1971), is of little or no

scientific consequence. Rather, the real issue is which people are helped under what circumstances (Kiesler, 1966, 1971). Edwards and Cronbach (1952) strongly suggested that ideally such research be done employing factorial designs wherein all relevant patient, therapist, and therapy variables be studied (Kiesler, 1966). While this is not within this writer's scope, it is the intent of this study to attempt to shed some light on one aspect that may eventually contribute to a more thorough examination of this vital area.

The following studies are important for two reasons. First of all, they were the studies which led to the formulation of the current project. Secondly, they are the only studies which have tried to alter the generalized expectancy of internal-external locus of control.

Possibly one of the earliest studies in this area was by a predoctoral psychology intern from the University of Washington (Smith, 1970). He hypothesized that crisis patients would initially be more externally oriented on the I-E scale than a similar group of noncrisis psychotherapy outpatients, but would show a significant shift toward the internal end of the dimension following a six-week crisis resolution period. The results were consistent with this hypothesis, and offered tentative support for the assertion that crisis intervention may produce positive personality change in a brief period of time.

Another of the studies utilizing psychotherapeutic means to alter I-E was done by Felton and Biggs (1972). Felton and Biggs administered the I-E scale to 84 Ss: 59 were experimental, receiving psychotherapy; 25 received no treatment. The experimental treatment consisted of four (4) 90-minute group therapy sessions plus one intensive 3-day weekend experience, during which Ss were taught the I-E theory in relation to their own concerns. Both groups received before and after administrations of the I-E scale, ten weeks being the elapsed interval. And the results all supported their hypotheses, which were that internality could be taught in intensive group therapy. There was an increase in internality for the experimental group, and no such increase for the comparison group. This is indeed a highly instructive study. It should be also noted, however, that the investigators were also the group therapy leaders, which raises the issue of their being more sensitized to externality and whether this sensitization enhanced the changes in the experimental group. Have the patients in fact changed, or did they just change the way they responded in order to please or comply with what they perceived the experimenters' wishes to be? The authors themselves are the first to assert that therefore the generalizability of their results are limited. This is one of the questions that the present study attempts to deal with in an empirical manner.

The study reported above by Felton and Biggs was based on two earlier studies (Pierce, Schauble and Farkas, 1970; Gillis and Jessor, 1970).

The study by Pierce, Schauble and Farkas (1970) was the result of earlier, not-yet-published works of theirs. Operating within the framework of the I-E construct, they wondered if, since successful therapy was characterized by changes from E to I, internalizing could be systematically taught to clients in the early stages of individual psychotherapy. They gave 15 Ss, 7 female, 8 male, the I-E test after the first session, during which they obtained their cooperation. The two therapists, familiar with the authors' intentions, also filled out the I-E scale for each of their clients. The first and last 20 minutes of the next session were the pre- and post-test comparison periods. The middle 20 minutes were used to instruct the clients in the I-E theory as it related to their problems.

The results of the above study showed that: (1) there was a significant change in the direction of internality, (2) that therapist-client ratings correlated  $+0.30$ . They suggest in their conclusions that perhaps only therapists familiar with the concept of I-E will be able to accurately assess client internalizing, and that they alone would be able to facilitate and enhance change in this area. As previously mentioned, this will be one of the questions the present research attempts to explore empirically.

Gillis and Jessor (1970) conducted an exploratory study of the effects of brief psychotherapy on belief in internal-external locus of control. They administered Rotter's I-E scale to 29 Ss, all patients admitted to a VA hospital. The experimental group consisted of 13 Ss; 6 received group therapy, 6 received individual psychotherapy, and one patient received both. The control group consisted of 16 Ss who did not receive therapy in any form. Between 9 and 11 weeks after the I-E scale was initially administered it was re-given to two groups. There were no significant differences between the two groups in either the pre- or post-testing. However, of the Ss who received some form of psychotherapy and were judged as improved there was a significant difference in the predicted direction. That is, these Ss manifested a shift in their I-E score and thus an increase in internality as a function of psychotherapy.

### Summary

Rotter (1975) as well as others has noted the enormous amount of research generated by the locus of control notion and the I-E scale itself. In spite of this large amount of research, there have been only a few studies attempting to alter this expectancy. Several studies were herein reviewed (Felton and Biggs, 1972; Gillis and Jessor, 1970; Pierce, Schauble and Farkas, 1970; Smith, 1970) which specifically attempted to alter the I-E score by means of some

psychotherapeutic procedure. The present study is a limited exploratory attempt to relate change in I-E scale score to be a function of engaging in psychotherapy. And specific aspects of the psychotherapeutic situation, namely accuracy of assessment of patients' I-E, possible factors contributing to this assessment, and I-E change will be empirically examined.

## CHAPTER II

Introduction

The ever-increasing research of the internal-external locus of control construct is shedding new empirical light on some old and thorny problems. Alienation, apathy, helplessness are some of the terms used to describe the feelings and psychological states of more and more people today. Feelings of helplessness and frustration have been linked causally in the popular media with the social upheavals that we are experiencing. Rotter (1966, p. 1) defines the internal-external locus of control concept as follows:

The effect of a reinforcement following some behavior on the part of a human subject, in other words, is not a simple stamping-in process but depends upon whether or not the person perceives a causal relationship between his own behavior and the reward. A perception of causal relationship need not be all or none but can vary in degree. When a reinforcement is perceived by the subject as following some action of his own but not being entirely contingent upon his action, then, in our culture, it is typically perceived as the result of luck, chance, fate, as under the control of powerful others, or as unpredictable because of the great complexity of the forces surrounding him. When the event is interpreted in this way by an individual, we have labeled this a belief in external control. If the person perceives that the event is contingent upon his own behavior or his own relatively permanent characteristics, we have termed this a belief in internal control.

Rotter (1975), in referring to the enormous popularity of this concept as judged by the amount of research initiated

involving this concept, states that it must surely be related to some persistent social problems. And while altering such an orientation would seem to be vital (Lefcourt, 1966), most studies have been concerned with individual differences associated with varying aspects of internal-external control of reinforcement construct. Thus, the purpose of the present work was to study empirically and in an exploratory way the usefulness of psychotherapy in altering the internal-external control of reinforcement expectancies.

### Method

#### Subjects

Ss consisted of 42 patient-therapist pairs, whose cooperation was enlisted just as they were about to begin psychotherapy at one of several psychoanalytically oriented out-patient psychotherapy clinics in New York City. The patients were generally neurotics and character disorders, with the more severely disturbed excluded by the intake workers at the time of the initial evaluation. After this selection step, either the patient or the therapist could decline to participate. A patient-therapist pair was complete when both parties agreed to participate.

#### Patient and Therapist Description

Table 1 contains a summary of the patient and therapist characteristics. Patients ranged in age from 19 to 42,

averaging about 25 and a half years old, and approximately 31% of the patients were male. The therapists ranged in age from 22 to 59, with a mean of 35, and just slightly under 10% were male. The number of years in the field ranged from 0 to 29, with a mean of 5 and 3/4 years (SD was approximately 5 and 1/2 years). The number of hours of training, defined as hours of classwork, supervision, workshops, etc. specifically related to doing psychotherapy, ranged from 0 to 5,000, with a mean of 2,316 and a SD of 3,419. The number of hours of personal therapy or analysis of the therapists ranged from 0 to 1,500 with a mean of 502 and SD of 415.

TABLE 1  
PATIENT AND THERAPIST CHARACTERISTICS

	Mean	SD	Range
Patient Age	25.7	5	19-42
Therapist Age	35	9.2	
Patient Sex	31 (31% male)		
Therapist Sex	10 (10% male)		
Therapist number of years in field	5.7	5.5	0-29
Therapist number of hours training	702	1,065	0-5,000
Therapist number of hours experience doing therapy	2,316	3,419	17-12,960
Personal therapy of therapist	502	415	0-1,500

## Selection of Clinical Facility

This section will sketch background and process by which the clinical setting was selected. After preliminary phone conversations, the following letter was sent to directors of clinics expressing an interest in cooperating with aims and procedures of this research.

Dear \_\_\_\_\_

I am a student in the Doctoral Program at the City College of the City University of N.Y. specializing in clinical psychology. I would like to interest you in cooperating with some research I am doing to meet the dissertation requirements of the Ph.D. program.

Briefly, the study is investigating whether and how psychotherapy effects one's sense of powerlessness. The Rotter scale, called the Internal-External Locus of Control scale, measures to what extent people feel they are responsible for what happens to them. Internals typically feel they are responsible to a large extent for rewards and/or punishments they receive. Whereas, externals see their lot as a function of luck or fate. This notion is considered to be a generalized expectancy which has been shown to effect how people approach a variety of situations, i.e., gathering information about themselves and their lives, stopping smoking, signing petitions to change something, etc.

One generally held goal of psychotherapy is to become more positively and constructively active, as opposed to either passivity and/or negative destructive activity. To see if therapy does alter this central way of viewing the world becomes a vital issue.

The procedure is the following: To have the client fill out the Rotter scale (23 forced choice items - takes about 5 minutes). At the beginning of therapy and again some time between the 6th and 10th interview. And, to have the therapist fill out the scale as he thinks the client would after

meeting him the first time (and/or before the 3rd interview). And, to have the therapist fill out the scales again between the 6th and 10th interview.

Essentially, I am using the Rotter as a Pre- and Post-measure to see if 6-10 weeks of therapy leads to some measurable change in a person's generalized expectancy of himself in his world.

It is an interesting piece of research that may have some very real benefits for all of us in the field.

If you have any questions you can feel free to contact me. I would be more than delighted to show you the material and discuss this with you in person.

Sincerely,

Directors of the various clinics were asked not to convey the purpose of the study to their staff, but only that there would be a Psychotherapy Research Project. The letter was as detailed as it is in order to gain cooperation through as thorough an understanding of the nature, background, and procedure of the project as possible. It seemed that being as clear as possible about what I wanted and what they would have to do made getting cooperation more likely.

#### Procedure Following Selection of Clinical Facility

One set of Intake Workers was paid \$150.00 for their cooperation -- \$75.00 at the start of the project and \$75.00 when all the data had been collected. They accounted for about 1/2 the Ss. Other Intake Interviewers cooperated without payment. The Intake Workers were given the following set of instructions:

Dear \_\_\_\_\_

I need your help to the following extent.

To ask each new client at Intake to fill out the Scale and Data Sheet (approximate time needed, 5-10 minutes).

To ask each therapist upon receiving any of these cases to fill out the Scale as they think the client would after having met him for the first time and not more than twice. And to fill out a Data Sheet pertaining to his own professional training (5-10 minutes).

Then after 6-10 interviews, both the therapist and client would fill out the Scale for the second time. And they would each fill out a Data Sheet indicating in a general way whether the therapy was or was not successful.

### Instructions to Therapists

The following instructions were given to the therapists:

#### INSTRUCTIONS

PLEASE FILL OUT FORM 1 /see Appendix E, page 58/ BETWEEN THE 1ST AND 3RD SESSION.

HAVE PATIENT FILL OUT FORM 2 /see Appendix F, page 65/ BETWEEN THE 6TH AND 10TH SESSION.

FILL OUT FORM 3 /see Appendix G, page 72/ BETWEEN THE 6TH AND 10TH SESSION.

UPON RECEIPT OF THE 3 FORMS IN THE ENCLOSED ADDRESSED ENVELOPE I WILL SEND YOU A CHECK FOR \$10.00.

### Forms and Unfolding of Project

After the Intake Worker decided to accept the client for individual psychotherapy, the client was given the Intake Form (see Appendix D, page 51). This consisted of an

introductory statement noting that this was a confidential research project and that all patients were asked to cooperate. Along with this there were the Instructions for the Scale, which were the instructions for the I-E scale. And finally, a brief data sheet requesting name, age, sex, length of time each felt he had had the problem bringing him to the clinic, and whether he thought the problem was internal or external in origin (See Appendix D, page 51).

When the patient was assigned to a therapist, the therapist received, along with the other information the Intake Worker usually passes along, the preceding Instructions to Therapists, and Forms 1, 2, and 3.

Form 1 (see Appendix E, page 58) consisted of an introductory statement noting that this was a confidential research project involving psychotherapy and that all therapists were being asked to cooperate. Then they were given instructions to the effect that they were to fill out the Rotter Scale as they thought that the patient would after having met him once and sometime before the fourth session. After this they were asked to fill out a Data Sheet requesting information pertaining to their respective ages, sex, educational background, number of hours of psychotherapy experience, whether they had found their own therapy helpful to them, etc.

Form 2 (see Appendix F, page 65) was to be filled out by the patient between the 6th and 10th session. This consisted

again of the Rotter scale with the instructions that each fill out the scale without reference to the first attempt, and then to note the extent of usefulness of his psychotherapy experience.

Form 3 (see Appendix G, page 72) was to be filled out by the therapist between the 6th and 10th session. This was the second administration of the Rotter Scale to be completed by the therapist again in terms of how he thought the patient would currently fill it out and was to be completed without reference to the first administration. Then the successfulness of the endeavor was to be noted.

The concludes the description of the four different forms used in the Pre- and Post-phases of therapy.

### The I-E Scale

The Rotter scale consists of 29 forced choice items, 23 of them being scorable. The scale is scored for externality: the higher the score, the more external the person; the lower the score, the more internal the individual is.

Each of the items consists of two statements, one endorsing the inevitability of events (external), and the other endorsing the controllability of events (internal). The subject is asked to select the statement of each pair in which he more strongly believes. He is asked to pick the one he believes to be more true, rather than the one he should choose or would like to be true. He is told that

this is a measure of personal belief and there are no right or wrong answers.

The scale has been shown to be fairly reliable over time. Rotter (1966) reports internal consistency correlations ranging from .65 to .79. Test-retest reliability correlations for one month ranged from .60 to .83. Two month test-retest correlations ranged from .49 to .61. Also, a number of studies have been done to attest to its construct validity (Phares, 1957; Butterfield, 1964; Lefcourt, 1965; Rotter, 1966; Lefcourt, 1966; Danes, 1968).

### Hypotheses

According to Lefcourt (1966) two questions of immediate interest that have not been investigated in any depth concern the origins and sources of control expectancies and the operations for altering such orientations. While this study does not intend to be such an in-depth investigation of the developmental aspects, it does seek to be an empirical exploratory study concerning one of the above questions, namely, whether psychotherapy will lead to changes in internal-external expectancy.

Hypothesis I: That psychotherapy leads to changes in external expectancy, as judged by patient and therapist.

### Procedure:

A. Patient rating -- patient will be administered the I-E scale prior to therapy and again after 6-10 weeks.

B. Therapist rating -- therapist will be asked to fill out the I-E scale twice, both times based on how he feels the patient would, at the beginning and after 6-10 weeks of therapy.

In addition, it is important to know if the patient's judgement of the success of his treatment to this point is related to changes in his external expectancy. Thus, hypothesis II.

Hypothesis II: Patient's judgement of the success of his psychotherapy will be related to changes in his external expectancy.

Procedure: Patient will be given an eight-point scale on which he is to rate the successfulness of his experience of psychotherapy (scale developed by Perlman, 1970) (see Appendix F, page 65). Related to this is whether changes of the patient will be related to whether the therapist judges the treatment as having been successful. Thus...

Hypothesis III: That changes in expectancy of patient will be related to therapist's judgement of the successfulness of therapy.

Procedure: Therapist will be asked to rate the success of therapy on an eight-point scale, and this will be related to the amount of change in external expectancy of the patient (see Appendix G, page 72).

The next question which emerges is whether there is a relationship between change in patient's expectancy as

judged by the therapist and the therapist's view of the successfulness of the therapy.

Hypothesis IV: That changes in external expectancy of patient as judged by the therapist will be related to judgment of the successfulness of therapy as seen by the therapist. In effect, this means that the therapists judge their therapeutic endeavors as successful when their patients become more "internal;" that is, when they see their patients as becoming more "internal."

Procedure: The therapist will have been asked to rate the patient on the I-E scale pre- and post-therapy, and this will be related to the therapist's rating of the successfulness of the therapy.

If the patient's external expectancy is important to the way in which he conducts his life, as the research would indicate, then the accurate assessment of this in the initial phase of therapy will be related to the change in expectancy on the part of the patient. The point being that the more accurate the initial assessment of a patient, the more it will lead to greater change in the patient. If external expectancy is important and is not picked up by the therapist, then it will be dealt with only peripherally and thus we would expect less change. Thus...

Hypothesis V: That accuracy of therapist's estimate of how patient would fill out the I-E scale will be related to the degree of change in external expectancy.

Procedure: Accuracy will be determined by the extent of agreement between the patient's and therapist's score on the initial administration of the I-E scale to each.

Lastly, an attempt to relate the therapist's own experience, training, and therapy to his degree of accuracy might yield some information as to what it might be in a therapist's background that contributes to his making a more or less accurate assessment of a patient's level of external expectancy. Thus...

Hypothesis VI: The therapist's involvement in his own treatment will lead to more accurate assessment of the patient's degree of external expectancy.

Procedure: Therapists will be asked to complete a Data Sheet (see Appendix E, page 58) containing questions pertaining to experience in doing therapy, training, personal therapy, and its felt-usefulness in doing therapy.

### Summary

Being able to alter a person's sense of powerlessness, apathy, lack of goal-striving, is a crucial problem in these times. Several studies have been done that show that psychotherapy may be effective in this regard. The goal of the present work was that it be an essentially empirical and exploratory study, replicating and extending in a limited fashion the previous work done, to show that psychotherapy is effective in altering the control expectancy of an individual.

A number of hypotheses were generated on the basis of the previous research done in this field, and were detailed in the previous section. Essentially they had to do with the effectiveness of psychotherapy in altering the control expectancy of an individual. Also, whether patients and therapists experience therapy as having been successful when they also both experience the patient as having changed his control expectancy. Also studied was the relationship between the degree of change and the degree of accuracy of assessment on the part of the therapist. Lastly, the therapist's own therapy, training, etc., were also studied in relation to accuracy of initial assessment and degree of change.

After establishing a cooperative relationship with a clinical facility, the procedure for examining the above hypotheses consisted of the following. The Intake Worker, after having decided to accept the patient for individual psychotherapy, had the patient fill out the I-E scale. Then each therapist was asked upon receiving any of these cases to fill out the I-E scale as he thought the client would after having met him for the first time. A Data Sheet was also filled out at this time, gathering information about the therapist's own therapy and training in therapy. Then, after 6-10 weeks, both the therapist and patient filled out the scale for the second time. Again, they each filled out a Data Sheet indicating in a general way whether the therapy was or was not successful.

## CHAPTER III

RESULTSData Analysis

Once the data had been collected, it was punched onto IBM cards and processed using a package program called PSTAT by the City College Computer Facilities. The program computed means, standard deviations (SDs), high and low scores, and intercorrelations of the variables. With an N of 42 and a nominal significance level of .05, any correlation over .3044 was taken as interpretable. The concept of nominal significance level is being employed since many of the hypotheses cannot be interpreted independently of one another. Table A (Appendix H, p. 79) contains a list and description of the variables. Table B (Appendix H, p. 81) presents the raw data of this study. Table C (Appendix H, p. 82) contains a summary of the means, SDs, and high and low scores of all the variables of this study. Table D (Appendix H, p. 84) contains the interpretable intercorrelations of all the variables, that is, those correlations which were found to exceed .3044.

Results Related to Hypothesis I

The basic idea underlying this study is the possibility of/for change. Specifically, I was concerned with the Internal-External Locus of Control Expectancy, the belief

that one's rewards come as a result of one's own behavior or from external sources. Externality had been empirically linked with feelings of helplessness, powerlessness, alienation, and with a problem-solving approach which essentially involved avoiding the problem, which obviously kept such an individual stuck, feeding further into his sense of helplessness and powerlessness. Thus, Rotter (1966, 1971, 1975) and Lefcourt (1966) as well as others (Felton and Biggs, 1972; Gillis and Jessor, 1970; Pierce, Schauble and Farkas, 1970; Smith, 1970) have suggested that methods for reversing the development of the expectancy of externality be studied. Further, Rotter (1971) noted that in 1962 the average I-E scale score for college students was about 8 and rose to about 11 in 1971, so it could also be said that this is becoming a greater problem. Therefore, the first hypothesis stated that, based on the studies cited above, 6-10 weeks of psychotherapy would lead to reductions in externality as reported by patient and therapist.

Brief psychotherapy was defined in this study as consisting of 6-10 weeks of therapy based on research of previous studies (Gillis and Jessor, 1970; Smith, 1970).

The studies regarding the test-retest reliability indicated that there was a systematic average decrease in externality of about 1 scale unit over the two-month period (Rotter, 1971). Therefore, we would have to have a proportionately larger decrease to show that psychotherapy had an

impact on changing a person's degree of externality. Table 2 contains the means and SDs of both the patients' and therapists' scores before therapy, after therapy, and the resulting differences or changes. That is, the change score for each patient was obtained by subtracting his after-therapy score from his before-therapy externality score.

TABLE 2

CHANGE AS THE DIFFERENCE BETWEEN BEFORE AND AFTER SCORES  
ON THE I-E SCALE AS REPORTED BY PATIENT AND THERAPIST

	<u>Patient Report of Change</u>	<u>Therapist Report of Change</u>
Before mean	11.4	13.5
SD	4.5	5.5
After mean	11.2	12.9
SD	4.8	5.5
Change (before minus after)	.19 (N.S.)	.62 (N.S.)
SD	3.7	5.9

The difference in externality for the patient as reported by the patient was .19 and was not significant. The difference between the before- and after-therapy externality scores as estimated by the therapist was .62 and was not found to be significant. That is, the average change for each group was not found to be significantly different from zero, and much less than 1.

This is not to say that change did not take place, since, as can be seen in Table 2, the SDs of the change scores are quite large, indicating a large amount of variability. Thus, across subjects, large and opposite changes took place and to a large extent cancelled each other out, resulting in no consistent changes overall, when means are contrasted. So, while on an overall basis there does not appear to be change taking place, the SDs indicate that there is indeed change taking place on an individual level, but it is not a consistent increase or decrease on a group basis.

Visual inspection of the before-therapy scores of patient and therapist (as seen in Table 2) would seem to indicate that the patients see themselves as more internal than the therapists see them. However, this difference was not found to be significant at the .05 level.

### Results Related to Hypothesis II

It was hypothesized that patients' judgement of the success of their psychotherapy would be related to change of their external expectancy. Table 3 consists of the correlations of change with the ratings of success. The correlation between the patients' report of change and the patients' rating of success was not found to be significant. However, looking at Table 4, which presents a comparison of the patients' and therapists' ratings of success, we see that patients tend to rate their therapy more highly in terms of

its success than do therapists. And this difference was found to be significant. Thus, while the mean ratings of both groups tend to be on the positive side, patients tend to rate their therapy as significantly more successful than do their therapists.

TABLE 3

CORRELATIONS OF PATIENT AND THERAPIST RATINGS OF SUCCESS WITH REPORTED EXTENT OF CHANGE

	<u>Change of Patient as Reported by Patient</u>	<u>Change of Patient as Reported by Therapist</u>
Rating of Success as Reported by Patient	.01	-.02
Rating of Success as Reported by Therapist	.06	-.05

TABLE 4

COMPARISON OF PATIENT AND THERAPIST RATINGS OF SUCCESS<sup>1</sup>

	<u>Rating of Success</u>	
	<u>Mean</u>	<u>SD</u>
Patient	6.3	1.5
Therapist	4.9	1.2
Difference	1.4 <sup>2</sup>	

1. On an 8-point scale, 8 = most, 1 = least successful.

2. Correlated data t test gave a t of 4.654, which surpassed the nominal significance level of .05.

### Results Related to Hypothesis III

Hypothesis III stated that changes in the external expectancy of the patient would be found to be related to the therapist's judgement of the successfulness of therapy. This latter hypothesis was based on a finding of Gillis and Jessor (1970) that showed that Ss who were rated improved also shifted their I-E scores in the direction of increased internality.

Correlating the patient's degree of change as reported by the patient with the degree of success as reported by the therapist yielded an  $r$  of .06 (see Table 3), which was not interpretable. Hence no systematic relationship seemed to exist between the patients' change in self-reported externality and the therapists' reports of the success of the therapy.

### Results Related to Hypothesis IV

It was hypothesized that changes in external expectancy of patient as judged by the therapist would be related to judgements of the successfulness of therapy as seen by the therapist. That is, therapists would judge their therapeutic work as successful when they viewed their patients as becoming more internal. Table 4 shows that therapists did tend to view the therapy as somewhat successful since the mean rating was 4.9 on an 8-point scale. However, correlating the degree of change in the patient as reported by the therapist

with the degree of success as judged by the therapist (see Table 3) yielded a slight negative association of  $-.05$ , which was not significant. Thus, there did not seem to be a relationship between patient's change and success of therapy, both viewed by the therapist.

#### Results Related to Hypothesis V

The reasoning behind hypothesis V was that if external expectancy is important and is not picked up by the therapist, then it will be dealt with only peripherally and thus we would expect less change. The point being made here is that the more accurate the initial assessment, defined as the extent of agreement or disagreement between the patient's score at the beginning of therapy and the therapist's guess or estimate of the patient's I-E responses, the more it will lead to greater change in the patient. Therefore, hypothesis V stated that accuracy of (extent of agreement or disagreement between) therapist's estimate of how the patient would fill out the I-E scale will be related to the degree of change in external expectancy of the patient.

Extent of agreement was handled conceptually and statistically as follows. The therapist's estimate of the patient's I-E score was subtracted from the patient's I-E score. Therefore, the resulting difference without regard for sign was a measure of the extent of disagreement, and the greater the absolute difference between the therapist's estimate and

the patient's score, the greater the disagreement. And the smaller the difference, the more the agreement between therapist and patient regarding the extent of externality of the patient at the beginning of therapy. This variable was called the initial nondirectional disagreement since it was based on the absolute difference between the two scores without regard for sign.

When the difference between the latter two scores (therapist estimate subtracted from patient score) is obtained keeping the sign, the result is a directional disagreement. Thus, this variable was called the initial directional disagreement. And the score is positive when the patient sees himself as more external than the therapist sees him. That is, the first number in the equation (the patient's score on the I-E scale) is larger than the therapist's estimate of the patient, which indicates that the patient sees himself as more external than the therapist sees him. Stated the other way around, the therapist sees the patient as more internal than the patient sees himself. Conversely, if the resulting difference yielded a negative score, this would indicate that the patient sees himself as more internal than does the therapist.

Table 5 presents a comparison of correlations of the extent of change with initial nondirectional and directional disagreement.

TABLE 5

CORRELATIONS OF INITIAL DIRECTIONAL AND NONDIRECTIONAL  
DISAGREEMENT WITH EXTENT OF CHANGE AS REPORTED BY PATIENT

---

	<u>Patient Change</u>
Initial Nondirectional Disagreement	-.08
Initial Directional Disagreement	.34 <sup>1</sup>

---

1. With an N of 42 and a nominal significance level of .05 any correlation over .3044 was taken as interpretable.

The obtained correlation between degree of change as reported by patient and initial nondirectional disagreement was -.08, which was not significant. Therefore, nondirectional disagreement between patient and therapist, disagreement without regard to the direction of the disagreement, was not found to be related to change in externality.

However, as also can be seen in Table 5, we obtained an interpretable correlation of .34 between initial directional disagreement and change in patient externality. Therefore, when the disagreement is such that the therapist views the patient as more internal than the patient views himself, this disagreement was found to vary positively with increases in internality in the patient. Thus, we can conclude that change in externality during and as a function of therapy is in part related to initial directional disagreement to the extent that the disagreement is in the direction of seeing the patient as more internal than he sees himself.

### Results Related to Hypothesis VI

It was thought that an attempt to relate the therapist's own experience, training, and therapy to his degree of initial accuracy of assessment (defined in this study as directional and nondirectional disagreement) might yield some information as to what it is in a therapist's background that contributes to his making more or less accurate assessment of a patient's level of external expectancy.

TABLE 6

CORRELATION OF THERAPIST CHARACTERISTICS WITH INITIAL NONDIRECTIONAL AND INITIAL DIRECTIONAL DISAGREEMENT BETWEEN PATIENTS' SELF-REPORT AND THERAPISTS' ESTIMATE OF PATIENTS' EXTENT OF EXTERNALITY

<u>Therapists'</u> <u>Characteristics</u>	<u>Disagreement</u>	
	<u>Initial</u> <u>Nondirectional</u>	<u>Initial</u> <u>Directional</u>
Number of years in field	-.15	.24
Number of hours training	.17	.15
Number of hours experience	.01	.37 <sup>1</sup>
Number of hours personal therapy	-.08	.41 <sup>1</sup>

1. With an N of 42 and a nominal significance level of .05 any correlation over .3044 was taken as interpretable.

Table 6 presents the correlations of therapist characteristics with initial nondirectional and initial directional disagreement between patient's self-report and therapist's estimate of patient's extent of externality. The results

indicate that the number of hours of experience doing therapy and the number of hours of the therapist's own personal therapy correlate significantly with the initial directional disagreement. Therefore, we can conclude that the tendency to view the patient as more internal than the patient sees himself (which was shown above to be related to the patient's changing in the direction of greater internality) is related to the therapist's having more experience doing therapy and having had more of his/her own personal therapy.

#### Additional Findings

An attempt was made to predict variables 7 (patient report that therapy was helpful), 15 (patient report of change), 18 (initial directional disagreement), and 20 (initial nondirectional disagreement) in this study using stepwise multiple regression.

Only two of the four multiple Rs exceeded the nominal significance level of .05 selected to determine the interpretability of the results of this study. Thus, the following are the final regression equations used to predict patient change (variable 16) and initial directional disagreement (variable 18), which previously (see Table 5) were also found to vary together.

Change in externality of the patient (variable 16), as the difference between his externality scores before and

after therapy, was one of the major variables of this study. Six predictor variables were entered into the final regression equation, which had a multiple R of .6624 and a probability level of .002 of occurring by chance. The six predictor variables in the final regression equation in order of appearance were: 1. Initial Directional Disagreement, 2. Age of therapist, 3. Initial Nondirectional Disagreement, 4. Therapist Report that his own therapy was helpful in doing therapy, 5. Amount of personal therapy of therapist, 6. Amount of training in therapy.

Accuracy of initial assessment, defined above as the extent of agreement or disagreement between patient I-E score and therapist estimate of patient's I-E responses, was another important variable in this study. And, as noted above, it was further partitioned into extent of disagreement that was directional and nondirectional.

Initial directional disagreement (variable 18) yielded a final regression equation consisting of four variables with a multiple R of .5609 and a probability level of .006. The four predictor variables in order of appearance were: 1. Amount of personal therapy of the therapist, 2. Sex of therapist, 3. Sex of patient, 4. Amount of experience in doing psychotherapy.

In summary, the results were as follows:

Hypothesis I - not significant

Hypothesis II - not significant

Hypothesis III - not significant

Hypothesis IV - not significant

Hypothesis V - confirmed

Hypothesis VI - confirmed

## CHAPTER IV

DISCUSSION

The purpose of this study was to investigate the extent to which therapy would decrease one's sense of externality. Several small studies were reviewed that suggested that change was possible utilizing brief psychotherapy or some combination of educative and therapeutic techniques. The present study was an attempt to replicate and perhaps extend the findings of these earlier studies by using more conventional psychotherapeutic means exclusively.

The main hypothesis, that there would be a systematic decline in externality following 6-10 weeks of psychotherapy, was not confirmed. In fact, increases as well as decreases in externality were obtained, which obviously cancelled each other out, resulting in no systematic change or decline in externality on a group-wide basis. It should be recalled that in the test-retest reliability studies reported by Rotter (1966) there was an average decline in externality of approximately one I-E scale unit, without any attempt to decrease the external expectancy, as we had assumed would be part of the goal of therapy. Perhaps it would be appropriate at this point to recall the basis upon which 6-10 weeks of therapy was selected as adequate for yielding such

change. The studies that the current one was based on showed that change does take place during such a brief interval. For example, Smith (1970) found that following a six-week period of crisis intervention there was a consistent shift towards internality. Two studies (Felton and Biggs, 1972, and Pierce, Schauble and Farkas, 1970) showed significant change in the direction of internality, but it seemed to be more a function of direct education to the extent of lecturing each patient about how he was being external. Gillis and Jessor (1970) did not obtain a significant decline in externality until they made this comparison with those patients that the therapists judged to be improved. That is, in these latter cases, there was seen to be a decline in externality following a course of brief therapy. (Parenthetically, this was the basis of our hypotheses relating success as seen by both patient and therapist with change as seen by both patient and therapist.) And, in addition, some people did become more internal in the current study, and some also became more external. So one cannot conclude that the time period (6-10 weeks) is too short. Rather, the specific factors relating to enhancing change in the desired direction have not been sufficiently teased out, isolated, and tested in this study.

Three hypotheses dealt with ratings of success of therapy and change or decline in externality. They will be discussed together since they appear to share a common conceptual weakness which will now be elaborated.

It had been hypothesized that change in the patient as seen by both patient and therapist would vary together with ratings of success of therapy by both patient and therapist. None of these relations was found to be statistically significant. Perhaps this can be accounted for by suggesting that reduction in externality is not seen as the goal of therapy by either patient or therapist. This is partly supported by the two studies above in which the therapists lectured their patients on externality, indicating that for them (the therapists) it clearly is a goal of therapy, but they also suggested this may not be the case with therapists not familiar with this notion. And I would like to elaborate this further. It is unlikely that patients seek therapy because they experience themselves as high in externality. They come for therapy because of more global and less dynamic reasons; for example, they are nervous, feel bad, or are depressed. So that becoming more internal may not necessarily be seen as a goal of therapy. And this may be true of therapists, also. It would be interesting to examine this in a research study. That is, to compare the effectiveness of therapists who see internality as a goal (without their being familiar with the specific concept) with those therapists with whom internality is not the goal of therapy.

The fifth hypothesis stated that accuracy of therapist assessment as defined by the agreement between the therapist's

estimate and the patient's response would be related to the degree of change in external expectancy of the patient. As was stated above, agreement (or disagreement) was seen to have two components: the magnitude of the disagreement, and the magnitude combined with the direction of the disagreement. The magnitude of agreement or disagreement by itself was not found to be related to change. However, the magnitude and the direction of the disagreement combined to yield a significantly positive correlation with change. Specifically, change was seen to be greatest where the therapist was found to view the patient as more internal than the patient saw himself. This is a very interesting finding and, should it be supported by further research, would suggest that the tendency to see others as internal is one important variable influencing the effectiveness of therapists, that is, in helping others change and likewise become more independent. This will be elaborated further after the next hypothesis.

The sixth hypothesis had to do with relating therapist characteristics with initial accuracy of assessment, defined in this study as directional and nondirectional disagreement. We found that personal therapy and experience in doing therapy correlated significantly and positively with the tendency to view patients as more internal than they viewed themselves. And, as stated above, this varied directly with change in externality. Thus, it appears that therapists

with more personal therapy and more experience in doing therapy tend to see their patients as more internal, and this is related to changes in this direction.

Garfield and Kurtz (1976) recently concluded that the personal therapy of the therapist has not been shown to be a factor enhancing his professional effectiveness, and that the tendency of therapists to become involved in their own therapy was based more on conviction and belief than empirical support. And they assert this following a very careful presentation showing that most clinical psychologists find it necessary to engage in their own personal therapy. Findings from our study do not confirm their conclusion that the personal therapy of the therapist is not related to increased professional effectiveness. We found that therapists with more personal therapy tended to be more effective professionally, as defined by their being more likely to enhance change in externality.

This suggests that being in therapy is related to seeing one's patients (and perhaps oneself) as more inclined to internality. This is not to say that they are, but that they can become more internal. Related to this is whether and how the therapist's own degree of externality affects his effectiveness as a therapist.

If this is so (that more experienced therapists see others as more internal, that this is related to increases

in internality, and is viewed as a positive goal of therapy) then this is an optimistic finding worthy of further study. That is, we are here concerned with the potential for seeing change in oneself in others, as well as studying the resistance to change. "Nor will change occur quickly when the problem reflects years of effort on the part of the parents to indicate to the person that he is unable to get along by himself." (Sullivan, 1954, p. 238) It seems that seeing others as external fosters resistance to change rather than growth. And further, that those therapists who tend to see their patients as external, helpless, alienated, unable to make it on their own without the help of external sources may be helping their patients to become this way. On the other hand, therapists who see their patients as potentially more internal, as being able to see a connection between their own behavior and their rewards, may be helping their patients to become more like this. If this is supported by further research, then it will lend additional backing to the idea that the therapist's notion of human nature is an important determinant in how he functions (Gruen and Hertzman, 1972) to bring about change in another.

There were two obvious and related limitations in this study. The first was the relatively small N of 42. The second was the limited range of therapist experience represented in this study. As regards the first limitation,

sample size, several interesting findings were suggestive, but the power of these results would be increased with a larger N. Similarly with representativeness of therapist experience -- those people who cooperated with this project were relative beginners as compared to the entire range of therapists practicing psychotherapy.

It would be exciting to repeat this study with adequate manpower to insure appropriate and representative sampling procedures and incorporating changes in design necessitated by the limitations of the present study. For example, the current project did not take account of differences in I-E as a function of diagnosis. It is conceivable that people with a certain diagnosis would change more quickly than other people with a different diagnosis. Whether this is so is also worthy of future study.

Future research that would seek to relate change in I-E with some behavioral response also would be worthwhile. This is especially so since people who are highly external were found in previous research to avoid activity in general, especially activity which would be likely to enable them to either learn more about themselves or their condition (psychological or physical). Externals were also found to be less likely to engage in remedial behaviors. Thus, studying if changes in externality would lead to seeking more information, and engaging in more remedial activity, would indeed be relevant and an important part of future research in this area.

APPENDIX A

Letter to Directors of Potentially Cooperative Clinics

Dear

I am a student in the Doctoral Program at the City College of the City University of N.Y. specializing in Clinical Psychology. I would like to interest you in cooperating with some research I am doing to meet the dissertation requirements of the Ph.D. program.

Briefly, the study is investigating whether and how psychotherapy effects one's sense of powerlessness. The Rotter scale, called the Internal-External Focus of Control scale, measures to what extent people feel they are responsible for what happens to them. Internals typically feel responsible to a large extent for rewards and/or punishments they receive. Whereas, externals see their lot as a function of luck or fate. This notion is considered to be a generalized expectancy which has been shown to effect how people approach a variety of situations, i.e., gathering information about themselves and their lives, stopping smoking, signing petitions to change something, etc.

One generally held goal of psychotherapy is to become more positively and constructively active, as opposed to either passivity and/or negative-destructive activity. To see if therapy does alter this central way of viewing the world becomes a vital issue.

The procedure is the following: To have the client fill out the Rotter Scale (23 forced choice items - takes about 5 minutes). At the beginning of therapy and again sometime between the 6th and 10th interview. And to have the therapist fill out the Scale as he thinks the client would after meeting him the first time (and/or before the 3rd interview). And to have the therapist fill out the Scales again between the 6th and 10th interview.

Essentially, I am using the Rotter as a Pre- and Post-measure to see if 6-10 weeks of therapy leads to some measurable change in a person's generalized expectancy of himself in his world.

It is an interesting piece of research that may have some very real benefits for all of us in the field.

If you have any questions you can feel free to contact me. I would be more than delighted to show you the material and discuss this with you in person.

Sincerely,

Paul Feinberg

PF:es

APPENDIX B

Letter of Instructions to Intake Worker  
Regarding Procedure of Project

Dear

I need your help to the following extent.

To ask each new client at Intake to fill out the Scale and Data Sheet (approximate time needed 5-10 minutes).

To ask each therapist upon receiving any of these cases to fill out the Scale as they think the client would after having met them for the first time and not more than twice. And to fill out a Data Sheet pertaining to their own professional training (5-10 minutes).

Then after 6-10 interviews both the therapist and client would fill out the Scale for the second time. And, they would each fill out a data sheet indicating in a general way whether the therapy was or was not successful.

APPENDIX C

Instructions to Therapists  
Regarding Procedure of Project

INSTRUCTIONS

PLEASE FILL OUT FORM 1 BETWEEN THE 1ST AND 3RD SESSION.

HAVE PATIENT FILL OUT FORM 2 BETWEEN THE 6TH AND 10TH SESSION.

FILL OUT FORM 3 YOURSELF BETWEEN THE 6TH AND 10TH SESSION.

UPON RECEIPT OF THE 3 FORMS IN THE ENCLOSED ADDRESSED ENVELOPE I WILL SEND YOU A CHECK FOR \$10.00.

APPENDIX D

Intake Form

To Be Filled Out By Client Initially

PSYCHOTHERAPY RESEARCH PROJECT

This is for research purposes only, and as such all information will remain confidential. All clients applying for psychotherapy are being asked to cooperate with this project. PLEASE FILL OUT THE ACCOMPANYING SCALE AND DATA SHEET AND RETURN AS QUICKLY AS POSSIBLE. Thank you.

Instructions for Scale

This is a questionnaire to find out the way in which certain important events in our society affect different people. Each item consists of a pair of alternatives lettered a. or b. Please select the one statement of each pair (and only one) which you more strongly believe to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true. This is a measure of personal belief: obviously there are no right or wrong answers.

Please answer these items carefully but do not spend too much time on any one item.

In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be the case as far as you're concerned. Also try to respond to each item independently when making your choice; do not be influenced by your previous choices.

1. a. Children get into trouble because their parents punish them too much.  
b. The trouble with most children nowadays is that their parents are too easy with them.
2. a. Many of the unhappy things in people's lives are partly due to bad luck.  
b. People's misfortunes result from the mistakes they make.
3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.  
b. There will always be wars, no matter how hard people try to prevent them.
4. a. In the long run people get the respect they deserve in this world.  
b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.
5. a. The idea that teachers are unfair to students is nonsense.  
b. Most students don't realize the extent to which their grades are influenced by accidental happenings.
6. a. Without the right breaks one cannot be an effective leader.  
b. Capable people who fail to become leaders have not taken advantage of their opportunities.
7. a. No matter how hard you try some people just don't like you.  
b. People who can't get others to like them don't understand how to get along with others.
8. a. Heredity plays the major role in determining one's personality.  
b. It is one's experiences in life which determine what one is like.

9.
  - a. I have often found that what is going to happen will happen.
  - b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.
10.
  - a. In the case of the well-prepared student there is rarely if ever such a thing as an unfair test.
  - b. Many times exam questions tend to be so unrelated to course work that studying is really useless.
11.
  - a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
  - b. Getting a good job depends mainly on being in the right place at the right time.
12.
  - a. The average citizen can have an influence in government decisions.
  - b. This world is run by the few people in power, and there is not much the little guy can do about it.
13.
  - a. When I make plans, I am almost certain that I can make them work.
  - b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.
14.
  - a. There are certain people who are just no good.
  - b. There is some good in everybody.
15.
  - a. In any case getting what I want has little or nothing to do with luck.
  - b. Many times we might just as well decide what to do by flipping a coin.
16.
  - a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
  - b. Getting people to do the right thing depends upon ability, luck had little or nothing to do with it.

17.
  - a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
  - b. By taking an active part in political and social affairs the people can control world events.
18.
  - a. Most people don't realize the extent to which their lives are controlled by accidental happenings.
  - b. There is really no such thing as "luck."
19.
  - a. One should always be willing to make mistakes.
  - b. It is usually best to cover up one's mistakes.
20.
  - a. It is hard to know whether or not a person really likes you.
  - b. How many friends you have depends upon how nice a person you are.
21.
  - a. In the long run the bad things that happen to us are balanced by the good ones.
  - b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.
22.
  - a. With enough effort we can wipe out political corruption.
  - b. It is difficult for people to have much control over the things politicians do in office.
23.
  - a. Sometimes I can't understand how teachers arrive at the grades they give.
  - b. There is a direct connection between how hard I study and the grades I get.
24.
  - a. A good leader expects people to decide for themselves what they should do.
  - b. A good leader makes it clear to everybody what his job is.
25.
  - a. Many times I feel that I have little influence over the things that happen to me.
  - b. It is impossible for me to believe that chance or luck plays an important role in my life.

26.
  - a. People are lonely because they don't try to be friendly.
  - b. There's not much use in trying too hard to please people, if they like you, they like you.
27.
  - a. There is too much emphasis on athletics in high school.
  - b. Team sports are an excellent way to build character.
28.
  - a. What happens to me is my own doing.
  - b. Sometimes I feel that I don't have enough control over the direction my life is taking.
29.
  - a. Most of the time I can't understand why politicians behave the way they do.
  - b. In the long run the people are responsible for bad government on a national as well as on a local level.

PSYCHOTHERAPY RESEARCH PROJECTClient Data Sheet

Name

Date

Age

Sex

A certain problem has helped you to decide to seek out the services of this agency. How long have you felt you had this problem?

Is it a problem you feel you have within yourself (a personal problem) or is it an external-situational problem (i.e., because of outer circumstances or other people)?

After some time has passed you will be asked to fill out the scale again. Thank you for your cooperation.

APPENDIX E

Form 1 - To be Filled Out by Therapist Initially

PSYCHOTHERAPY RESEARCH PROJECT

This is for research purposes only, and as such all information will remain confidential. All therapists involved in doing psychotherapy are being asked to cooperate with this project.

Please fill out the accompanying Scale according to the instructions that follow and then be sure to complete the Therapist Data Sheet. When Project is completed I will be glad to discuss the results. Thanks again for your cooperation.

Client \_\_\_\_\_ is in therapy with you. Please fill out the following scale in the manner in which you think the client would. You probably do not feel you know the client well enough at this point, but nevertheless your knowledge at this point will be most helpful.

Instructions for Scale

This is a questionnaire to find out the way in which certain important events in our society affect different people. Each item consists of a pair of alternatives, letter a. or b. Please select the one statement of each pair (and only one) which you more strongly believe to be the case as far as your client is concerned. Be sure to select the one you actually believe your client will select rather than the one you think they should select. This is a measure of personal belief: obviously there are no right or wrong answers.

Please answer these items carefully but do not spend too much time on any one item. Also try to respond to each item independently when making your choice; do not be influenced by your previous choices.

1. a. Children get into trouble because their parents punish them too much.  
b. The trouble with most children nowadays is that their parents are too easy with them.
2. a. Many of the unhappy things in people's lives are partly due to bad luck.  
b. People's misfortunes result from the mistakes they make.
3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.  
b. There will always be wars, no matter how hard people try to prevent them.
4. a. In the long run people get the respect they deserve in this world.  
b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.
5. a. The idea that teachers are unfair to students is nonsense.  
b. Most students don't realize the extent to which their grades are influenced by accidental happenings.
6. a. Without the right breaks one cannot be an effective leader.  
b. Capable people who fail to become leaders have not taken advantage of their opportunities.
7. a. No matter how hard you try some people just don't like you.  
b. People who can't get others to like them don't understand how to get along with others.
8. a. Heredity plays the major role in determining one's personality.  
b. It is one's experiences in life which determine what one is like.

9.
  - a. I have often found that what is going to happen will happen.
  - b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.
10.
  - a. In the case of the well-prepared student there is rarely if ever such a thing as an unfair test.
  - b. Many times exam questions tend to be so unrelated to course work that studying is really useless.
11.
  - a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
  - b. Getting a good job depends mainly on being in the right place at the right time.
12.
  - a. The average citizen can have an influence in government decisions.
  - b. This world is run by the few people in power, and there is not much the little guy can do about it.
13.
  - a. When I make plans, I am almost certain that I can make them work.
  - b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.
14.
  - a. There are certain people who are just no good.
  - b. There is some good in everybody.
15.
  - a. In any case getting what I want has little or nothing to do with luck.
  - b. Many times we might just as well decide what to do by flipping a coin.
16.
  - a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
  - b. Getting people to do the right thing depends upon ability, luck had little or nothing to do with it.

17.
  - a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
  - b. By taking an active part in political and social affairs the people can control world events.
18.
  - a. Most people don't realize the extent to which their lives are controlled by accidental happenings.
  - b. There is really no such thing as "luck."
19.
  - a. One should always be willing to make mistakes.
  - b. It is usually best to cover up one's mistakes.
20.
  - a. It is hard to know whether or not a person really likes you.
  - b. How many friends you have depends upon how nice a person you are.
21.
  - a. In the long run the bad things that happen to us are balanced by the good ones.
  - b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.
22.
  - a. With enough effort we can wipe out political corruption.
  - b. It is difficult for people to have much control over the things politicians do in office.
23.
  - a. Sometimes I can't understand how teachers arrive at the grades they give.
  - b. There is a direct connection between how hard I study and the grades I get.
24.
  - a. A good leader expects people to decide for themselves what they should do.
  - b. A good leader makes it clear to everybody what his job is.
25.
  - a. Many times I feel that I have little influence over the things that happen to me.
  - b. It is impossible for me to believe that chance or luck plays an important role in my life.

26. a. People are lonely because they don't try to be friendly.
- b. There's not much use in trying too hard to please people, if they like you, they like you.
27. a. There is too much emphasis on athletics in high school.
- b. Team sports are an excellent way to build character.
28. a. What happens to me is my own doing.
- b. Sometimes I feel that I don't have enough control over the direction my life is taking.
29. a. Most of the time I can't understand why politicians behave the way they do.
- b. In the long run the people are responsible for bad government on a national as well as on a local level.

PSYCHOTHERAPY RESEARCH PROJECTTherapist Data Sheet

Name

Age

Sex

Years in field

Degree

# hours of graduate and post-graduate training, i.e., seminars, supervision, workshops, etc., in Psychotherapy

# hours of therapy experience

# hours of personal therapy for self

To what extent was it helpful to you as a therapist? Circle appropriate number.

1    2    3    4    5    6    7    8

not helpful  
at all

very helpful

If you were not in therapy do you think it might have helped you as a therapist? Circle appropriate number.

1    2    3    4    5    6    7    8

not helpful  
at all

very helpful

After some time has passed, you will be asked to fill out the scale again.

APPENDIX F

Form 2 - To Be Filled Out By Client Between 6th-10th Interview

PSYCHOTHERAPY RESEARCH PROJECTClient Instructions: Second Administration

Please fill out the Scale again and then answer the questions that follow.

Remember that each item consists of a pair of alternatives lettered a. or b. Please select the one statement of each pair (and only one) which you more strongly believe to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true. This is a measure of personal belief: obviously there are no right or wrong answers.

Please answer these items carefully but do not spend too much time on any one item.

In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be the case as far as you're concerned. Also try to respond to each item independently when making your choices; do not be influenced by your previous choices or by the way you filled this scale out the first time. Thanks again for your cooperation.

1. a. Children get into trouble because their parents punish them too much.  
b. The trouble with most children nowadays is that their parents are too easy with them.
2. a. Many of the unhappy things in people's lives are partly due to bad luck.  
b. People's misfortunes result from the mistakes they make.
3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.  
b. There will always be wars, no matter how hard people try to prevent them.
4. a. In the long run people get the respect they deserve in this world.  
b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.
5. a. The idea that teachers are unfair to students is nonsense.  
b. Most students don't realize the extent to which their grades are influenced by accidental happenings.
6. a. Without the right breaks one cannot be an effective leader.  
b. Capable people who fail to become leaders have not taken advantage of their opportunities.
7. a. No matter how hard you try some people just don't like you.  
b. People who can't get others to like them don't understand how to get along with others.
8. a. Heredity plays the major role in determining one's personality.  
b. It is one's experiences in life which determine what one is like.

9. a. I have often found that what is going to happen will happen.  
b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.
10. a. In the case of the well-prepared student there is rarely if ever such a thing as an unfair test.  
b. Many times exam questions tend to be so unrelated to course work that studying is really useless.
11. a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.  
b. Getting a good job depends mainly on being in the right place at the right time.
12. a. The average citizen can have an influence in government decisions.  
b. This world is run by the few people in power, and there is not much the little guy can do about it.
13. a. When I make plans, I am almost certain that I can make them work.  
b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.
14. a. There are certain people who are just no good.  
b. There is some good in everybody.
15. a. In any case getting what I want has little or nothing to do with luck.  
b. Many times we might just as well decide what to do by flipping a coin.
16. a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.  
b. Getting people to do the right thing depends upon ability, luck had little or nothing to do with it.

17. a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.  
b. By taking an active part in political and social affairs the people can control world events.
18. a. Most people don't realize the extent to which their lives are controlled by accidental happenings.  
b. There is really no such thing as "luck."
19. a. One should always be willing to make mistakes.  
b. It is usually best to cover up one's mistakes.
20. a. It is hard to know whether or not a person really likes you.  
b. How many friends you have depends upon how nice a person you are.
21. a. In the long run the bad things that happen to us are balanced by the good ones.  
b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.
22. a. With enough effort we can wipe out political corruption.  
b. It is difficult for people to have much control over the things politicians do in office.
23. a. Sometimes I can't understand how teachers arrive at the grades they give.  
b. There is a direct connection between how hard I study and the grades I get.
24. a. A good leader expects people to decide for themselves what they should do.  
b. A good leader makes it clear to everybody what his job is.
25. a. Many times I feel that I have little influence over the things that happen to me.  
b. It is impossible for me to believe that chance or luck plays an important role in my life.

26.
  - a. People are lonely because they don't try to be friendly.
  - b. There's not much use in trying too hard to please people, if they like you, they like you.
27.
  - a. There is too much emphasis on athletics in high school.
  - b. Team sports are an excellent way to build character.
28.
  - a. What happens to me is my own doing.
  - b. Sometimes I feel that I don't have enough control over the direction my life is taking.
29.
  - a. Most of the time I can't understand why politicians behave the way they do.
  - b. In the long run the people are responsible for bad government on a national as well as on a local level.

PSYCHOTHERAPY RESEARCH PROJECTClient Instructions: Second Administration

Name \_\_\_\_\_ Date \_\_\_\_\_

Now that you have been in therapy for some time or have stopped please answer the following:

To what extent do you feel therapy has been helpful?

1 2 3 4 5 6 7 8

not helpful  
at all

very helpful

Are you still in therapy? If "no" -- how many sessions did you attend?

Briefly state why you felt therapy was or was not (is or is not) successful.

## APPENDIX G

Form 3 - To Be Filled Out by Therapist  
Between 6th-10th Interview

PSYCHOTHERAPY RESEARCH PROJECTTherapist Instructions: Second Administration

Please fill out the Scale again and then answer the questions that follow. Be sure to fill out the Scale as you think the client would.

Remember that each item consists of a pair of alternatives lettered a. or b. Please select the one statement of each pair (and only one) which you believe your client would presently select. Be sure to select the one you actually believe your client would, rather than the one you think he should select.

Please answer these items carefully but do not spend too much time on any one item. Also try to respond to each item independently when making your choices; do not be influenced by your previous choices or by the way you filled this scale out the first time.

1. a. Children get into trouble because their parents punish them too much.  
b. The trouble with most children nowadays is that their parents are too easy with them.
2. a. Many of the unhappy things in people's lives are partly due to bad luck.  
b. People's misfortunes result from the mistakes they make.
3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.  
b. There will always be wars, no matter how hard people try to prevent them.
4. a. In the long run people get the respect they deserve in this world.  
b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.
5. a. The idea that teachers are unfair to students is nonsense.  
b. Most students don't realize the extent to which their grades are influenced by accidental happenings.
6. a. Without the right breaks one cannot be an effective leader.  
b. Capable people who fail to become leaders have not taken advantage of their opportunities.
7. a. No matter how hard you try some people just don't like you.  
b. People who can't get others to like them don't understand how to get along with others.
8. a. Heredity plays the major role in determining one's personality.  
b. It is one's experiences in life which determine what one is like.

9.
  - a. I have often found that what is going to happen will happen.
  - b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.
10.
  - a. In the case of the well-prepared student there is rarely if ever such a thing as an unfair test.
  - b. Many times exam questions tend to be so unrelated to course work that studying is really useless.
11.
  - a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
  - b. Getting a good job depends mainly on being in the right place at the right time.
12.
  - a. The average citizen can have an influence in government decisions.
  - b. This world is run by the few people in power, and there is not much the little guy can do about it.
13.
  - a. When I make plans, I am almost certain that I can make them work.
  - b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.
14.
  - a. There are certain people who are just no good.
  - b. There is some good in everybody.
15.
  - a. In any case getting what I want has little or nothing to do with luck.
  - b. Many times we might just as well decide what to do by flipping a coin.
16.
  - a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
  - b. Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.

17. a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.  
b. By taking an active part in political and social affairs the people can control world events.
18. a. Most people don't realize the extent to which their lives are controlled by accidental happenings.  
b. There is really no such thing as "luck."
19. a. One should always be willing to make mistakes.  
b. It is usually best to cover up one's mistakes.
20. a. It is hard to know whether or not a person really likes you.  
b. How many friends you have depends upon how nice a person you are.
21. a. In the long run the bad things that happen to us are balanced by the good ones.  
b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.
22. a. With enough effort we can wipe out political corruption.  
b. It is difficult for people to have much control over the things politicians do in office.
23. a. Sometimes I can't understand how teachers arrive at the grades they give.  
b. There is a direct connection between how hard I study and the grades I get.
24. a. A good leader expects people to decide for themselves what they should do.  
b. A good leader makes it clear to everybody what his job is.
25. a. Many times I feel that I have little influence over the things that happen to me.  
b. It is impossible for me to believe that chance or luck plays an important role in my life.

PSYCHOTHERAPY RESEARCH PROJECTTherapist Instructions: Second Administration

Client \_\_\_\_\_ has been/  
 is in therapy with you. To what extent do you feel it is/  
 was/has been successful. Circle appropriate number.

1 2 3 4 5 6 7 8

not at all

very successful

Is client still in therapy with you? If "no" -- how many  
 sessions did he/she attend?

Briefly state why you felt therapy was or was not (is or is  
 not) successful. (Thanks.)

Just a reminder that I will be glad to discuss the results  
 at the conclusion of the project. Your cooperation has been  
 much appreciated.

## APPENDIX H

Tables A-D

TABLE A

LIST OF VARIABLES  
DATA COLLECTED FOR EACH SUBJECT

<u>Number</u>	<u>Name</u>	<u>Description</u>
1	Pt. Externality before	Pt. I-E Scale score at beginning of therapy
2	Th. Estimate Pt. Externality before	Therapist estimate of Patient Externality at the beginning of therapy (1-3 sessions)
3	Pt. Externality after	Pt. I-E Scale score 6-10 weeks after therapy
4	Th. Estimate Pt. Externality after	Therapist Estimate of Patient Externality after 6-10 weeks of therapy
5	Pt. Age	Years
6	Pt. Sex	Female = 0, Male = 1
7	Pt. therapy helpful	8 point scale; 1 - least; 8 = most
8	Th. Age	Years
9	Th. Sex	Female = 0; Male = 1
10	Th. Years in field	Years
11	Th. No. hours training in therapy	No. of hours of courses, classes, supervision, etc., specifically related to training in Psychotherapy
12	Th. No. of hours experience doing therapy	Hours
13	Th. No. of hours personal therapy	Hours
14	Th. personal therapy helpful	8 point scale; 1 = least; 8 = most

TABLE A  
(continued)

<u>Number</u>	<u>Name</u>	<u>Description</u>
15	Th. therapy successful	8 point scale; 1 = least; 8 = most
16	Pt. change	I-E before -- I-E after (1-3)
17	Th./Pt. change	Th. estimate before -- Th. estimate after (2-4)
18	Initial Directional Disagreement	Variable No. 1 - Variable No. 2
19	Informed Directional Disagreement	Variable No. 3 - Variable No. 4
20	Initial Nondirec- tional Disagreement	The absolute difference between Variable 1 and Variable 2 without regard to sign
21	Informed Nondirec- tional Disagreement	The absolute difference between Variable 3 and Variable 4 without regard to sign

TABLE B

RAW DATA<sup>1</sup>

S	Variables														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1	13	18	9	17	26	0	8	26	0	4.50	744	760	0	0	5
2	17	20	16	20	32	0	4	27	0	4.75	320	960	190	7	4
3	9	7	6	6	28	0	8	31	1	5.50	200	500	300	7	6
4	8	16	17	23	32	0	5	57	0	0.00	75	24	280	7	5
5	8	20	4	10	20	0	8	35	0	10.00	400	4000	800	8	5
6	12	12	13	11	25	1	2	36	0	5.00	200	1400	300	8	4
7	13	8	16	9	24	0	8	22	0	2.00	0	50	45	8	5
8	11	9	3	12	24	0	3	25	0	2.00	500	25	200	3	6
9	11	16	9	4	25	1	8	25	0	1.50	400	1000	52	6	5
10	21	9	10	17	27	0	6	39	0	5.00	375	5000	1500	8	6
11	15	7	13	11	28	0	8	56	0	16.00	1440	12960	1232	8	6
12	12	18	14	18	21	0	5	29	0	5.00	450	350	250	8	6
13	14	6	11	9	29	0	6	29	0	5.00	450	350	250	8	5
14	6	21	6	7	23	0	6	42	0	3.00	500	700	300	8	4
15	22	18	20	17	22	0	8	42	0	3.00	500	700	300	8	5
16	21	9	19	11	26	0	5	33	0	11.00	650	10000	775	8	6
17	7	5	4	12	22	0	8	33	0	11.00	650	10000	760	8	4
18	18	4	16	5	23	0	6	48	1	5.00	300	1575	450	8	4
19	8	7	9	3	29	0	6	39	0	5.00	400	5000	1500	8	6
20	19	20	21	11	22	0	6	37	0	6.00	300	4200	300	7	6
21	7	22	9	11	24	1	6	25	0	3.00	85	105	50	7	6
22	16	9	15	12	26	0	6	46	0	3.00	950	1400	680	8	6
23	11	4	10	6	33	1	6	34	1	11.00	2600	5000	720	8	6
24	11	14	16	12	25	0	6	34	0	4.00	600	1560	325	8	5
25	10	12	11	14	19	0	7	28	0	3.00	100	75	200	8	5
26	15	21	10	3	22	0	4	31	0	4.00	4800	1500	1000	8	4
27	14	13	12	13	31	1	8	46	0	6.00	5000	6000	800	8	3
28	6	9	6	7	29	0	6	32	0	29.00	617	1300	1200	8	2
29	7	14	6	9	19	0	0	24	0	2.50	58	120	0	0	0
30	12	18	12	19	19	1	7	28	1	2.00	100	17	600	6	0
31	7	3	9	10	21	0	7	33	0	11.00	1000	3000	1500	8	5
32	14	17	19	21	25	1	0	42	0	16.00	1500	3000	400	0	6
33	8	16	12	12	23	0	7	59	0	15.00	1000	12500	660	8	5
34	8	12	14	15	27	1	5	30	0	8.00	650	450	300	8	5
35	9	16	7	19	27	0	5	43	0	2.50	500	200	500	8	6
36	10	12	15	21	25	1	8	47	0	2.50	40	50	800	8	4
37	7	13	6	13	40	1	5	31	0	1.00	250	72	300	8	5
38	6	20	8	22	23	0	6	34	0	3.00	100	540	72	8	5
39	8	18	4	16	42	1	8	31	0	1.00	250	72	300	8	5
40	5	17	5	18	22	1	6	31	0	1.00	250	72	300	8	5
41	9	20	13	23	21	0	6	29	0	0.50	116	600	400	8	5
42	12	18	13	13	27	1	8	27	0	2.00	75	75	200	8	6

<sup>1</sup>See Table 2 for names corresponding to variable number.

TABLE B  
RAW DATA<sup>1</sup>

Variables														
5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
26	0	8	26	0	4.50	744	760	0	0	5	4	1	-5	-8
32	0	4	27	0	4.75	320	960	190	7	4	1	0	-3	-4
28	0	8	31	1	5.50	200	500	300	7	6	3	1	2	0
32	0	5	57	0	0.00	75	24	280	7	5	-9	-7	-8	-6
20	0	8	35	0	10.00	400	4000	800	8	5	4	10	-12	-6
25	1	2	36	0	5.00	200	1400	300	8	4	-1	1	0	2
24	0	8	22	0	2.00	0	50	45	8	5	-3	-1	5	7
24	0	3	25	0	2.00	500	25	200	3	6	8	-3	2	-9
25	1	8	25	0	1.50	400	1000	52	6	5	2	12	-5	5
27	0	6	39	0	5.00	375	5000	1500	8	6	11	-8	12	-7
28	0	8	56	0	16.00	1440	12960	1232	8	6	2	-4	8	2
21	0	5	29	0	5.00	450	350	250	8	6	-2	0	-6	-4
29	0	6	29	0	5.00	450	350	250	8	5	3	-3	8	2
23	0	6	42	0	3.00	500	700	300	8	4	0	14	-15	-1
22	0	8	42	0	3.00	500	700	300	8	5	2	1	4	3
26	0	5	33	0	11.00	650	10000	775	8	6	2	-2	12	8
22	0	8	33	0	11.00	650	10000	760	8	4	3	-7	2	-8
23	0	6	48	1	5.00	300	1575	450	8	4	2	-1	14	11
29	0	6	39	0	5.00	400	5000	1500	8	6	-1	4	1	6
22	0	6	37	0	6.00	300	4200	300	7	6	-2	9	-1	10
24	1	6	25	0	3.00	85	105	50	7	6	-2	11	-15	-2
26	0	6	46	0	3.00	950	1400	680	8	6	1	-3	7	3
33	1	6	34	1	11.00	2600	5000	720	8	6	1	-2	7	4
25	0	6	34	0	4.00	600	1560	325	8	5	-5	2	-3	4
19	0	7	28	0	3.00	100	75	200	8	5	-1	-2	-2	-3
22	0	4	31	0	4.00	4800	1500	1000	8	4	5	18	-6	7
31	1	8	46	0	6.00	5000	6000	800	8	3	1	0	1	0
29	0	6	32	0	29.00	617	1300	1200	8	2	0	2	-3	-1
19	0	0	24	0	2.50	58	120	0	0	0	1	5	-7	-3
19	1	7	28	1	2.00	100	17	600	6	0	0	-1	-6	-7
21	0	7	33	0	11.00	1000	3000	1500	8	5	-2	-7	4	-1
25	1	0	42	0	16.00	1500	3000	400	0	6	-5	-4	-3	-2
23	0	7	59	0	15.00	1000	12500	660	8	5	-4	4	-8	0
27	1	5	30	0	8.00	650	450	300	8	5	-6	-3	-4	-1
27	0	5	43	0	2.50	500	200	500	8	6	2	-3	-7	-12
25	1	8	47	0	2.50	40	50	800	8	4	-5	-9	-2	-6
40	1	5	31	0	1.00	250	72	300	8	5	1	0	-6	-7
23	0	6	34	0	3.00	100	540	72	8	5	-2	-2	-14	-14
42	1	8	31	0	1.00	250	72	300	8	5	4	2	-10	-12
22	1	6	31	0	1.00	250	72	300	8	5	0	-1	-12	-13
21	0	6	29	0	0.50	116	600	400	8	5	-4	-3	-11	-10
27	1	8	27	0	2.00	75	75	200	8	6	-1	5	-6	0

<sup>2</sup> for names corresponding to variable numbers.

TABLE C

SUMMARY STATISTICS  
(N = 42)

<u>Number</u>	<u>Name</u>	<u>Lowest Score</u>	<u>Highest Score</u>	<u>Mean</u>	<u>Standard Deviation</u>
1	Pt. Externality before	5.00	22.00	11.36	4.47
2	Th. Estimate Pt. Externality before	3.00	22.00	13.52	5.53
3	Pt. Externality after	3.00	21.00	11.17	4.78
4	Th. Estimate Pt. Externality after	3.00	23.00	12.90	5.52
5	Pt. Age	19.00	42.00	25.67	5.00
6	Pt. Sex	0.00	1.00	0.31	0.47
7	Pt. Therapy helpful	2.00	8.00	6.28	1.50
8	Th. Age	22.00	59.00	35.15	9.16
9.	Th. Sex	0.00	1.00	0.10	0.30
10	Th. Years in field	0.00	29.00	5.75	5.55
11	Th. No. hours training in therapy	0.00	5000.00	702.26	1065.16
12	Th. No. of hours experience doing therapy	17.00	12960.00	215.76	3419.16
13	Th. No. of hours personal therapy	0.00	1500.00	502.17	414.71
14	Th. personal therapy	3.00	8.00	7.64	0.93
15	Th. therapy successful	0.00	6.00	4.93	1.21
16	Pt. change	-9.00	11.00	0.19	3.73
17	Th./Pt. change	-9.00	18.00	0.62	5.94

TABLE C  
(continued)

<u>Number</u>	<u>Name</u>	<u>Lowest Score</u>	<u>Highest Score</u>	<u>Mean</u>	<u>Standard Deviation</u>
18	Initial Directional	-15.00	14.00	-2.17	7.42
19	Informed Directional	-14.00	11.00	-1.74	6.36
20	Initial Nondirectional Disagreement			6.40	4.20
21	Informed Nondirectional Disagreement			5.30	3.90

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TABLE D  
INTERPRETABLE CORRELATIONS<sup>1, 2, 3</sup>

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	
1			68													33		67	51			
2				42					-31	-33		-32	-46				54	-80	-32			
3	68							32								-47		36	54			
4		42														-31	-54	-32	-69			
5						33																
6					33																	
7																						
8			32									50	40									
9		-31																				
10		-33										57	52								-38	
11												32	35									
12		-32						50	57	32			54						37			
13		-46						40	52	35	54								41			
14																						
15																						
16	33	-47	-31																34			
17		54	-54																-45	34		
18	67-80	36	-32									37	41			34	-45		55			
19	51-32	54	-69														34	55			-38	
20																					33	
21									-38												-38	33

<sup>1</sup>See Table 2 for names corresponding to variable numbers.

<sup>2</sup>With an N of 42 and a nominal significance level of .05 any correlation over .3044 was taken as interpretable.

<sup>3</sup>Decimal points omitted.

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