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PATIENT-THERAPIST MISMATCHING ON LOCUS OF CONTROL AND ITS
EFFECT ON TREATMENT REJECTION BY LOWER SOCIO-ECONOMIC,
MINORITY PATIENTS

City University of New York

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ITS EFFECT ON TREATMENT REJECTION BY LOWER SOCIO-
ECONOMIC, MINORITY PATIENTS

by

Vincent Gong

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8/6/84 Anderson J. Franklin
date Chairman of Examining Committee

August 13, 1984 Herbert D. Saltzman
date Executive Officer

Professor Anderson J. Franklin

Professor Harold Wilensky

Professor Laurence Gould
Supervisory Committee

The City University of New York

Abstract

PATIENT-THERAPIST MISMATCHING ON LOCUS OF CONTROL AND
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by

Vincent Gong

Advisor: Professor A. J. Franklin

The present study investigated the effects of patient-therapist locus of control mismatching on treatment rejection by lower socio-economic, minority patients. It was hypothesized that patients who reject treatment following the intake process have dissimilar locus of control scores from their therapists. The perceived quality of the interview relationship was also examined in relation to patient-therapist locus of control matching/mismatching and to treatment rejection. In addition, other factors related to treatment rejection, such as sex, ethnicity, and social class of therapists and patients were investigated.

Forty-four patient-therapist pairs at a university psychological center were included in the sample. Seventy-five percent of the patient sample and fifty-two percent of the therapist sample were minority group

members.

The Rotter I-E Control Scale (1966) was administered to both the therapist and the patient before the first intake interview. Following the intake process, the Weibe-Pierce version of the Barrett-Lennard Relationship Inventory was administered to both therapists and patients to evaluate the perceived quality of the intake relationship.

An analysis of the data revealed that patient-therapist locus of control mismatching was not significantly related to treatment rejection. There was also no significant relationship between the perceived quality of the intake relationship and locus of control mismatching or treatment rejection. In addition, unlike previous locus of control studies, the data indicated that external patients do not reject treatment significantly more often than internal patients, nor do internal therapists lose more minority patients. Further analysis revealed several significant correlations among those patient-therapist pairs where the patient accepted treatment. Therapist sex and patient-therapist sex matching were significantly correlated with the patient's evaluation of the interview relationship.

The results are reviewed in light of difficulties typical to clinic-based research. These include: (a) clinic/therapist resistance to research; (b) limitations in research procedure; (c) sample characteristics; and (d) relative inexperience of the therapists.

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Chapter 1

Introduction

Background of the Problem

One of the more perplexing and persistent problems facing clinicians practicing psychotherapy concerns those patients who begin treatment but who terminate and drop out of treatment quite early. Generally, these terminations are initiated by the patient in the absence of a mutual agreement with the therapist that treatment has been completed. Various surveys have shown that anywhere from 30-60% of patients referred to a mental health clinic and accepted for therapy will terminate within the first six treatment visits (Baekelund & Lundwall, 1975).

A large subgroup of this population is those patients who terminate following the initial intake interview. The extent of this problem is revealed by the fact that 20-50% of those patients applying for treatment at outpatient psychiatric clinics fail to return after the first or second visit (Baekelund & Lundwall, 1975). Among this population, it is generally agreed that the highest drop-out rate occurs amongst the lower socio-economic, minority patients (Brandt, 1965; Brill & Storrow, 1960; Dodd, 1970;

Feister & Rudestam, 1975; Hollingshead & Redlich, 1958; Sue, 1977; Yamamoto, James, Bloombaum & Hatem, 1967).

Numerous studies have examined the phenomenon of early termination among lower socio-economic, minority patients and have drawn conclusions based upon class specific, patient characteristics or therapist characteristics (Garfield & Bergin, 1978). The findings of these studies generally suggest an interaction effect between the characteristics of lower class, minority patients and the characteristics of the therapist. These researchers propose that the interaction between patient and therapist variables has the greatest explanatory value with regard to early termination. Although these studies have not focused directly on the intake interview process, they propose that patient-therapist interaction variables do contribute to these patients' decision to accept or reject treatment.

Of the numerous variables thought to enter into the process of psychotherapy, the relationship between therapist personality and patient personality was chosen for examination in this study. More specifically, the influence of patient-therapist personality matching on treatment rejection following

the intake interview is the central focus of this research. The personality variable chosen for investigation is the internal-external locus of control dimension (Rotter, 1966).

The internal-external locus of control dimension (I-E) is a general expectancy variable operating within Rotter's social learning theory. Most simply, it refers to the degree to which an individual believes that reinforcements and events that happen to him/her are contingent upon his/her own behavior. Recently, researchers have begun to examine the effects of differences between the therapist's and patient's locus of control on the therapy process.

Many studies have shown differences in perceived locus of control as a function of ethnic group membership and socio-economic status (Joe, 1971). These studies have consistently found that minority group members and lower class individuals tend to be more external on the locus of control dimension. In contrast, several studies have found that mental health personnel tend to be more internal on the dimension of locus of control (Beckman, 1972; Felton, 1973; Martin & Shepel, 1974). Sue (1978) proposes that differences between the therapist's and patient's perceived sense

of personal control can lead to a misunderstanding of interpersonal dynamics and, consequently, early termination in treatment.

The main focus of this proposed research is to investigate patient-therapist matching on the I-E locus of control variable and its effect on the early termination of lower class, minority patients following the intake interview.

Importance of Research

The abundance of historical and current research relating to treatment rejection in outpatient mental health services speaks to both the urgency and importance of this topic. In that this phenomenon is particularly pronounced in community outpatient clinics, which are the most active in providing services to lower socio-economic, minority populations, additional information regarding the relationship between this group and mental health servicing is necessary.

Researchers have proposed that the initial intake interview stands as a critical stage, where both the treatment provider and the patient determine the appropriateness of the service (Pope, 1979). Historically, patients who have passed through this

critical stage seem to be quite homogenous with regard to demographic characteristics, resulting in but a small segment of the community becoming effective consumers of mental health services. In order to expand the provision of services, there is a need to develop means with which to design service strategies that would address the treatment of lower socio-economic, minority patients.

Chapter 2

Review of Related Literature

The Relationship Between Race/Social Class and Early Termination

Several studies have asserted that lower class, minority patients are more likely to drop out after a shorter period of treatment than white patients of a higher socio-economic status. Rosenthal and Frank (1958) reported that 70% of the black patients, as compared to 40% of the whites in their study, attended less than 6 or more hours of therapy. Similarly, Schaffer and Meyers (1954) found significant correlations between a patient's social class and duration of treatment. Using the Hollingshead measure to define social class, they reported that of those patients who came for just one visit, 75% were from the lower class. In contrast, 74% of those patients who remained in treatment for 25 or more sessions were from the middle to upper classes. Feister and Rudestam (1975) also reported that patients from the lower two social classes on the Hollingshead Index remained in treatment for a shorter duration than the upper social classes.

In their review of the literature, Baekelund and Lundwall (1975) report comparable findings about the relationship between social class and early termination in 35 out of 57 investigations examining this issue. Dodd (1970) also found that patients with more education and from higher socio-economic classes generally stayed longer in treatment. In addition, his review of the literature revealed that racial minorities were found to drop-out of treatment more quickly than whites in a significant number of studies. In many of these studies, a failure to return following the initial intake interview was subsumed in their definition of early termination.

Several studies have focused on isolating patient characteristics which independently contribute to early termination of treatment. Lorr and McNair (1964) portray the early terminator as "not anxious or does not admit to being anxious or self dissatisfied. He is likely to have had a history of antisocial acts, he admits to being undependable and impulsive, and may be authoritarian" (p. 11). Similarly, Taulbee (1958) found that the following pretherapy patient characteristics were related to acceptance and engagement with treatment: minimal defensiveness,

persistence, an introspective attitude, feelings of inadequacy and inferiority, strong dependency needs, emotional responsiveness, and feelings of depression or anxiety. In addition to the aforementioned, Luborsky, Chandler, Averbach, Cohen, and Bachrach (1971) found that level of motivation, intelligence, anxiety, and education were significant predictors of treatment continuation. Agreement of these findings with previously reported studies is substantial (Auld & Meyers, 1954; Frank, Gliedman, Imber, Nash & Stone, 1957; Hiler, 1954; Rubenstein & Lorr, 1956).

While these personality characteristics were stated to be discriminating variables in these studies, few studies have directly examined their relationship to treatment rejection following the initial, intake interview (Garfield & Bergin, 1978). Accordingly, the correlation of consistent and uniform personality characteristics with acceptance of treatment does not appear to be well established. In addition, few of these attributes have been systematically studied in relation to social class or ethnic background. Yet, several interpretations emerge with regard to the characteristics of lower class, minority patients who terminated treatment early or reject treatment

altogether.

These characteristics include the lower class, minority patients' emphasis on the present rather than the future; tendency to be more concrete and task oriented; tendency to be less other directed and less likely to conform to social and expert opinion; presentation of physical symptoms as opposed to psychological symptoms and poor motivation (Baekelund and Lundwall, 1975). In addition, Baekelund and Lundwall (1975) suggest that these patients' treatment expectations contribute to their early termination.

A careful perusal of the literature yielded very little evidence that duration of psychotherapy depended on the independent action of class-related personality characteristics (Brill & Storror, 1960; Garfield, 1978). In fact, Affleck and Garfield (1970) found that therapists' judgments of hypothesized therapeutic assets of the patient failed to show a significant relationship to the continuation of treatment. Lorion (1974) suggests that prior assumptions concerning help-seeking attitudes and treatment expectations among lower class, minority patients must be carefully re-evaluated. Also, several studies have revealed that certain therapists were successful in retaining lower

class, minority patients who were predicted treatment terminators (Baum & Felsner, 1966; Imber, Nash & Stone, 1955; Learner & Fiske, 1973; McNair, Lorr & Callahan, 1963). These findings suggest that patient characteristics do not fully address the phenomenon of treatment rejection by lower class, minority patients.

In their review of the literature, Baekelund and Lundwall (1975) conclude that the therapist's attitudes and behaviors also influence whether a patient stays in or commits him/herself to treatment. According to this review, some of the characteristics of the therapist who is apt to drive his/her patient from treatment include: ethnocentrism, unconcern for, dislike of, or boredom with the patient and negative feelings about medication and or reluctance to give it. Shapiro (1974) asserts that rejection of treatment could be the patient's behavioral reaction to the negative feelings of the therapist. He found that of those patients toward whom the therapist felt positively tended to commit themselves to treatment, whereas those patients toward whom he/she felt less positively rejected treatment. These findings have strong implications for the mental health servicing of lower class, minority populations.

The mental health community has consistently subscribed to and acted upon particular attitudes related to the socio-economic and ethnic status of a patient. There is a preponderance of evidence that clearly indicates that a person's social class and race figure importantly in whether or not he/she will be accepted for treatment (Brill & Storrow, 1960; Cole, Branch & Allison, 1962; Schaffer & Meyers, 1954; Yamamoto et al., 1968). Lower class, minorities are referred or accepted into treatment at a significantly lower rate than white, middle class patients. Hollingshead and Redlich (1958) suggest that that psychotherapists tend to select "good" patients, that is, those who possess social and intellectual status similar to their own. Similarly, Rosenthal and Frank (1958) conclude that therapists consider as good patients those with whom they can communicate and who share their value system. Reflecting this preference, Schofield (1964) proposed that most therapists tend to be attracted to "clients who present the 'YAVIS' syndrome--clients who are youthful, attractive, verbal, intelligent, and successful" (p. 135).

A number of studies have examined the therapist's reaction to his/her patient's socio-economic status.

Learner and Fiske (1973) found that the therapists in their study appeared to prefer and be more comfortable with upper-class, white patients who were most similar to themselves. Brill and Storrow (1960) concluded that the patient's social class was related to the affective reactions of the therapist. The intake therapists reacted less positively to the lower class patients than to the middle class patients. Nash et al. (1965) revealed a relationship between the patient's socio-economic status with the therapist's rating of patient attractiveness and ease of establishing rapport. Each of these variables was found to be related to continuation of treatment. Parloff (1961) argues that the therapist's perception of his/her patient influences the quality of the relationship he/she is able to establish with the patient. Finally, Learner and Fiske (1973) propose that the therapist's attitudes and expectations may frequently introduce a handicapping effect on the engagement of lower class, minority patients.

The findings of these studies strongly suggest an interaction between lower class, minority patient characteristics and therapist characteristics which can affect the duration of treatment. In that the initial

intake interview is the first contact point for both the patient and therapist, the interaction of patient-therapist variables may play an important role in the continuation or rejection of treatment. This is the critical stage where both the therapist and patient develop their initial perceptions of the potential and suitability of continued treatment. A review of the literature on the effects of patient-therapist matching on the therapy process supports this proposition.

Patient-Therapist Matching and the Continuation of Treatment

The relationship between patient and therapist during psychotherapy is believed to have an important bearing on the outcome and process of treatment (Freud, 1949; Rogers, 1951; Sullivan, 1956). It is frequently assumed that the fact of a patient's remaining in treatment may be interpreted as evidence of the "goodness of fit" in the relationship (Parloff, 1961). This assumption reflects an emphasis on field theory, which conceives of the therapy interview as an interpersonal process in which the patient's behavior is not seen as a function of his/her personality alone, nor of the therapist's personality or skills alone. Rather, the patient's behavior is dependent on the

nature of the interaction between patient characteristics and therapist characteristics.

Early studies have supported this proposition. Hiler (1958), using the Rorschach to differentiate productive versus unproductive patients, found a significant amount of patient-therapist interaction in the retention of each patient group for therapy. His results revealed that certain therapists were more successful with the unproductive patients than other therapists and vice versa. Similarly, Garfield, Affleck and Muffly (1963) found that patient-therapist congruence on selected behaviors and perceptions during the first therapy interview was significantly related to duration of treatment. The results of these studies strongly suggest that individual therapists do differ with regard to the type of patients tending to continue or discontinue treatment with them.

There have been attempts by researchers to discover patient and therapist combinations that are predictive of "goodness of fit" (Landfield, 1971; Landfield & Nawes, 1964; Lesser, 1961; McLachlen, 1972; Mendelson, 1965, 1966; Saplosky, 1965). Garfield and Bergin (1978) state that such a research strategy assumes that "felicitous combinations of therapists and

patients might be formed on the basis of some general characterological tendencies of the participants, which are independent of the treatment setting but which, nevertheless make their inevitable appearance" (p. 252). These researchers imply that a matching of these characteristics could enhance the evolution of a therapeutic relationship, whereas mismatching could limit its development. Matching between the therapist and patient during the intake interview could foster a greater commitment to treatment by both parties.

Previous studies where socio-cultural variables have served as a basis for investigating patient-therapist combinations reflect the assumption that socio-cultural differences between therapist and patient imply substantial differences in cultural and socialization experiences. Baekelund and Lundwall (1975) suggest that the "therapist's values and implicit expectations about the patient's life goals and conduct of his treatment may differ greatly from the ideas that the patient himself has about such matters" (p. 742). Miranda et al. (1976) assert that this gap can become a source of a great deal of tension, impeding the development of therapeutic rapport and leading to the rejection of treatment.

Hollingshead and Redlich (1958) assert that socio-cultural differences can contribute to early termination. They observed that the therapist and patient cannot be too far apart socially and psychologically unless the therapist has a real and sympathetic understanding of the patient's class and culture. Pope (1979) states,

"People who are socially remote are likely to share few experiences; their values are likely to be dissimilar and the forms of behavior for which they are rewarded, quite different. One may therefore assume that social distance will tend to weaken the relationship between an interviewer and interviewee, while social proximity will tend to strengthen it" (p. 469).

Several studies have examined the issue of patient-therapist combinations with lower class, minority patients. Although not directly related to early termination, Carkuff and Pierce (1967) examined the relationship between therapist race and social class with patient depth of self-exploration. Congruent race and social class of patient and therapist was found to be significantly related to patient depth of self-exploration. Similarly, the research literature on A-B therapist types has suggested that B-type therapists are more effective than A-type therapists in working with lower class patients (Carson, 1967; McNair et al., 1963). It is

hypothesized that the interest areas of B-type therapists are more congruent with lower class patients. In addition, a discrepancy between lower class patients and therapists expectations about treatment has been shown to contribute to early termination (Freedman, Engelhardt, Hankoff, Glick, Kaye, Buchwald & Stark, 1958; Garfield et al., 1963; Goldstein, 1960; Heine & Trosman, 1960). Finally, Pettit, Pettit and Walkowitz (1974) investigated the relationship between values, social class and duration of treatment. She found a relationship between the interaction of social class and the discrepancy between patient and therapist values and continuation. Given the large role dissimilarity could play in the drop out rate amongst lower class, minority patients, it is important to identify specific factors which influence the relationship between patient and therapist during the initial intake interview.

Although a myriad of personality variables may be operative in contributing to the phenomenon of treatment rejection, one dimension of particular interest relates to an individual's view of personal control. More specifically, the degree of control one believes he/she has over positive or negative events,

circumstances and situations in his/her life. This stands as an important variable to investigate in that it generally reflects an individual's matrix of values, attitudes, opinions, and expectations, directly influencing how he/she thinks about and defines events. Within the context of a mental health interview one's sense of personal control could influence an individual's process of examining the presenting problem, expectations about the interview exchange, and/or the value placed upon the relative importance of life events. Given that the intake interview is an interpersonal encounter involving the active interaction between a therapist and a patient, one can assume that the personal control values of both participants will be operative in the context of the exchange.

The variable chosen here to investigate this dimension of personal control is Rotter's (1966) internal-external locus of control concept. Many studies have demonstrated differences in perceived locus of control as a function of ethnic group membership and socio-economic status (Joe, 1971). These studies have consistently shown that minority group members and lower class individuals tend to be

more external on the locus of control dimension. In contrast, several studies have found that mental health personnel tend to be more internal on the dimension of locus of control (Beckman, 1972; Felton, 1973; Martin & Shepel, 1974). Recently, researchers have begun to examine the effects of differences between the therapist's and patient's locus of control on the therapy process. Sue (1978) proposes that differences between the therapist's and patient's perceived sense of personal control can lead to a misunderstanding of the patient's psychological dynamics. He suggests that this could be a central influence on the high rate of treatment rejection amongst the lower class, minority patients. In order to examine this question, an exhaustive review of the large body of locus of control research was conducted.

Locus of Control: A Definition

Rotter's (1966) concept of internal versus external control of reinforcement developed out of social learning theory. His interest was in identifying a moderator variable that could predict individual differences in generalized expectancies for reinforcement and in turn help predict behavior. The concept of internal versus external locus of control

(I-E) describes the degree to which an individual believes that reinforcements are contingent upon his/her own behavior. Internal control refers to those individuals who believe that reinforcements are contingent upon his/her own behavior, capacities, or attributes. External control refers to individuals who believe that reinforcements are not under their personal control but rather are under the control of powerful others, luck, chance, fate, etc. In any given situation, external individuals, though desirous of an available reinforcement, may believe that no behavior in his/her repertoire will allow him/her to be effective in securing the reinforcement. Rotter (1966) states that depending on one's past reinforcement experiences, a person will develop a consistent attitude tending toward internal or external locus of control as the source of reinforcement.

Rotter (1966) asserts that these generalized expectancies reflect an important personality characteristic which allows for defining an individual's dimension of generalization from situation to situation and making broad predictions from limited data. Although he does assert the importance of this dimension, Rotter (1975) does suggest that, akin to

other personality constructs, an individual's locus of control represents only one of many variables that enter into the prediction of behavior. Its relative importance is a function of the novelty or ambiguity of the situation. The importance of this generalized expectancy goes up as the situation is more novel and ambiguous to the individual.

Several hundred studies concerned with the relationship between locus of control and particular personality features have been carried out. The review of this literature reveals a dichotimization of personality features associated with either internal or external locus of control (Joe, 1971; Lefcourt, 1966, 1972; Phares, 1976; Rotter, 1966). High internality has been associated with greater job efficiency, higher need achievement, greater school success, greater attempts at mastering the environment, greater expression of satisfaction with life, lower anxiety, and greater willingness to accept responsibility for personal actions. In contrast, externals have been observed to be anxious, dogmatic, less trustful of others, having a low need for social approval, and having a greater tendency to use sensitizing modes of defense.

Although these findings have been consistent, several researchers assert that there exist problems with the conceptualization of specific personality features from internal-external locus of control (Gurin, Gurin, Lao & Beattie, 1969; Lefcourt, 1972; Rotter, 1975). They suggest that caution should be taken in the interpretation of the findings from these studies on a number of dimensions. First, there is a failure of this research to treat the reinforcement value as a separate variable. Accordingly, there may exist differential interest in the attainment of a goal between individuals. Secondly, there is a question of the "specificity-generalizability" of the specific task. In many of the studies there was little control over the structure, familiarity, or ambiguity of the task, allowing for less generalizability of the results. And, lastly, there is concern over the "good guy-bad guy" dichotomy which has emerged from these studies. Research and clinical psychologists assume that it is good to be internal and bad to be external. There is a danger in assuming all good things are internal while all bad things are characteristic of externals. By so doing, one eliminates the important consideration of numerous social, political, economic, and racial

influences on these generalized expectancies and the evaluation of their effectiveness within these contexts (Garcia et al., 1975; Gilbert, 1974; Gurin et al., 1969; Rotter, 1975; Stebbins and Stone, 1977; Sue, 1978).

Rotter's I-E Locus of Control Scale (1966):

Unidimensionality versus Multidimensionality

The Rotter I-E Scale for Adults is the most widely used scale in the literature on locus of control. The scale consists of 29 pairs of statements, including six filler statement pairs, and uses a forced-choice format. Each statement pair consists of an internal and an external statement. The scale provides a wide sampling of situations within which a person's internal-external attitudes might be expected to effect behavior.

Although it is an extensively used scale, there has been some criticism regarding various possible methodological weaknesses of the scale. Several researchers have questioned the unidimensionality of the scale.

Gurin et al. (1969) postulated that the general Internal-External Control Score did not distinguish between the belief that I-E control operates generally

in society and the application of this to one's own personal situation. These researchers emphasized the importance of this self-other distinction in the prediction of behavior. Similarly, Mirels (1970) factor analyzed the items on the Rotter I-E Scale (1966) and identified two separate factors: a belief concerning felt mastery over one's life and a belief concerning the extent to which an individual citizen is deemed capable of exerting impact on social institutions. These results were replicated by McDonald and Tseng (1971) and Abrahamson et al. (1973), who also found a third factor comprised of items pertaining to control over being liked or disliked. Also, Levenson (1973) found three locus of control factors: internality, control by powerful others and control by chance factors.

Although Rotter (1975) does not oppose the factor analysis of his scale, he asserts that the broad concept of internal versus external control is viable in that most samples of subjects do show a better-than-chance relationship between attitudes of subjects toward fate, luck, and control by powerful others or the belief in personal control. In addition, during the early development of the I-E Scale, two factor

analyses were performed, both of which showed that most of the variance was accounted for by the one general factor. The other factors, containing only a few items, accounted for a small proportion of the variance (Franklin, 1963; Rotter, 1966). Also, none of the dimensions that have been factored out have demonstrated a significantly higher relationship than that of the score of the total test. Given the exploratory nature of this research examining the general influence of locus of control on treatment rejection, the original Rotter I-E Control Scale (1966) will be employed.

Socio-Economic Status, Race and Its Relationship to Locus of Control

There is evidence that Rotter's I-E Control Scale (1966) is sensitive to socio-economic and ethnic influences. Differences in attitudes of internal-external control between ethnic groups and social classes have been reported in several studies. Previous studies indicate that blacks and lower class individuals generally score more external than whites and middle class persons (Battle & Rotter, 1963; Lefcourt & Ladwig, 1965, 1966). Similarly, The Report on Equality of Educational Opportunity revealed that

blacks and other minority children were more externally oriented than whites (Coleman, Campbell, Hobson, McParrland, Mood, Weinfeld & York, 1966). Also, studies dealing with an isolated tri-ethnic community found whites to be most internal, followed by Mexican-Americans, and Native Americans who were the most external (Jessor, Graves & Lefcourt, 1968). In addition, cross-cultural comparisons revealed that a person's culture influences his/her preference for items on the I-E Scale. Seemingly, those cultures which approach the "Protestant Ethic" orientation tend to highly value internal control attitudes (Hsieh, Shybut & Lotsof, 1969; Parson et al., 1974).

As mentioned in a previous section, there is an implicit assumption by research and clinical psychologists that internal control is associated with positive characteristics. If one maintains this assumption, most minorities and lower class individuals would be regarded as unhealthy and as possessing less desirable traits. Several investigators have examined this assumption in relation to this group and argue that the interpretation of externality must account for the socio-cultural context (Crandall, Katkovsky & Crandall, 1965; Hersch & Scheibe, 1967; Hsieh et al.,

1969). They postulate that within various cultures, externality may be viewed as acceptable.

Gurin et al. (1969) also questions the implicit assumption that internal control is desirable, particularly with respect to minorities and the lower class. These investigators postulate negative implications for internal orientation within this group. An internal orientation based on responsibility for failure may be reflective of intrapunitiveness rather than a positive adaptation. According to Gurin this group's tendency towards externality results from their experience with

"many external obstacles that have nothing to do with chance--the operation of the labor market which can lead to layoffs over which individuals have no control, poor transportation facilities which reduce their possibilities in the job hunt, the tendency of employers to hire within the social network of those already on the payroll, etc. In addition, there are class-tied obstacles to many kinds of opportunities and to resources which open up other opportunities, which may be perceived by low income persons as external but not a matter of randomness or luck. For minorities there is also the external factor of racial discrimination which operates over and beyond the class constraints they may or may not experience. Discrimination may be perceived as operating quite the opposite of chance--systematically, predictably, and reliably." (p. 33)

Because of these experiences these individuals may be realistically seeing a discrepancy between their ability and attainment. The external rather than the internal orientation may be associated with more effective behavior within this context. These data are consistent with the theoretical expectation that individuals who are restricted by environmental barriers and feel subjected to limited material opportunities will develop an externally oriented outlook (Joe, 1971).

Sue (1978) proposes that if these considerations are denied, this can lead to a misunderstanding of the psychological dynamics of the lower class, minority patient. He hypothesizes that this could result in responses by both therapist and patient leading to the rejection of treatment following the initial intake interview.

There is a growing body of clinical research which examines the relationship between locus of control beliefs and treatment outcome issues. Akin to many of the early termination studies, this research has emphasized the role of patient locus of control and its interaction with treatment process issues. A review of this body of research reveals that patient locus of

control alone is not sufficient for the occurrence of several treatment phenomena.

Patient Locus of Control and Treatment Rejection

Locus of control and patient treatment rejection has been given but a cursory glance resulting in little past research. Yet, given the novelty of the initial stages of therapy, it has been assumed that patients will bring their locus of control expectations into treatment. Strickland (1978) concludes from her review of the research that beliefs about internal versus external control are related in a significant way to health-related behaviors including psychotherapy.

Traditionally, it has been postulated that external patients are more prone to dropping-out of treatment since they may not see how their behavior keeps them from getting what is desired. In his original monograph, Rotter (1966) discussed elements of an individual, in terms of locus of control, which he felt helps predict whether a patient is disposed to remaining in treatment. He suggests that the individual who holds strong beliefs that he/she can control his/her destiny is: (a) more alert to useful information for future behavior, (b) takes steps to improve his/her environmental condition, and (c) places

greater value on skills, achievement, reinforcements, and abilities. According to Rotter's hypothesis, internals are both more apt to change with treatment than externals and will perceive therapy as potentially more beneficial.

Similarly, the reviews by Strickland (1978) and Baker (1979) propose that individuals with an internal orientation tend to take a more active role than externals in insuring their own continued health, and to take more precautionary health measures than externals.

In addition, some investigators assert that the defensive function of externality may make externals particularly resistant to the therapy process. Phares, Ritchie and Davis (1968) propose that externals have a ready-made defense: Since they believe they have little or no control over their personal life, they may not believe they can develop the responsibility for what happens to them.

Although this traditional assumption is supported by much research, a number of studies have surfaced which report conflicting findings. Several investigators suggest that although internals appear to make more gains in therapy, they too, will block and

resist certain attempts at influence.

Manuk, Heinrichsen and Ross (1975) examined the effect of patient locus of control upon treatment-seeking behavior. In this study the level of life stress was controlled. The results indicated that externally oriented individuals demonstrated more treatment-seeking behavior than did internals at times of low stress. Under high stress, no difference in treatment-seeking behavior was found between internal and external subjects.

More specifically, Noweki and Duke (1978) found that those patients who dropped out following the intake interview tended to be internally oriented. They also reported that internal therapy patients remained in counseling for fewer sessions than externals even though both groups had expected to stay a similar number of sessions. Gilbert (1979) proposed that internals may reject treatment once they feel back in control but before they have learned effective ways of coping with the stresses resulting from events that they may experience as uncontrollable.

Several other studies which have investigated the relationship of patient locus of control to dropping out of therapy, or length of treatment, found no

significant differences between internal and external patients (Lee, 1979; Morgan, 1978; O'Leary, 1976).

Given the contradictory reports about treatment rejection and patient locus of control, no clear, definitive generalizations can be made. Yet, Gilbert (1974) suggests that there persists a pervasive belief system among both academically oriented and clinically oriented psychologists which perceives internals as: (a) more effective and having greater mental health than externals, (b) exhibiting behaviors and personality characteristics which are valued more positively, and (c) more successful in therapy than externals.

While differences between internals and externals have been reported in the research literature, the results do not definitively indicate that one reflects more health and attractiveness than the other (Gilbert, 1974). What this may reflect is the marked preference among clinicians for clients with an internal locus of control (Harari, 1979).

Assuming that therapists do hold these beliefs about externality of their patients and its undesirability, the question arises about the effects of these values on treatment rejection by the external

lower class, minority patient.

Locus of Control and Psychotherapy

There also exists a body of locus of control research which evaluates the interaction between patient locus of control and patient preference in treatment modality. Since many researchers have found that internals demonstrate a resistance to conformity pressures (Crowne & Liverant, 1963; Gore, 1962; Strickland, 1965), it has been traditionally assumed that these individuals would tend towards a preference for non-directive treatment conditions (Fry, 1975). On the other hand, externally oriented individuals, in their tendency towards compliance to and dependence on perceived authority (Brando & McDonald, 1971; Ritchie & Phares, 1968) might be expected to prefer and function more effectively within a treatment condition which is structured and directive. Numerous studies have been conducted to determine whether a relationship exists between the patient's locus of control and their preference for a certain type or modality of treatment. The results of this group of studies have not been entirely consistent.

Several studies have proposed a direct relationship between patient locus of control and

preferred treatment modality. Helwig (1977) investigated the relationship between patient locus of control and choice of directive versus non directive styles of treatment or interviewing among both college students and psychiatric patients. The analysis of this data indicated that in both sample populations, there was a significant relationship between externality and preference for directive treatment. Jacobsen (1971) examined locus of control and its influence on the patient's choice of therapist. The subjects of this study were identified as either internal or external by the Rotter I-E Control Scale (1966). They were then provided with two separate descriptions representing either the analytic or behavioral approach to treatment. The results of this study revealed that the therapist representing the more directive, behavioral approach was chosen by those subjects scoring in the external direction.

Similarly, Friedman and Dies (1974), using text-anxious students, investigated the patient's locus of control and its relationship to preference for control within therapy. In this study, the subjects were randomly assigned to either an unstructured discussion-oriented condition or a structured desensitization

process. Although no clear relationship was found with regard to preferred treatment condition, the external subjects felt more dissatisfaction with treatment in both conditions because they perceived too much control having been left to them. In contrast, the internal subjects perceived an optimal degree of control in both conditions.

Abramowitz, Abramowitz, Roback and Jackson (1974) investigated treatment effectiveness as a function of patient locus of control and treatment condition. The subjects of this study were college students seeking assistance at the university counseling center to improve interpersonal functioning and personal adjustment. The subjects were randomly assigned to either a directive or non-directive treatment group. The results revealed that the overall outcome for internals was more positive when they had been in a non-directive treatment condition. These findings indicated the opposite for the externally oriented subjects.

Although the aforementioned studies conclude a direct relationship between patient locus of control and preferred treatment condition, several studies using similar methods and sample populations have found

conflicting results. Kilman (1974) found that externals, when asked to state their preference for membership in a shared leadership versus controlled leadership condition, chose the former. Within this sample of university students, he found no significant differences in preference between those who scored as internals or who scored as externals on the Rotter I-E Scale.

In another study, it was found that both internals and externals expressed a preference for less directive treatment styles. This investigator concluded that it was the subject's perception of the therapist's standing on the participation-control dimension, rather than therapeutic ideology which was the most influential on the subject's preference (Wilson, 1974).

Schmidt (1972) investigated patient satisfaction with treatment as a function of locus of control and therapy style. The subjects of this study were randomly assigned to one of three treatment conditions: Rational-Emotive Therapy; Gestalt Therapy; Client-Centered Therapy. His results did not indicate a relationship between patient locus of control and satisfaction with any treatment condition. In addition, he did not find a significant relationship

between patient locus of control and satisfaction with directive or non-directive therapists.

Albrecht (1979) investigated patient locus of control and intake interview structure. He randomly assigned 54 university students seeking therapy to either structured or unstructured intake interviews. He hypothesized that: (a) internals, as compared to externals, would demonstrate more self-directed, responsible behavior in the unstructured interview format, (b) internals would report greater satisfaction with unstructured interviews, while external subjects would report greater satisfaction with the structured intake format, and (c) externals would score higher on the Anxiety Behavior List than the internals, in both intake conditions. The exhaustive analysis of data revealed no significant relationship between internal versus external control in either interview condition on any of the three variables.

Marburg (1981) studied patient locus of control and the role of brief, individual, directive or non-directive treatment in facilitating personal adjustment. He found that the interaction between the effect of directive/non directive psychotherapy and internal/external locus of control was not significant.

The conflicting results of these studies investigating patient locus of control and treatment conditions does not allow for definitive generalizations regarding locus of control and treatment interview preference. Also, in that these studies did not directly examine this relationship with regard to treatment rejection, it is difficult to determine its influence on this phenomenon.

In addition, these studies which investigated the relationship between patient locus of control and treatment modality did not determine how the therapist's personality may have influenced the treatment process. In each study, it is not clear whether the necessary steps were taken to insure that each therapist was indeed offering significantly different treatment conditions. The question arises as to the possibility that the therapist's personality (locus of control, in this case) may influence the style with which he/she approaches and provides treatment (Messor, 1980).

The study by McLachlen (1972) provides some support for this notion of personality, "conceptual level" in this study, influencing personal style. In this study, he found that the cognitive orientation of

the therapist was highly correlated with therapeutic style. He proposed that patients who were matched with their therapist on "conceptual level" would tend to improve more than those patients who were mismatched.

Several investigators have assessed the internal versus external expectancies of mental health personnel and its impact on the treatment of lower class minority patients. Berman (1979) investigated the extent to which four different groups of therapists (black/white, male/female) include social factors in their assessment of their patients' problems. In this study, an instrument evaluating the individual-societal continuum, essentially paralleling Rotter's I-E Scale (1966) was used. This instrument was thought to have the ability to discriminate the cultural content of the diagnoses. The results of this investigation revealed strong race differences. The black and white therapists differed significantly in their use of an individual or societal focus to diagnose patient problems. A societal focus was more evident, more frequently, in the evaluations made by the black therapists than the white therapists. The results of this study suggest the presence of distinct sets of norms operating within different socio-cultural groups

with regard to the understanding of patient problems.

Similarly, Li Rac (1979) examined the degree to which clinical perception may be influenced by the socio-cultural distance between therapist and patient. She suggested that since a therapist formulates clinical impressions based upon both personal experience and professional training, which could be predicated on a different socio-cultural matrix, the potential for distortions in assessment and therapeutic action may be quite high. The results of her study revealed that with greater socio-cultural distance between therapist and patient there was a greater disparity between how the patient evaluated his/her personality traits and how the therapist evaluated these traits. She concluded that it is important that a therapist be familiar with the frame of reference shaping a patient's experience to accurately understand the individual's communication and behavior.

Finally, Gilbert (1979) asserts that the personal control orientation of therapists and their attitudes towards internal versus external control can, very well, influence treatment. He suggests that therapists who hold an internal orientation and value it may have difficulty in recognizing and dealing with aspects of

external perception in their patients.

These findings strongly suggest that a therapist's locus of control influences his therapy style and that the matching of patient and therapist on the locus of control variable could have an effect on the treatment process.

Widman (1978) investigated the relationship between two therapist personality traits and their effect on patient I-E orientation as therapy progresses. The therapist personality traits included locus of control and level of self-disclosure. Although a significant difference was obtained between pre- and post-test means for patient I-E score, this investigator did not report a significant relationship between patient orientation change and either therapist variable.

In another study, Dubnicki (1977) examined patient-therapist matching on the I-E locus of control variable and its effect on the therapy process. The focus of this study related to investigating the effects of this matching upon patients' moving towards greater internality and both patients' and therapists' evaluations of the presence or absence of positive therapeutic conditions. Analysis of the data revealed

that the matching of therapist and patient did not affect the patient's move towards greater internality. Yet, both therapists and patients differed significantly in their perception of the level of positive therapeutic conditions. The therapists consistently rated themselves higher than their patients.

Similarly, Meehl (1980) investigated the effect of patient-therapist locus of control matching on therapy outcome. Different from previous studies, he constructed a locus of control measure which examined a person's perception of the locus of the problem and locus of solution. In addition, he attempted to evaluate the effects of patient-therapist matching on this measure on early termination. Analyses of the data revealed that computed agreement on the locus of the problem and solution was unrelated to therapy change or outcome. Yet, perceived agreement between patient and therapist was positively related to therapy outcome. Although his findings were not directly related to early termination, he asserts that "it is reasonable to assume that the locus of the problem and solution must be negotiated and agreed upon before effective problem solving can be taken" (p. 83).

Although these studies have failed to demonstrate a significant relationship between patient-therapist locus of control matching and therapy change, there are subtle indications that it participates in the development of a treatment climate which can influence treatment duration. Dubnicki's (1977) finding that locus of control matching can influence the therapist's and patient's perception of the therapeutic climate and Meehl's (1979) study revealing the importance of patient-therapist perceived agreement seem to support this notion.

Sue (1978) stresses the importance of this notion in the treatment of lower class, minority patients. In his article "Eliminating Cultural Oppression in Counseling: Towards a general Theory," he proposes a general working theory of how race- and culture-specific factors interact in such a way as to produce people with differing perceptions of locus of control and locus of responsibility. He strongly suggests that the internal locus of control and locus of responsibility world view characterizes Western therapeutic treatment. Accordingly, most therapists are of the opinion that people must take responsibility for their own actions and can improve their lot in life

through their own effort and abilities. Although he does not question the general value or accuracy of this position, Sue suggests that it may be inappropriately applied to lower class or minority patients who do not share this world view. In these cases, the differences in world views between therapist and patient can lead to a misunderstanding of interpersonal dynamics. The therapist may perceive the socio-culturally different patient as a poor treatment risk. These patients may be viewed as lacking courage, ego strength, and being overly passive. In turn, the patient may question the credibility and trustworthiness of the therapist and question his/her ability to understand his difficulties. Sue suggests that this could be a central influence on the high rate of early terminations and treatment rejection amongst lower class, minority patients.

Specific Aims of Proposed Research

A review of the research literature shows that both the therapist's and patient's locus of control can influence the psychotherapy process. Although few studies have specifically investigated the relationship between locus of control matching and treatment rejection following the initial, intake interview,

there are indications that patient-therapist matching on this variable can affect the development of a treatment climate which can influence treatment engagement. The main focus of this proposed research is the examination of patient-therapist mismatching on the internal-external locus of control variable and its effect on the rejection of treatment by lower class, minority patients. In addition, this proposed study will investigate the presence or absence of a positive therapeutic relationship in those patient-therapist pairs where treatment rejection has occurred.

Hypotheses to be Tested

1. Patients who reject treatment following the initial intake interview have dissimilar locus of control scores from their therapists.
2. Patients who rejected treatment will express a low evaluation with regard to the quality of the interview relationship with their therapist as well as have dissimilar locus of control scores.
3. Patients who reject treatment will be more external in locus of control than those who accept treatment.

4. There will be a greater rate of treatment rejection among therapists who score as high internal locus of control.

Chapter III

Method

Subjects

The subjects of this study included 52 patient-therapist pairs drawn from a university Psychological Center. The Psychological Center was located at 137th Street and Convent Avenue in the West Harlem Area of Manhattan. It was staffed by doctoral students supervised by clinical faculty. The center's staff was comprised of both minority and non-minority group members. The primary mode of treatment at the Psychological Center was individual, psychoanalytically oriented psychotherapy. The Psychological Center's service population included both university students and community residents. This population was diverse in its ethnic composition, with black and hispanic minority group members from lower socio-economic backgrounds being well represented.

Patients. The patients in this study were students, enrolled at the university who had voluntarily referred themselves to the university's Psychological Center for individual psychotherapy. This patient sample consisted of 32 females and 20 males with the mean age of 25.2 years. Seventy-five

percent of this patient sample were minority group members; the remaining 25% were non-minority group members (whites). Eighty percent of the patient sample were identified as lower-middle to lower socio-economic status as measured by the Hollingshead Scale.

Of the original 52 patients who participated in this study, 44 completed all three measures involved with this research project. These included (a) Rotter Internal-External Locus of Control Scale (1966), (b) Weibe-Pierce Revised Version of the Barrett-Lennard Relationship Inventory (1973), and (c) received a referral to treatment with which they either accepted or rejected. The remaining eight patients completed the two required inventories but had not been referred for treatment at the close of the research project.

Among the 44 patients who completed all research requirements, there were 26 females and 18 males. The mean age for these patients was 24.5 years with an age range from 18 to 40 years. Seventy-five percent of these patients were minority group members (Table 1).

Table 1

Ethnic Group Breakdown of Patient Sample, N=44

Ethnic Group	N	%
Hispanics	15	34.1
Blacks	16	36.4
Asians	2	4.5
Whites	11	25.0

Eighty-two percent of this patient sample were identified as being of lower-middle to lower socio-economic status as measured by the Hollingshead Scale (Table 2).

Table 2

Socio-economic Status of Patient Sample, N=44

Hollingshead Class	N	%
I	0	0
II	8	18.2
III	13	29.5
IV	17	38.6
V	6	13.7

Therapists. The therapists of this study included 14 female and 7 male, second year doctoral students in Clinical Psychology functioning as intake therapists at the Psychological Center. The mean age for this therapist group was 30.5 years, with an age range from 25 to 41 years. Fifty-two percent of this therapist sample were identified as minority group members (Table 3).

Table 3
Ethnic Group Breakdown for Therapist Sample

Ethnic Group	N	%
Hispanics	5	23.8
Blacks	5	23.8
Asians	1	4.8
Whites	10	47.6

Fifty-seven percent of the therapist group were identified as from middle to lower socio-economic status as measured by the Hollingshead Social Class index. The remaining 43% ranked themselves as from Class I or II of the Hollingshead measure (Table 4). Of this total therapist group, two therapists withdrew from the research project by failing to complete and

submit the patient/therapist inventories required in the research.

Table 4

Socio-economic Status of the Therapist Group

Hollingshead Class	N	%
I	4	19.0
II	5	23.8
III	11	52.4
IV	1	4.8
V	0	0

Measures

The locus of control of therapists and patients was determined by the Rotter Internal-External Control Scale (1966). The Rotter I-E Scale (1966) is a forced-choice, self-report inventory consisting of 29 statement pairs. Subjects were instructed to choose the one statement from the pair which most closely reflected their attitude. Each statement pair includes both an internal and an external response. The scale provides a wide sampling of situations within which a person's internal-external attitudes might be expected to affect behavior.

A comprehensive review of the work on the development, validity, and reliability of the scale has been reported by Rotter (1966). Reliability measures reported for the Internal-External Control Scale has been consistent. The test-retest reliability reported by Rotter (1966), for varying samples and for intervening time periods varying from one to two months, ranged between .49 and .83. Hersch and Scheibe (1967) found similar results, .48 to .84, for a 2 month period. Similarly, Harrow and Ferrante (1969) found that over a 6 week period, a test-retest reliability of .75 was computed. In addition, a number of researchers reported good discriminant validity for the Internal-External Scale. They reported very low correlations with such variables such as intelligence, social desirability, and political affiliation (Hersch & Scheibe, 1967; Minton, 1967; Rotter, 1966). In addition, the internal consistency coefficients have ranged from .67 to .79 (Rotter, 1966).

Also, the convergent validity of the I-E Scale has been quite satisfactory. Over 50% of the internal-external locus of control studies have used the Rotter Scale (1966). These studies indicate better-than-chance individual differences in perceived locus of

control. This provides support for the notion that the Rotter I-E Control Scale (1966) is sensitive to these differences (Joe, 1972; Lefcourt, 1966, 1972; Minton, 1967; Rotter, 1966).

The Weibe and Pierce Revised Version of the Barrett-Lennard Relationship Inventory (1973) was used to measure the perceived quality of the intake relationship among all patient-therapist pairs participating in the study. The items of this instrument were originally designed to evaluate the perceived presence or absence of a therapist's empathy, acceptance, congruence, and genuineness. For the purposes of this study, this inventory was administered to both therapists and patients to evaluate the perceived presence or absence of these conditions. The shorter rather than the extended version of the Relationship Inventory was used to insure greater cooperation from both therapists and patients.

The Relationship inventory contains 32 statements regarding how one feels and behaves towards another person. The statements are of a likert scale type. Each statement is evaluated according to how strongly the subject agrees or disagrees. The point values range from +3, indicating strong agreement, to -3,

indicating strong disagreement. Each subscale area, representing the individual therapeutic conditions, is scored separately. The total score is obtained by summing the four subscale scores.

The statistical analysis of the original Barrett-Lennard Scale (1963) obtained a mean split-half reliability coefficient for the various subscales of .86 and a mean intercorrelation of .45. Although reliability and validity data have not been collected for the Weibe and Pierce version, it is similar to the original instrument from which its items were taken.

Procedure

The Rotter Internal-External Control Scale (1966) was administered to both the intake therapists and patients before they began the intake interview process. The I-E Scale was attached to the clinic's treatment application form. The patient was instructed to complete all the questions on both the treatment application and the I-E Scale. The intake therapists completed the I-E Scale at the beginning of this research project. In this case, the I-E Scale was administered to those therapists participating in an intake supervision group. Under no circumstances did the patient and therapist have contact before the

administration of this inventory.

To insure a uniformity in approach, similar instructions were presented to each subject. These instructions stated: (a) they were completing an opinion survey, (b) it would require 10-20 minutes to complete, (c) they were to answer all the questions by choosing the statement from each pair with which they most agreed, (d) that there were no right or wrong answers, and (e) that their responses would be confidential and analyzed anonymously.

Upon completion of the I-E Scale, the subject's answer sheet was coded to insure anonymity. The patient's answer sheet was coded according to their assigned clinic case number and removed from the treatment application. This procedure guarded against the intake therapist being influenced by his/her familiarity with the test results. The therapist's answer sheet was coded by letter. After the formal assignment had been made each intake patient-therapist pair was coded according to the assigned clinical case number.

The Weibe and Pierce version of the Barrett-Lennard Relationship Inventory was administered to evaluate the perceived quality of the intake

relationship. To avoid the potential of data attrition with time, both therapist and patient of each pair were requested to complete the Relationship Inventory immediately following the first intake interview. The therapists self-administered their inventory, coded it according to the assigned clinic case number, and deposited it into a data collection box. As for the patients, they were referred by the therapist to the researcher. At that time, the researcher administered the inventory to the patient. To recruit his/her participation, the patient was told: (a) the clinic was gathering information to help evaluate current services, (b) the information would be used to help design future services, and (c) his/her responses would be confidential. Again, these answer forms were matched according to the assigned clinic case number.

Finally, only those patients who were accepted for treatment and contacted within a month of the completion of the intake process were included to participate in this study.

Statistical Analyses

Upon the completion of the Rotter I-E Control Scale, both the therapists and patients were evaluated in terms of the internal or external directionality of

their scores. The median score for each group was computed. Patients and therapists who scored above the median value were considered external. If their scores fell below the computed median value, they were considered internal. A patient-therapist pair was considered matched if their locus of control scores fell on the same side of the computed median value. Mismatched pairs consisted of those patient-therapist pairs whose respective scores were on the opposite side of the median value.

A multiple regression analysis was performed to examine the first hypothesis: whether patient-therapist matching on the locus of control variable affected patient acceptance or rejection of treatment. The regression analysis was used to determine the power of the relationship between patient-therapist locus of control matching and patient acceptance/rejection of treatment. The strength of this relationship was compared to the predicting value of all other independent variables examined in this project. These included patient's and therapist's age, sex, ethnicity, socio-economic status, Relationship scores, and Rotter scores. In addition, Pearson correlations were computed to examine whether there were significant

relationships within each Treatment Fate Group. In other words, separate correlations were computed for the treatment acceptance group and the treatment rejection group to assess trends associated with each group.

The multiple regression analysis was also performed to statistically examine the second hypothesis. Here, the relationship between patient-therapist matching and the evaluation of the interview relationship by both the therapist and patient was assessed. It was hypothesized that therapists and patients who were mismatched on the locus of control dimension would produce significantly lower scores on Weibe and Pierce Revised Relationship Inventory. Again, Pearson correlations were computed to examine whether there were significant relationships within each treatment fate group. Correlations were computed for the total relationship score and all subtest scores for the treatment acceptance group and the treatment rejection group. Finally, t-tests comparing the mean scores of all Relationship scales between the matched group and mismatched group were computed. Therapist and patient scores of both groups were compared. An examination of all 52 subjects on these variables was

also performed.

The third hypothesis, that among those patients who reject treatment there would be more externals, was evaluated by both the computation of Pearson correlations and t -tests. Pearson correlations were computed to examine the relationship between the patients' Rotter scores and Treatment Fate. T -tests were computed to compare the mean Rotter scores between patients in the treatment acceptance group and the treatment rejection group.

Finally, it was hypothesized that there would be a higher rate of treatment rejection amongst those interview therapists who scored as internals. To evaluate this hypothesis, Pearson correlations were computed to assess the relationship of therapist Rotter scores with patient acceptance or rejection of treatment. In addition, a t -test was performed comparing patient treatment fate between therapists who scored as "extreme" externals and therapists who scored as "extreme internals" on the Rotter I-E Locus of Control Scale.

Chapter IV

Results and Discussion

Patient-Therapist Mismatching on Locus of Control and Its Effect on Treatment Rejection

Quite similar to previous early termination studies, 32% of the patients in this research sample rejected treatment following the initial intake interview. Of note was that treatment rejection occurred exclusively amongst the minority patients in this sample (Table 5).

Table 5

Ethnicity and Treatment Fate

Ethnic Group	Treatment	%	Treatment	%
	Acceptance		Rejection	
Hispanics	7	23	8	57
Blacks	11	37	5	36
Asians	1	3	1	7
Whites	11	37	0	0

The first hypothesis was that among those patients who rejected treatment, there would be more patient-therapist pairs with dissimilar locus of control scores. Computing the median value for each group and

designating therapists and patients as internal or external resulted in 11 therapists (\bar{X} -12.72) and 22 patients (\bar{X} -14.01) in the external group and 10 therapists (\bar{X} -7.8) and 22 patients (\bar{X} -7.09) in the internal group.

A multiple regression analysis was computed to determine the power of the relationship between patient-therapist locus of control matching and treatment fate. The results of this analysis indicated that patient-therapist matching was not significantly related to treatment fate within this sample population ($p > .05$). In addition, the Pearson correlations which were computed failed to reach significance ($p > .05$), indicating an absence of trends on this dimension for either treatment acceptors or treatment rejectors.

The results of these analyses indicate that patient-therapist matching on the locus of control variable was not significantly related to treatment acceptance within this sample population.

Although the results of these analyses indicate that patient-therapist matching on the locus of control variable was of no significance, its influence may have been hidden by certain characteristics unique to this sample population. Of note was the lack of distinction

between therapists and patients on several variables. Most importantly, there was little difference between therapists, as a group, and the patient, as a group, in terms of their Rotter Locus of Control Scores. Although the range of their scores differed (Therapists 5-17; Patients 2-20), there was little difference on how they were distributed (Therapists= \bar{X} -10.38, SD-3.1; Patients= \bar{X} -11.15, SD-4.7). Unlike previous research findings which consistently suggested that minority patients tend to score external and therapists tend to score in the internal direction, both the therapists' and patients' locus of control scores in this research sample did not significantly differ from Rotter's (1975) college sample (\bar{X} =11, SD=4.0). The result was the falling of scores within the mid-range, rendering the designation of internal versus external, and matching versus mismatching, as relatively non-distinctive. This was particularly true in the therapist group. The power of distinction between internal therapists and external therapists was quite weak given the narrowness in their range of scores. The lack of significant results may be a function of this relative lack of variability in the locus of control scores, rather than the unimportance of

matching on the locus of control dimension.

Secondly, unlike many mental health service centers, the therapist group was relatively matched with the patient group in terms of ethnicity. Fifty-two percent of the therapists participating in this research project were minority group members. This ethnic parallel between therapists and patients may have contributed to the lack of distinction in the locus of control scores between therapists and patients. A further implication may involve the relative unimportance of Rotter matching on treatment acceptance within the context of a service center which reflects the ethnic make-up of its service population. Yet, only with further research comparing the influence of Rotter matching within a multiethnic clinic to its influence within a non-ethnically mixed service center can such an assumption be confirmed.

Thirdly, this research project was executed at a psychological center on a university campus. The sample of therapists and patients were drawn from this university population. Previous research on the Rotter has indicated that locus of control can be influenced by level of education. Thus, despite the fact that the therapists of this study were advanced Ph.D. students,

their academic experiences may not have been sufficiently dissimilar from their university patient counterparts. In that both the patients and intake therapists were students at a large university, the lack of distinction between their locus of control scores may have been but a reflection of their shared experience in negotiating the demands of academic living. Future research with matching on Rotter's Locus of Control Variable may yield more significant distinctions if the study were to utilize professional, more experienced therapists within a non-academic community setting.

In spite of the characteristics of the research sample, a greater sample size may have generated a broader range of locus of control scores and a greater number of matched or mismatched dyads from which to evaluate distinctions. In that the data were collected within an active clinic setting, the control for manipulating the matching or mismatching of dyads was strictly limited. Data collection was highly dependent upon the cooperation of clinic therapists. Akin to many clinical research projects, this proved problematic in the collection of the type and breadth of data necessary for the most comprehensive analysis.

There was a variance in the participation by individual therapists. Although each therapist was instructed to submit the research questionnaires for all the patients they evaluated (approximately six per therapist), the completed cases by therapists ranged from one to five. This resulted in a lower total of matched and mismatched dyads desired and necessary for a more comprehensive analysis. The power of the Rotter Locus of Control Scale may have been restricted by the size of this research sample.

The Relationship Between Treatment Rejection and the Therapists'/Patients' Evaluation of the Quality of the Interview Relationship

It was hypothesized that among those dyads where the patient rejected treatment, both the therapist and patient would express a low evaluation of the quality of the interview relationship. This group's evaluation of the relationship would be significantly lower than those patient-therapist dyads where the patient accepted treatment. It was also hypothesized that the greater the dissimilarity in therapist/patient locus of control scores, the lower the evaluation would be. A multiple regression analysis was computed to evaluate the power of the relationship between the scores

obtained from the Weibe-Pierce Revised Barrett-Lennard Relationship Inventory and treatment fate. In addition, Pearson correlations were computed for both the Treatment Accepting and Treatment Rejecting Group, in order to reveal possible trends in these groups' independent evaluation of the interview relationship.

The relationship between treatment fate following the intake interview and the Total Weibe-Pierce Relationship Score did not reach significance ($p > .05$). Further analyses of the four subscales (Regard, Congruence, Empathy, Unconditionality) also failed to reach a .05 level of significance. The results of this regression analysis also indicated a non-significant relationship between Patient-Therapist Locus of Control Mismatch and the obtained scores on the Relationship Inventory ($p > .05$). Pearson correlations and t -tests also failed to reach significance. These results indicate that the relationship factors investigated may not encompass the complete array of interpersonal influences which participate in a patient's decision to accept or reject treatment.

Yet, caution should be taken in the interpretation of these findings. The absence of significant results may well be a function of the limitations of the Weibe-

Pierce version of the Barrett-Lennard Inventory.

Although the items in this revised inventory were drawn from the original scale via a factor analytic method, the inclusion level (.50) may not have been sufficient in constructing a rigorous investigative tool. Also, the limited size of the present research sample may have restricted the variability in the responses to the inventory items.

In addition, the original Barrett-Lennard Relationship Inventory was designed to measure the qualities of a relationship within the context of an ongoing treatment. Although there have been studies which administered the inventory during the initial interviews, the scale was most often administered following three to five therapy sessions. The present study differs from these previous clinical studies in that the evaluation of the relationship variables was attempted following the initial interview. Given this context, the lack of significant results can be partially explained by the following considerations.

First, the Weibe-Pierce instrument may be limited in distinguishing significant differences in response styles without a critical period of experience between the therapist and patient. Given the brevity of

contact between the therapist and patient in this research project, the participants' responses may have reflected some difficulty in matching the inventory items to their single interview experience. The items on the inventory may require more contact time between the therapist and patient in order for the participants to respond from a more informed, discriminating perspective. Also, the guided inquiry mode of the intake interview may not have allowed for the type of interaction between the therapist and patient which would fully test out these relationship variables. The information gathering mode of the intake interview may have produced similarities in the actual interview process from one interviewer to the next.

Locus of Control for Treatment-Rejecting Patients

It was hypothesized that among those patients who reject treatment there would be significantly more who scored as externals on the Rotter I-E Locus of Control Scale than those patients who accept treatment. Analysis of the patient locus of control scores revealed a range of scores from 2 to 20 with the mean of 11.12 and a standard deviation of 4.7. A median split was computed for this patient group where those patients who scored from 2 to 10 were considered

Internals and those patients who scored from 11 to 20 were considered Externals.

Pearson correlations were computed to assess the relationship between patient locus of control and treatment fate. This analysis failed to indicate a significant relationship. Given the previously cited low variability of Rotter scores, an analysis of extreme Rotter scores was computed. Here only those patients who had Rotter scores of 15 or above (Externals) and from 2 to 8 (Internals) were used for the analysis. This resulted in a comparison of 17 "extreme internals" to 12 "extreme externals." A t-test analysis was computed to determine mean differences with regards to treatment fate. This analysis also failed to reach significance (t=.17, df=21.6, p>.05).

Unlike previous reviews of locus of control clinical research, these findings indicate that external patients do not reject treatment significantly more often than internal patients. These findings stand as support for the more recent research findings which challenge the traditional assumption that externals are more prone to reject treatment. These findings have important implications for the provision

of treatment to minority patients. Historically, this patient population has been consistently assessed as externally directed. Given the treatment risks which are associated with externality, service providers would often have reservations in accepting these patients for treatment and refer them to treatment modalities which were less oriented towards psychotherapy. Although further research is necessary to draw a more definitive conclusion, these findings suggest that a reassessment of our traditional assumptions regarding this patient population is warranted.

Finally, the importance of these findings rests in its suggestion that patient locus of control alone does not fully address the phenomenon of treatment rejection by a primarily minority patient sample. Rather, it serves to support the importance of interaction variables between therapist and patients which are operative in the interview process.

Therapist Locus of Control and Treatment Fate

It was hypothesized that therapists who score as "high internal" would experience a significantly higher rate of treatment rejection than external therapists. The analysis of therapist Rotter scores revealed a

range from 5 to 17 with a mean of 10.38 and a standard deviation of 3.1. Pearson correlations were computed to assess the relationship between therapist locus of control scores and treatment fate. The analyses revealed coefficients that did not reach significance ($p > .05$). Given the previously cited low variability of therapist locus of control scores, an analysis of cases where the therapist scored as "extreme internal" or "extreme external" was performed. This resulted in the analysis of 20 cases seen by internal therapists and 16 cases seen by external therapists. The results of the t -test failed to reach significance ($t = .60$, $df = 32.6$, $p > .05$).

The results of these analyses indicate that therapist locus of control alone does not significantly influence treatment rejection amongst a predominantly minority patient sample. Yet, caution should be taken in drawing definitive conclusions from this data, in that the power of distinction between internal therapists and external therapists was weak given the narrowness of their range of scores. In that the majority of their scores fell within the mid-range of the internal-external continuum, the distinction between internal therapists and external therapists may

have been statistically insignificant.

In addition, the format of the initial intake interview may have limited the influence of therapist locus of control. The intake interview tends toward a directed inquiry with the objective of gathering certain classes of information, and the therapist's style of interaction may not have varied considerably, given the structured context. Unlike previous studies which examined varying styles of treatment process and their impact on internal or external patients, the focused nature of the initial intake process may not have afforded these same distinctions in experience.

Additional Relevant Findings

The Influence of Patient Ethnicity and Socio-Economic Status on Treatment Fate. The results of the multiple regression analysis revealed that the patient's ethnicity, as defined as minority or non-minority, was significantly related to treatment fate following the initial intake interview (multiple $r=.423$, $F=9.25$, $p<.01$). It appeared that of the 44 patients used in this analysis, the minority patients rejected treatment at a significantly higher rate than those patients who identified themselves as non-minority. As can be seen by reviewing Table 5, 42.4%

of the minority patients rejected treatment following the intake interview. Of this group of patients, 36% were black, 57% were hispanic, and 7% were asian. These findings were in contrast to the non-minority patients where 100% of these patients remained in treatment following the initial interview (See Table 5).

Although these findings should be interpreted with caution, given the small sample size, they do concur with previous research findings which have shown that minority patients tend to reject treatment at a significantly higher rate than non-minority patients. In their review of the literature, Baekelund and Lundwall (1975) found race to be a significant factor in treatment duration in a large percentage of studies which they evaluated. Although the present data must be viewed with caution, the treatment rejection by the minority patients in this sample should stand as an important concern for future service delivery considerations.

The results of the multiple regression analysis also revealed that the socio-economic status of the patient was significantly related to treatment fate (multiple $r=.485$, $F=6.3$, $p<.01$). These findings

indicated that the patients who ranked themselves as from the upper class background rejected treatment at a significantly higher rate (Table 6). Fifty percent of those patients who ranked themselves as from Class II backgrounds failed to return for treatment following their initial intake interview, whereas only 28% of those patients from the lower three socio-economic status rankings failed to return for treatment.

Table 6

Socio-economic Status and Treatment Fate

Hollingshead Index	Reject	%	Accept	%
I	0	0	0	0
II	4	29	4	14
III	3	21	10	33
IV	4	29	13	43
V	3	21	3	10
Total	14	100	30	100

These findings are surprising, as previous literature has reported that patients from lower socio-economic backgrounds tend to reject treatment

significantly more often than patients from middle and upper class backgrounds. Yet, given the extremely small sample of the higher SES rankings, it is difficult to fully assess the significance of these findings. Since 82% of this research sample ranked themselves as from the three lower SES rankings, the findings of the regression analysis may have been influenced by the skewed nature of this research sample. Given the location of the Psychological Center (West Harlem) and its predominantly low income service population, it is not entirely surprising that higher SES patients were under-represented in this research sample.

Significant Variables Amongst Those Patients Who Accepted Treatment. Post hoc analysis revealed several significant correlations amongst those patient-therapist pairs where the patient accepted treatment. Amongst these variables, the therapist's sex was found to be significantly correlated to the patient's evaluation of the interview relationship on several measures. The therapist's sex was found to be positively related to the patient's evaluation of his/her felt experience of respect in the relationship ($r=.5$, $p<.01$). According to these data, female

therapists tended to be experienced as having more positive responses to the patient than male therapists.

Another notable finding was that the therapist's sex was also significantly correlated with the patient's evaluation of the therapist's congruence in the interview situation ($r=.47, p<.01$). Here the patient is evaluating the therapist's ability to appear honest, direct, sincere, and unthreatened in his/her interaction with the patient. Again, there was a significant relationship suggesting that female therapists tended to be experienced as more congruent than male therapists.

Finally, the therapist's sex was also found to be significantly related to the patient's evaluation of the overall quality of the interview relationship ($r=.45, p<.01$). This evaluation score includes the summation of all four scales on the Weibe-Pierce Revised Version of the Barrett-Lennard Relationship Inventory (Respect, Congruence, Empathy, and Unconditional Regard). Again, there was a significant relationship between female therapists and the patient's overall evaluation.

These results are not altogether surprising in that reviews of the literature on the effects of the

therapist sex have reported higher ratings of satisfaction with female therapists by patients of both sexes (in this study, 40% of the patients accepting treatment were male and 60% were female). These findings seem to reflect cultural stereotypes with regard to sex-based behavior. In general, women tend to be perceived as demonstrating understanding, caring, and empathy in a more open manner than men. Whether this was actually demonstrated in the interactions of the intake interview process is unclear, given the design of this research project.

In addition, these findings also support the predominant view that a high level of therapeutic qualities such as empathy, regard, congruence, and unconditionality, are associated with positive treatment outcome. Since the above analyses were performed with the patient group which accepted treatment, it is not surprising that the patient's evaluation of therapeutic qualities would move in a more positive direction.

Yet these results should be interpreted with caution. Firstly, the male-female differences may be confounded by the greater number of female therapists who participated in this study. Secondly, in computing

treatment acceptance levels between female and male therapists, there was not a significant difference in the percentage of patients who returned for treatment between each therapist group (male therapists=69%, female therapists=66%). Thus, although there may have been significant differences in the evaluation of therapeutic conditions, these differences did not significantly influence treatment acceptance as a function of therapist sex. And, thirdly, the above cited significant correlations did not reach a level of significance when compared with the treatment rejecting group. At most these significant correlations relating to therapist sex suggest a response direction which merits further investigation.

In addition to therapist sex, patient-therapist sex matching was found to generate significant correlations with several relationship measures among treatment accepting patients. Sex matching was found to be significantly correlated with the patient's evaluation of his/her experience of respect in the interview relationship ($r=.64$, $p<.001$). Among this treatment accepting patient group, patient-therapist sex matching was significantly associated with the patient's rating of positively balanced responses from

the therapists.

Sex matching was also found to be significantly correlated with the patient's rating of congruence during the interview situation. There was a significant relationship suggesting that patients who were matched with their therapists on the dimension of sex tended to experience their interviewers as more honest, direct, sincere, and unthreatened ($r=.52$, $p<.01$).

Patient-therapist sex matching was also found to be significantly associated with the patient's evaluation of the therapist's level of empathy ($r=.47$, $p<.01$). Within this treatment accepting patient group, patient-therapist matching on sex seemed related to the patient's experience of the therapist's ability to be accurately aware of and sensing the meaning of his/her communications.

Finally, patient-therapist sex matching was found to be significantly correlated with the patient's overall evaluation of the interview relationship. Matching on this dimension seemed to be positively associated with a higher evaluation of the interview process amongst those patients who accepted treatment.

Again, these findings are not surprising.

Positive evaluations of the therapeutic conditions have been generally associated with positive outcome. The fact that these correlations were found within the patient group who later accepted treatment merely supports this general assumption. Yet, caution should be used in the overall interpretation of these findings. Since there were considerably more female patients and therapists than males, these findings may be confounded by the weighting towards female participants. The evaluation of sex matching with regard to these variables was computed with an emphasis on female-female matched pairs. Again, the appearance of a significant relationship with sex matching among treatment-accepting patients indicates but a trend which warrants further investigation.

Within this treatment-accepting patient group, there was also a significant correlation between the patient's socio-economic background and the therapist's rating of his/her own level of unconditional regard ($r=.43$, $p<.01$). These findings suggest that the therapists felt their affective responses to the patients' productions were constant regardless of the content presented and that their self-ratings on this measure tended to be higher with patients from the

lower socio-economic status groups. Although these findings suggest that therapist attitudes are important in engaging patients from a lower socio-economic background, the skewed nature of this patient sample on this dimension renders this interpretation tentative at best.

Chapter V

Conclusion

Summary

A consistent problem facing clinicians practicing psychotherapy concerns those patients who begin treatment but who terminate and drop out of treatment quite early. A large subgroup of this population is those patients who terminate following the initial intake interview. Among this population, it is generally agreed that the highest drop-out rate occurs among the lower socio-economic, minority patients.

Earlier studies have investigated the phenomenon of early termination among lower socio-economic, minority patients and have drawn conclusions based upon class specific, patient characteristics or therapist characteristics. The findings of these studies generally suggest an interaction effect between the characteristics of this patient population and the characteristics of the therapist. These researchers propose that the interaction between patient and therapist variables has the greatest explanatory value with regard to early termination.

The present study investigated the effects of patient-therapist locus of control matching or

mismatching on the dropping out process by lower socioeconomic, minority patients. The following hypotheses were examined:

1. Patients who reject treatment following the initial intake interview have dissimilar locus of control scores from their therapists.

2. Patients who reject treatment will express a low evaluation with regard to the quality of the interview relationship with their therapist as well as have dissimilar locus of control scores.

3. Patients who reject treatment will be more external in locus of control than those who accept treatment.

4. There will be a greater rate of treatment rejection among therapists who score as high internal locus of control.

In addition, other factors related to dropping out, such as the sex, ethnicity, and social class of therapists and patients were investigated.

Forty-four patients who had voluntarily referred themselves to treatment at a university Psychological Center were included in the sample. Nineteen therapists participated in this research project. The Rotter Internal-External Control Scale (1966) was

administered to both the intake therapists and patients before they began the intake interview process. Under no circumstances did the patient and therapist have contact before the administration of this inventory. The Weibe and Pierce version of the Barrett-Lennard Relationship Inventory was administered to evaluate the perceived quality of the intake relationship. To avoid the potential of data attrition with time, both the therapists and patients completed this inventory following the first intake interview. Treatment drop-out was defined as the patient's failure to continue treatment following the intake process. Only those patients who were accepted for treatment and contacted within a month of the intake process were included in the sample.

The findings of the present study were similar to previous early termination studies. Thirty-two percent of the patients in this research sample rejected treatment following the initial intake interview. Of note was that treatment rejection occurred exclusively among the minority patients in this sample.

An analysis of the effects of patient-therapist locus of control matching on treatment fate did not reach significance. The results of this analysis

indicated that patient-therapist matching was not significantly related to treatment fate within this sample population. Further analysis of trends within both the treatment accepting and treatment rejecting groups also proved to be non-significant.

A multiple regression analysis was computed to evaluate the power of the relationship between the scores on the Weibe-Pierce Revised Barrett-Lennard Relationship Inventory and treatment fate. Analysis of the relationship between treatment fate and the total Weibe-Pierce Relationship Score did not reach significance. Further analysis of the four subscales also failed to reach significance. The results of this regression analysis also indicated a non-significant relationship between therapist-patient locus of control mismatch and the obtained scores on the Relationship Inventory.

Pearson correlations were computed to assess the relationship between patient locus of control and treatment fate. Unlike previous locus of control clinical research, these findings indicated that external patients do not reject treatment significantly more often than internal patients. These findings stand as support for the more recent research findings

which challenge the traditional assumption that externals are more prone to reject treatment.

Pearson correlations were also computed to assess the relationship between therapist locus of control scores and treatment fate. In addition, a t-test analysis of "extreme internal therapists" and "extreme external therapists" was performed. The results of these analyses indicated that therapist locus of control alone does not significantly influence treatment rejection among a predominantly minority patient sample.

Post hoc analysis revealed several significant correlations among those therapist-patient pairs where the patient accepted treatment. Among these variables, therapist sex and sex matching was found to be significantly correlated to the patient's evaluation of the interview relationship on several measures. Although the above cited significant correlations did not reach significance when compared to the treatment rejecting group, they do suggest a response direction which merits further investigation.

Although the results of these analyses indicate that patient-therapist matching was not significantly related to treatment fate, future research in this area

should not be discouraged. The absence of significant variability may have been secondary to the size of this research sample. In addition, the findings indicating that patient characteristics and therapist characteristics alone are not sufficient in accounting for treatment rejection, serve to support the importance of interaction variables between therapists and patients which are operative in the interview process. Finally, the significant trends found in the post hoc analysis strongly suggest the importance of interaction variables in the patient's experience of the interview relationship.

Problems in Clinical Research

Conducting research within a clinic setting presents its own unique demands. Unlike laboratory based research projects where the researcher assumes the executive role in managing the experimental conditions, the researcher in the clinic setting is highly dependent upon the active cooperation of both the patients and the clinic staff. Such cooperation enhances the researcher's ability to generate a research sample, develop the most efficient research design, select the necessary measures, and to minimize bias in the data. Although such "cooperation" is an

ideal condition for clinic-based research, it is often elusive and difficult to attain.

As with many clinic-based research projects, a reluctance to cooperate in the present research effort was evidenced in each stage of its development. Surprisingly, this was most pronounced amongst the clinic staff. From the project's inception, the clinic administration voiced concern about how the study might interfere with its service delivery goals. Although enthusiastic about the goals of the study, they were concerned that the research project would encroach upon the interview relationship and introduce premature transference issues. To ameliorate these concerns the clinic proposed strict limitations on data collection procedures and the controlled matching of patient-therapist pairs. The subjects of the study were included by request or solicited. At this point, the collection of data was highly dependent upon the clinic therapists utilizing the research measures during the first interview.

Akin to many clinical research projects, this proved to be problematic in the collection of the type and breadth of data necessary for the most comprehensive analysis. From the beginning the

therapists were ambivalent about their participation in the research project. Their reservations included: (a) the research's potential to interfere with the intake relationship; (b) the additional work which the study placed upon them; and (c) the fear that the study was geared towards evaluating them personally or professionally. As a result, the participation by the therapists in this study was quite variable. Two therapists "silently withdrew" from the project by failing to submit the necessary forms. Several therapists were consistently "forgetful" about completing the necessary forms and had to be continually reminded to direct their patients to the researcher for the final questionnaire. As a result, the number of completed questionnaires varied from one therapist to the next. Although each therapist was instructed to submit the research questionnaires for all the patients they evaluated (six per therapist), the completed cases by therapists ranged from one to five. Combating this attrition of data required active management on the part of this researcher.

Researchers should be alerted to these potential difficulties in conducting clinic-based research projects. Unlike laboratory based studies where such

conditions are controllable, clinic-based research requires additional effort in developing a supportive research environment. Involving clinic staff in the development of a study, emphasizing the study's significance and relevance to their work, utilizing the most parsimonious measures, and engaging the staff as associates in the evaluation of the research activity are but a few steps that can enhance their level of participation and cooperation. Quite central to the clinic-based researcher's task is to minimize the "cross-purposes" status that is so often associated with research within a clinic setting. By encouraging a sense of "partnership" and shared purpose in research, clinic-based studies may confront fewer restraints and have freer access to a naturally rich laboratory.

Recommendations for Future Research

Although the major hypotheses of this study were not statistically supported, the influence of patient-therapist locus of control matching may have been hidden by certain characteristics unique to this sample. These include: (a) relative lack of variability in locus of control scores, (b) patient-therapist ethnic and educational similarity, (c) skewed representation in the areas of ethnicity, sex, and

socio-economic status, and (d) small sample size. Future investigators should be alert to the potential for such sample characteristics when designing a patient-therapist matching research study. The following recommendations for future research are suggested from the results of this study.

Most important, a larger sample should be used. Such a procedure may generate greater variability in both patient and therapist scores. This would allow for a clearer distinction between groups and between subjects within each group. The distinguishing power of the test instruments may also be enhanced.

Secondly, the deliberate matching or mismatching of therapists and patients is recommended. This procedure would provide some assurance that each patient-therapist group could be equally represented. In addition, the control of other variables, such as sex, ethnicity, and socio-economic status would be enhanced. In that such a strategy requires cooperation from the therapists and the clinic administrators, they should be active participants in the development of the research project.

Thirdly, both the sex and ethnicity of the therapist group should be controlled. This procedure

may allow for a more precise evaluation of their effect on the dependent variable. Matching effects on these variables may also be investigated.

Fourth, a wider representation of patients on the variables of ethnicity and socio-economic status is recommended. This procedure may enhance the analysis of their effect on the dependent variable.

Finally, the utilization of professional, more experienced therapists within a non-academic community setting is recommended.

Appendix A

Rotter's Internal-External Control Scale

For each number there are two statements, a. and b. Read both statements and then circle the letter of the statement (either a. or b.) you agree with. If you agree with both choose the one that you agree with more. If you don't agree with either try to choose the one that is less disagreeable.

When you have completed each test, please check over your answers to be sure that you did not skip any questions.

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 they're like.

9. a. I have often found that what is going to happen will happen.
b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.
10. a. In the case of 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 my case getting what I want has little or nothing to do with luck.
- b. Many times we might 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 really is no such thing as "luck".
19. a. One should always be willing to admit mistakes.
- b. It is usually best to cover up one's mistakes.
20. a. It is hard to know whether or not a person really likes you.
- b. How many friends you have depends upon how nice a person you are.
21. a. In the long run the bad things that happen to us are balanced by the good ones.
- b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.
22. a. With enough effort we can wipe out political corruption.
- b. It is difficult for people to have much control over the things politicians do in office.
23. a. Sometimes I can't understand how teachers arrive at the grades they give.
- b. There is a direct connection between how hard I study and the grades I get.
24. a. A good leader expects people to decide for themselves what they should do.

- b. A good leader makes it clear to everybody what their jobs are.
25. a. Many times I feel that I have little influence over 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.

Race _____

Occupation _____

Education _____

Parent's occupation _____

Parent's level of education _____

Appendix B

Weibe-Pierce Revised Version of the Barrett-Lennard Relationship Inventory

Below are listed a variety of ways that one person could feel or behave in relation to another person. Please consider each statement with respect to whether you think it is true or not true in your present relationship with your intake therapist. Mark each statement in the left margin according to how strongly you feel it is true or not true. Please mark every one. Write in +1, +2, +3; or -1, -2, -3 to stand for the following answers.

- +1: I feel that it is probably true, or more true than untrue
- +2: I feel it is true.
- +3: I strongly feel that it is true.
- 1: I feel that it is probably untrue, or more untrue than true.
- 2: I feel it is not true.
- 3: I strongly feel that it is not true.

- ___ 1. He/she respects me.
- ___ 2. He/she pretends that he/she likes me or understands me more than he/she really does.
- ___ 3. He/she understands my words but not the way I feel.
- ___ 4. He/she is interested in knowing what my experiences mean to me.
- ___ 5. He/she is disturbed whenever I talk about or ask about certain things.
- ___ 6. He/she likes seeing me.
- ___ 7. He/she behaves just the way he/she is, in our relationship.
- ___ 8. He/she appreciates me.
- ___ 9. I do not think that he/she hides anything from himself/herself that he/she feels with me.
- ___ 10. If I feel negatively toward him/her, he/she responds negatively to me.
- ___ 11. He/she cares about me.
- ___ 12. His/her own attitudes toward some of the things I say, or do, stop him/her from really understanding me.
- ___ 13. I feel that I can trust him/her to be honest with me.

- ___ 14. At times he/she was warmly responsive to me,
at other times cold or disapproving.
- ___ 15. He/she is interested in me.
- ___ 16. He/she appreciates what my experiences feel
like to me.
- ___ 17. He/she sometimes responds to me with quite a
lot more warmth and interest than he/she does
at other times.
- ___ 18. He/she does not really care what happens to
me.
- ___ 19. He/she does not realize how strongly I feel
about some of the things we discuss.
- ___ 20. There were times when I felt that his/her
outward response was quite different from
his/her inner reaction to me.
- ___ 21. His/her general feeling toward me varied
considerably.
- ___ 22. He/she seems to really value me.
- ___ 23. I don't think that he/she is being honest
with himself/herself about the way he/she
feels toward me.
- ___ 24. I feel that he/she is being genuine with me.
- ___ 25. At times he/she responded quite positively to
me, at other times he/she seemed indifferent.

- _____ 26. At times he/she was not at all comfortable
but we continued, outwardly ignoring it.
- _____ 27. He/she feels deep affection for me.
- _____ 28. He/she usually understood all of what I said
to him/her.
- _____ 29. He/she does not try to mislead me about
his/her own thoughts and feelings.
- _____ 30. He/she regards me as a disagreeable person.
- _____ 31. He/she feels contempt for me.
- _____ 32. When I did not say what I meant at all
clearly he/she still understood me.

3a. List the jobs you have held in the past five years beginning with your present or your most recent job.

From-To	Type of Work	Type of Business	Weekly Salary
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3b. What is the highest school grade you have completed? _____

3c. If you are presently attending school what is your major? _____

3d. Have you been in the Armed Forces? _____
 Dates of Active Service _____

3e. Have you had any serious illnesses, operations, injuries or disabilities? _____ (If so, please describe with approximate dates.)

- 3f. Have you ever been hospitalized for medical or psychological reasons? _____ (If so, please describe with approximate dates.)
- 5a. Did your mother work outside the home any time during your childhood (up to age 15)? _____.
If yes, how old were you when she started to work?

- 5b. Are or were your parents (please check):
Always living together _____ Separated _____
Divorced _____ Mother remarried _____
Father remarried _____
- 5c. When you were a child how religious was your family? (Please check)
Not at all ___ minimally ___ moderately ___
strongly ___ Catholic ___ Jewish ___
Protestant ___ Other (specify) _____

5d. List the ages and sex of all of your brothers and sisters (include any who have died) starting with the oldest. Include yourself ("me"). If any have had any serious illnesses or problems, please describe.

5e. If anyone close to you has died (parents, spouse, children, sister, brother, or close friend) please indicate the relation, age at death, year and cause of death.

6a. With whom are you living at the present time?

(Check as many as apply.)

Father ___ Mother ___ Brother or Sister ___ Alone

___ Spouse ___ Friends ___ Your children ___

Relatives ___ Other (explain) ___

- 6b. If married, what is your husband or wife's main occupation? _____
- 6c. List the age and sex of each of your children. If they have had any illness or problems please describe.
- 7a. Who told you about this psychological center?
(specify friend, teacher, etc.)

- 7b. What was their opinion of the Center as a place for you? (circle one)
- | | | | | |
|---------|------------|----------|----------|------------|
| very | moderately | somewhat | slightly | not at all |
| helpful | helpful | helpful | helpful | helpful |
- 7c. Have you ever been in therapy? Yes ___ No ___
- 7d. Has anyone very close to you sought psychological help? Yes ___ No ___
- 7e. How much do you think they were helped?
- | | | | | |
|-----------|------------|----------|----------|------------|
| very much | moderately | somewhat | slightly | not at all |
|-----------|------------|----------|----------|------------|
- 7f. About how long do you expect to be in therapy?
- | | | | | |
|----------------------|----------|----------|----------|-----------------------|
| less than
1 month | 2 months | 4 months | 6 months | more than
6 months |
|----------------------|----------|----------|----------|-----------------------|

7g. What is your present belief that the results you want in therapy will be achieved?

very strongly	strongly	moderately	slightly	do not
believe results	believe	believe	believe	believe
will be achieved				results
				will be
				achieved

7h. About how long after you begin therapy do you expect to start seeing results?

less than	2 months	4 months	more than	after therapy
1 month			6 months	is terminated

8. What is your weekly income? (include allowances, etc.) _____ How many dependents do you have?

9. To what extent (if any) are you supported by your family, spouse, or other (if other, state whom)

10. If you are not completely self-supporting, please list your family income and number of dependents in your family (number of people who do not earn an income but are supported in the household).

11. If you have any questions or comments or preferences for type of psychological services, please write them below and the interviewer will discuss them with you.

11a. Would you be interested in group therapy only, or in addition to individual therapy?

Thank you for completing this questionnaire.

Please return this questionnaire to the secretary at the front desk. You will be called for an interview within two weeks. Keep the General Information page for future reference.

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