INITIAL INTERVIEW: IMPACT OF GENDER AND
SEX-ROLE ORIENTATION

THESIS

Presented to the Graduate Council of the
North Texas State University in Partial
Fulfillment of the Requirements

For the Degree of

MASTER OF SCIENCE

By

So-kum Catherine Tang, B.A.
Denton, Texas
December, 1984

The present study examined the impact of gender and sex-role orientation on therapy effectiveness. Previous research suggested that same-sex pairings and androgynous therapists would be most desirable. Interviewers (therapists) were 25 male and 15 female third-year doctoral psychology students, each interviewing a male and a female undergraduate student (client). Results did not support the hypothesis that gender and sex role were powerful predictors of therapy effectiveness. However, this study did find that therapist self-rated interpersonal competency and accurate self-perception predicted therapy effectiveness for female clients. Therapists' consistency in using various parameters (techniques) of therapy was related to client perceived effectiveness. Opposite-sex pairings were less likely to result in momentary feelings of discomfort during initial interviews.
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INITIAL INTERVIEW: IMPACT OF GENDER AND SEX-ROLE ORIENTATION

Each sex is socialized to have distinctive feelings, behaviors, and role expectations (Kagan, 1964; Mussen, 1969). Bakan (1966) termed agency and communion the two fundamental differences between men and women. Agency, according to Bakan, is characterized by self-protection, self-assertion, and the urge to master. Communion is characterized by a sense of openness, cooperation, and the display of affection toward others. While both sexes contain aspects of each mode, Bakan argues that agency is characteristically masculine, and communion characteristically feminine. Research on sex-role stereotypes supports Bakan's views by suggesting that women and men are perceived to have different personality characteristics (Rosenkrantz, Vogel, Bee, Broverman, & Broverman, 1968; Spence, Helmreich, & Stapp, 1975). Females are thought to be emotionally open, nurturant, and affiliative; while males are assumed to be emotionally inhibited, self-assertive, and aggressive.

These sex-role stereotypes pervade the structure of our families (Bernard, 1974), our educational systems (Frazier & Sadker, 1973), media communications (Sternglanz & Serbin, 1974), and work roles (O'Leary, 1974). Through the process of socialization, these stereotypes are internalized by us
as children, and remain with us through adulthood as conscious or unconsciously components of our personalities.

Bergen and Luckman (1966) maintain that therapeutic process reflects the broader social context. Thus, the behaviors and reactions of both clients and therapists will be influenced by their gender differences and their internalized concepts of sex-appropriate behaviors. This, in turn, influences the therapeutic relationship and the effectiveness of therapy.

Sex pairing is one of the significant controversies in the therapeutic process. Advocates of same-sex pairing believe that biological gender defines similarity in personality and experience (Carter, 1971; Chesler, 1972). However, investigations of sex pairing are inconsistent.

Studies supporting same-sex pairing indicate that it increases level of empathy offered by therapists to clients (Daane & Schmidt, 1975; Hill, 1975), and positively affects clients' ratings of satisfaction (Howard, Orlinsky, & Hill, 1970; Person, Person, & Newmark, 1974), levels of self-exploration, and affective self-disclosure (Hill, 1975).

On the other hand, some research indicate that opposite-sex pairing results in greater client disclosure (Fuller, 1963; Vann, 1974). Other studies have found neither same- nor opposite-sex pairing to predict therapeutic outcome (Breisinger, 1976; Petro & Hansen, 1977; Taylor, 1972).
A possible explanation for the inconsistent findings of the sex pairing research may be the omission of the therapists' and/or the clients' sex-role orientation (Feldstein, 1979). Although behaviors are learned through socialization, individuals sometimes also learn behaviors that deviate from the sex-role stereotypes of society (Bem, 1974). In addition to feminine women and masculine men, there are also masculine women, feminine men, androgynous men or women (those with both feminine and masculine characteristics), and so-called undifferentiated individuals, i.e., those who do not identify with either masculine or feminine characteristics (Bem, 1976; Spence, Helmreich, & Stapp, 1975). Therefore, it may be useful to consider both the gender and the sex-role orientation of clients and therapists.

In addition to sex-appropriate therapist behaviors, Kaplan (1979) defines structural and functional components of the therapist's role. The structural role involves establishing and defining rules of the therapeutic relationship, including when and where to meet, what is appropriate for discussion, and what is expected of the client and the therapist. According to Langs (1973), the structural component represents the authority dimension of the therapist's role and requires independence, emotional distance, and assertiveness. These are consistent with masculine patterns of sex-role socialization.
The functional role in therapeutic process includes providing empathy, showing compassion for others, and being a good listener. Traits of the empathic dimension are consistent with the feminine stereotype, emphasizing behaviors that are nurturant, interpersonally astute, and sensitive to others' feelings.

Kaplan (1979) concludes that for therapists of both sexes, the possession of both authority and empathy would be most desirable for all modes of therapy. In other words, androgynous therapists would be most desirable for a wide range of therapies and clients.

However, results of research investigating impact of client and therapist sex-role orientation on therapy are inconsistent. Studies have indicated that androgynous therapists have more favorable relationships with their clients (Petry, 1982), receive higher ratings of comfort in disclosing (Banikiotes, 1981), and are rated higher than traditional therapists in perceived attractiveness, expertness, and trustworthiness (Porche, 1983).

On the other hand, Highlen and Russell (1980) failed to find any effect of client or therapist sex-role orientation on therapist ratings. Hotelling (1982) found that the congruence of client and therapist sex role did not influence therapeutic outcome.

Although the argument that androgynous therapists are most desirable for all modes of therapy and all types of
clients has intuitive appeal, it does not appear to be entirely supported by empirical data. There are several possible explanations for these inconsistent research findings.

Gender and sex-role orientation of the client and therapist together may emerge as critical interactional factors that affect clients' perceptions of therapists and the therapeutic relationship. For example, Banikiotes (1981) found a gender by sex-role interaction in differential comfort in disclosure. Feldstein (1979) indicated that frequency of client self-disclosure was affected by client sex, therapist sex, and therapist sex-role orientation. Male clients disclosed most to feminine female therapists and least to masculine female therapists. Female clients, in contrast, disclosed most to feminine male therapists and least to masculine male therapists.

Another possible explanation for the inconsistent research results may be related to whether the particular client problems are sex-role or not sex-role related. However, this argument has not received consensus among researchers. Banikiotes (1981) failed to find differential comfort in disclosure with regard to problem type. Other studies have found effects for problem type (Boulware & Holms, 1970; Lee et al., 1980). Lee et al. (1980) report that female therapists are preferred for childbearing problems and male therapists for vocational concerns.
The overall purpose of this study is to identify variables that affect the therapeutic relationship and continuation expectancy after the initial interview. The general hypothesis is that client and therapist gender, sex-role orientation, and problem type will have an impact on therapy effectiveness. The specific hypotheses are as follows:

(1) Same-sex pairing of client and therapist will be more effective than opposite-sex pairing. People of the same gender share similar physiological experience, and encounter similar gender-related problems. These similarities in experience will facilitate understanding, empathy, and self-disclosure (Daane & Schmidt, 1957; Hill, 1975), conditions thought to be conducive to successful therapeutic relationship. Carter (1971) and Chesler (1972) even suggest that the sharing of similar life experience between client and therapist will itself provide the necessary conditions for personal growth of client.

(2) The difference in effectiveness between male and female clients will be greater for sex-typed therapists than for androgynous therapists. Since androgynous therapists can embody both stereotypic masculine and feminine characteristics (Bem, 1976; Spence, Helmreich, & Stapp, 1975), they should be able to integrate the structural and functional roles of therapists (Kaplan, 1979). They presumably also have a broader repertoire of behaviors than
sex-typed therapists, whose behaviors are based on what is considered appropriate for their sex (Kaplan & Sedney, 1980). Therefore, androgynous therapists should be more consistently effective for clients of differing gender.

(3) Therapists with high interpersonal competency will be perceived as more effective than therapists with low interpersonal competency. People with high competency possess characteristics necessary for effective social interactions (Foote & Cottrell, 1955). They are sociable, popular, persuasive, and influential (Holland & Baird, 1968), suggesting that they may be more efficient in interacting with clients.

(4) Androgynous therapists will report higher interpersonal competency than sex-typed therapists. It is thought that their more flexible behavioral repertoires should lead to greater interpersonal competency across a range of social settings.

(5) Androgynous therapists will be more effective in therapy with opposite-sex clients having sex-specific problems than will sex-typed therapists. More specifically, androgynous male therapists will be better than masculine male therapists for female clients with sex-specific problems, and androgynous female therapists will be better than feminine female therapists for male clients with sex-specific problems.
Lee et al. (1980) suggest that differential expertise is required for different types of problems. Sex-specific problems are those encountered more by those of one sex than the other. Therapists of the same sex as the clients or those with sex-appropriate behavioral repertoires (androgynous therapists) should be better able to understand the clients' problems since they share with them either similar biological experiences or social attitudes and behaviors.

(6) Androgynous therapists will be more flexible in using the various parameters or techniques of therapy across client types (male vs. female) than will sex-typed therapists. Kaplan and Sedney (1980) describe the androgynous person as having a broad repertoire of responses, flexibility in response to situational demands, and effectiveness in dealing with the environment. Therefore, androgynous therapists should be capable of modulating their behaviors across situational variables such as client gender. Sex-typed therapists, even if they are willing to be flexible, may lack the cross-sex behavior patterns, which would allow them to vary their responses across client types.

(7) Therapists who are flexible in employing different parameters of therapy for male and female clients will be more effective in therapy than therapists who employ the same parameters for both male and female clients.
(8) Therapists who are sensitive to the situational demands of the individual client and alter their intended use of various parameters of therapy to fit the client should be more effective than therapists who do not alter their techniques to fit the client.

(9) Therapists who are accurate perceivers of their parameters of therapy will be more effective in therapy than inaccurate perceivers. People who can accurately perceive their own behavior are apt to be more accurate perceivers of others. These people are self-conscious and good at self-presentational skills for purposes of impression management in social relations (Deaux & Wrightsman, 1984). Therapists possessing these characteristics should be more effective in therapy than those who do not.

(10) The difference in the number of negative reactions which therapists evoke in their male and female clients will be greater for sex-typed therapists than for androgynous therapists.

(11) Androgynous therapists will be more effective with opposite-sex clients than will sex-typed therapists.

Method

Subjects

The interviewees (clients) were 40 male and 40 female undergraduate students enrolled at a moderately-sized southern university. The students received extra credits in psychology courses for participating in research.
The interviewers (therapists), 25 male and 15 female, were third-year doctoral students in either clinical, counseling, or behavioral medicine programs in the psychology department of the same university. They all had completed two years of training which included supervised practicum experiences with either college students or clients from the local community. The interviewers received neither pay nor experimental credit for their participation.

Instruments

Sex-role orientation. Sex-role orientation was measured by the Bem Sex Role Inventory (BSRI; Bem, 1974). The BSRI requires a person to indicate on a 7-point scale (Appendix R) how well each of the 20 masculine, feminine, and neutral personality characteristics describe herself/himself. The scale ranges from 1 ("Never or almost never true") to 7 ("Always or almost always true"). According to Bem (1974), a characteristic was qualified as masculine if it was judged to be more desirable in American society for a man than for a woman, and as feminine if it was judged to be more desirable for a woman than for a man.

The internal consistency of the BSRI, as indicated by the coefficient alpha, computed separately for Masculinity and Femininity in two normative samples (Nunnally, 1967) showed both to be highly reliable (Masculinity $\alpha = .86, .86$; Femininity $\alpha = .80, .82$). The correlations between Masculinity and Femininity scores were nonsignificant,
supporting their hypothesized independence. The test-retest reliability (four-week interval) was: masculinity _r_ = .90, femininity _r_ = .90, androgyny _r_ = .93. The BSRI was not correlated with social desirability.

Interviewees and interviewers were classified as either androgynous, sex-typed (masculine or feminine), or undifferentiated on the basis of the cutoff median scores (4.89 for Masculinity score; 4.76 for Femininity score) utilized by Bem (1977). Those scoring above the median on both scales were classified as androgynous; those below the median on both, undifferentiated; those above on Femininity and below on Masculinity, or above on Masculinity and below on Feminine as sex-typed.

**Measures of interpersonal competency.** Self-assessment of interpersonal skills in social situations was measured by the Interpersonal Competency Scale (IPCS: Holland & Baird, 1968). This 20-item scale (Appendix Q) was modeled after the work of Foote and Cottrell (1955) who defined interpersonal competency as the acquired ability for effective interactions. Scale items simply reflected those factors which Foote and Cottrell believed to be conducive, or typical of positive self-regard in social situations. These factors were health, intelligence, empathy, autonomy, judgement, and creativity. Holland and Richards (1965) found that interpersonal competency was unrelated to educational and intellectual abilities.
The reliability (KR-20) of the scale for college students was .69 and .67 for males and females respectively. The test-retest reliability (one-year interval) was .63 for males and .67 for females. The scale has shown an ability to predict popularity one year after its administration (Holland & Baird, 1968).

**Measures of interview style.** The style or preference for various schools of therapy was measured by the Parameters of Psychotherapy (PI: Shostrom & Riley, 1968). The resulting combination of parameters would be descriptive of a therapist's style or approach to counseling and psychotherapy. The Parameters consisted of descriptions of ten dimensions of therapy: caring, ego-strengthening, encountering, feeling, interpersonal analyzing, pattern analyzing, reinforcing, self-disclosing, value reorienting and reexperiencing.

In Shostrom and Riley's study (1968), the parameters were rated by judges on a 8-point rating scale, ranging from 0 ("Not apply") to 7 ("Applied extremely") on the series of films, *Three Approaches to Psychotherapy*, in order to analyze the therapeutic techniques of Carl Rogers, Frederick Perls, and Albert Ellis. Of the ten scales, Rogers' client-centered therapy scored highest on caring (6.1) and feeling (5.9); Perls' gestalt therapy scored highest on encountering (6.3), feeling (5.4), and interpersonal analyzing (6.1);
Ellis' rational emotive therapy scored highest on value-reorienting (4.7) and pattern analyzing (5.5).

In the present study, interviewers self-rated each parameter on a 9-point scale (Appendix P) of how characteristically they used that parameter in their work with clients. This was completed before and after each interview. The scale ranged from 1 ("Extremely uncharacteristic") to 9 (Extremely characteristic).

**Problem type:** Sex-specific vs. not sex-specific. A problem checklist based on Ginn (1975) was used to classify client problems as sex-specific or not sex-specific. In Ginn's study, there were 35 problems (Appendix U) typically presented by women, 16 problems typically presented by men, and 22 presented equally by men and women. Of the 16 estimated in the male direction, 8 would be considered educational-vocational concerns dealing with effectiveness in college and postcollege plans. The remaining 8 problems were those most usually attributed to males: alcohol, drugs, anger, and sex. The problems seen as typically female were mostly concerned with physical complaints, relationships, and emotionality. The problems that clients actually discussed were then classified into male-specific, female-specific, or non-specific based on Ginn's findings.

**Effectiveness of therapy.** Six measures of the effectiveness of therapy were obtained from each client after the interview. These were: impression ratings of
attractiveness, expertness, trustworthiness, confidence ratings, continuation expectancy, and positive button-press responses.

(1) Impression Ratings. The impressions of a therapist's characteristics were measured by the Counseling Rating form (CRF: LaCrosse & Barak, 1976). Strong (1968) suggested that therapy represented an interpersonal influence process. Therapists that were perceived as expert, attractive, and trustworthy should be more influential with clients than those that were not perceived as such.

Based on Strong's suggestion (1968), LaCrosse and Barak (1976) constructed the Counseling Rating Form (CRF) which consisted of 36 7-point bipolar items (Appendix AA) intended to measure three dimensions of perceived therapist effectiveness: expertness, attractiveness, and trustworthiness. Each dimension was measured by 12 items (Table 12, Appendix L), randomly ordered throughout the list. Scores of each dimension were computed by summing the scores of the 12 items, ranging from a minimum of 12 to a maximum of 84.

Higher scores indicated perceptions of greater expertness, attractiveness, and trustworthiness. Perceived expertness has been defined as the client's belief that the therapist possesses information and means of interpreting information which allow the client to obtain valid
conclusions about and to deal effectively with her/his problems (Strong & Dixon, 1971). Perceived attractiveness has been defined as the client's liking, admiration, and positive feelings about the therapist (Schmidt & Strong, 1970). Perceived trust-worthiness has been defined in terms of the therapist's sincerity, openness, and absence of motions for personal gain (Barak & LaCrosse, 1975; Strong, 1968).

The internal consistencies of the scales were assessed by the split-half method using the Spearman-Brown formula. Reliability coefficients were: .87 for expertness, .85 for attractiveness, and .91 for trustworthiness (LaCrosse & Barak, 1976). The three dimensions accounted for 35% of the outcome variance in continuation expectancies after initial interviews (LaCrosse, 1980).

(2) Confidence Ratings. Interviewee's confidence in the effectiveness of the therapists in providing help was measured by the Confidence Rating Form (Cash, Begley, McCown, & Weise, 1975). A list of 15 types of personal problems were selected on the bases of their relevance to a college population. The subjects were to determine the degree of confidence they would place in the therapist's effectiveness with 15 particular types of personal problems on a 6-point rating scale. This scale had been used in previous research (Cash & Kehr, 1978; Lewis & Walsh, 1980) to measure counseling outcome expectancy.
For the present study, four additional problem areas were included in the rating form: employment worries, poor academic performance, "losing grip" on reality, and religious conflicts. A total of 19 problems (Appendix Y) was presented to the interveiwees after the interviews. They were asked to indicate the degree of confidence they had for the therapists to be effective in providing help to each of the problems on a 8-point rating scale, ranged from 1 ("Very nonconfident") to 8 ("Very confident").

(3) **Continuation expectancy.** Each interviewee had to indicate their expectation of the interview on three statements (Appendix BB). Each statement was constructed on an 8-point scale, ranged from 1 ("Very unlikely") to 8 ("Very likely").

The interviewees were to indicate: (1) their optimism about the general helpfulness of the interviewers if they were to continue therapy for the one to three problems they had checked off before the interview, (2) the likelihood that they would return for a second interview with the interviewers, and (3) the likelihood that they would recommend the interviewers to a friend who wanted therapy.

High scores indicated optimism about the helpfulness of the therapists, positive continuation expectancy, and satisfaction in the interview. The composite scores would indicate positive expectancy which was an indication of effectiveness of therapy.
(4) **Positive Button-press responses.** During the interview, when the bleeper made sounds at one-minute intervals, interviewees had to indicate their feelings by pushing either the green or red button of the light box which they were holding. If the interviewees' feelings were comfortable, they would push the green button. If their feelings were uncomfortable, the red button would be pressed. The number of positive button-press responses were recorded and counted as one of the six measures of the effectiveness of therapy.

**Therapist's self-perceived effectiveness of therapy.** The therapist's self-perceived effectiveness of therapy was measured by the confidence rating form and the continuation expectancy form. The forms were completed by the therapists after each interview.

**Procedure**

The interviewers (therapists). The graduate students were recruited and informed that this was a project to create a tape bank of recordings on initial interviews. The materials in the tape bank would be available for use in research or for training of future graduate students in interview skills.

The first session involved completing questionnaires about interview experiences, self-descriptions, parameters of psychotherapy, and a self-assessment checklist. The second and third session involved interviewing a subject
(undergraduate student) for 12 to 15 minutes. One interview would be with a male and one would be with a female subject.

The experimenter brought the subject and a bleeper to the interview room. During the interviews, the bleeper would sound at intervals, acting as cues for the subjects to push a button on the light box which they would be holding. The subjects would have concerns in mind to discuss, and the interviewers' task was to conduct the interviews just as they would typically interview individuals in the clinic. The conduct of the interviews was the same for male and female subjects.

The interviews started when the experimenter left the interview room. The interviewers did not receive signals for stopping, but after 12 to 15 minutes, they had to bring the interview to a close as they would typically end an interview. A clock was situated in the interview room so that they could easily monitor the time. The interviews were videotaped and the interviewers were video- and audiotaped. However, subjects were audiorecorded only.

At the end of the interviews, the experimenter returned to the room with a packet containing questionnaires about the interviews, confidence ratings, and parameters of psychotherapy for the interviewers. The questionnaires took about 10 to 15 minutes to complete.

Consent forms were obtained in order that the recordings would be included in the tape bank as materials
for future research and training. The interviewers were explained that their anonymity on the tapes and questionnaires would be assured as much as possible with videorecording.

The interviewees (clients). Undergraduate students were recruited for participation in interviews to discuss their problems. Before the interviews, the subjects completed questionnaires on demographics, sex-role orientation, and interpersonal competency. They were also given a list containing a number of problems that college students commonly reported. They were to check off one to three of the problems that they felt genuine to themselves and that they would be willing to discuss with the interviewers.

After the subjects had completed the questionnaires, they were shown the bleeper and the light box which contained a red and a green button. They were explained that a bleeper was placed on a table in the interview room. They had to hold the light box in the palms of their hands. During the interviews, the bleeper would sound at intervals. Each time the bleeper made a sound, they had to push either the red or the green button. If their feelings were more positive and comfortable, they would push the green button; if their feelings were more negative and uncomfortable, they would push the red button. Only subjects' voices were recorded, and consent forms were obtained.
After the instructions were given, each subject was then brought to the interview room and introduced to her/his therapist. After the interviews, the subjects returned to the reception room to complete the impression ratings, confidence ratings, and continuation expectancies. These questionnaires required 10 to 15 minutes to complete.

After the questionnaires were completed, the experimenter played back the tape of the interviews to each subject. The recording was stopped each time the bleeper made a sound. Subjects then described what they were experiencing when they pressed the button during the interviews, and what therapists' behaviors contributed to their experiences. The subjects' responses were recorded verbatim. When the whole interview had been played back, the subjects were thanked for their participation, their questions about the study were answered, and credit slips were given.

Results

Gender By Sex-role Effect

Table 1 (Appendix A) and Table 2 (Appendix B) represent the mean ratings of therapists by their male and female clients on the six measures of effectiveness of therapy: continuation expectancy, confidence ratings, trustworthiness, attractiveness, expertness, and positive button-presses. A 2 (therapist gender) X 2 (therapist sex role: androgynous, sex-typed) multivariate analysis of
variance (MANOVA) was run for both male and female clients. Table 3 (Appendix C) represents the summaries of the results, showing no significant main or interaction effects on therapy effectiveness (all p's > .05). All subsequent univariate F-tests were nonsignificant (all p's > .05).

A 2 (therapist gender) X 2 (therapist sex role) MANOVA was done for the mean differences between male and female clients' ratings of their therapists on therapy effectiveness. The results, included in Table 3, show nonsignificant interaction and main effects (all p's > .05).

Table 4 (Appendix D) indicates the mean differences between male and female clients in their negative button-presses. A 2 (therapist gender) X 3 (therapist sex role: androgynous, sex-typed, undifferentiated) analysis of variance (ANOVA) was run. Table 5 (Appendix E) represents the ANOVA results, showing a significant main effect for therapist gender, \( F (1,39) = 8.57, (p = .006) \). The results indicate that male therapists generally evoked more negative button-presses from male clients, whereas female therapists had more negative button-presses from female clients.

**Interpersonal Competency Effect**

The mean therapist self-report on interpersonal competency scores are represented by Table 6 (Appendix F). A 2 (therapist gender) X 3 (therapist sex role) ANOVA was run, and results are summarized in Table 5, indicating nonsignificant interaction and main effects (all p's > .05).
All therapists were classified as having high or low interpersonal competency according to a median split (male = 13, female = 12). Table 7 (Appendix G) represents the summaries of a 2 (therapist gender) X 2 (therapist interpersonal competency: high, low) MANOVA for both male and female clients. Nonsignificant results were obtained from male clients (all p's > .05), whereas female clients showed a significant interaction effect, $F = 2.44$, ($p = .047$). The results illustrate that therapists who report to have high interpersonal competency are perceived as more effective in therapy by their female clients, but not by their male clients.

**Flexibility of Parameters of Psychotherapy**

(1) Flexibility between male and female clients:

Table 8 (Appendix H) represents the mean absolute difference scores from therapists' post-interview self-reports of Parameters of Psychotherapy for their male and female clients. A 2 (therapist gender) X 3 (therapist sex role) ANOVA was run, and results are included in Table 5, showing nonsignificant interaction and main effects (all p's > .05).

Table 9 (Appendix I) represents correlations of the above flexibility scores with each of the six measures of therapy effectiveness for both male and female clients. These correlations ranged from -.24 to .03 for male clients (all p's > .05); and from -.34 to .14 for female clients,
significant negative correlations on trustworthiness, attractiveness, and expertness (all $p$'s < .05).

(2) Flexibility between Pre- and Post-interview:
Separate flexibility scores were calculated from the absolute differences between pre- and post-interview parameters. Table 9 shows the correlations between these scores and each of the six measures of therapy effectiveness for the therapists' male and female clients. Correlations ranged from -.16 to .01 for male clients (all $p$'s > .05); and from -.31 to -.13 for female clients, with significant negative correlations on continuation expectancy, confidence ratings, and trustworthiness (all $p$'s < .05).

Accuracy of Perception

The therapists were evaluated on the accuracy of their perception of parameters by two independent raters. The interrater reliability showed 71 percent agreement ($p$ < .05). The therapists were then classified as accurate and inaccurate perceivers according to the median split of the differences between their own scores and an independent rater's scores on the ten parameters (male = 15, female = 17). A 2 (therapist gender) X 2 (accurate, inaccurate perceivers) MANOVA was run for both male and female clients, and results are represented by Table 10 (Appendix J). Only female clients showed a significant main effect on therapists' accuracy of perception $F = 2.42$, ($p = .049$). The results show that if therapists are accurate perceivers
of their use of parameters, they are rated as more effective in therapy by female clients, but not by male clients.

Sex-specific vs. Non-sex-specific Problems

Table 11 (Appendix K) represents the mean ratings of therapists' opposite-sex clients with sex-specific problems on therapy effectiveness. A one-way MANOVA for androgynous and sex-typed therapists was run for male therapists, showing nonsignificant results (all $p's > .05$), a MANOVA for the same purpose could not be done for female therapists because of a small number of cases.

Discussion

The present study does not support the general hypothesis that client gender, therapist gender, and therapist sex-role orientation will have an important impact on therapy effectiveness. Also, it does not support the contention that same-sex pairing is more effective than opposite-sex pairing. In contrast to previous findings (Howard, Orlinsky, & Hill, 1970; Person, Person, & Newmark, 1974) that same-sex pairing positively affects clients' ratings of satisfaction, the present study finds that therapists generally evoked more negative button-presses from same-sex clients.

Similar to the results of Highlen and Russell (1980), the present study fails to find any effect of therapist's sex role on therapy effectiveness. And contrary to Kaplan's (1979) argument that androgynous therapists should be most
desirable for all clients, this study shows no difference between androgynous and sex-typed therapists in their effectiveness of therapy across client gender.

There are two possible explanations to these findings. The first reason may lie in the power of this study to detect gender and sex-role effects. This study contains only 25 male and 15 female therapists, and when they are further classified according to their sex role, the number in some categories reduces to five. On the other hand, previous studies have shown inconsistent results about the effects of gender and sex role. There are as many findings supporting as failing to support their impact. This study, thus, further indicates that gender and sex role do not appear to be powerful or robust indicators of therapy effectiveness.

Although the present study fails to support the hypothesis that androgynous therapists are higher in interpersonal competency and more flexible in employing different parameters of therapy than sex-typed therapists, some interesting findings emerge on the variables. When therapists report high interpersonal competency, they are perceived as more effective in therapy by female clients, but not by male clients. Moreover, when therapists have accurate perception about their parameters of therapy, they are rated as more effective by female, but not by male clients. These results can be explained in terms of the
sensitivity of females in decoding verbal and nonverbal behaviors (Hall, 1978). Since female clients, in general, are better or more accurate decoders, they may be better able to distinguish different competency levels of therapists. They can perceive certain types of therapists as more effective than the others, while male clients cannot tell the difference.

Kaplan and Sedney (1980) describe androgynous people's flexibility in response to situational demand as an effective skill in dealing with their environment. In terms of therapeutic relationship, therapists who are flexible in their parameters before and after interviewing their clients, will be more effective in therapy. The present study, in general, shows negative correlations between flexibility of parameters and effectiveness of therapy, i.e., the higher the flexibility, the less effective in therapy. Thus, the present results indicate that consistency, rather than flexibility, in using parameters of therapy is related to perceived effectiveness.

This study does not support the hypothesis that androgynous therapists are more effective with opposite-sex clients having sex-specific problems for male therapists. Most clients in our study present non-sex-specific problems during the interviews, e.g., test anxiety, poor grades, and decisions about majors. Thus, with the present sample size,
this design may not have had the power to detect these possibly subtle interaction effects.

In conclusion, the present analogue results, along with the inconsistent findings from past research, indicate that gender and sex-role variables are unreliable predictors of therapy effectiveness. However, therapist self-rated interpersonal competency and accurate self-perception do predict therapy effectiveness for female clients, who are likely to be more accurate evaluators of interpersonal behaviors than are males. In addition, the present results indicate that opposite-sex therapist-client matchings are less likely to result in momentary feelings of discomfort in initial therapy interviews.
### Appendix A

#### Table 1

Mean Ratings of Therapists on Therapy Effectiveness By Male Clients

<table>
<thead>
<tr>
<th></th>
<th>Male Therapists</th>
<th>Female Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Androgynous Sex-typed</td>
<td>Androgynous Sex-typed</td>
</tr>
<tr>
<td></td>
<td>( N = 8 )</td>
<td>( N = 7 )</td>
</tr>
<tr>
<td></td>
<td>( N = 15 )</td>
<td>( N = 5 )</td>
</tr>
<tr>
<td>Continuation Expectancy</td>
<td>21.50</td>
<td>19.60</td>
</tr>
<tr>
<td>Confidence Ratings</td>
<td>118.86</td>
<td>113.20</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>71.63</td>
<td>67.80</td>
</tr>
<tr>
<td>Attractiveness</td>
<td>70.25</td>
<td>67.00</td>
</tr>
<tr>
<td>Expertness</td>
<td>74.00</td>
<td>66.00</td>
</tr>
<tr>
<td>Positive Button Press</td>
<td>10.12</td>
<td>9.60</td>
</tr>
</tbody>
</table>
Appendix B

Table 2
Mean Ratings of Therapists on Therapy Effectiveness
By Female Clients

<table>
<thead>
<tr>
<th></th>
<th>Male Therapists</th>
<th>Female Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Androgynous Sex-typed</td>
<td>Androgynous Sex-typed</td>
</tr>
<tr>
<td></td>
<td>(N = 8)</td>
<td>(N = 15)</td>
</tr>
<tr>
<td>Continuation Expectancy</td>
<td>18.86</td>
<td>20.47</td>
</tr>
<tr>
<td>Confidence Ratings</td>
<td>105.75</td>
<td>118.87</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>70.25</td>
<td>74.47</td>
</tr>
<tr>
<td>Attractiveness</td>
<td>67.50</td>
<td>70.87</td>
</tr>
<tr>
<td>Expertness</td>
<td>66.88</td>
<td>73.27</td>
</tr>
<tr>
<td>Positive Button Press</td>
<td>10.50</td>
<td>10.73</td>
</tr>
</tbody>
</table>


Appendix C

Table 3

MANOVA Summaries for Therapist Gender and Sex Role on Therapy Effectiveness

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>M Clients</th>
<th></th>
<th>F Clients</th>
<th></th>
<th>M-F diff. scores</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>F</td>
<td></td>
<td>P</td>
<td></td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>Gender(A)</td>
<td>6</td>
<td>1.64</td>
<td>.18</td>
<td>.99</td>
<td>.45</td>
<td>.66</td>
<td>.68</td>
</tr>
<tr>
<td>Sex Role(B)</td>
<td>6</td>
<td>.99</td>
<td>.45</td>
<td>1.39</td>
<td>.25</td>
<td>1.51</td>
<td>.21</td>
</tr>
<tr>
<td>A x B</td>
<td>6</td>
<td>.94</td>
<td>.48</td>
<td>1.91</td>
<td>.12</td>
<td>1.87</td>
<td>.12</td>
</tr>
</tbody>
</table>
Appendix D

Table 4
Mean Difference Scores Between Male and Female Clients (Male minus Female) on Negative Button-presses

<table>
<thead>
<tr>
<th>Sex-role Orientation</th>
<th>Androgynous</th>
<th>Sex-typed</th>
<th>Undifferentiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Therapists</td>
<td>4.00</td>
<td>1.27</td>
<td>-1.00</td>
</tr>
<tr>
<td>(N = 8)</td>
<td>(N = 15)</td>
<td>(N = 2)</td>
<td></td>
</tr>
<tr>
<td>Female Therapists</td>
<td>-2.57</td>
<td>-2.00</td>
<td>0.00</td>
</tr>
<tr>
<td>(N = 7)</td>
<td>(N = 5)</td>
<td>(N = 3)</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E

Table 5
ANOVA Summaries for Therapist Gender and Sex-role Effect

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Negative Button-Press</th>
<th>Interpersonal Competency</th>
<th>Flexibility Across Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>MS</td>
<td>F</td>
<td>MS</td>
</tr>
<tr>
<td>Gender(A)</td>
<td>1</td>
<td>137.28</td>
<td>8.57**</td>
<td>9.63</td>
</tr>
<tr>
<td>Sex Role(B)</td>
<td>2</td>
<td>7.71</td>
<td>.48</td>
<td>15.99</td>
</tr>
<tr>
<td>A x B</td>
<td>2</td>
<td>28.31</td>
<td>1.77</td>
<td>11.13</td>
</tr>
<tr>
<td>Residual</td>
<td>34</td>
<td>16.02</td>
<td></td>
<td>8.18</td>
</tr>
</tbody>
</table>

** p < .01
Appendix F

Table 6

Mean therapist Self-report Interpersonal Competency Scores

<table>
<thead>
<tr>
<th>Sex-role Orientation</th>
<th>Androgynous</th>
<th>Sex-typed</th>
<th>Undifferentiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Therapists</td>
<td>14.13</td>
<td>12.87</td>
<td>11.00</td>
</tr>
<tr>
<td>(N = 8)</td>
<td>(N = 15)</td>
<td>(N = 2)</td>
<td></td>
</tr>
<tr>
<td>Female Therapists</td>
<td>13.86</td>
<td>16.00</td>
<td>11.67</td>
</tr>
<tr>
<td>(N = 7)</td>
<td>(N = 5)</td>
<td>(N = 3)</td>
<td></td>
</tr>
</tbody>
</table>
Appendix G

Table 7

MANOVA Summaries of Therapist Gender and Interpersonal Competency on Therapy Effectiveness

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Male Clients</th>
<th></th>
<th>Female Clients</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>p</td>
<td>F</td>
<td>p</td>
</tr>
<tr>
<td>Gender(A)</td>
<td>6</td>
<td>1.00</td>
<td>.44</td>
<td>.93</td>
<td>.49</td>
</tr>
<tr>
<td>Interpersonal Competency(B)</td>
<td>6</td>
<td>.76</td>
<td>.61</td>
<td>2.49</td>
<td>.04*</td>
</tr>
<tr>
<td>A x B</td>
<td>6</td>
<td>2.11</td>
<td>.08</td>
<td>2.45</td>
<td>.05*</td>
</tr>
</tbody>
</table>

*p < .05
Appendix H

Table 8
Mean Absolute Differences Between Male and Female Clients' Post-interview Parameters of Psychotherapy Scores

<table>
<thead>
<tr>
<th>Sex-role Orientation</th>
<th>Androgynous</th>
<th>Sex-typed</th>
<th>Undifferentiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Therapists</td>
<td>11.75</td>
<td>12.67</td>
<td>13.00</td>
</tr>
<tr>
<td>(N = 8)</td>
<td>(N = 15)</td>
<td>(N = 2)</td>
<td></td>
</tr>
<tr>
<td>Female Therapists</td>
<td>14.86</td>
<td>10.40</td>
<td>12.00</td>
</tr>
<tr>
<td>(N = 7)</td>
<td>(N = 5)</td>
<td>(N = 3)</td>
<td></td>
</tr>
</tbody>
</table>
Appendix I

Table 9
Summaries of Correlations Between Flexibility and Therapy Effectiveness

<table>
<thead>
<tr>
<th></th>
<th>Cross-sex Flexibility</th>
<th>Pre-Post Flexibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M Clients</td>
<td>F Clients</td>
</tr>
<tr>
<td>Continuation</td>
<td>-.21</td>
<td>-.10</td>
</tr>
<tr>
<td>Confidence</td>
<td>-.22</td>
<td>-.15</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>-.24</td>
<td>-.33**</td>
</tr>
<tr>
<td>Attractiveness</td>
<td>-.19</td>
<td>-.34**</td>
</tr>
<tr>
<td>Expertness</td>
<td>-.19</td>
<td>-.32**</td>
</tr>
<tr>
<td>Positive Button</td>
<td>.03</td>
<td>.14</td>
</tr>
</tbody>
</table>

*p < .05 (df = 38, one-tailed)

**p < .025 (df = 38, one-tailed)
Appendix J

Table 10

MANOVA Summaries for Therapist Gender and Accuracy of Perception on Therapy Effectiveness

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Male Clients</th>
<th>Female Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>P</td>
</tr>
<tr>
<td>Gender(A)</td>
<td>6</td>
<td>.99</td>
<td>.45</td>
</tr>
<tr>
<td>Accuracy(B)</td>
<td>6</td>
<td>.95</td>
<td>.47</td>
</tr>
<tr>
<td>A x B</td>
<td>6</td>
<td>1.00</td>
<td>.44</td>
</tr>
</tbody>
</table>

*p < .05
Appendix K

Table 11

Mean Ratings of Therapists with Opposite-sex Clients Having Sex-specific Problems on Therapy Effectiveness Measures

<table>
<thead>
<tr>
<th></th>
<th>Male Therapists</th>
<th>Female Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Androgynous Sex-typed (N = 4)</td>
<td>Androgynous Sex-typed (N = 11)</td>
</tr>
<tr>
<td>Continuation</td>
<td>16.75</td>
<td>19.91</td>
</tr>
<tr>
<td>Confidence</td>
<td>110.25</td>
<td>117.45</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>72.00</td>
<td>72.55</td>
</tr>
<tr>
<td>Attractiveness</td>
<td>72.50</td>
<td>70.36</td>
</tr>
<tr>
<td>Expertness</td>
<td>67.00</td>
<td>71.55</td>
</tr>
<tr>
<td>Positive Button</td>
<td>12.00</td>
<td>10.91</td>
</tr>
</tbody>
</table>
### Appendix L

#### Table 12

**Three Dimensions of Perceived Counselor Behaviors in Counseling Rating Form**

<table>
<thead>
<tr>
<th>Expertness</th>
<th>Attractiveness</th>
<th>Trustworthiness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alert</td>
<td>Agreeable</td>
<td>Genuine</td>
</tr>
<tr>
<td>unalert</td>
<td>disagreeable</td>
<td>phony</td>
</tr>
<tr>
<td>Analytic</td>
<td>Appreciative</td>
<td>Dependable</td>
</tr>
<tr>
<td>diffuse</td>
<td>unappreciative</td>
<td>undependable</td>
</tr>
<tr>
<td>Clear</td>
<td>Attractive</td>
<td>Honest</td>
</tr>
<tr>
<td>vague</td>
<td>unattractive</td>
<td>dishonest</td>
</tr>
<tr>
<td>Confident</td>
<td>Casual</td>
<td>Open</td>
</tr>
<tr>
<td>unsure</td>
<td>formal</td>
<td>closed</td>
</tr>
<tr>
<td>Experienced</td>
<td>Cheerful</td>
<td>Reliable</td>
</tr>
<tr>
<td>inexperienced</td>
<td>depressed</td>
<td>unreliable</td>
</tr>
<tr>
<td>Informed</td>
<td>Enthusiastic</td>
<td>Respectful</td>
</tr>
<tr>
<td>ignorant</td>
<td>indifferent</td>
<td>irrespectful</td>
</tr>
<tr>
<td>Insightful</td>
<td>Likeable</td>
<td>Selfless</td>
</tr>
<tr>
<td>insightless</td>
<td>unlikeable</td>
<td>selfish</td>
</tr>
<tr>
<td>Intelligent</td>
<td>Friendly</td>
<td>Straightforward</td>
</tr>
<tr>
<td>stupid</td>
<td>unfriendly</td>
<td>deceitful</td>
</tr>
<tr>
<td>Logical</td>
<td>Close</td>
<td>Sincere</td>
</tr>
<tr>
<td>illogical</td>
<td>distant</td>
<td>insincere</td>
</tr>
<tr>
<td>Prepared</td>
<td>Sociable</td>
<td>Trustworthy</td>
</tr>
<tr>
<td>unprepared</td>
<td>unsociable</td>
<td>untrustworthy</td>
</tr>
<tr>
<td>Skillful</td>
<td>Warm</td>
<td>Believable</td>
</tr>
<tr>
<td>unskillful</td>
<td>cold</td>
<td>suspicious</td>
</tr>
</tbody>
</table>
Instructions to interviewers

"Dr. Critelli and Dr. Schneider's research team is embarked on a project to create a tape bank of recordings of initial interviews. The bank is conceptualized as analogous to a data bank. The materials in the data bank will then be available for use in research or for training of graduate students in interview skills.

The first session involves completing questionnaires. This can be done anytime but we ask that you to complete the questionnaires prior to session two. Sessions two and three involve interviewing a subject for 12 to 15 minutes. One interview will be with a male subject and one will be with a female subject. After you have completed all three sessions, you may review your taped interviews, if you wish, by getting in touch with Dr. Schneider. An experimenter on the research team (Catherine Tang, 565-1273) will contact you to arrange a convenient time for you to interview the subjects.

In order that these recordings can be included in the tape bank as material for future research and training, we are asking you to sign a consent form to allow us to use the recordings. Your anonymity on the tapes and questionnaires will be assured as much as possible with videorecording. These recordings will not be used for any evaluative purposes.
Since the conduct of the interviews is always the same, directions for the interviews are as follows: The experimenter will bring the subject and a bleeper to the interview room. During the interview the bleeper will sound at intervals. Do not be concerned with the sound, it is a monitoring cue for the subject to push a button on the box which he/she will be holding.

During the interview, the subject will have concerns in mind to discuss. Your task is to start and conduct the interview just as you typically interview individuals in the clinic. Your signal to start the interview is when the experimenter leaves the interview room. You will not receive a signal for stopping the interview. After 12 to 15 minutes, bring the interview to a close as you typically would end an interview. A clock will be situated in the interview room so that you can easily monitor the time.

The interview will be recorded. You will be video and audiotaped. The subject will be audiorecorded only. If you hear any sounds coming from the cameras during the interview, do not attend to them. They are merely camera adjustments to focus the picture.

After the end of the interview, remove your microphone and leave it on the chair. The experimenter will return to the room with a packet. The packet will contain some questions for you to complete about the interview. The experimenter will take you to a room and wait till you
complete the questionnaires. Please work quickly and answer every question. Your first impression is your best answer.
The questionnaires will take about 10 to 15 minutes to complete. If you have any questions about the procedure, please ask them now. If you understand the procedure, please sign the consent form now."
Appendix N

Informed Consent

I hereby give consent to Dr. L. Schneider, Dr. Critelli to perform or supervise the following investigational procedure or treatment:

to videotape initial interviews with a student from the subject pool and to use this tape and information in future research and training.

I have (seen, heard) a clear explanation and understand the nature and purpose of the procedure or treatment; possible appropriate alternative procedures that would be advantageous to me (him, her); and the attendant discomforts or risks involved and the possibility of complications which might arise.

I have (seen, heard) a clear explanation and understand the benefits to be expected. I understand that the procedure or treatment to be performed is investigational and that I may withdraw my consent for my (his, her) status. With my understanding of this, having received this information and satisfactory answers to the questions I have asked, I voluntarily consent to the procedure or treatment designated in Paragraph 1 above.

__________________________
Date

SIGNED: ___________________  ___________________
        Witness                        Subject

Instructions to persons authorized to sign:
If the subject is not competent, the person responsible shall be the legal appointed guardian or legally authorized representative.
If the subject is a minor under 18 years of age, the person responsible is the mother or father or legally appointed guardian.
If the subject is unable to write his name, the following is legally acceptable: John H. (His X mark) Doe and two (2) witnesses.
Appendix O

Interviewer Experience Questionnaire

1. Name ____________________ Sex: M F Age: ________

2. Ethnic Status: ______ Black-American
    ______ Mexican-American
    ______ Oriental-American
    ______ White-American
    ______ Other (Please specify) ______

3. How many semesters of practicum experience in counseling/psychotherapy have you completed in a MA/MS program (do not count practicums in testing)?

4. How many semesters of practicum experience in counseling/psychotherapy have you completed in a Ph.D. program (do not count practicums in testing)?

5. Have you completed the internship requirement for the Ph.D.?
    ______ Yes ______ No

6. Excluding time in numbers 3, 4, and 5 (above), how many years of experience in doing counseling/psychotherapy (do not count practicums in testing)?
Appendix P

Parameters of Psychotherapy

The Parameters Instrument (PI) is a self-report form that reflects no preference for any single school of psychotherapy; indeed, it was developed to differentiate between and yet give fair treatment to such diverse therapists as Albert Ellis, Fritz Perls, and Carl Rogers. Below a table is presented which defines the ten parameters of psychotherapy.

By means of the Parameters of Psychotherapy Instrument you are to describe as accurately as you can, the way you characteristically work with clients. In the space provided next to each dimension describe the degree of emphasis you place on each dimension using the following 9-point scale:

1. Extremely Uncharacteristic
2. Quite Uncharacteristic
3. Fairly Uncharacteristic
4. Somewhat Uncharacteristic
5. Relatively Neutral
6. Somewhat Characteristic
7. Fairly Characteristic
8. Quite Characteristic
9. Extremely Characteristic

Ca Caring. The therapist's attitude of loving regard for the individual whether expressed by unconditional warmth or aggressive critical caring.

Es Ego-strengthening. Helping the person to develop his thinking, feeling, and perceptive ability so that he can cope with life more effectively.

En Encountering. Providing the experience of active encounter between person and therapist, each of whom is being and expressing his real feelings.
Fe Feeling. Helping the person to experience, in a psychologically safe relationship, feelings which he has found too threatening to experience freely.

IA Interpersonal Analyzing. The analyzing by the therapist of the person's perceptions or manipulation of the therapeutic relationship, and therefore of his other interpersonal relationships in life.

PA Pattern Analyzing. The analyzing of unworkable patterns of functioning and assisting in the development of adaptive or actualizing patterns of functions for the person.

Rn Reinforcing. The therapist rewards behavior that is growth-enhancing as well as socially adaptive, and/or punishes behavior that is negative or self-defeating.

Rx Reexperiencing. The therapist assists the person in the reexperiencing of past influential learnings, and assists him in desensitizing the pathological effects of these learnings on his present functioning.

SD Self-disclosing. The exposing by the therapist of his own adaptive and defensive patterns of living which encourages the person to do the same thing.

VR Value Reorienting. The reevaluation by the therapist of the person's loosely formulated value orientations (assumptions about self and others, etc.) which enables the patient to commit himself/herself to examinations and operational values.
Appendix Q

Self Assessment Checklist

Directions:

If you feel the statement is true for you, check the space to the left of the item.

If you feel the statement is false for you, leave the space to the left blank.

1. I have a reputation for being able to cope with difficult people.

2. I find it easy to talk with all kinds of people.

3. I find it easy to play many roles - student, leader, follower, church goer, athlete, traveler, etc.

4. I am good at playing charades.

5. People seek me out to tell me about their troubles.

6. My physical endurance is greater than that of the average person my age.

7. I think I have unusual skill for assessing the motivation of other students.

8. My physical energy is greater than that of the average person my age.

9. I have unusual skills for making groups, clubs, or organizations function effectively.

10. If I want to, I can be a very persuasive person.

11. I have a clear picture of what I am like as a person.

12. I know what I want to do with my life.

13. My physical health is excellent.

14. My friends think that I am shrewd and insightful about other people.
15. I have good coordination.
16. I would enjoy being an actor (actress).
17. Most of the time, I have an optimistic outlook.
18. My friends regard me as a person with good practical judgment.
19. I am seldom ill.
20. I believe I have good practical judgment.
### Appendix R

**Characteristic-Self Description**

Instructions: Please rate how well each of the following characteristics describes yourself using the following scale:

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>never or almost never true</td>
<td>always or almost always true</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Make your rating in the space next to each item:

- 1. Self-reliant
- 2. Yielding
- 3. Helpful
- 4. Defends own belief
- 5. Cheerful
- 6. Moody
- 7. Independent
- 8. Shy
- 9. Conscientious
- 10. Athletic
- 11. Affectionate
- 12. Theatrical
- 13. Assertive
- 14. Flatterable
- 15. Happy
- 16. Strong personality
- 17. Loyal
- 18. Unpredictable
- 19. Forceful
- 20. Feminine
- 21. Reliable
- 22. Analytic
- 23. Sympathetic
- 24. Jealous
- 25. Has leadership abilities
- 26. Sensitive to the needs of others
- 27. Truthful
- 28. Willing to take risks
- 29. Understanding
- 30. Secretive
- 31. Makes decisions easily
- 32. Compassionate
- 33. Sincere
- 34. Self-sufficient
- 35. Eager to soothe hurt feelings
- 36. Conceived
- 37. Dominant
- 38. Soft spoken
- 39. Likable
- 40. Masculine
- 41. Warm
- 42. Solemn
- 43. Willing to take a stand
- 44. Tender
- 45. Friendly
- 46. Aggressive
- 47. Gullible
- 48. Inefficient
- 49. Acts as a leader
- 50. Childlike
- 51. Adaptable
- 52. Individualistic
- 53. Does not use harsh language
- 54. Unsympathetic
- 55. Competitive
- 56. Loves children
- 57. Tactful
- 58. Ambitious
- 59. Gentle
- 60. Conventional
Appendix S

Instructions to interviewees before completion of questionnaires.

"You will have a brief interview with a psychology graduate student who is completing training in counseling and psychotherapy. Before the interview, we would like you to complete some questionnaires. In addition, you will be given a list of problems which will help you to decide on a topic or topics to talk about during the interview.

When filling out the forms, please work as quickly as you can. Do not spend too much time thinking about the items or checking over your answers. Your first impression is most important."
Appendix T

Biographical Information sheet

Name____________________ Sex: M  F  Age __________

Ethnic Status:
___ Black-American
___ Mexican-American
___ Oriental-American
___ White-American
___ Other (Please specify) _________________________

If you have ever talked to a high-school counselor or other professional helper (that is, psychiatrist, psychologist, social worker, etc.) while in high-school, was it concerning:

___ Educational-vocational concerns
___ Personal-social concerns
___ Both educational-vocational and personal-social concerns
___ I have never talked with a counselor or other professional helper while in high-school

If you have ever talked to college counselor or other professional in college, was it concerning:

___ Educational-vocational concerns
___ Personal-social concerns
___ Both educational-vocational and personal-social concerns
___ I have never talked with a counselor or other professional helper while in college.

If you have ever talked to a professional helper during any period in your life other than while you were in high-school and/or college, was it concerning:

___ Educational-vocational concerns
___ Personal-social concerns
___ Both educational-vocational and personal-social concerns
___ I have never talked with a professional helper during any other period in my life.
Appendix U

Problem Checklist

Instructions: The following list contains a number of problems that college students commonly report. Please check off 1 to 3 of the problems that feel genuine to you and that you would be willing to discuss with the interviewer. During the interview, please try to discuss one or more of the problems you checked off.

- Nervous
- Feeling failure in college
- Contemplating suicide
- Insomnia
- Financial problems
- Too easily led by others
- Often feel nauseous
- Bothered by nightmares
- Having a troubled or guilty conscience
- Not knowing how to study effectively
- Afraid of things I know I should not be
- Disappointment in a love affair
- Too self-centered
- Excessive drinking
- Not being the kind of person I should be
- Wanting more freedom
- Feel weak and exhausted much of the time
- Excessive use of drugs
- Losing my temper
- Feeling inferior
- Boyfriend-girlfriend problems
- Examination panic
- Too easily discouraged
- Worrying about exams
- Hurting other people's feelings
- Fearful of and avoid members of other sex
- Confused in some of my religious beliefs
- Afraid of making mistakes
- Having feelings of extreme loneliness
- Being criticised by my parents
- Sometimes bothered by thoughts of insanity
- Sometimes acting childish or immature
- Not very attractive physically
- Compulsive behavior
- Too inhibited in sexual matters
- Overeating
- Worry about unimportant things
- Wanting love and affection
Lacking privacy in living quarters
Not spending enough time in study
Purpose of going to college not clear
Doubting the wisdom of my vocational choice
Difficulty with marriage
Having no close friends
Bothered by unwanted and disturbing thoughts
Afraid of employment after graduation
Lacking self-control
Losing my temper
Needing information about occupations
Unable to concentrate well
Moodiness; "having the blues"
Easily and frequently become depressed
Frequent headaches
Pretending to be something I am not
Feel that I'm a complete blank; don't know what to do
Undecided on major
Having angry, hostile feelings towards others
Sexual needs unsatisfied
Not getting along with member of my family
Doubting my masculinity or femininity
Lacking self-confidence
Worrying about the possibility of hurting others
Wanting to improve my mind
Wanting more chance for self-expression
Ill at ease with other people
Hearing or seeing unusual things
Fearful of close relationship with others
Feelings too easily hurt
Find it hard to talk about things
Being talked about or watched
Can't forget an unpleasant experience
Feeling that no one understands me
Not meeting anyone I like to date
Often experience feelings of panic
Wondering if I'll ever find a suitable mate
Appendix V

Instructions to interviewees after completion of questionnaires.

"During the interview, we would like you to try to talk about one or more of the problems that you checked off on the list of problems. Assume that you were going to seek counseling for the problem or problems you checked.

When you enter the interview room, there will be a box like this on the chair. During the interview, please hold the box in your hand, out of the view of the interviewer.

Individuals notice their feelings change back and forth during the interview. One moment they may feel relatively comfortable, understood, warm, optimistic, or cheerful, and the next moment they may feel relatively less-at-ease, misunderstood, saddened, or indifferent to what is going on at the moment.

A bleeper will sound at intervals during the interview. When the bleeper sounds, if your feelings are more positive and comfortable, push the green button. When the bleeper sounds, if your feelings are more negative, push the red button.

You will find it easy to notice these mood changes if you attend to your feelings during the interview. For example, your feelings might be associated with:
Appendix V--Continued

a) something you are doing or saying
b) something you are thinking or feeling
c) something the interviewer is doing or saying
d) feelings you might be "picking up" from the interview
e) the topic being discussed
f) something going on outside the interview room

I am interested in your immediate reactions and feelings. Do not hesitate to push the button that indicates your immediate feeling whether it be positive and comfortable, or negative and uncomfortable.

Most people are a little hesitant to report negative or uncomfortable feelings, but we are interested in knowing each time you feel even the slightest bit negative or uncomfortable. So be sure to press the red button each time you hear the bleeper and your feelings show any tendency in the negative direction.

When you enter the interview room, I will put the bleeper on the table next to your chair. When you enter the room, you will also find a small microphone on your chair. Please put on the neck microphone by slipping over your head. The interview will be recorded. The interviewer will be videotaped. However, only your voice will be recorded. You will not appear on the videotape. The interviews are being recorded so that they can be used in future research projects and for training future psychology graduate students.
When the interview is over, please remove the microphone and place it on your chair. After the interview, you will get to see the playback. In order that these recordings can be of benefit, we are requesting you to sign the consent form, allowing us to use these recordings in research and training. Your identity in any of these recordings will be anonymous except for the sound of your voice.

Are there any questions? Do you understand the procedures?
Appendix W

Informed Consent

I hereby give consent to Dr. L. Schneider, Dr. Critelli to perform or supervise the following investigational procedure or treatment:

*to make an audiotape recording of my initial interview with a clinical, counseling, or behavioral doctoral student, and to use this tape in future research and training.*

I have (seen, heard) a clear explanation and understand the nature and purpose of the procedure or treatment; possible appropriate alternative procedures that would be advantageous to me (him, her); and the attendant discomforts or risks involved and the possibility of complications which might arise.

I have (seen, heard) a clear explanation and understand the benefits to be expected. I understand that the procedure or treatment to be performed is investigational and that I may withdraw my consent for my (his, her) status. With my understanding of this, having received this information and satisfactory answers to the questions I have asked, I voluntarily consent to the procedure or treatment designated in Paragraph 1 above.

__________________________
Date

SIGNED: __________________   __________________
Witness                      Subject

Instructions to persons authorized to sign:
If the subject is not competent, the person responsible shall be the legal appointed guardian or legally authorized representative.
If the subject is a minor under 18 years of age, the person responsible is the mother or father or legally appointed guardian.
If the subject is unable to write his name, the following is legally acceptable: John H. (His X mark) Doe and two (2) witnesses.
Appendix X

Interviewer's Impressions

Instructions:
Circle the number to indicate your impression of each of the following:

1. Disregarding time limitations, rate your conduct of the interview in terms of the degree to which it represents how you typically conduct a first interview:

   very unrepresentative 1 2 3 4 5 6 7 8 representative

2. If the subject were to continue counseling with you about his or her concerns, how optimistic would you be about your ability to be generally helpful to the subject?

   very pessimistic 1 2 3 4 5 6 7 8 optimistic

3. If the subject were to continue counseling about his or her concerns, how likely do you feel that the subject would be to return for a second interview with you?

   very unlikely 1 2 3 4 5 6 7 8 likely

4. How likely do you feel the subject would be to recommend you to one of his or her friends who wanted counseling?

   very unlikely 1 2 3 4 5 6 7 8 likely
Appendix Y

Interviewer's Confidence Ratings

Instructions:
In the space provided next to each number, indicate how much confidence you have that you would be effective in providing help to the subject for each of the following problems. Give a confidence rating to each item using the following scale:

very nonconfident 1 2 3 4 5 6 7 8 very confident

___ 1. Study problem
___ 2. Poor academic performance
___ 3. Choosing a major
___ 4. Public-speaking performance
___ 5. Employment worries
___ 6. Test anxiety
___ 7. Insomnia
___ 8. Drug problems
___ 9. Alcoholism
___ 10. General anxiety
___ 11. Shyness
___ 12. Depression
___ 13. Dating difficulties
___ 14. Concerns about sexuality
___ 15. Parental conflicts
___ 16. Inferiority feelings
___ 17. Lack of friends
___ 18. "Losing grip" on reality
___ 19. Religious conflicts
Appendix Z

Instructions to interviewees after interviews:

"We would like to get your impressions of the interview. Please work as quickly as you can through these rating forms. Remember your first impression is the best answer. Do not spend too much time thinking about the items or checking over your answers."
Appendix AA

Impression Ratings

Instructions:
In this questionnaire you are asked to give your impression of the interviewer who conducted your interview.

For example, if you feel that one end of the scale is very accurate in describing your impression of the interviewer, you should place a mark as follows:

fair __:__:__:__:_X:_ unfair
OR
fair X:__:__:__:_:_:_ unfair

If you feel that one end of the scale is quite close in describing your impression of the interviewer, you should place a mark as follows:

rough __:__:__:_:__:_:_ smooth
OR
rough __:__:_X:_:__:_:_ smooth

If you feel that one end of the scale is only slightly related to your impression of the interviewer, you should check as follows:

active __:__:__:_:__:_:_ passive
OR
active __:__:_X:_:__:_:_ passive

If you feel neutral, that is, both sides of the scale seem to describe your impression of the interviewer equally, or if the adjectives are irrelevant, then place a mark in the middle:

liberal __:__:__:_X:_:__:_:_ conservative

Work as quickly as you can without looking back and forth through your answers. Your first impression is the best answer.
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<thead>
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<th>Positive</th>
<th>Negative</th>
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</thead>
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<td>Antonym</td>
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<td>inexpert</td>
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</tr>
<tr>
<td>unreliable</td>
<td>reliable</td>
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</tbody>
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Appendix BB

Continuation Expectations

Instructions:
Circle the number to indicate your expectation for each of the following.

1. If you were to continue counseling for the 1 to 3 problems you checked off before the interview, how optimistic would you be about the general helpfulness of the interviewer?

   no optimism 1 2 3 4 5 6 7 8 extreme optimism

2. If you were to continue counseling for the 1 to 3 problems that you checked off before the interview, how likely is it you would return for a second interview with the interviewer?

   very unlikely 1 2 3 4 5 6 7 8 very likely

3. How likely is it that you would recommend the interviewer to a friend who wanted counseling?

   very unlikely 1 2 3 4 5 6 7 8 very likely
Appendix CC

Instructions to interviewees after completion of post-interview questionnaires.

"I am going to play back the interview for you. Each time you have made a button press, I will stop the recording. I would like you to describe your feelings which were either positive and comfortable or negative and uncomfortable. For example, your feelings might have been associated with:

a) something you are doing or saying
b) something you are thinking or feeling
c) something the interviewer is doing or saying
d) feelings you might be "picking up" from the interview
e) the topic being discussed
f) something going on outside the interview room

Please be as specific as you can."
References


