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The Social History of Therapists and Their Clients, as Related to Outcome of Therapy

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THE SOCIAL HISTORY OF THERAPISTS AND THEIR CLIENTS, AS RELATED TO OUTCOME OF THERAPY

(TITLE)

BY

Howard A. Bernstein

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ABSTRACT

The present study was concerned with the concept of therapist-patient pairing or similarity-dissimilarity. From previous research, it appears that certain therapist types work better with certain client types.

In the current study, three therapists and twenty-four clients were used to develop the concept of pairing further using social history as a basis. The results indicate that global similarity generally leads to more positive outcome. However, we are unable to draw any firm conclusions, primarily due to the small sample size. It does appear that social history may be a useful area to continue investigations in the area of pairing.

The effectiveness of psychotherapy has been subjected to vast experimentation, particularly during the past two decades. In the initial stages of evaluation, the question was often asked, "Does psychotherapy work?" Research quickly pressed forward from this question to a more specific one, "How do different approaches to therapy differ in effectiveness?". It was soon concluded that both questions were much too broad and would provide little assistance in improving the outcomes of therapy. Consequently, the broad questions were segmented into smaller, more detailed portions. The psychotherapeutic relationship which we shall be concerned with became a major topic of investigation. This relationship was further broken down into three categories: the patient as an outcome variable, the therapist as an outcome variable, and the therapist-patient interaction as an outcome variable, (Meltzoff & Kornreich, 1970). In regard to the patient, several areas have been examined. Among the most widely evaluated are diagnoses, severity of maladjustment, background, organismic, demographic, motivational and attitudinal variables. The therapists' effects have been examined primarily in relation to qualifications, personal characteristics and attitudes, (Meltzoff & Kornreich, 1970).

The present study is concerned with the therapist-

patient interaction variables. Previous research has dealt primarily with personality, expectations, social-class, values and race. A review of these factors follows.

THERAPIST-PATIENT PERSONALITY VARIABLES

Two major hypotheses have been investigated regarding the effects of personality on the outcome of therapy. The therapist-patient similarity hypothesis postulates that when a therapist and his client have similar personalities, the outcome of therapy tends to be in a more positive direction. The dissimilarity hypothesis claims that when a therapist and his client are dissimilar in personality, the outcome of therapy is enhanced.

Therapist-Patient Similarity

Length of Stay in Therapy

A major method of comparing the effectiveness of similarity is to relate it to the length of stay in therapy. A significant contribution to this area has been made by G. A. Mendelsohn and M. H. Geller. In their initial investigation (1963), they administered the Myers-Briggs Type Indicator (MBTI) to the clients and their therapists. The test measures judgement-perception, thinking-feeling, sensation-intuition and extraversion-introversion. The difference scores were obtained for each pair and related to the number of counseling sessions. The results indicate that the

length of counseling was significantly correlated to greater overall similarity. The experimenters conclude that greater client commitment to counseling occurs when the counselor is similar to the client in cognitive-perceptual orientation.

Mendelsohn and Geller (1965) attempted a replication and extension of their previous findings. Sixty-two per cent of the subjects from their previous study completed a rating scale of attitudes towards the counseling process and outcome. A cluster analysis of responses indicated three clusters: evaluation, comfort-rapport and counselor competence. These clusters showed low positive correlations with each other. The investigators found that similarity on the MBTL as measured by Cronbach and Gleser's D^2 (1953) and as related to the attitude scale, yielded a curvilinear relationship. That is, middle similarity produced highest scores.

Mendelsohn (1966) attempted another replication of his first study since the 1965 results did not support the original similarity hypothesis as strongly. The MBTI was administered to 201 clients and their therapists. The results indicated that similarity between counselor and client leads to a greater number of counseling sessions, but also greater variability in the number of sessions. In simpler terms, if similarity is low,

counseling is almost always short. When similarity is high, the length of counseling is variable.

Mendelsohn and Geller (1967) continued their data analysis of their 1966 study. Their results, however, are inconsistent and they discuss the variability of the effects of similarity on the counseling relationship.

The studies of Mendelsohn and Geller were followed by other studies using length of stay in therapy as a measure of success. Lowinger and Dobie (1966) used this method with 300 patients and 16 therapists. The therapists completed a questionnaire of patient similarities in initial contacts. The experimenters found a significant positive relationship between initial therapist-patient similarity and outcome in terms of the number of visits made by the patient.

Linear relationships, that is high similarity is associated with positive outcome and increased length of counseling, have also been demonstrated by Tuma and Gustad (1957), Axelrod (1952), Heine and Trosman (1963). Others such as Schopler (1958) report no relationship and negative relationship as outlined in another section.

Assumed Similarity and Modifications in the Personality

Another approach to this study of personality is

the client's assumed or ascribed similarity between him and his therapist. This construct was originally developed by Fiedler (1950) but was not associated with outcome until a later date. Sechrest (1962) found that assumed similarity between the self of the client and his perception of the therapist increased significantly during therapy. That is to say, patients viewed themselves as becoming more like their therapists during the course of therapy. Whether they actually did was not assessed.

Greater improvement was also observed by Sapolsky (1965) in those patients who viewed themselves as being similar to their therapists. To a sample of 25 hospitalized female patients and their therapists, he administered the Fundamental Interpersonal Relations Orientation Behavior Scale (FIRO-B). It was used as a device to measure outcome as well as perceptions of the dyadic relationship. The degree of compatibility in the dyad was found to be positively correlated to the outcome of therapy.

An approach closely related to the previous one of assumed similarity is that of Schrier (1953). Schrier hypothesized that the patient modifies his personality in the direction of his therapist's. Using rating scales of therapist-patient personality characteristics,

he draws his conclusion. Namely, at the end of short-term therapy, identification of the client to the therapist is highly correlated to the rapport between them and the strength of therapeutic success.

Using the same hypothesis, Sheehan (1953) investigated Rorschach changes during therapy in relation to personality of the therapists. Rorschachs were administered before and at the conclusion of therapy. Degree of improvement was separately rated by each therapist. Shifts were made toward the Rorschach of their therapists by 17 out of 21 clients. This allows the experimenter to conclude that the patient shifts or modifies his personality in the direction of the therapist's. This provides additional support for the similarity hypothesis.

The Curvilinear Hypothesis

A dissertation by Gerler (1958) was concerned with the degree or amount of similarity as related to outcome. Fifty-seven clients and their therapists were utilized in this sample. Personality was rated by the Ewing Personal Rating Form. Statistically significant differences were obtained, indicating that a medium amount of similarity was more conducive to a positive outcome. There was not a significant difference between

high or low similarity groups.

Similar results were obtained by Carson and Heine (1962). The authors measured personality via the MMPI. Their sample consisted of four therapists and 35 female and 25 male out-patients. Success in therapy was measured by supervising psychiatrists, degree of patient satisfaction, therapists' judgement of outcome, occupational adjustment, adequacy of interpersonal relationships and symptomatic status. One of the conclusions by the authors is that marked differences in personality decreases the positive effects of therapy. Consequently, a moderate amount of similarity is felt to be related to successful outcome.

A study by Mendelsohn and Geller (1965) has previously discussed the curvilinear hypothesis. Middle similarity was associated with high criterion scores using the MBTI.

Specific Personality Variables

Specific personality factors have been found to be related to successful outcomes. Rather than study overall similarity of personality, Axelrod (1952) finds ideation to be a significant factor. In this study, the overall or "global" evaluation showed only a chance

relationship. Therefore, congruent ideation between therapist and patient seems to be a highly significant factor in the outcome of therapy. It is surprising that unusually few studies have been attempted using specific rather than "global" variables. Specific reference to this fact is made at the conclusion of the personality section.

Tuma and Gustad (1957) found that similarity in the areas of dominance, social presence and social participation, as measured by the California Personality Inventory, lead to more successful outcomes. Supporting trends appeared in the areas of anxiety and self-acceptance.

Vogel (1961) confirmed one of the findings of Tuma and Gustad (1957). Namely, that no relationship existed between the similarity of therapist and patient authoritarianism and patient change.

Other researchers have found dissimilarity of specific variables leads to a more positive outcome. Examples of this hypothesis are presented in the following section.

Therapist-Patient Dissimilarity

Despite the vast support that the similarity hypothesis has attained, strong evidence has also been discovered that supports the dissimilarity hypothesis. This evidence is presented below.

General Measures

In a detailed analysis of the psychotherapeutic relationship, Snyder and Snyder (1961) found strong support for the dissimilarity hypothesis. Twenty-five patients and their therapist took the Edwards Personal Preference Schedule (PPS). Three of four patients whose scores on the PPS were most similar to their therapist's were rated by him as most difficult and unsuccessful. The four least like the therapist were rated as the most successful and having the best rapport. Caution should be used in interpreting these results since only one therapist was used in the sample. The results, however, are highly suggestive.

In a study involving 24 adult out-patients, Carr (1970) found that in the initial phase of therapy incompatible patients and therapists seek compatibility as a basis for establishing productive communication. However once this communication is established, compatibility

becomes unimportant and the incompatible patients report a greater symptom reduction.

Cutler (1958) found that therapists' responses to patients' statements that were relevant to the therapists' conflict areas were judged less adequate than therapists with unrelated conflicts. He concludes that a therapist who is paired with a client having a similar conflict to his own will have less successful results.

The Gordon Personal Profile, Gordon Personal Inventory, and the Edwards Personal Preference Schedule were administered to 47 counselors and 208 clients in a study by Bare (1967). The clients were seen weekly for 10 weeks and then rated: (1) helpfulness of counseling, (2) how well they knew their counselor, and (3) counselor empathy. Personality measures were then related to the previous measures. The results indicate that outcome is most positive when counselors were unlike their clients on measures of original thinking, vigor, and responsibility.

Howard et al., (1970) investigated therapist-patient pairing on four variables: catharsis, mastery-insight, encouragement, and nothing. The sample involved 118 female patients and 27 therapists. A positive outcome is reported when the therapist, (1) has a life

situation dissimilar to the patients', (2) maintains distance from the patients' problems, and (3) respects the patients' life status. The first conclusion gives strong support to the hypothesis currently being reported.

Specific Measures of Dissimilarity

In the present study, we are concerned with the concept of therapist-patient pairing. The current section is highly related to that concept. It attempts to demonstrate that specific factors related to the therapist and patient have a strong influence on the outcome of therapy. A more detailed explanation follows this section.

Bandura et al., (1960) studied therapists' approach-avoidance reactions to expressions of hostility. Tape recordings of interviews were coded for the number of approach or avoidance reactions by the therapists and frequency of hostility expressed by patients. Therapists who were rated as having conflicts in the area of hostility tended to avoid or evade their clients' expressions of hostility more often than therapists who had fewer conflicts in the area of hostility. Conversely, therapists with fewer hostility conflicts tended to approach client verbalizations of hostility

more frequently. Since it is generally accepted that "working through" conflicts is essential for success in therapy, dissimilarity in the area of hostility is essential for success in treatment.

In a study similar to the previous one, Winder et al., (1962) found similar results in relation to dependency conflicts. Therapists' behavior was evaluated with parents of emotionally disturbed children. When expressions of dependency are approached, the patient remains in therapy. If avoided, the frequency of dependency decreases and the patient terminates prematurely.

The variables of dominance-submission and love-hate were tested in two pilot studies by Swensen (1967). In keeping with the dissimilarity hypothesis, Swensen concludes that patients are most likely to have a satisfying relationship if they complement each other (are opposites) on the above dimensions. Swensen concludes that his hypothesis has not been conclusively confirmed but does merit further investigation. Dominance-submission has also been studied in relation to outcome by Snyder (1961), Plummer (1966), and Tuma and Gustad (1957). Their results further support the work of Swensen (1967) and the concept of dissimilarity.

Conclusions of the Similar and Dissimilar Hypotheses

Both of these positions have presented information in an attempt to verify their hypothesis. The two conclusions seem contradictory, however, several writers have been able to justify these differences. It is first essential to note that a large number of these studies were developed with the objective of determining which interaction variables can be applied to the concept of therapist pairing. That is, what types of clients will have maximum gains with what types of therapists. With this in mind, a paper read at the Conference on Psychotherapy Research by Levinson (1961) states that therapist-patient similarity cannot be thought of as a unitary trait. Some similarities may facilitate good relationships and therapeutic progress, while others may be sources of impasse.

Wogan (1970) restates, "It should be pointed out that similarity (or for that matter, dissimilarity) is not a unitary term. Similarity (or dissimilarity) along one dimension, does not imply similarity (or dissimilarity) along another."

Bergin and Strupp (1972) agree with these conclusions with reference to therapist-patient pairing in relation to process and outcome. They conclude, "There

is increasing evidence that in those cases where the patient-therapist relationship is an important ingredient of the change process, particular pairings of patient and therapist types may enhance or retard positive outcomes.... We suggest that this domain might be ripe for a major study." In another article in the same text, they state, "Perhaps the concept of therapist-patient pairing would be more appropriate (than global measures). Research might then focus on which specific therapist characteristics are more often related to positive outcome with regard to specific client characteristics. Thus, for example, it might be found that clients who score low on a dominance scale, show the highest probability of improvement with a therapist who scores at a moderate level on the same scale but a lower probability of improvement with therapists who are high or low. Complex contingencies might then be developed for starting given probabilities of improvement by including in the matrix a large number of personality dimensions. This would avoid the pitfalls of global measures of personality and would also resolve the dilemmas that arise when the concept of similarity (or dissimilarity) is invoked."

Additional confusion arises from the assessment of client-counselor similarity. Different methods of obtaining the difference scores as well as different

measures of outcome, may account further for seemingly contradictory results, (Mendelsohn, 1966).

In view of the previous quotations, it is postulated that the similarity and dissimilarity hypotheses are not contradictory, but rather a result of design. If the concept of therapist-patient pairing is utilized, it only makes sense that similarity on some dimensions and dissimilarity on others would lead to successful pairing and positive outcome.

THERAPIST-PATIENT EXPECTATIONS

The findings in the area of expectations leave little doubt that the expectations of therapists and patients have a direct effect on the outcome of psychotherapy.

Similarity of Expectations

A significant amount of work in this area has been accomplished by Goldstein (1962). He concludes that the most relevant of expectations is that of prognostic expectancies - the degree of patient improvement that is anticipated by the therapist and patient. That is, if a therapist and client both feel that improvement will be positive, there is a greater chance for improvement than if their expectations were negative. Goldstein goes so far to conclude, "In general, and of greatest importance, material clearly pointed to expectations as a major determiner of human behavior."

In this vein, Heine and Trosman (1960) administered a specially designed questionnaire to 46 psychiatric outpatients, at intake and after six weeks. The treatment aims expressed by the patient, and the means by which he expected to reach his goal were highly related to

continuance in therapy. The authors conclude that mutuality of expectations between therapists and patients is essential.

In a text by Lennard and Bernstein (1960) the authors attempt to apply sociological concepts to the psychotherapeutic relationship. They consider therapy: (1) as a system of action, (2) as an informal exchange system, (3) as a system of role expectations, and (4) they consider the interrelations between communication and expectations for the therapist-patient dyad. They place significant emphasis on the therapist and patient expectations. One of many conclusions is that similar expectancy is essential for progress. Psychotherapy is severely hampered in the situation where the role and behavior expectancies of the therapist and patient are dissimilar. Congruency of therapist-patient role behavior expectancy is a prerequisite for effective treatment.

Continuance in Therapy

Similar results were found by Overall and Aronson (1963) using continuance in therapy as the dependent variable. Forty patients of lower socioeconomic class were tested by means of a questionnaire, administered before and after the initial interview. The greater

the discrepancy between the expectations and perception of the interview, the less likely the patient was to return for treatment.

These findings were confirmed by Clemes and D'Andrea (1965). Each of nine therapists administered five structured and five unstructured initial interviews to patients in an adult out-patient clinic. Patients' expectations about psychotherapy were obtained before the interviews. Patients with compatible expectations rated their anxiety significantly lower than patients experiencing incompatible interviews. The therapists rated those interviews incompatible with the patients expectations, as the most difficult to conduct. The kind of interview did not make a significant difference. Also, patients having congruent expectations remained in therapy longer.

Apfelbaum (1950) also concludes that major differences in expectancies lead to a negative outcome and early termination in therapy. A Q-sort questionnaire measured patients' expectations of what their therapist would be like. A cluster analysis revealed expectations of nurturance, criticism, and a good model of adjustment. These expectations were found to be stable during the course of therapy, and related to the length of time a patient remained in therapy, (i.e., nurturance expecters

remained longer than criticism expecters). Patients who used the therapist as a model were the best adjusted group as measured by the MMPI. This study is of vast importance since it reveals two important facts. Firstly, expectations are stable. That is, if congruence in expectations is essential for positive outcome, initial incongruent clients are hampered even before they begin treatment. Secondly, the study points out that if a client does not identify with his therapist, he will be less successful and discontinue treatment at an early stage.

A more complex and expanded design was carried out by Goin (1965). Patients were assigned to two groups; the advice group and the no advice group. Patients in the advice group tended to report the greatest improvement. Seventy-five per cent of the patients terminated treatment without notifying the therapist and their average stay was four visits. Sixty-one per cent of the patients had expected treatment to last ten visits or less. This suggests that patients tended to act in accordance with their initial expectations. It was also concluded that the patient is helped more when he receives therapy that is congruent with his expectations.

The same conclusion was drawn by Levitt (1966).

It was hypothesized that, "The more the patient finds the therapeutic situation fails to conform to his pre-conception of it, the less likely it is to affect him favorably." This hypothesis was verified as was Goin's (1965).

Much work has been accomplished on the importance of expectations. The list is mammoth, however, some examples of the importance of similarity include: Lipkin (1954), Goldstein and Shipman (1961), Friedman (1963), and Severinsen (1966).

Conclusions of Research in Expectations

The results of the presented studies consistently demonstrate the importance of the expectations of both the therapist and his client. The results seem to be much more conclusive than personality studies. In general, it appears similarity of expectations strongly effects positive outcomes.

SOCIAL CLASS

"Although this is generally not considered to be a similarity variable because there are no or very few lower-class therapists, and it is the difficulties in working with lower-class patients that have raised this issue, there is some justification for viewing this as a similarity variable. Many writers have noted the difficulty when patient and therapist are of a different socio-economic class," (Bergin & Strupp, 1972). These authors clearly outline and justify the perception of socioeconomic class as an interaction variable. The results of such studies are clearly consistent and are presented below.

Problems of Communication: Direct Authoritarian Approach

Hollingshead and Redlich (1958) are often quoted because their system of class evaluation is often used to assign subjects into sample groups. A detailed analysis is not essential for our purpose but only the distinction that there are five classes; the highest status being in class one and the lowest in class five. Although known primarily for the development of this system, these authors have also made several significant

conclusions. They have demonstrated that the therapists' attitudes towards their patients were positively related to the patients' social class. This was true even when the range of maladjustment was limited to a neurotic sample. The authors felt that therapists are generally unable to understand lower-class values, and hence are less prone to like persons holding these values. Furthermore, the therapists technical skills are threatened by the lower-class patients' tendency to demand the therapist to relate in an authoritarian manner.

Shaffer and Myers (1954) conclude that the relevance of social class is more limited than is often thought. They are primarily concerned with the communication between the therapist and patient. Again reference is made to the lower-class patient having a need to be told what to do, and the therapists' inability to react in this manner because it is incongruent with his training.

Results and conclusions become increasingly similar to the above studies. Carlson et al., (1965) point out that the problems of communication lead to markedly negative outcomes. Therapists have major difficulties in reconciling an indicated direct treatment approach. The results of these studies are so similar that methods of dealing with this communication

problem should be studied, rather than continuing to demonstrate that it exists.

Diagnosis and Treatment

Some evidence has been presented that lower-class patients exhibit differences in symptoms and consequently diagnosis. Such results were clearly demonstrated by Moore et al., (1963). The experimenters evaluated 200 schizophrenic women to determine the relationship between social class and clinical picture. The group was divided into two sub groups, according to Hollingshead's method. Of the 90 upper end class patients, the majority were found to have psychic suffering that was demonstrated through anxiety. The 110 lower-class patients were found to exhibit mostly somatic reactions, and much more frequently suffered from hallucinations. Differences in symptoms, as related to class, are clearly evidenced here.

Numerous investigators conclude that lower-class patients remain in treatment for a shorter period of time than do middle or upper-class patients. This effect was demonstrated by Imber et al., (1955). Table #1 demonstrates this factor. The authors also conclude that the outcome of therapy with lower-class patients will be significantly less productive.

Table #1

Length of Stay in Therapy of Lower and Middle Class Patients

Number of Interviews	Lower Class		Middle Class	
	#	%	#	%
0 - 4	18	42.9	2	11.1
5 or more	24	57.1	16	88.9
Total	42	100	18	100

Similar results were obtained by Myers and Schaffer (1954), using Hollingshead's (1958) method of class division. Lower-class patients remained in therapy a significantly shorter period of time than the upper classes. The results are demonstrated in Table #2. These authors also investigated the treatment that clients received. In 195 successive cases in an out-patient clinic, it was clearly demonstrated that the upper classes receive preferential treatment. This factor is presented in Table #3.

Table #2

Length of Stay in Therapy Among Different Classes

Length of Contact	Class and Per cent			
	1	3	4	5
Less than 1 week	11.8	26.9	37.5	47.6
1 - 9 weeks	29.4	26.9	33.3	38.1
More than 10 weeks	58.8	46.2	29.2	14.3

Table #3

Percentage Distribution of Patients by Social Class and Intake Conference Decision

Conference Decision	Social Class			
	1.	2.	3.	4.
No treatment recommended	11.8	9.6	27.2	64.3
Assigned to staff	35.3	17.3	2.8	0
Assigned to resident psychiatrist	29.4	35.8	30.6	2.4
Assigned to medical student	0	9.6	26.4	23.8
Assigned to other students	5.9	7.7	9.7	7.1
Referred to other agencies	11.8	17.3	4.2	2.4
Unknown	5.9	0	4.2	0

It has clearly been demonstrated that lower-class patients tend to terminate therapy early. It is not known, however, what effect differential treatment may have on this factor.

Therapists' Class or Educational Level

It has been repeatedly demonstrated that therapists of lower classes or educational levels are as effective or more effective than professionals, with lower-class patients.

This relationship was demonstrated by Deane and Ansbacher (1962) by the use of attendants or psychiatric aids as therapeutic agents. The authors conclude that commonality of background and language, and the attendants' close associations with the patients have enormous therapeutic value.

Poser (1966) used the outcome of group therapy for psychotic patients as the dependent variable in assessing the efficacy of trained and untrained therapists. The latter group were undergraduate students with no training or experience in psychotherapy. Criterion of behavior change was measured by psychological test performance of 295 patients before and after five months of therapy. The lay therapists

achieved slightly better results than the professionals. The clients were primarily of lower educational and social class which allowed the experimenter to conclude that a lower educational level therapist may prove more positive with patients of similar levels.

In a study by Carkhuff and Truax (1965), ward staff acted as group therapists for 80 hospitalized mental patients. Seventy other patients acted as controls. At the end of a three month period, significant improvement was noticed in the ward behavior of the treatment group when compared with the control group. A low social status is related to the lay therapists by the nature of their jobs and education. It was concluded that lower-class therapists are more effective with patients of similar status than are professionals.

Conclusions

The vast majority of studies cited indicate that social class is an important variable in the outcome of therapy. "It cannot be repeated too often, that the degree of socio-economic difference or similarity between the therapist and patient, may be one of the most important factors in determining the results of psychotherapy," (Lesse, 1964). This variable would certainly

be useful in the concept of pairing, however, there are few, if any, lower-class therapists.

THERAPIST-PATIENT VALUES

Research on values is most difficult to design. Value similarity may really have a great deal to do with similarity in mental health. Values and mental health are easily confounded, (Bergin & Strupp, 1972).

General Considerations

Therapists' attitudes regarding their influence of values was surveyed by Wolff (1954). His results found that 40% of therapists believe that their values have a direct influence upon the patient, 24% saw an indirect influence, and only 28% saw no influence.

Along similar lines, Goldstein (1971) concludes that major differences lead to markedly negative outcomes.

A review of the literature and empirical investigations on values was conducted by Kessel and McBrearty (1967). The psychotherapeutic relationship is viewed in terms of interpersonal attraction and influence. They conclude that some degree of therapist-patient value similarity is considered a prerequisite for positive attraction, effective communication and

influence of the therapist over the patient.

A medium similarity on the dimension of values was found to be the most positive range by Cook (1966). Ninety clients were administered the Semantic Differential, before and after counseling. The clients were then placed in three groups of 30, according to the degree of value similarity between the client and his counselor according to the D^2 technique of Cronbach and Gleser (1952). The groups were then compared for average change in the meaning of values. A medium range was most often associated with success in counseling.

Revision of Values

A major design in assessing the importance of values is the amount of revisions of patients' values in the direction of their therapists'.

Rosenthal (1955) found that patients who improve in therapy tended to revise certain of their values in the direction of the therapists' values. Twelve patients and their therapists were given a battery of tests, before and after therapy. The moral values of patients who were unimproved tend to become less like their therapists: however, the improved patients re-

vised certain values, such as those of the Allport-Vernon-Lindzey scale.

Congruence and change in values were examined in two schizophrenic patients by Parloff et al., (1960). Although his sample size is unusually small, his investigation is very detailed and yields interesting results. One patient was unchanged after 3 1/2 years of intensive individual therapy. The other was discharged as recovered after 1 1/2 years. The unsuccessful patient increased in value congruence during the first six weeks but not thereafter. The successful one increased in congruence over the course of therapy but declined over the last 15 sessions. After eight months, the successful patient was significantly closer to the therapist's values than was the other patient.

Similar results were found by Welkowitz et al., (1967) using a considerably larger sample. The experimenters hypothesized that therapists and their own patients would have more similar value systems than would therapists randomly paired with patients who were not their own. They also postulated that a direct relationship between similarity of therapist-patient values and the therapists' subjective evaluations of improvement in the patient would exist. There were 38 therapists, all M.D.'s or Ph.D.'s with several years of

experience. The patients numbered 44 and were mostly in their mid-twenties and above average in intelligence. Values and improvement were evaluated by the Strong Vocational Interest Blank, the Morris Ways to Live, and a six-point Improvement Rating Scale. In addition to verifying both hypotheses, the experimenters also discovered that value similarity tends to increase with the duration of therapy.

Conclusions

There is moderate support for the hypothesis that therapist-patient values have an effect upon therapy. At this point, it seems that similar values are related to positive outcome. The amount of research is insufficient to draw a sound conclusion. As stated earlier, research in this area of values is difficult to design. It is felt that additional work is needed in this area.

RACE

In relation to other interaction variables, race has received little attention. The 1950's produced the majority of material in this area which may be a result of the drive for equality during that period. It appears that authors in this area are so sure that differences lead to negative outcomes that they "comment on" this difference, rather than research the difference itself.

One of the few exceptions of this is Yamamoto (1967). A previous study of 594 consecutive admissions to an outpatient clinic indicated that patients were being treated differently depending on race factors. The current study showed that therapists with low ethnocentricity more often treat ethnic minorities in proportions comparable with Caucasian patients. Therapists with greater feelings of ethnocentricity less often saw minority group patients in treatment. Ethnocentricity was measured by the Bogardus Social Distance Scale (BSDS). It is concluded that high ethnocentrism among therapists leads to an avoidance of minority group patients and consequently, negative outcomes.

As stated earlier, shockingly few studies have been conducted in this area. The remainder of cited

literature assumes that there are differences and they attempt to qualify them. It is also assumed by these authors that major differences will lead to markedly negative outcomes.

Adams (1950), for example, feels that the white therapist must penetrate the negro patient's defenses in order to reach the core of his personality. The therapist must ultimately draw the mentally sick negro patient away from his rationalizations. He must prepare the patient to face his hidden problems which are the same kind that cause anguish in men of all races.

Further commenting on the negro patient in therapy, Heine (1950) adds, "To dissolve the defense, the therapist must clearly communicate to the patient that he (the therapist) is interested in him only as an individual. This, we have said, is possible only if the therapist really does see the negro patients as individuals and not as symbols or representatives of the racial minority....When these barriers have been overcome, the treatment of the negro should not differ from the treatment of anyone else in this culture." Again, conclusions are drawn, not from experimental manipulation, but rather seemingly from experience.

Referring to a text by Seward (1956), the

Psychological Abstracts concludes, "The major part of the book deals with the psychodynamics of such minority groups as socioeconomic classes, Negroes, Jews, Indians and women, in an effort to provide them with appropriate treatment." The text implies that treatment is inappropriate as a result of the class or race of the client. It cannot be repeated too often that differences are assumed and vaguely documented.

Bernard (1953) feels that fuller knowledge of minority group patients' ways of life help in establishing effective communication and rapport throughout therapy. This may indeed be true and certainly points out that the author feels that racial differences can hamper therapy.

Conclusions

There are few documented studies in the area of race as a variable in therapy. All of the studies cited, however, have implied that dissimilarity causes the "majority" therapist and his clients additional obstacles to overcome. Major differences may lead to markedly negative outcomes, but certainly more documentation is essential.

PURPOSE OF THE STUDY

From the research previously cited, it is evident that there is much support for the concept of therapist-patient pairing. The majority of research has dealt with the global assessment of specific dimensions, (i.e., personality) as related to outcome. The literature previously cited suggests that global assessment is too broad and that specific factors, whether similar or dissimilar, should be related to outcome. The concept of pairing has been used primarily in relation to personality variables. However, as has been outlined, other variables such as social class, values, expectations and race can clearly be related to the concept of pairing. The use of the Social History Questionnaire (Best, 1971), allows us to employ the pairing concept with reference to a relatively new and uninvestigated area. Since pairing with respect to personality and the other cited dimensions seems so promising, it follows that additional dimensions, such as the Social History Questionnaire, could increase the probability of determining positive outcomes.

In the present study, the method of determining outcome was to allow each therapist to select five most improved, and five least improved clients. This design

is identical to the selection of clients used by Axelrod (1952). His study has been previously outlined. The only difference is that Axelrod has 10 psychiatrists select only four clients, two most improved and two least improved. This method of selection seems to be as adequate as other methods of measuring outcome. For example, the use of rating scales calls for a "value" judgement on particular dimensions, on the part of the therapist. We are unaware of what important aspects of outcome rating scales may understress, overstress, or what is essential or what is unnecessary. Other aspects of the inadequacy of rating scales include: the halo effect, proximity of ratings, central tendency, the contrast effect and the possibility of leniency. The measurement of outcome is indeed a difficult task. However, the present method appears to be a means of compensating for many problems in outcome measurement. We cannot overlook the fact that selection of clients is also a judgemental decision. However, the therapists all have large case loads. It is felt that because of the large reference group, there is sufficient discrimination between extreme ends of the improved and unimproved continuum to select two groups. In short, the moderately improved or moderately unimproved groups are omitted, and by this method extremes are adequately discriminated.

It should be noted that the groups in the pre-

sented study are of unequal numbers. This is a result of therapists selecting clients who have not taken the Social History Questionnaire.

The ultimate purpose of this type of study is to assess specific factors of the social histories of therapists and clients in order to produce more positive outcomes. In summary, we are interested in determining what "kinds" of patients work well, or have the most positive outcomes with what "kinds" of therapists. In terms of the similarity-dissimilarity hypotheses, it is postulated that some similarity, dissimilarity or neutrality will lead to either positive or negative outcomes, depending on the dimension in question.

METHOD

Subjects

Three therapists from the Coles County Mental Health Clinic were selected. The therapists' educational levels included an M.A. in Psychology, an M.S.W. and a Ph.D. in Psychology. Their experience ranged from 8-14 years and two were males and one was female. A total of 24 of their patients comprised the patient sample. The patients were both males and females and all patients were out-patients.

Assessment Instrument

The Social History Questionnaire (Best, 1971) was taken by all subjects. This instrument is a self-report test of a true-false design. It was designed to supplement or possibly take the place of the traditional intake interview. The Questionnaire is presented in Appendix "A" for the interested reader. Scales in the Questionnaire that were used include: Emotional Disturbance (ES), Thought Disturbances (TS), Behavioral Disturbances (BS), Psychosomatic Disturbances (PS), Marital Problems (MP), Childhood (CH), Education (ED), Relationship with Mother (RM), Relationship with Father (RF).

Procedure

All the therapists at the Mental Health Clinic were asked to select seven of their most improved and seven of their least improved clients. The rationale for this procedure as opposed to other measures, has been previously discussed. Four of the seven possible therapists submitted the required list. These four therapists were then asked to complete the Social History Questionnaire. However, only three therapists did complete it. The Social History Questionnaire is often used as a standard intake procedure at the Mental Health Clinic. The list of most improved and least improved clients was finalized by using only those clients who had taken the Social History Questionnaire.

Data Analysis

The three therapists' clients were separated into improved and unimproved groups. A t-test was conducted on each scale to determine if a difference existed between the two groups. A t-test was then conducted for each therapist's two groups, on each dimension.

The data was further analyzed by the D^2 method developed by Cronbach and Gleser (1953). This is the same procedure used by Mendelsohn (1966), Mendelsohn and Geller (1965, 1967) and Cook (1966). Similarity is equal to the square root of the sum of the squared differences between client and counselor scores on each dimension of the Social History Questionnaire. That is, for each scale, (1) the difference between the therapists' and clients' scores were calculated; (2) each difference was squared; (3) the total was calculated, (4) and the square root of this total was determined yielding a D^2 score for a particular scale. The smaller the D^2, the greater the similarity between the therapist and the client.

RESULTS

A comparison between the most improved and least improved groups of the combined patient sample is presented in Table #4. Inspection of the table indicates that there is a significant difference between the two groups on scales ES, RM and RF. Scales BS, PS, and CH are approaching significance.

The patients of therapist "A" did not show any statistically significant differences between the two groups, as outlined by Table #5.

The patients of therapist "B" differed on scale RF. Scales RM and BS begin to approach significance, but insufficiently, as outlined in Table #6.

The patients of therapist "C" differ significantly on scale PS. Table #7 indicates that no significant difference existed on the other scales.

Figures number 1, 2, and 3, and Table #8, represent the D^2 scores for each of the three therapists and their improved and unimproved groups.

It is noted for therapist "A" that his improved

TABLE 4

Comparison Between the Most Improved and Least Improved Groups of the Combined Patient Sample

Scale	t
ES	6.19
TS	.96
BS	2.03
PS	1.82
MP	1.51
CH	1.74
ED	1.56
RM	2.80
RF	3.26

critical t = 2.074 df = 22 $p < .05$

TABLE 5

Comparison Between the Most Improved and Least Improved Patients of Therapist "A"

Scale	t
ES	2.68
TS	1.66
BS	1.30
PS	2.34
MP	.90
CH	2.50
ED	1.39
RM	1.89
RF	2.06

critical t = 4.30 df = 2 $p < .05$

TABLE 6

Comparison Between the Most Improved and Least Improved Patients of Therapist "B"

Scale	t
ES	.23
TS	.15
BS	1.88
PS	.09
MP	.49
CH	.87
ED	1.17
RM	1.87
RF	2.18

critical t = 2.179 df = 12 $p < .05$

TABLE 7

Comparison Between the Most Improved and Least Improved Patients of Therapist "C"

Scale	t
ES	1.11
TS	.84
BS	.28
PS	2.91
MP	.89
CH	1.07
ED	0
RM	1.73
RF	1.29

critical t = 2.776 df = 4 $p < .05$

TABLE 8

D^2 Scores for Each Therapist on Each Dimension

Group	Scales								
	ES	TS	BS	PS	MP	CH	ED	RM	RF
	Therapist "A"								
Most Improved	10.29	4.24	4.47	5.38	0	4.47	2.24	1.00	4.12
Least Improved	27.46	8.06	3.60	13.89	11.18	10.82	7.28	4.12	6.08
	Therapist "B"								
Most Improved	38.86	15.29	4.47	10.95	5.19	19.82	7.54	9.32	25.21
Least Improved	43.53	17.66	21.67	11.57	7.34	12.92	13.15	11.04	18.76
	Therapist "C"								
Most Improved	27.82	9.27	5.39	3.46	7.68	5.74	6.56	1.00	5.48
Least Improved	36.05	11.66	7.35	12.85	14.86	12.25	8.54	6.40	4.24

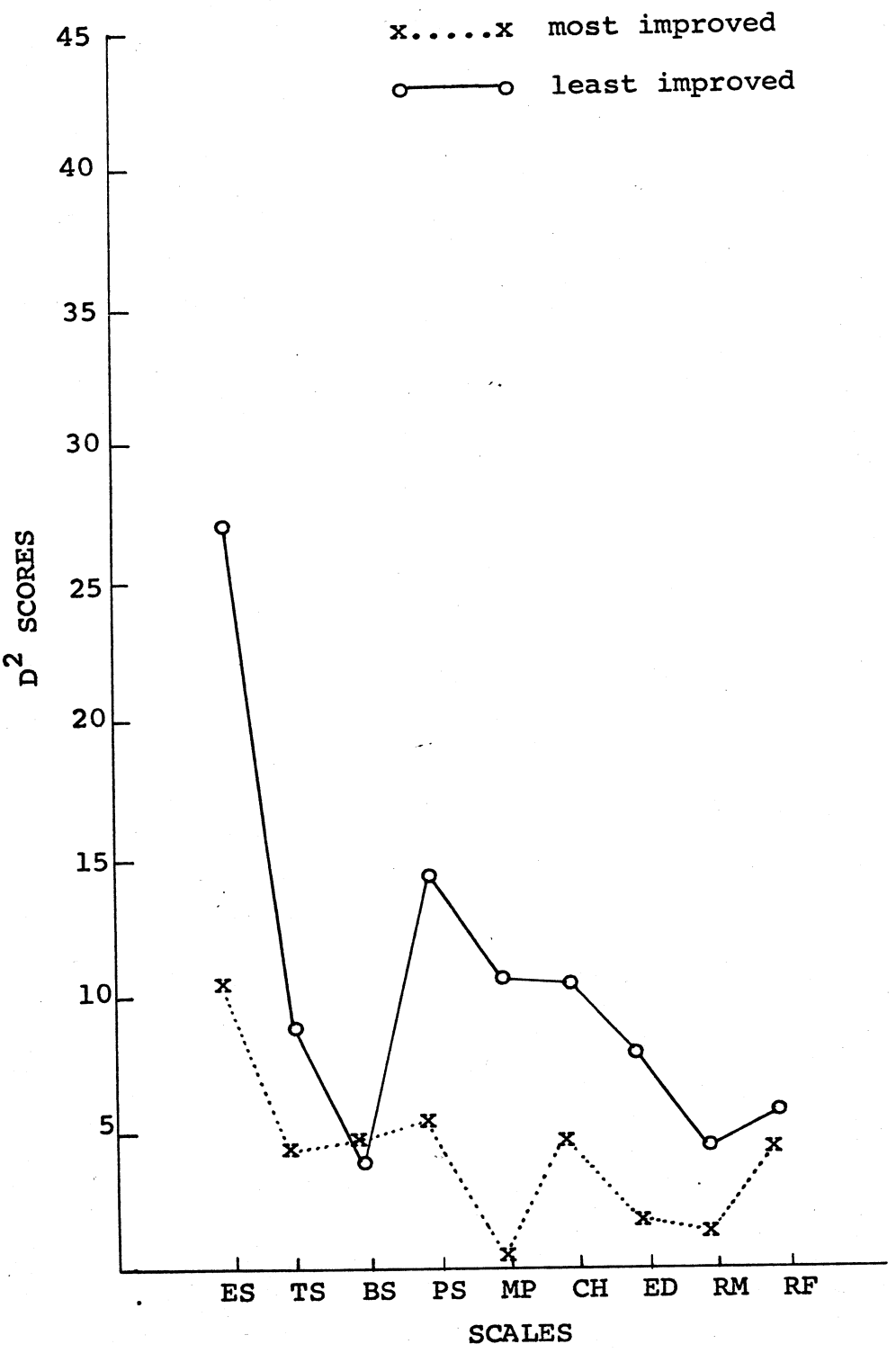

Fig. 1 D^2 Scores for Therapist "A"

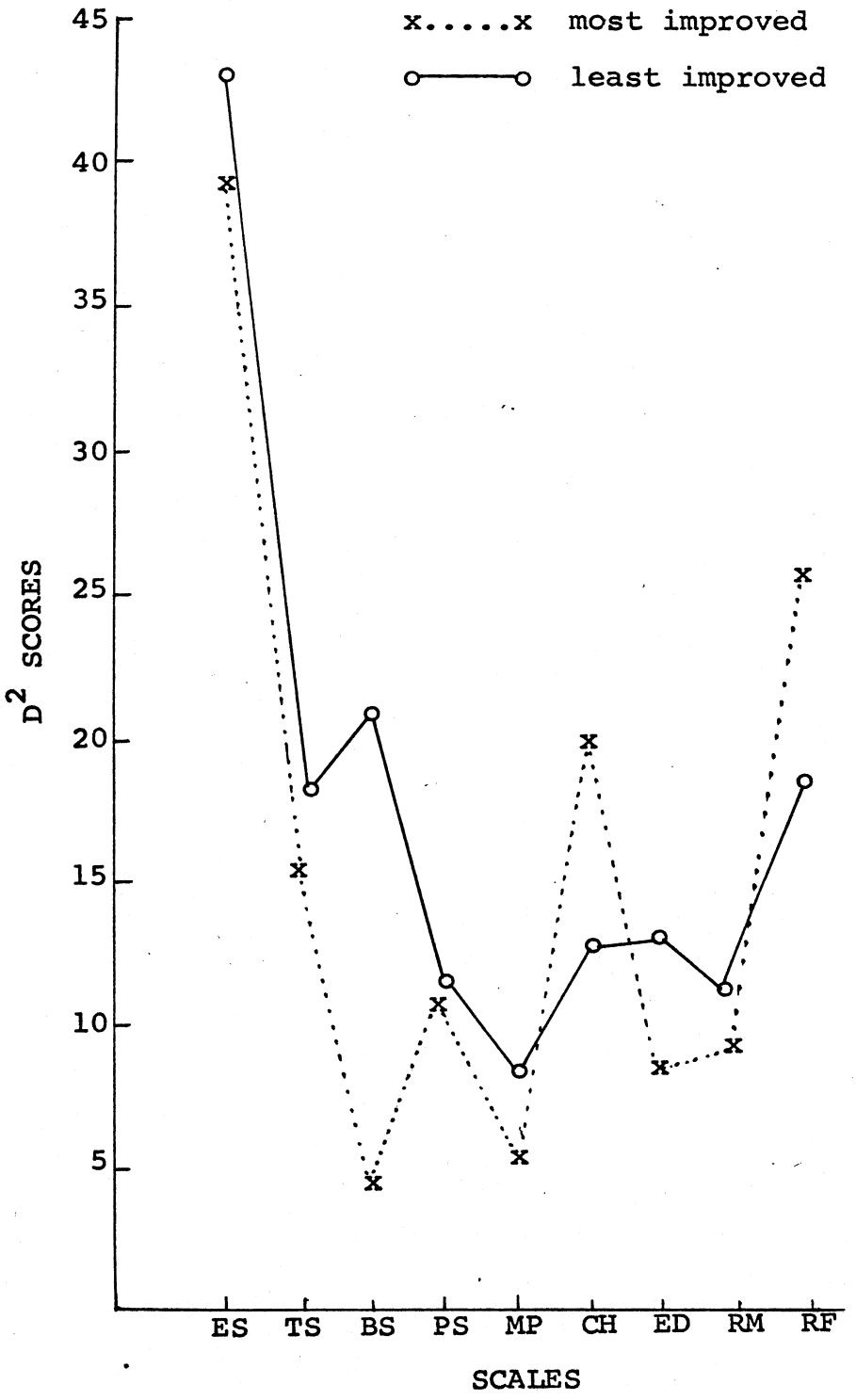

Fig. 2 D^2 Scores for Therapist "B"

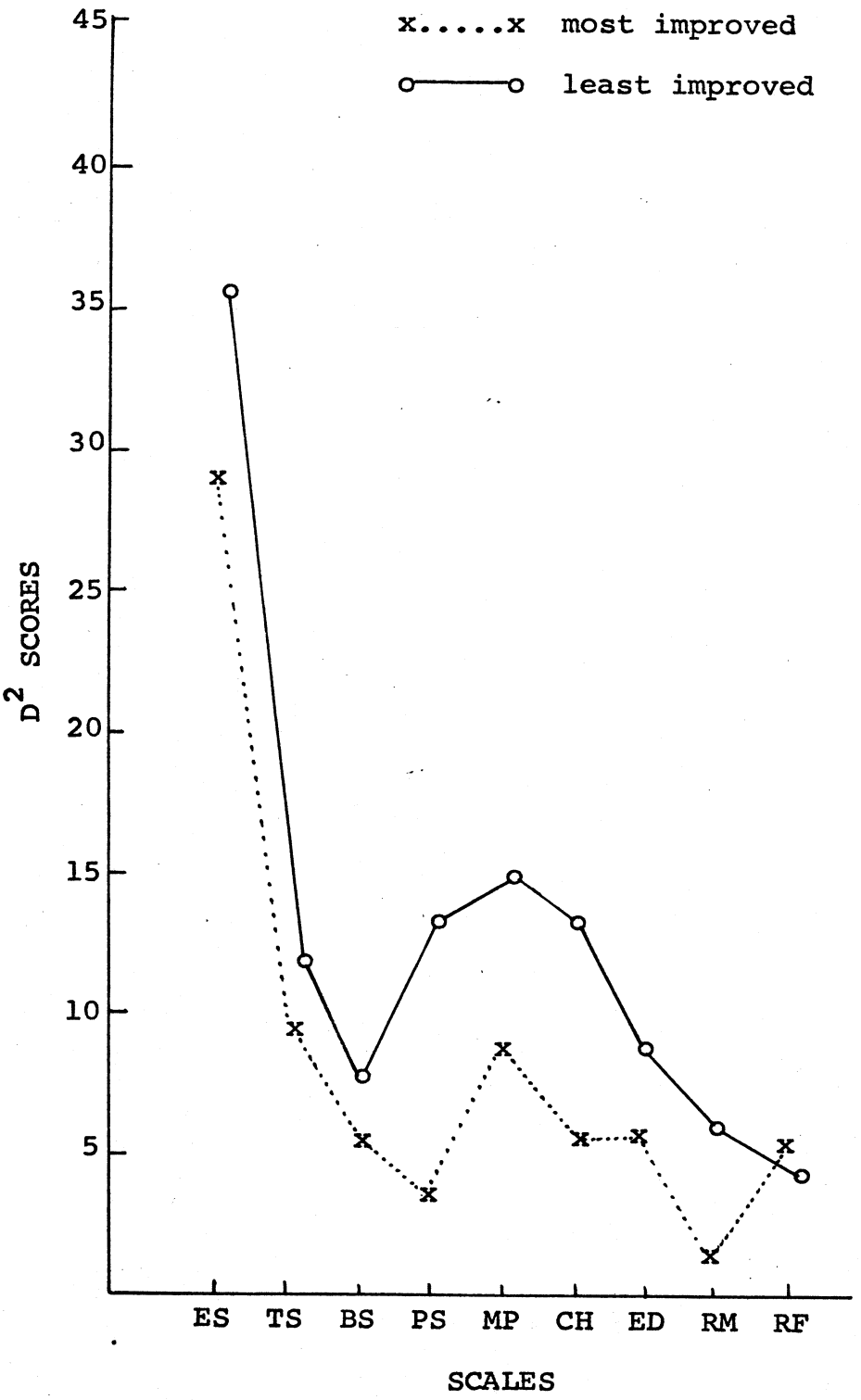

Fig. 3 D^2 Scores for Therapist "C"

group has a lower score on all scales with the exception of BS. That is, his improved group tends to be more similar to himself on each dimension except BS. Using the concept of "global" similarity, it may be said that therapist "A" appears to work better with people similar to himself, as indicated by the D^2. Furthermore, he would work best with people similar to him on all dimensions of the Social History Questionnaire, except BS where dissimilarity would tend to lead to positive outcome.

Therapist "B" generally follows the same pattern of overall or "global" similarity. That is, similarity leads to positive outcome. However, the unimproved group has scores similar to his on scales CH and RF. Consequently, the D^2 measure indicates that therapist "B" works best with clients who are similar on all dimensions, except CH and RF.

Therapist "C" again follows the similarity hypothesis in that her most improved clients have scores similar to hers. The only exception to this is scale RF where she has better results with patients dissimilar to her on this scale. Consequently, therapist "C" works best with clients similar to herself on all dimensions, except RF, where dissimilarity appears to lead to more successful results.

The preceding statements about the D^2 scores must be interpreted with extreme caution. They are most useful when there is a significant difference between the two groups on each dimension. The D^2 alone merely suggests and does not conclude.

No significant differences were found between the improved and unimproved groups of therapist "A". This implies that the type of client is immaterial for outcome of therapy with therapist "A", according to his t scores. However, his D^2 scores suggest that he works better with people similar to himself with the exception of scale BS. It is strongly noted that a small sample (N = 4) was used with this therapist. Consequently, a very large t (4.30) was required to reach significance. A larger sample may therefore produce different results.

With regard to therapist "B", it is crucial to note that a significant difference between his two groups existed on scale RF and that this scale is the only one where the unimproved group was more like the therapist. That is, for therapist "B", better outcome results will likely occur when a client has a similar score. To continue a step further, therapist "B", who had a poor relationship with his father, works less effectively with patients who also had poor father relationships.

The relationship between therapist "C"s t and D^2 scores allows us to make a conclusion regarding her PS scale. Namely, she works better with clients whose PS score is most like hers or she works best with clients with a low degree of psychosomatic complaint.

DISCUSSION

The concept of pairing or patient-therapist similarity or dissimilarity presents numerous methodological difficulties. The question of outcome has been debated by many experts. It appears that a "good" measure of outcome is far away. In terms of the present measure of outcome, it appears that the improved and unimproved groups generally come from the same population, or that the Social History Questionnaire does not discriminate between the two groups. However, when the data was pooled, we ended up with clients from three therapists whose measures of success or failure may differ. To further confound the problem, the number of clients was weighted by one therapist so that differences in outcome (if they do exist) were not equally balanced.

It is also important to point out that the sample size of the clients was not truly adequate. Therapist "A" had a sample of N = 4, which requires a very large t score for differences to occur, as was previously outlined.

One must always consider the instrument used when dealing with pairing or matching of clients and therapists. We would not expect a therapist to be high on scales such

as emotional disturbances and thought disturbances, as it would impair his functioning. However, scales such as CH, ED, RM and RF are certainly appropriate dimensions by which similarity can be measured.

Using the D^2 method of determining similarity, it is essential to note that overall or global similarity and not dissimilarity was the pattern in the present study. Again, a methodological problem is encountered. There are many "difference" measures and depending on the one used, different results may be obtained.

If we are determining what types of therapists work well with what types of clients, then the sample size of the therapists must be greatly increased. If, indeed, the long range effect of this type of research is to pair, then not only are large client samples needed, but also appropriate therapist samples. Ideally, we should be able to group similar therapists to determine if, in fact, they do work better with a particular client type. The ultimate goal in pairing or matching is to have a client take a test and assign him to a therapist on the basis of that test. A new or unexperienced therapist should be able to take a test and fit into a therapist type on the basis of his profile. From that type, we should be able to assign particular client types to him in order to achieve the most success-

ful outcome. We appear to be quite distant from this concept, however, research in the area appears to be promising.

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APPENDIX "A"

S O C I A L H I S T O R Y Q U E S T I O N N A I R E

This questionnaire contains a number of different statements. Read each statement and decide whether it is TRUE or FALSE for you.

Mark your answers on the special answer sheet you have. If a statement is true for you then put an X in the correct box under the T. If a statement is false for you, or if you do not agree with a statement, then put an X in the correct box under the F. If a statement does not apply to you or if you are uncertain about it then do not mark the answer sheet for that statement.

Be sure the number on the answer sheet is the same as the number for the statement you answer. Make your marks dark so they are easy to see.

Answer every statement as correctly as you can. Try to give some answer to each statement.

Randall H Best, Charleston, Ill. 61920

SOCIAL HISTORY QUESTIONNAIRE

1. My mental problems began very recently.
2. I have never been in trouble because of my behavior.
3. I like taking the responsibility for getting things done.
4. I cannot seem to get interested in anything.
5. I have threatened to kill someone.
6. I would much rather be alone than spend time with other people.
7. I often have strange ideas that do not make much sense to me.
8. I believe I know what my mental problems are and how they began.
9. I am very eager to please other people.
10. My mental problems have troubled me for a long long time.
11. I have been in trouble because of the bad things I have done.
12. I like to be the boss when I am with other people.
13. I get irritable whenever people make me do anything.
14. I sometimes buy things that could be used to kill people.
15. I am often disappointed by the things other people do.
16. I often believe things that are not true.
17. I do not know how my mental problems started.
18. I want other people to take care of me.
19. This is my first serious mental disturbance.
20. I have never been arrested.
21. I expect people to do whatever I tell them to do.
22. Sometimes I get so angry that I almost lose control of myself.
23. I have seriously planned to kill someone.

24. I often hold a grudge against people.

25. Sometimes I see things that are not really there.

26. There is very little that I can do about my problems.

27. I usually believe anything anyone tells me.

28. I had my first nervous breakdown after I was 25 years old.

29. I have been arrested several times.

30. I usually make a good impression on other people.

31. I have been in trouble at least once for getting into fights with people.

32. I tried to kill someone before.

33. I am often jealous of other people.

34. I sometimes hear voices talking when no one is there.

35. Most of my problems are caused by bad luck.

36. I am a very cooperative person.

37. Something bad happened to me and I have had a mental problem ever since.

38. I am not satisfied with my sex life.

39. Most of the time I act more important than I really am.

40. Most of the time I do not feel any emotion.

41. My husband (or wife) does not give me enough love and affection.

42. I have no close friends.

43. I have very few physical problems.

44. I have never received treatment for a mental problem before.

45. I let my friends tell me what to do too often.

46. I feel very little tension or anxiety.

47. I have been in trouble because of sex.

48. I expect everyone to admire me.

49. Sometimes my emotions are just the opposite of what they should be.

50. I often feel very lonely even when my husband (or wife) is with me.

51. I usually go out of my way to avoid people.

52. My health has been poor during the past six months.

53. In the past I received treatment for my mental problems at a mental health clinic.

54. I always agree with people.

55. I often feel tense and nervous.

56. I often have thoughts about sex that make me uncomfortable.

57. I have as much self-confidence as most people.

58. I always control my emotions and never lose my temper or get excited.

59. Sex is a problem in my marriage.

60. People are always making trouble for me.

61. I often worry about my health.

62. In the past I was a patient in a mental hospital.

63. I am a friendly person.

64. Lately I have been so scared and nervous that I could hardly stand it.

65. Sometimes I am sexually attracted to others of my own sex.

66. I am very proud and self-satisfied.

67. My emotions often change without warning.

68. My husband (or wife) and I argue almost all the time.

69. I believe other people are trying to hurt me in some way.

70. I often have trouble eating.

71. In the past I have been hospitalized on the psychiatric ward of a general hospital.

72. Most people like me.

73. I am tense and nervous almost all the time.

74. I have been involved in sex acts with others of my own sex.

75. Other people think I am conceited.

76. I often feel very happy and gay but then suddenly become very sad and depressed.

77. My husband (or wife) often criticizes me.

78. There is no one that I can really trust.

79. I often have stomach aches.

80. In the past I received private out-patient treatment for my mental problems.

81. I have many (more than ten) close friends.

82. Sometimes I get so nervous that I am unable to do things that I want to do.

83. I am a "social" drinker.

84. Most of the time I am not concerned about other people.

85. It is very hard for me to keep my emotions under control.

86. My husband (or wife) is very selfish.

87. I am easily embarrassed.

88. I have had problems with ulcers.

89. In the past I received individual psychotherapy.

90. I usually like people.

91. I often have sudden attacks of anxiety and severe tension.

92. Although I am not an alcoholic I could easily become one.

93. I tend to be a very selfish person.

94. Sometimes I lose all control of my emotions.

95. My husband (or wife) is very jealous.

96. It has always been hard for me to talk to people.

97. I have had problems with asthma.

98. In the past I have been in group therapy.

99. I am an affectionate person.

100. My problems with tension and anxiety began very recently.

101. I have a definite problem with alcohol.

102. I am a rather cold and unfeeling person.

103. Even though I know there is nothing to fear I am still afraid of one or two things.

104. My husband (or wife) is dishonest and cannot be trusted.

105. I am a very shy person.

106. Sometimes I have trouble breathing.

107. In the past I have been in family therapy with all (or most) of the members of my family.

108. I love everyone.

109. I have been tense and nervous for a long long time.

110. I am an alcoholic.

111. I am very strict with people whenever it is necessary.

112. I am afraid of many things even though I know there is no logical reason to be afraid.

113. My husband (or wife) has been unfaithful to me.

114. I often feel that I am just no good.

115. I often have trouble with back-aches.

116. In the past I received marriage counseling.

117. I am usually a considerate person.

118. I often feel very sad and depressed.

119. I have taken drugs but only as prescribed by a doctor.

120. I am impatient with other people when they make mistakes.

121. I often worry about things that are not really important.

122. My husband (or wife) is lazy and does not work hard enough.

123. I am almost always ashamed of myself.

124. I have trouble with rheumatism.

125. In the past I have taken medicine for my mental problems.

126. I almost always forgive people when they make mistakes.

127. Most of the time I feel sad, unhappy, and gloomy.

128. Taking drugs could become a problem for me if I am not careful.

129. I am often cruel and unkind with people.

130. It is almost impossible for me to stop my constant worrying.

131. Money is a big problem in my marriage.

132. I usually do whatever other people want me to do.

133. I have trouble with arthritis.

134. In the past I received shock treatments.

135. I usually try to comfort everyone.

136. I have many crying spells.

137. I have (or had) a problem with drugs.

138. I often criticize other people.

139. Sometimes I have to do certain things (like wash my hands) or else I get more and more nervous.

140. Drinking is a big problem in my marriage.

141. I am a mild-mannered peaceful person.

142. I am allergic to many different things.

143. I am satisfied with the treatment I received for my mental problems in the past.

144. I enjoy helping other people.

145. Whenever I am depressed I also feel tense and anxious.

146. I am addicted to drugs and will do anything to get them.

147. I am often angry with others and I let them know about it.

148. Sometimes it is hard for me to remember things.

149. My husband (or wife) makes me very nervous.

150. I almost always do what people want even when I really don't want to.

151. My skin is sensitive and I often break out in hives.

152. I believe the treatment here will help me with my mental problems.

153. I am too generous where other people are concerned.

154. I have had problems with depression for less than one year.

155. I often feel that life is not worth living.

156. I have been in trouble more than once for getting into fights with people.

157. I am often confused by the things that are happening around me.

158. My inlaws and I do not get along very well together.

159. I respect authority very much.

160. I have problems with high blood pressure.

161. I would like to have individual psychotherapy.

162. I often sacrifice myself for other people.

163. I have been depressed for a long long time.

164. I have attempted suicide even though I did not wish to kill myself.

165. People do things that make me angry enough to kill or seriously injure them.

166. Sometimes I do not know what day, month, or year it is.

167. It is very difficult for me to raise my children.

168. I am a dependent person who wants to be led by other people.

169. I have trouble with headaches.

170. I would like to be in group psychotherapy.

171. None of my brothers or sisters are married.

172. I do not believe I should be punished for anything I did in the past.

173. I have made at least one serious suicide attempt in the past.

174. I do not like it when other people boss me and tell me what to do.

175. Sometimes I do not know where I am even though I have been there before.

176. I spend less than the average amount of time raising my children.

177. I do so many things to get people to take care of me that they usually think of me as a clinging vine.

178. I often feel tired and listless.

179. I would like to have marriage counseling.

180. Not even half of my brothers and sisters are married.

181. I often feel very guilty.

182. If I ever tried to kill myself I would leave a suicide note.

183. I often complain about the way people treat me.

184. Sometimes I do not know who I am or what my name is.

185. I take more than average interest in raising my children.

186. I believe I have a mental problem that cannot be cured.

187. I often feel so tired that it is almost impossible for me to do anything.

188. I would like to take medicine for my mental problems.

189. Less than two of my brothers and sisters are still living.

190. I feel very guilty about some of the things I have done.

191. I have been unconscious for some time after a suicide attempt.

192. I rebel against doing almost anything that people want me to do.

193. I lost something very important to me within the last six months.

194. I pay less than average attention to raising my children.

195. I have at least one close friend.

196. Sometimes I have so much energy that I cannot rest but just have to keep going.

197. I would like to be hospitalized for my mental problems.

198. Less than four of my brothers and sisters are still living.

199. My childhood was happier than most.

200. My father was almost always kind and loving with me.

201. My parents often received money from a welfare agency or from charity.

202. I am employed at the present time.

203. I started school when I was about 6 years old.

204. My mother was almost always kind and loving with me.

205. My mother was a housewife during most of the time I was growing up.

206. I have about the same amount of energy that I always had.

207. When I was little I had few friends.

208. My childhood was very unhappy.

209. When I was little my father watched me almost all the time so I would not get into trouble.

210. My father had a steady job during most of his life.

211. I work part time now.

212. I liked school.

213. When I was little my mother watched me almost all the time so I would not get into trouble.

214. My mother worked outside the home when I was little.

215. Sometimes it is hard for me to do anything because I move so slowly.

216. Few people liked me when I was little.

217. I believe my mental problems began when I was a child.

218. My father usually let me do anything I wanted to do.

219. My father was often out of work when I was growing up.

220. I am unemployed at the present time.

221. I did not like school.

222. My mother usually let me do anything I wanted to do.

223. I always listened to my mother and did what she told me to do.

224. I think of myself as being in the "working class" of people.

225. I was very shy as a child.

226. When I was born my parents were pleased that I was a girl (or boy).

227. My father was too strict with me when I was growing up.

228. My father only has a grade school education.

229. I am retired at the present time.

230. In school I liked English and history.

231. My mother was too strict with me when I was growing up.

232. My mother only has a grade school education.

233. Most of the time I am satisfied with my marriage.

234. I was afraid of many things when I was little.

235. When I was a child my family was very large.

236. My father ignored me most of the time when I was little.

237. My father graduated from high school.

238. I have been steadily employed for a long time.

239. In school I liked math and science.

240. My mother ignored me most of the time when I was little.

241. My mother graduated from high school.

242. My husband (or wife) is the boss in our family.

243. When I was little I often refused to obey my parents.

244. I always got along well with my brothers and sisters when I was little.

245. My father neglected me when I was little.

246. My father graduated from college.

247. I never had any trouble holding a job.

248. In school I made good grades (mostly A's and B's).

249. My mother neglected me when I was little.

250. My mother graduated from college.

251. I live in or near the downtown section of my city.

252. I often had temper tantrums when I was little.

253. I have one or more brothers.

254. No matter what I did it was almost impossible for me to please my father.

255. My father continued going to school after he graduated from college.

256. I enjoy my work.

257. In school I only made average grades (mostly C's).

258. No matter what I did it was almost impossible for me to please my mother.

259. I lost someone very close to me during the last six months.

260. I live alone.

261. When I was a child I was so active and restless that I often got in trouble.

262. I have at least one sister.

263. My father almost never listened to anything I had to say.

264. My father was a heavy drinker.

265. I believe I would like working as a common laborer.

266. In school I made poor grades (mostly D's and F's).

267. My mother almost never listened to anything I had to say.

268. My mother was a heavy drinker.

269. I would return to the same place to live after being discharged from a mental hospital.

270. I had trouble with nightmares and bad dreams when I was little.

271. I was the oldest child in my family.

272. My father ruled the family when I was little.

273. My father often took drugs.

274. Semi-skilled work (such as practical nursing, meat cutting, or driving a taxi) is something I would like to do.

275. I failed at least one grade in school.

276. My mother ruled the family when I was little.

277. My mother often took drugs.

278. I have lived in the same place for more than one year.

279. When I was little I had trouble with bedwetting.

280. I was the middle child in my family.

281. My father almost always punished me whenever I was bad.

282. My father was unfaithful to my mother.

283. Skilled work (such as mechanics, carpentry, weaving, etc.) is something I would like to do.

284. I often skipped school.

285. My mother almost always punished me when I was bad.

286. My mother was unfaithful to my father.

287. I believe that people do not want me around any more.

288. I cried a lot more than most children do when I was little.

289. I was the youngest child in my family.

290. I never knew whether my father would punish me or just ignore the bad things I did.

291. My father had trouble with the law when I was little.

292. I would like to be a white collar worker (such as an office worker, bookkeeper, secretary, etc.).

293. I missed many days of school because I was too sick to attend.

294. I never knew whether my mother would punish me or just ignore the bad things I did.

295. My mother had trouble with the law when I was little.

296. I often feel annoyed and resentful toward my mother.

297. I was often cruel to animals when I was little.

298. I am an only child.

299. My father was cruel and brutal to me when I was little.

300. My father was usually in good health when I was little.

301. I would like to be a professional (such as a doctor, lawyer, or school teacher).

302. I was expelled from school at least once.

303. My mother was cruel and brutal to me when I was little.

304. My mother was usually in good health when I was little.

305. I went to a physician or mental health clinic for help with my mental problems before I came here.

306. When I was little I often set fires just for the "fun" of it.

307. I had no unusual childhood illness when I was little.

308. My father usually punished me too much when I was bad.

309. My father had much trouble with his health when I was little.

310. I believe I would enjoy dangerous work.

311. In school I often got into trouble with the teachers.

312. My mother usually punished me too much when I was bad.

313. My mother had much trouble with her health when I was little.

314. I would like to be a daredevil and do all kinds of dangerous things.

315. I attend church at least once each month.

316. I had no unusual accidents or injuries when I was little.

317. Even when I was bad my father almost never punished me.

318. My father had trouble with mental illness.

319. People expect more of me now than they did before.

320. I often had fights with the other children in school.

321. Even when I was bad my mother almost never punished me.

322. My mother had trouble with mental illness.

323. It is very difficult for me to talk to other people about myself.

324. I was at least 21 years old before I had my first mental problems.

325. When I was young my family often moved from one place to another.

326. My father usually punished me by giving me a spanking.

327. My father died before I was ten years old.

328. People expect less of me now than they did before.

329. In school I had few friends.

330. My mother usually punished me by giving me a spanking.

331. My mother died before I was ten years old.

332. I get along well with the other members of my family.

333. I did not have to wait very long before getting an appointment here.

334. My parents were divorced when I was a child.

335. My father usually punished me by scolding or by giving me a "lecture."

336. My father is still living.

337. I enjoy doing things at home such as watching T.V., gardening, or making minor repairs.

338. I have very little education.

339. My mother usually punished me by scolding or by giving me a "lecture."

340. My mother is still living.

341. I pay close attention to things other people say when I am in a group.

342. I almost always do the things that other people tell me to do.

343. During my childhood I was separated from one or both parents for several months.

344. Although my father often threatened to punish me he almost never did anything.

345. My parents were usually very warm and loving with each other.

346. I enjoy doing things outside the home such as going to parties, movies, sporting events, etc.

347. I have only been hospitalized once or twice for physical illness.

348. Although my mother often threatened to punish me she almost never did anything.

349. My parents were divorced when I was young.

350. My family and I do many enjoyable things together.

351. I have a good job in either the "trades," "skilled work," or "professions."

352. I did not live with my parents when I was a child.

353. I love my father.

354. My mother and father were almost always very pleasant to everyone.

355. I like to spend my free time in social activities.

356. I have never been treated for a head injury.

357. I love my mother.

358. I lived with my mother during most of the time I was growing up.

359. I believe most other people like me.

360. I have very few crying spells.

361. My mother died before I was ten years old.

362. I respect my father.

363. My parents argued much of the time while I was growing up.

364. I like to spend my free time either playing or watching sporting events.

365. I am a good person.

366. I respect my mother.

367. My mother remarried (if father died or left the family).

368. I get along well with the other people in a group.

369. I usually "jump" whenever I hear a sudden loud noise.

370. My father died before I was ten years old.

371. I have no particular feelings of any kind toward my father.

372. My parents sometimes hit each other when they were angry.

373. I like to spend my free time by myself.

374. I believe people with mental problems should be hospitalized.

375. I have no particular feelings of any kind toward my mother.

376. I lived with my father during most of the time I was growing up.

377. I am very cooperative when I am in a group of other people.

378. It is very difficult for me to get interested in doing odd-jobs around the house.

379. I dislike my father.

380. Sometimes my parents were separated when I was little.

381. I believe that whenever something happens it is for the best.

382. It was my own decision to get help for my mental problems.

383. I dislike my mother.

384. My father remarried (if mother died or left the family).

385. I get nervous and uncomfortable whenever I am in a group of strangers.

386. It is often hard for me to dress myself.

387. I always felt closer to my father than to my mother.

388. I was separated from one or both parents during childhood.

389. I am very proud of the many things I have accomplished in the past.

390. I do not want treatment for my mental problems to take very long.

391. I always felt closer to my mother than to my father.

392. There are many things wrong with my mind.

393. I like to know what I am going to talk about before I get into a group discussion.