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An Examination of the Personality Trait of Dependence as a Factor Influencing Social Work Practice

Evelyn J. Eisenberg
Wilfrid Laurier University

AN EXAMINATION OF THE PERSONALITY TRAIT OF DEPENDENCE AS A FACTOR INFLUENCING SOCIAL WORK PRACTICE:

A Research Proposal

A Research Essay

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By

EVELYN J. EISENBERG, B.A.

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ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

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CHAPTER I

RESEARCH PROPOSAL

Proposal Source

The embryonic conceptualization for this research proposal began to grow slowly in the writer's mind from the beginning of her professional training. It had three etiological sources: her own variable successes with different clients in treatment; empirical observation of the also variable results with clients experienced by her colleagues; and the literature she sought in the course of professional training, and in quest of a solution to the partly formed questions in her mind.

In the instance of the first two sources, she wondered t o what extent, she as a person, apart from social work experience, or lack of it, influenced the treatment successes or failures with certain clients that she experienced. She began to see that she certainly had more success in terms of subjective and objective outcomes of better client functioning with some clients than with others. Yet for herself and for other social workers, she was unable to pinpoint exactly what it was between social worker and client that contributed to ostensible "success" or "failure" in treatment.

It was evident that the supervisors in the agencies she worked chose the clients on intake for each worker, but by what criterion this matching procedure was performed, was obscure.

The literature the writer encountered and sought out to further elucidate the forming problem was extremely diverse, but did synthesize

her thinking into certain avenues or approaches. Several of these avenues led to the final conceptualization as it will be related herein. Several of the main themes in the literature related to her formulation by this research were these.

Charles Truax[1], an extremely prolific researcher in the preface to a collection of his research studies states that counselling on psychotherapy "is aimed at producing constructive behavioral and personality change in the clients it seeks to serve". He adds that its rapid growth implies a high degree of effectiveness, but an amount of evidence suggests that counselling or psychotherapy is not superior to "no treatment" at all. He quotes Eysenck's[2] research to the effect that the average result of most counselling is ineffective.

On the other hand, Barrett - Lennard defined what he felt to be significant aspects of a helping relationship:

> " . . . a helping relationship is any relationship in which one person facilitates the personal development or growth of another, where he helps the other become more mature, adaptive, integrated, or open to his own experience".[3]

He sees six related but distinguishable aspects of the relationship:

1. empathic understanding,
2. the helper's attitudes,
3. care and respect for the client, which is,
4. unqualified as well as
5. availability to the client, and
6. congruence within the relationship.

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[1]Truax, C. B., Counselling and Psychotherapy Process and Outcome (Arkansas Rehabilitation Research & Training Centre, University of Arkansas, 1966), p. 1.

[2]Eysenck, H. J., The Effects of Psychotherapy: an evaluation 1952.

[3]Barrett - Lennard, G. T., Significant Aspects of a Helping Relationship (Ottawa: 1965)

[4]Ibid.

several of these are very similar to the points made by Rogers in Client - Centred Therapy.

Carkhuff and Berenson, who have surveyed the available literature, and researched questions of the efficacy of counselling, have examined Truax's work, and extended it, preface one of their books thusly:

> "If counselors and psychotherapists functioned in real life the way most of them do in the therapeutic hour, they would be patients. The professional helpers to whom we turn because human sustenance is not available in the general environment are themselves functioning at ineffectual levels of those dimensions related to constructive change or gain. Beyond their counselling and psychotherapy, their distorted perceptions and communications lead to the deterioration of their own significant human relationships. They find the same lack of personal fulfillment in their daily living that their clients do. Perhaps more important, they cannot allow the clients to find more in life than they themselves have found."[5]

This cogent and compelling statement on the rather awesome responsibility of the therapist to his client via his own personal development, coupled with Fox's identification of several traits of the alcoholic personality, led the writer to a final sythesis of the research question.

Fox[6] noted four characteristics of alcoholic personalities that had important implications for their treatment. All are vestigial infantile traits.

One is the low threshold for tension management on dealing with feelings of rejection.

Another is hostility, especially toward those closest to the alcoholic.

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[5]Berenson, B. G. and R. R. Carkhuff, Beyond Counselling and Psychotherapy (N.Y., Holt - Rhinehart, Winston, 1967) p. 11.

[6]Fox, Ruth, Aspects of Alcoholism (Montreal, Lippincott, 1966) vol. 2 p. 21.

A third trait is eccentricity in the feeling of separateness from others, in that the only reality of interpersonal relationships is by way of the gratification of needs.

The fourth trait is dependency. Fox uses the example of the efficacy of Alcoholics Anonymous. The alcoholic needs to believe in a being above him to take care of him.

It is evident that dependency, being the prime infantile trait, forms the interconnecting matrix underlying the behavioral traits of the alcoholic patient. Dependency then, seemed to this writer to be a prime focus in treatment of the alcoholic patient, and that final outcome of treatment would possibly be an indication of how well or how poorly the therapist proved able to work with the patient toward dealing with and resolving this residual infantile trait.

Since the extent to which the therapist has mastered his own conflicts and needs, and is able to seek fulfillment in his own life, affect his functioning in the therapeutic hour, as Berenson and Carkhuff feel, the writer attempted to link what is known about the alcoholic patient to what is unknown about his therapist. As a result, the writer began to question to what extent a therapist with an unresolved conflict could assist a client with the same conflict.

Proposal Relevance

Perhaps for too long social workers have assumed that along with professional training the student also resolves his conflicts about certain areas of his own functioning. Supervision is an implied safeguard to ensure that the beginning professional will have an added opportunity to gain further knowledge in application of his skills.

However, no systematic approach has been instituted to specifically assist a new social worker with conflicts which could have very significant bearing on his treatment methods and results.

A valid question then, is whether a social worker, within the existent educational and practice system, is enabled to resolve his own conflicts. In addition, has the profession assumed a proficiency its practitioners do not in effect possess?

Taking another glance at therapeutic effectiveness, Truax and Carkhuff conclude after conducting well-controlled studies that counselling and psychotherapy have no overall positive effect; however, valid specific instances do exist in which individual therapists and clinics are indeed positively effective.[7] These results mean that to obtain a zero effect, some clients must have been helped, and others harmed. Therefore, they add from their review of available evidence, that on the average, therapeutic enterprise may be harmful as often as helpful, with an average overall effect comparable to no professional help.[8]

Eysenck wrote this about the problem in 1952 after conducting a survey of the treatment results of neurotic patients by three treatments:

> "Patients treated by means of psychoanalysis improve to the extent of 44 per cent; patients treated electrically improve to the extent of 64 per cent; patients treated only custodially or by general practitioners improve to the extent of 72 per cent. Thus there appears to be an inverse correlation between recovery and psychotherapy; the more psychotherapy, the smaller the recovery rate".[9]

The qualification for this statement are these: in the first two treatments, the incidences of "not improved" and "stopped treatment" have been included; the survey results were compared with the best available estimates of recovery without benefit of therapy.

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[7] Truax, op. cit.

[8] Ibid.

[9] Eysench, H. J., The Inefficiency of the Therapeutic Processes with Adults in Berenson, B. and R. Carkhuff Sources of Gain in Counselling and Psychotherapy (New York: Holt, Rhinehart, Winston, 1967)

Truax and Carkhuff recommend that more specified research into the particular areas elucidated by their studies be conducted. Further study is needed for several valid reasons.[10]

The evidence suggests that relatively unspecified kinds of therapists are effective. As well, clients receiving counselling or psychotherapy show great variability in terms of positive or negative changes in therapeutic outcome.

A third factor pointing to a need for further research is the fact that what is in fact labelled "counselling" or "psychotherapy" is a heterogeneous collection of psychological conditions producing varying degrees of positive and negative change in the client. This latter point suggests that research can make significant impact on the effectiveness of the rehabilitation process by concerning itself with identifying, isolating, and measuring and relating to client therapeutic coutcome the dimensions of the therapeutic process.[11] To this end, Truax studied counselling performed with college underachievers, juvenile delinquents, neurotic out-patients, and psychotic in-patient populations.[12] The important variable he found that facilitated positive therapeutic gains in the patient was the counselor's interpersonal skill in providing certain basic therapeutic conditions. These conditions he found to be

1. accurate empathic understanding,
2. non-possessive warmth, and the
3. therapist's genuinenness, congruence, and integration within the relationship.

The proposed research study will examine whether or not there is any relation between the therapist's personality traits and his functioning with certain clients. An exploration of therapeutic outcome with

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[10] Truax, op. cit.

[11] Ibid.

[12] Ibid.

alcoholic patients who have extreme dependency needs may elucidate therapist variables associated with providing facilitative therapeutic conditions. The main variable to be examined is that of the therapist's own dependency needs.

Relation to Social Work Practice, Knowledge, Research

The major implications of this research proposal for practice are several: first, it is not only sensible but imperative that clinics and agencies identify effective and ineffective or even harmful individual practitioners.[13] Such an identification can only benefit the client and the public good. Thus for, individual practitioners records have almost never been attempted, perhaps due in large part to the resistence of the helping professions to accept the difficult concept that counselling and psychotherapy can be harmful as well as helpful.[14]

Presently, in practice we know that supervisors in certain agencies choose cases on intake in some fashion for their social workers. This is not a standardized method of selection. More knowledge concerning the worker in relation to certain types of cases or clients could facilitate this process, thereby improving service to the client.

In order to do this, we must know more about how personality traits function in the social worker - client relationship. In supervision also, areas involving personality traits may be mapped out for more intensive examination by the social worker and his supervisor. In this way, findings could facilitate growth of the individual social worker, thereby improving his therapeutic flexibility and widening his face to face relationship skills.

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[13] Ibid.

[14] Ibid.

A completed study by Bergin and Solomon looked at the question of the personality of the therapist in relation to his therapeutic functioning. Direct implications for practice can be drawn from such research. The authors examined the relation between personality and performance correlates of empathic understanding specifically in therapy.[15] They report that their data confirms their hypotheses that personality disturbance in the therapist is related to lowered levels of accurate empathy.

Jerome Frank's discussion of the dynamics of the therapeutic relationship further defines the relevance of continued study to social work knowledge and practice. He states that:

> "All forms of psychotherapy, whatever their underlying theories, and whatever techniques they employ, attempt to promote beneficial changes in a patient's attitudes and symptoms through the influence of a therapist with whom the patient has a close relationship."[16]

Frank has noted here that the close relationship between patient and therapist is an integral part of treatment. As well he goes on to clarify a rarely mentioned but extremely crucial facet - that of the inherent, structured, dependency within the therapeutic situation itself. He writes:

> "All forms of psychotherapy seem to produce certain similar effects based on a quality common to the relationships they offer. This common feature is the patient's reliance on the therapist to relieve his distress."[17]

He describes this situational dependency in four contexts: culturally, the treatment situation itself, therapist variables, and patient variables.[18]

Briefly, Frank notes that cultural attitudes define illness and its treatment. At present, the dominant treatment for mental illness in our

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[15] Bergin, A.E. & S. Solomon, Personality and Performance Correlates of Empathic Understanding in Psychotherapy. Paper read at American Psychology Association, Philadelphia, September, 1963.

[16] Frank, Jerome D., The Dynamics of the Psychotherapeutic Relationship, Psychiatry, February, 1959.

[17] Ibid.

[18] Ibid.

culture is psychotherapy, and the best qualified dispenser of treatment is considered to be the psychiatrist. This factor has been studied extensively by Thomas Szasz in his thought - provoking treatise on the subject - The Myth of Mental Illness.

The treatment situation is structured whereby aspects of the situation give cues to the patient in order to impress him with the importance of the procedure he is about to undergo. The intake interview itself is a form of preparation - a kind of rite of passage. The cues and procedures impress the patient with the importance of treatment, and its promise of relief. Like hospital admission which clearly emphasizes the staff's control over the patient, so do intake procedures train the patient to assume a dependent role in the acceptance of treatment from an "expert".

Of therapist factors influencing psychotherapy and its efficacy, Frank feels:

> "In addition to as yet ill-defined personal characteristics, two attitudes of the therapist foster the patient's confidence in him. One is his faith in the patient's capacity to benefit from treatment, which is implied in the mere act of accepting him as a patient. The therapist's acceptance of the patient may be influenced by his own feelings . . . "[19]

The writer takes Frank to mean here that personal characteristics of the therapist of which we know relatively little, may influence his attitudes toward certain patients, and thus his eventual treatment outcome with them. Frank adds that the therapist's feelings about certain patients

> " . . . Make some psychotherapists unwilling to accept alcoholics or patients with anti-social disorders for treatment . . . "

> " . . . The other therapeutically patent attitude of the therapist is his confidence in his theory and method of treatment."[20]

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[19] Ibid.

[20] Ibid.

Perhaps the therapist's confidence in his methods breaks down when faced with certain patients. It seems imperative that we understand this relation.

And of the patient variables affecting the relationship:

> "The extent to which the patient accepts the cues offered by the culture, the treatment situation, and his therapist as prepresenting potential relief depends, of course, also on his own attributes. Many complex and as yet poorly understood factors influence a patient's ability to develop trust in his therapist."[21]

Frank adds that perhaps a major personal determinant of the patient's faith in treatment is the degree of his distress which may

(i) increase his "hunger" for relief, or

(ii) the distress may be a sign that he is trusting therapy - willing to expose his weakness and vulnerability.

It is evident that much is unknown about the inter-relationship in the treatment dyad, which has led to conjecture and speculation.

Some of the most illuminating research relative to this research proposal has been done by Truax, and his associates. They have developed several therapist rating scales: the "Accurate Empathy Scale", the "Non-possessive Warmth" or "Unconditional Positive Regard Scale", and the "Therapist Genuineness or Self-Congruence Scale", all developed in 1961 and 1962.

They utilized these scales, and pre and past therapy tests of patient change, which they define as the "degree of change in personality functioning based primarily on the Rorschach and M.M.P.I. given before therapy and late in therapy."[22] They found a strong tendency for therapists of improved patients to be rated at consistent high values of

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[21] Ibid.

[22] Truax, Ibid.

accurate empathy throughout treatment as based on the "Accurate Empathy Scale". Patients showing deterioration had therapist's with lower levels of accurate empathy throughout therapy. An analysis of the resultant distribution indicated highly significant differences (p. c. 01) between the two groups of patients - the most improved as opposed to the deteriorated patients.

Truax also reports that the level of "Accurate Empathy" in therapy was significantly higher for successful cases than for failures at the same level of significance (p. c. 01). Therefore, he concludes a positive relation between "Accurate Empathy" and outcome of therapy.[23] In his work toward resolving the question of causation, Truax suggests that his total studies suggest that therapists who exhibit "Accurate Empathy", "Non-Possessive Warmth", and "Genuineness", are effective therapists. The greater extent to which these elements are present in the therapeutic encounter, the greater is the resulting constructive personality change in the patient. He emphasizes that these findings are stable for a variety of therapists, regardless of their training or theoretical background orientation, as well as for a wide variety of patients, in a variety of therapeutic contexts in individual and group counselling.

Further analysis was performed on the following questions:

1. Who causes the therapist to be accurately empathetic, non-possessively warm and genuine?
   Is it the patient or therapist who determines the level of "Accurate Empathy" that occure in the relationship?
2. Do therapist offered conditions determine the depth of patient engagement in the process of self-exploration?

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[23] Ibid.

In an analysis of the data gathered when many different therapists see one patient, it emerged that different therapists produced different levels of non-possessive warmth (p c. 01) and genuineness (p c .05).[24] Different patients did not tend to evoke different levels of non-possessive warmth (p c .40) or genuineness (p c .50)

Truax's findings then point to a significant amount of the responsibility residing within the therapist to provide a facilitating atmosphere for the patient's personality change. Truax himself sees the implications of his research thusly: he feels that the rehabilitation process will be facilitated by eliminating "psychonoxious" therapists. For, as he has found, therapist's able to communicate a high level of "Accurate Empathy", "Non-Possessive Warmth" and "Genuineness", produce constructive behavioral and personality change in their clients. Those therapists unable to communicate thusly by reason of training or personality tend to be damaging to their patients.

The importance of further research into the social worker - client relationship to extend the profession's body of knowledge and its practitioner's practice skills is clear - for one, the findings are directly applicable to the training of effective therapists.

As well, on a holistic basis, Truax's words seem most relevant:

> "Certainly it seems likely that if we can identify and quantify the effective elements in the psychotherapeutic relationship, then the same approach and tools can be used to identify the same elements in the parent - child relationship, the husband - wife relationship, or indeed in any other human encounter.
>
> In essence, the implication is that the more we learn about how to help people, the more we also know about how not to hurt people. Thus psychotherapy research is of potentially enormous significance to society in its contribution to facilitation of constructive development of the human individual."[25]

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[24] Ibid.

[25] Ibid.

CHAPTER II

SURVEY OF RELEVANT LITERATURE

Introduction

The literature surveyed in the following pages explores the salient material published in the professional and scientific writings of social work, psychology, psychiatry and psychoanalysis.

Research studies and writings have been examined in relation to the therapeutic encounter itself, the problem of assessing outcome of therapy, therapy with alcoholic patients, the main studies that have examined the significance of therapist variables to therapeutic outcome, and finally an exploration of Henry A. Murray's personology, specifically his "need concept" - the theoretical framework upon which this research proposal is based.

Of the writers examining the therapeutic situation itself, most can be grouped into four theoretical bases - psychoanalytic, client - centred, behavioral, and eclectic.

The main theorists examining this question are Alexander,[1] Halpern and Lesser,[2] Ferenczi,[3] Fenichel,[4] Fliess,[5] Fromm - Reichmann,[6] Reik,[7] and Sullivan.[8]

Among the client - centred theorists are Jourard,[9] Rogers,[10] and Truax.[11] Walpe[12] and Eysenck[13] are the behaviorists, and the eclectics

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[1]Alexander, F., Fundamentals of Psychoanalysis (New York: W.W. Norton, 1948)

[2]Halpern, H. & L. Lesser, Empathy in infants, adults and psychotherapists, 1960

[3]Ferenczi, S., The Principle of relaxation and neo - catharsis, 1930

[4]Fenichel, O., The Psychoanalytic Theory of Neuroses (New York: W.W. Norton, 1945)

[5]Fliess, R., The metapsychology of the analyst, 1942

[6]Fromm - Reichmann, F., Principles of Intensive Psychotherapy, (Chicago: University of Chicago Press, 1950)

[7]Reik, Theodor, Listening with the Third Ear, (New York: Farrar, Strauss, 1949)

[8]Sullivan, H.S., Concepts of Modern Psychiatry, in Psychiatry, 1940

[9]Jourard, Sidney M., The Transparent Self (Princeton, N.J.: D. Van Nostrand Co. Inc., 1964)

[10]Rogers, C.R., Client - Centred Therapy (Cambridge, Mass.: Riverside Press, 1951)

[11]Truax, C. B., Ibid

[12]Walpe, J., Psychotherapy by Reciprocal Inhibition (Stanford, California: Stanford University Press, 1958)

[13]Eysenck, H. J., Ibid

number among them, Fox and Goldin,[14] Hobbs,[15] Strunk,[16] Strupp,[17] and Truax[18] and Carkhuff.[19] All these theorists stress the importance of the therapist's ability to do the following:

1. Sensitively and accurately understand the patient, and empathetically know his "inner world", and communicate both to the patient;
2. To communicate warmth and acceptance; and
3. Communicate his own genuineness and integration within the therapeutic encounter.[20]

Psychoanalytic Theorists

Fromm - Reichmann,[21] a psychodynamic theorist notes the following as important components of the therapeutic technique:

1. The clarification of a patient's difficulties with others through observation and investigation of the vicissitudes of the mutual inter-relationship between doctor and patient;

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[14] Fox, R.E. & Goldin, Ibid

[15] Hobbs, N., Sources of gain in psychotherapy, in American Psychologist, 1962

[16] Strunk, O.J., Empathy: A review of theory and research, Psychology Newsletter, 1958

[17] Strupp, H.H., Nature of the psychotherapist's contribution to the treatment process, 1960

[18] Truax, C.B., Ibid

[19] Berenson, B. F. & R. R. Carkhuff, Ibid

[20] Truax, C. B., Ibid

[21] Fromm - Reichmann, F., Ibid

2. The encouragement of recall of forgotten memories;
3. The investigation and scrutiny of the anxiety connected with such recall, including the patient's resistence against this recall, and his security operations with the psychiatrist who tries to effect it;
4. Between memories, patient's and doctor's interpersonal experiences, the patient's communications are interpreted with regard to their unconscious genetic and dynamic implications.

In this passage Fromm - Reichmann has emphasized the interpersonal relationship between doctor and patient as vehicular to the analytic process. She speaks of this relationship further: the goal of intensive therapy is to

1. Alleviate the patient's emotional difficulties in living, and,
2. To eliminate the symptomatology via insight into and understanding of the unconscious roots of the patient's problems, genetically and dynamisally, by the patient and doctor. Such understanding and insight frequently promotes changes in the dynamic structure of the patient.[22]

She feels then that interpretative give and take, and discharge by affect and insight relieves the patient, as well as the non-verbal interplay between patient and doctor.[23] In sum, she sees psychotherapy as an interpersonal process between patient and therapist, having two prerequisites. First, there must be respect extended to the patient by his doctor, and secondly, the problem of the interview is to facilitate the access to awareness of information about interpersonal problems in order to clarify for the patient troublesome aspects of his life and to ultimately resolve his symptomatology.[24] In her book, Principles of Intensive Psychotherapy, she directly addresses the problem of dislike

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[22] Ibid.

[23] Ibid.

[24] Ibid.

of certain patients by the therapist. The root of this problem, she feels, is the patient's ability to touch off the therapist's own unresolved anxieties.

The examples used to illustrate this process are the following: the schizoid therapist will likely experience difficulty with a manic-depressive patient's mood swings; a maternal therapist will bother an aloof patient who is trying to get away from a mother's overprotection. A therapist who is by personality timelessly curious will usually have better results with psychotic patients.[25] It follows then, as she notes, that a therapist should learn what type of patients respond best to his personality, as it colors his type of therapeutic approach.[26]

In this research proposal, this writer is attempting to explore further the points Fromm - Reichmann has made. If the patient touches off his therapist's own unresolved conflicts, and if personality colors a therapist's therapeutic approach, an examination of outcome with alcoholic patients who could touch off a therapist's unresolved dependency needs would be one method of examining the inter-relation Fromm - Reichmann has been discussing.

Social Work Theorists

Hollis, one of the most prolific writers in social work has also examined the client - worker relationship in the dynamics of treatment. She writes:

> "On the worker's part, no matter what the form of treatment, the attitude must be a positive one, with concern for the client's well-being, liking, respect, and acceptance of him as an individual, and a wish for him to be happier, or at least more comfortable. For himself, it must include confidence in his skill and in the possibility of its effectiveness in aiding the client. The more full the worker is of counter transferance of any sort, the more likely it is that client will sense that he can trust the worker to influence him.[27]

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[25] Fromm - Reichmann, F., Ibid

[26] Ibid.

[27] Hollis, Florence, Casework: A Psychosocial Therapy (N.Y.: Random House, 1964)

Unfortunately, there are few recommendations for assisting the worker to deal with a situation that does not approximate this ideal or how he is to ensure his freedom from negative counter - transferences, although Hollis does mention that casework training has not in itself prepared workers for psychoanalytic therapy, but may have rendered a good base from which to proceed. She notes also that a careful personal analysis is a basic requirement for work with the unconscious.[28] As we have seen, whether or not the unconscious is the focus of therapy, the therapist's personality influences the treatment he renders certain patients. Hollis examines this factor in this manner:

> "The worker is also sometimes unrealistic in his reactions to the client. He, too, may identify the client with an early or later figure in his life, or may bring into the treatment relationship distorted ways of relating to people that are part of his own personality. Although a very important part of the worker's training consists in developing awareness of these tendencies in order to keep them at a minimum, they are never completely overcome and may therefore be part of the reality to which the client is reacting.[29]

Whereas Hollis is aware of this detrimental aspect in the relationship, beyond supervision, as yet no educational or professional safeguards are utilized to aid both client and worker in such a situation. In attempts to further study exactly what does go on in the worker - client interview, Hollis examined case records to find out what the worker did in each case.[30] Six categories of specific techniques emerged:

A. sustaining,

B. use of authority to express an opinion,

C. exploratory conversation for ventilation,

D. reflection - thinking about the pattern of a situation,

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[28] Ibid.

[29] Ibid.

[30] Hollis, Florence, Explorations in the Development of a Typology of Casework Treatment, Social Casework, Vol. XLVIII, #6, June 1967.

E. looking at personality structure, and

F. reflective consideration about significant events in the client's past.

By content analysis, 40% of the interactions fell into the C and D areas, while B was used approximately 6%, and E and F less than 1%. This study seems a step in the right direction, and a further area of concern might be to examine which therapists use certain techniques, and why, if this is related to client need and treatment focus, or therapist variables.

Margaret Cork, a social worker who has for many years worked with alcoholic and addicted patients has several interesting points to make about the patient's characteristics, and the therapist's role with these patients. She states:

> "Other studies would seem to indicate that there is no one alcoholic personality, but it would appear that most alcoholics do have certain common characteristics which, together with the continued excessive drinking, play a significant part in the quality of family life which may be experienced by all members."[31]

She notes, however, that certain common characteristics are often overlooked by the social worker is treatment of the alcoholic. These are:

1. an inability to take proper responsibility,
2. a lack of self - discipline,
3. an over - dependency,
4. a pre-occupation with self,
5. a negative attitude toward authority,
6. a sense of inadequacy,
7. an unrealistic, immature approach,
8. limited interests,
9. shallow or superficial ways of relating to people.[32]

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[31] Cork, R. Margaret, Alcoholism and the Family, paper read at the Alcoholism and Drug Addiction Research Foundation Annual Course (London: University of Western Ontario, May, 1964)

[32] Ibid.

Of the third, over - dependency, is one which Cork feels cannot be met or accepted by other family members and which makes it difficult or impossible for the alcoholic to meet the normal dependency needs of his children.[33] Of the therapist in relation to his treatment of alcoholic patients, Cork is very clear:

> "In general the therapist . . . should be warm, interested, giving individuals who at the same time are able to see and maintain reality - oriented limits. They should be relatively free from prejudices toward drinking or fears of drunkenness as well as from inhibitions that prevent frank discussion of the drinking problem. A moralizing or punitive attitude toward the alcoholic's drinking or acting - out behavior can limit the effectiveness of treatment. Those attempting to help these very insecure dependent individuals should be comfortable in assuming, to a degree, the role of a good or wise parent. . . . as with all parents, the therapist should be able to lessen the dependent relationship appropriately and free the patient to become a relatively more independent person . . . Frequently the dependency is so great it may be a threat to some insecure or inexperienced therapists, and the more mature qualities and strengths are not fully recognized or used."[34]

Cork's observations and experience would seem to bear out suspicions that the therapist's own dependency needs may prove an important variable in therapeutic outcome with these patients.

Another social worker, Lillian Ripple reports on methods used in studying therapeutic outcome. The criterion for outcome studied answered the following question:

> "How well off was the client at case closing with respect to the problem which he brought to the agency and with respect to his general adjustment?"[35]

Ripple states that considerations of both absolute and relative status are involved in the three criteria:

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[33] Ibid.

[34] Ibid.

[35] Ripple, Lillian, Motivation, Capacity and Opportunity - studies in Casework theory and Practice, (Chicago: University of Chicago Press, 1964).

1. level of adjustment at case closing,
2. change in level of adjustment from case opening to closing,
3. status with respect to the problem at case closing.

For the first two criteria she used the "Scale of Adaptive and Adjustive Status",[36] which employs a rating scale from 1 (inadequate) to 11 (excellent) to denote patient functioning. Ratings are made on the basis of 12 component factors:

1. understanding or reality
2. self-understanding
3. self-responsibility
4. self-acceptance
5. occupational efficiency
6. physical health
7. emotional health
8. effectiveness in social living within the family
9. effectiveness in social living outside the family
10. social environment within the family
11. social environment outside the family
12. material circumstances.

As well, for ratings on the third criterion - status at case closing, a five point scale was developed to note whether the problem was

1. no longer present (provision is made for notation if problem was believed to have disappeared for purely fortuitous reasons)
2. substantially ameliorated
3. alleviated
4. unchanged
5. aggravated

Ripple reports that these scales were applied to relevant data (case record material) by two experienced case analysts. These ratings

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[36] Institute of Welfare Research, Community Service Society of New York.

were then checked for an acceptable level of rating agreement and were found to be statistically sound at an appropriate level of significance.[37]

Research in such directions, with refinment of methods as used by Ripple will do much to enhance our knowledge of therapeutic outcome, with relevance to improvement in practice as well as knowledge and theory of the therapeutic interaction.

Psychological Research

For the present, the psychologists have been most prolific in this area of research into the efficacy of psychotherapy and counselling. Many of their insights are valuable millstones in this research.

Lorr and McNair state that if psychotherapy and its relative effectiveness is to be appraised, certain basic conditions must be satisfied. It must be possible to:

1. describe patients objectively in terms relevant for psychotherapy,
2. to measure change in terms permitting a comparison of different types of treatment,
3. to describe the therapeutic techniques employed, and
4. to describe the personality of the therapist as it relates to his ability to influence different types of patients.[38]

These authors administered to patients in psychotherapy an inventory of statements constructed to define eight constructs constituting a good therapeutic relationship. These constructs were proposed by Feidler and the interpersonal categories developed by Leary in 1950 and 1957 respectively.[39]

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[37] Ripple, op. cit.

[38] Lorr, M. & D. McNair, Methods Relating to Evaluation of Therapeutic Outcome

[39] Ibid.

The eight constructs comprising the inventory were as follows:

1. directiveness
2. nurturance
3. understanding
4. acceptance
5. egalitarianism
6. independence - encouraging
7. critical detachment
8. hostile rejection

In the resultant analysis, these inventory factors corresponded to concepts utilized by the researchers as five correlated factors were indeed identified.[40]

A question remains, however, as to the extent to which the perceptions of the patients represent distortions or actual therapist behavior. These researchers feel that an unequivocal answer is not yet possible, but that inventories do measure sets of perceived interpersonal behavior, associated with the patient's response to treatment. This response itself is useful in understanding the therapeutic relationship. About the direct question of therapist personality and outcome of patient in therapy, Lorr and McNair state the following:

> "There is little solid research evidence to indicate that the therapist's personality influences the results he obtains. However, the assumption has the status of a clinical truism. The requirement of a personal analysis for the practice of psychoanalysis is based on wide acceptance of the assumption."[41]

The work of Whitehorn and Betz has examined this assumption. They studied the psychotherapeutic relationship between physicians and their schizophrenic patients.[42] To this aim they investigated the degree of

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[40] Ibid.

[41] Ibid.

[42] Whitehorn, J. C. & B. J. Betz, A study of psychotherapeutic relationships between physicians and schizophrenic patients, 1954.

success of young residents with their schizophrenic patients on their wards. They chose seven physicians who seemed to have the best results, and seven who seemed to have the worst results. Each group treated approximately fifty patients each. The significant differences they found in the "best results" group were that these physicians saw the patient in terms of the personal meaning of their behavior to the patient, rather than as a case history; these physicians worked toward patient - oriented goals rather than toward symptom reduction. In addition, these doctors used active personal participation - a person to person relationship, and developed this so that the patient trusted and felt confidence in them.[43]

An experimental study to examine Roger's theoretical formulation of the necessary and sufficient conditions for therapeutic change was performed by Halkides.[44] Her hypotheses was that there was a significant relationship between the extent of constructive personality change in the client, and these therapeutic variables:

A. the degree of empathic understanding of the client manifested by the counselor,
B. the degree of positive affective attitude (unconditional positive regard) shown the client by the therapist,
C. the extent to which the therapist's response matches the client's expression in the intensity of affective expression.

From a group of ten "most successful" cases and ten "least successful" cases, she took an early and late recorded interview, and randomly picked nine patient - therapist interaction units (nine early and nine late units from each case). These were randomized and presented to three independent judges to listen to, four separate times each. These units

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[43] Ibid.

[44] Halkides, G., An experimental study of four conditions necessary for therapeutic change, unpublished doctoral dissertation, University of Chicago, 1958.

were then rated on a seven point scale for degree of empathy, therapist's positive regard to the patient, therapist congruence and genuineness, and degree therapist's response matched patient's emotional intensity. Halkides rates high reliability between the judges' ratings - correlations of .80. Her hypotheses was confirmed in this study. "Success" in therapy is associated with a high degree of empathic understanding, unconditional positive regard, and therapist genuineness.

Truax and Carkhuff, the bulk of whose work involves psychotherapy research, feel that it is clear to the researcher that not all that happens in psychotherapy is beneficial or even relevant to constructive change in the patient. The therapeutic relationship which appears as an end in itself is not the goal of psychotherapy - it may be a means to an end, but not the goal per se.[45] They also state that it is evident that present models must be modified and expanded to include a multitude of therapist, patient, process and contextual variables, alone and in their interactions, in order to understand the process of psychotherapy.

Therapist characteristics, namely personality, attitudinal and other personal variables, influences upon the therapist's role concept, and specialized techniques used by the therapist must be taken into consideration when attempting to understand therapeutic process. Therapist variables may have an impact only as they interact with patient variables - degree of initial disturbance, personality traits and structure, initial expectations, demographic characteristics. Situational variables in the form of atmosphere in which therapy occurs, and the "set" created for the patient are impinging forces upon the resultant therapy.[46]

In response to their question "What are the effective elements in psychotherapy that produce constructive behavioral and personality change?",

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[45] Truax C. B. & R. Carkhuff, Concreteness: A Neglected Variable in Research and Psychotherapy, 1964.

[46] Ibid.

Truax and Carkhuff postulate a general linear equation as a useful model. The equation involves therapist variables, patient variables, situational and interactional variables, error, and a constant, equally an index of constructive personality change.[47]

Outcome criterion should include a number of different measures topping significant areas of human functioning: self-report questionnaires, for instance, the MMP and Q-sort; measures of gross functioning - discharge rates from institutions, productivity and earning power, educational and vocational standing; relationship satisfaction as reported by significant others; gross behavioral measures - therapist judgement ratings.[48]

Truax, Carkhuff and Berenson all concur that the higher the conditions of accurate empathy, non-possessive warmth, and therapist genuineness are rated on these scales, regardless of other therapist or client characteristics, the greater will be the constructive personality and behavioral change in the client. Client change and score on these scales are therefore positively related.

Carkhuff and Berenson add however, that:

> "Perhaps most important, and often forgotten, is the fact that between 60% and 70% of the client population studied do improve in functioning over a one to two year period. In spite of the evidence of the low levels of conditions offered clients, we must attempt to explain client changes, however minimal and however low their absolute level of improved functioning."[49]

In relation to one condition - empathy, they report that the therapist's final, not his initial, level of empathic understanding is related to patient improvement in therapy.[50]

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[47] Ibid.

[48] Ibid.

[49] Berenson, B.F. & R. Carkhuff, Ibid.

[50] Ibid.

The implication is that ultimately, the therapist's effectiveness is related to his continuing depth of understanding rather than his ability to "Technique it" furing early phases of therapy. Indeed, too much empathy too early in therapy may have a deleterious effect upon patient development.[51]

In one study, "concreteness" emerged statistically significant in contributing to effective therapy, for outweighing empathy, positive regard and genuineness. The material discussed in therapy must be personally meaningful to the client.[52] The implication of concreteness being the most important factor in therapy is one of training.

> " . . . it would appear that we could most easily train therapists to function at high levels of concreteness because it is less tied to the personality makeup or life style of the therapist."[53]

Tentative evidence suggests that dimensions of possible positive relation to client change in the therapist are:

1. the therapist's self-disclosure
2. the therapist's confidence
3. his sponteneity
4. his intensity
5. his openness and flexibility
6. and his commitment to the client.

From the shifting focus gathered by these researchers so far, it is likely that much more work must be done before we can conclusively point out exactly what are the crucial variables in effective and deleterious psychotherapy, and before we are able to train therapists to be greatly effective.

Studying the aspect of compatibility and therapeutic outcome, Mendelsohn and Rankin used the Fundamental Interpersonal Relations

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[51] Ibid.

[52] Ibid.

[53] Ibid.

Orientation and Behavior Scale (F. I. R. O. -B) and administered it to both client and counselor, then examining therapeutic outcome.[54] Compatibility was found in this study, to be a poor predictor of outcome for males, but a good predictor of outcome for females. That is, compatibility in the "control" need area related positively to outcome, but in the "inclusion" and "affection" need areas was related to negative outcomes. In essence then, this study yeilded no significance.

The authors feel that the results they obtained point to the necessity of examining potential sex differences in the clinical relationship, and to the possibility to empirically based client - counselor matching.

Gardner[55] has surveyed studies of therapist attitudes toward patients, and notes these as the salient points. Prognosis in many studies is correlated with the therapist's affective attitudes, or as Gardner states of attitudes:

> " . . . the ubiquitous but insufficiently realized effects of the therapist's attitudes as they permeate and color his clinical observations and judgements."

Another factor is motivation: therapists seem to like patients who are motivated for therapy better (who has defined "motivation has not been stated here.) Therapists like friendly patients better than unfriendly ones.

A fourth factor is dependency. Dependent clients evoked more therapist friendliness than dominant clients, leading researchers to think that friendliness and dependency are interdependent variables. However, this interdependence did not hold true at later stages of therapy. As born out by Hollingshead and Redlich's major study, therapist attitudes are related to social class, a more favorable outcome and

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[54] Mendelsohn, G. A. & N. O. Rankin, Client - Counselor Compatibility and the Outcome of Counselling, 1969.

[55] Gardner, Gail, The Facilitative Relationship in Berenson, B. & R. Carkhuff, Sources of Gain in Counselling and Psychotherapy.

positive therapist attitude being shown toward those patients in the upper class echelons. As well, Gardner notes a more favourable therapist attitude toward more altruistic and idealistic patients than their converse.

More detailed work studying the therapeutic dyad has been done by Orlinsky and Howard.[56] They report that in the research literature, the systematic and quantitative is made up mainly of objective observation by non-participants, and that these evaluations are after the fact. They see a paucity of literature dealing with what the patient and therapist see, hear, and feel during sessions, about what patients want or think of their therapist. In order to look into this aspect, these authors set up their "Psychotherapy Session Project" involving 60 patients, 17 therapists, and 890 sessions. Questionnaires were filled out on 470 of these sessions. The therapists were psychiatrists, clinical psychologists, and social workers all with at least six years of counselling experience.

From the questionnaires, these authors gathered data on good as opposed to poor sessions, or the ideal session. In total, in the "ideal Session", the patient desired self-understanding and collaborative involvement with his therapist. This result is more intense in the reported "ideal sessions."

As well, the authors found that the following were important factors in the reported "ideal sessions" as reported by patient and therapist:

1. "Collaborative analytic progress" - patient and therapist working together to deepen patient insight by using dreams, childhood memories.

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[56] Orlinsky, D. E. & K. J. Howard, Inside Psychotherapy, in Psychology Today, Vol. 2, July, 1968.

2. "Mutual personal openness" - a sharing between patient and therapist in which the latter reports greater personal involvement in "ideal sessions."
3. "Healing magic" - the eupharic feeling the patient who has experienced an "ideal session" reports.

Blane, a theorist who has synthesized the relevant literature on the personality of the alcoholic, offers interesting insights into the possible treatment of this patient population. Dependency, and difficulties with it, has been noted by many observers to play a crucial role in the personality of alcoholic patients.[57] Blane views dependency as an underlying need state and as a directly observable behavior that is not in itself a central factor in alcoholism.[58] Dependency, by this theorist, is understood as a mental construed, not generally amenable to direct observation. Dependency needs are usually of central importance in the alcoholic's personality makeup, but does not mean that openly dependent behavior is always part of the alcoholic's repertoire of actions. Behaviorally, and important for treatment, is the method the alcoholic chooses to solve the conflict over dependent wishes.[59]

Blane has noted three methods of dealing with dependency among alcoholic patients.

In the first, the alcoholic openly relies on others, usually by entering a life of wandering, or skid row. Blane postulates an early dissolved home life, in which the drifting pattern is an attempt to recapitulate the childhood dependent relationships by attachment to a person who will care for, nurture, and protect the alcoholic.

A second method of coping is an assiduous avoidance of relationships involving open expressions of dependent behavior. Blane calls these

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[57] Blane, H. T., The Personality of the Alcoholic (New York: Harper and Row, 1968)

[58] Ibid.

[59] Ibid.

persons "counterdependent", and notes that it is highly defensive behavior.

A third method, Blane sees as the fluctuation between denying dependency and displaying these needs. These persons find temporary solutions to their needs.[60]

The therapist treating alcoholic patients should be aware of these methods of coping with dependency as they pose a patient variable crucial to eventual therapeutic outcome.

Theoretical Framework - H. A. Murray's Personology

The theoretical framework of Murray - his personology, and his motivational theory and concept of need form the theoretical basis for the proposed study. Murray's work is operationalized in the development of empirical criteria for measurement in the form of an instrument for measuring personality - the "Personality Research Form", by D. N. Jackson. Murray defines "personality" this way:

> "Personality is the governing organ of the body, an institution, which, from birth to death, is ceaselessly engaged in transformative functional operations."[61]

Murray has emphasized consistently the organic quality of behavior, indicating that a single segment of behavior is not to be understood in isolation from the rest of the functioning person.[62]

His definition then contains several components. He points out the abstract nature of personality, in that it is a theoretical construct which is related to specific empirical events in a life, but is not a summary of them.

Second is a longitudinal emphasis - the personality refers to a series of events which ideally span a lifetime.

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[60] Ibid.

[61] Murray, H. A., Toward a Classification of Interaction in Hall & Lindzey, Theories of Personality

[62] Ibid.

Third, personality should reflect the enduring and recurrent elements of behavior as well as the novel and unique.

Last, personality orders and governs: it produces integration among the disporate impulses and constraints to which the individual is exposed.[63]

Murray's contributions to psychological theory have been most distinctive in his representation of man's striving, seeking, desiring, wishing, and willing. His position then, is primarily a motivational psychology.[64] His formulations are characterized by several distinctive elements. He insists that an adequate understanding of human motivation must rest upon a system employing a large enough number of variables to partially reflect the complexity of human motives. As well, he has strived to provide empirical definitions for his variables which far exceed the operational effectiveness of the preceding schemes of human motivation. As a result, Murray has formulated a set of concepts which bridge the gap between clinical description and the demands of empirical research.[65]

The need concept has been the focus of his conceptual efforts; although the need concept has been widely used in psychology, no other theorist has analyzed it as scrupulously or has provided such a complete taxonomy of needs. He writes:

> "A need is a construct (a convenient fiction or hypothetical construct) which stands for a force . . . in the brain region . . . which organized perception, apperception, intellection, conation and action in such a way as to transform in a certain direction on existing, unsatisfying situation."[66]

Need emerges then, as of abstract or hypothetical status; linked to underlying physiological brain processes; which can be internally or

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[63] Ibid.

[64] Ibid.

[65] Ibid.

[66] Ibid.

externally aroused; produces activity until the organism - environment situation has been altered to reduce the need; sometimes is accompanied by particular emotions or feeling.[67]

The existence of a need can be inferred on the basis of the following:

1. The affect or end result of the behavior,
2. The particular pattern or mode of behavior involved,
3. The selective attention and response to a particular class of stimulus objects.
4. The expression of a particular emotion or affect, and
5. The expression of satisfaction when a particular effect is achieved or disappointment when the effect is not achieved.[68]

Murray has defined twenty needs following an intensive study of a small number of subjects. These same needs are the personality traits that Jackson's "Personality Research Form", an operationalization of the theory, measures. Murray has also categorized these twenty needs into five areas.

Primary or viscerogenic needs refer to physical satisfactions; secondary or psychogenic needs are derived from the primary, but are characterized by a lack of focal connection to them - exhibition, dominance, acquisition, are some of these needs. Overt needs usually are expressed in motor behavior, while covert needs remain in the fantasy or dream world, due to their unacceptability to convention or societal standards. Focal needs are linked to limited classes of environmental objects. Diffuse needs are generalized, and applicable in almost any environmental setting. Proactive needs are largely internally determined, becoming active as a result of the person, rather than the environment.

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[67] Ibid.

[68] Ibid.

Reactive needs are activated in response to environmental events. The fifth classification of needs involve process activity, model and effect needs. The first two needs are tendencies to perform certain acts for the sake of the performance itself - process being random and like non-functional operations of various processes; model needs involve doing something with a certain degree of excellence or quality. Effect needs lead to a desired state or end result.[69]

As has been noted, the operationalization of Murray's need concept through the development of an empirical measurement has been implemented by Jackson. His Personality Research Form measures the 20 needs for males and females, as defined by Murray.

It is intended that by utilizing this test instrument as a method of defining need for people or dependency upon others, in the proposed research study, the gap between clinical description and empirical research may be bridged.

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[69] Ibid.

CHAPTER III

THE RESEARCH PROPOSAL

Rationale - Formulative - Exploratory Study

The proposed study is one described by Kahn's[1] "Table of Differentiating Characteristics of Research" as a Formulative - Exploratory study. The primary study aim is to derive hypotheses for further testing, and to develop research strategy and priorities.[2]

The proposed study will gather information concerning the therapeutic relationship between social workers and their clients who are experiencing difficulties involving alcohol. The study attempts to discover whether there is a patterning between the personality traits of both therapists and clients, and any subsequent relationship to the outcome of therapy. If patterning between personality traits does emerge, the hypotheses derived for further testing will be of prime importance in this study.

There is, in a formulative - exploratory study, general sensitivity to variables.[3] This study will discover whether there is, or there is not, a relation between the independent variable of the personality trait by dependency, and any other variables to be found.

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[1]Kahn, Alfred, Table of Differentiating Characteristics of Research in N. A. Polansky (ed), Social Work Research (Chicago: University of Chicago Press, 1966) p.

[2]Ibid.

[3]Ibid.

Hypotheses are generally not formulated concretely in an exploratory study, but there is a sensitivity to the emergent hypotheses.[4] Future hypotheses may be formed involving the personality of the therapist and resultant therapeutic outcome of the patient. As well, systematic differences involving outcome and patient and therapist personality traits, in relation to strength of traits may yeild corollary hypotheses to be tested.

Sampling in an exploratory study is informally considered for range of cases rather than for representativeness of size.[5] In this study, only certain therapists and patients fulfilling the variable definitions will be considered. In a more sophistocated study, representativeness will be a crucial variable. Variables are sought, not controlled for.[6] Certain variables of sex, age, marital status of therapist may prove to be related to the personality trait of dependency, thus indirectly influency outcome of therapy. Therefore, no controls for these variables enter into this present study proposal. The flexibility of this method is appropriate. As well, the focus of the study may shift with new insights gained from the pilot study, which is the next step in implementation of this proposal.

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[4] Ibid.

[5] Ibid.

[6] Ibid.

CHAPTER IV

METHODOLOGY OF RESEARCH PROPOSAL

Study Questions

This study plans to explore within the theoretical framework of the need concept of H. A. Murray, the therapeutic relationship in terms of treatment outcome for alcoholic patients.

The therapeutic relationship will be examined as a function of the personality trait of dependency as measured on five of the "Personality Research Form's" scales. These are:

1. "Affiliation",
2. "Autonomy",
3. "Exhibition",
4. "Social Recognition", and
5. "Succorance".

These scales have been chosen because they ostensibly measure a subject's need for people, and are therefore an indicator of social and emotional dependence.[1]

These scales will be administered to the therapist, and to the patient at the commencement of his treatment with his assigned therapist. These scores will be statistically analysed for relation with each other, and with therapeutic outcome. Also studied will be the gross or overall functioning of the patient after treatment, as well as emerging significant patterns between treatment outcome and characteristics of the therapist, ie. age, sex, marital status, number of dependents, score on the "Personality Research Form" scales.

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[1] See figure #2 for female norms of these scales.

The research questions are these:

1. Is there a relation between the personality traits of social workers, and their clients, in terms of their scores on dependency scales, and the outcome of treatment for these same clients experiencing difficulty with dependency in the form of a problem with alcohol?
2. What is the nature of this relationship, if any, as indicated by therapeutic outcome?

Major Variables Defined

The variable definitions are as follows:

"social worker" - a therapist working in a government agency, having qualified for an M.S.W. or equivalent from an accredited school of social work. ("social worker" is interchangeable with "therapist")

"client" ("patient") - a person who is referred by any source, or seeks help from the agency, the presenting problem of whom involves alcohol on the part of the person who seeks help.

"cases" - number of clients in treatment with each social worker, with the exclusion of collaterals.

"dependency" - the personality trait or need as defined and measured on the five dependency scales of the "Personality Research Form".[2] The individual scales are thusly defined for females:

1. "Affiliation" - friendly, outgoing, enjoys being with friends and people in general, makes an effort to win friendships and maintain.
2. "Autonomy" - tries to avoid or break away from restraints, confinements, or restrictions of any kind; enjoys being unattached, free, not tied to people, places or obligations.
3. "Exhibition" - enjoys being conspicuous, dramatic, colorful, wants to be the centre of attention.

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[2]Jackson, D. N., Personality Research Form (New York: Research Psychologists' Press, 1966)

4. "Social Recognition" - desires to be held in high esteem, to have a good reputation, concerned with what people think about her, works for approval and recognition of others rather than for her own satisfaction.
5. "Succorance" - desires and needs support, protection, love, advice, feels insecure without this, seeks sympathy and reassurance; confides difficulties to a receptive person.

"Therapeutic outcome" - the results of the therapeutic interaction measured by the total and gross functioning of the patient after treatment.

Measures of gross functioning will include:

1. Self-reports of overall functioning,
2. Terms of termination, mutual or not,
3. Vocational stability and earning power,
4. Relationship satisfaction by self-report and by those of significant others (ie. family),
5. Control of drinking to excess by self and other reports, as well as,
6. The objective measure of number of days absent from work per three months before as compared with three months after treatment.

All the above will be rated on point scales, in that point 1 will be the poorest measure with 6 being the best outcome. The highest possible score will be 36, 18 being the median. Therefore 18 and less is a "poor" outcome, 19 and higher considered a "good" outcome.

Study Populations

The therapist population consists of the M.S.W. social worker who

1. has chosen to work on a clinical interdisciplinary team, with
2. alcoholic or problem drinker patients, on an
3. out-patient basis.
4. These social workers have chosen to work in a research focused government agency.

Some evidence of a self-sorting procedure is found in Seiss and Jackson's study (See figure #1) where a link between occupational interests and personality has been attempted. The authors used multi-method factor analysis to appraise the common variance between Personality Research Form scales and the Strong Vocational Interest Blank.[3]

Virtually all the "Strong" scales reflecting social service are represented on the vertical axis together with Personality Research Form scales for Dominance, Nurturance, Exhibition among others. Experimental psychologist alone defines the opposite pole of this dimension.

The horizontal axis is defined at one end by the traditional literary-creative "strong" scales of lawyer, advertizing, artist, and the Personality Research Form scales of Impulsivity and Change.

The other end of this axis charts business detail interests - accountant and office worker - and the Personality Research Form scales for Order and Cognitive Structure.

The authors hope that with this kind of data, a theory of vocational interests may be rooted in personality theory. The authors note that the Personality Research Form is not the ultimate procedure for personality assessment, and certainly developments will ensue. At the present time, however, this technique is available for us to use.

With data from the proposed research using the Personality Research Form, this writer hopes that personality traits will be knowledgeably utilized in therapeutic techniques. For instance, patients and therapists may possibly be matched for personality variables in order to maximize beneficial outcome for the patient, and minimize therapeutic dysfunctions and poor outcome.[4]

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[3]Jackson, D.N., A Modern Strategy for Personality Assessment: The Personality Research Form (London: Dept. of Psychology, University of Western, October, 1966) Research Bulletin No. 30,

[4]Mendelsohn, G.A. and N.O. Rankin, Client - Counselor Compatibility and the Outcome of Counselling, 1969

The patient population is the group of persons who

1. voluntarily seek assistance
2. from the Alcoholism and Drug Addiction Research Foundation (A.D.A.R.F.) to be studied.

Basically, within the operation of the agency, the patient may be referred by any source, but must come to the agency voluntarily, and be documented as part of admission procedures in the agency, which is part of a wider network gathering research material for all such agencies in the province. After documentation and assessment procedures, the patient is assigned a therapist by the Clinical Director.

The patient's history may be quite varied in consideration of former treatment. For this study's purpose, the patient may have been treated by any other agency, or the present one, but is not presently seen by other agencies, and is readmitted to the agency participating in the study between the study cut-off dates.

Sampling Procedures

The sample will be drawn from the total number of social work therapists who have the "therapists" defined requirements. A likely number considering the size of most A.D.A.R.F. Clinics would be approximately ten or more. This is a small number, but even half this number can still be submitted to statistical analysis.

Since all agencies are representative of the Alcoholism and Drug Addiction Research Foundation function and focus on addictions, and vary in size but not philosophy or policy, one agency could be used in the study as representative, if a large enough sample size could be found in it. In addition, there is a built-in control for the effects of different therapeutic techniques, since the treatment approach is that of a reality - oriented one, in which the patient must accept the reality and consequences of his drinking behavior.[5] Different therapeutic approaches then, will not be considered a variable affecting the therapeutic outcome.

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[5]Aharan, C., Director London Branch, A.D.A.R.F., personal communication.

The sample size of patients will be the number of cases assigned to the therapist between the cut-off dates of the study (approximately one year in duration) or when 25 cases for each therapist have been studied, which ever occurs first. Thus if 10 therapists participate, the patient sample will be 10 x 25 = 250 cases. Twenty-five cases have been chosen for each therapist, as this number is the size of the average small caseload of a therapist in this agency sitting. It is the number then, which would yeild a pattern or trend in the therapist's overall functioning.

All attempts to follow the agency's normal functioning will be made. The cases will be assigned randomly as is normally done in the agency. As well, the test will be administered on documentation day along with the normal intake procedures in order to minimize any possible side effects. Since the agency is research oriented, any artifacts introduced by the extra test administration are unlikely.

Data Collection and Analysis

The five Personality Research Form scales utilized have specific normative scores for male and female subjects. Thus for females, the scores above the 50th percentile on a 20 point scale for

(1) Affiliation are 17 or more;
(2) Exhibition are 9 or more;
(3) Social Recognition are 17 or more;
(4) Succorance are 11 or more; and for
(5) Autonomy are 6 or more.[6]

Subjects scoring above the 50th percentile on the first four and below the 50th percentile on Autonomy will be considered as highly dependent (High) on each of these scales.

A subject scoring high on a minimum of three scales will be considered an overall "high" dependence subject. He will be considered a "low" dependent subject if he scores lower than the 50th percentile on a minimum of three scales.

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[6] See Figure #2

An analysis of any other therapist variables yeilded that may affect the trait of "high" or "low" dependency may be completed using correlations between the variable and high or low dependency. For instance, between "high" or "low" dependency and sex, a Pearson Product Moment Correlation[7] would determine any significant relation. The same could be done for marital status, age in five year spans, and whether subject has children or not. As well, a T. test for a difference of means might be utilized in the above instances.[8]

Problems: Validity, Reliability, and Co-operation

Jackson[9] reports substantial evidence for convergent validity (for like traits) and for discriminant validity (for unlike traits) in analysis of the Personality Research Form. Internal structural validity analysis yeilds an average item - total correlation of approximately .60.[10] External validity analysis correlating test scores with behavior yeilded a median correlation between Personality Research Form scales and the corresponding behavior rating was .52.[11] The author reports that the test's inter - item reliability on its final scale is .91, which is sufficient for our purposes.[12]

The three faceted approach of the specific agency chosen - the Alcoholism and Drug Addiction Research Foundation - that of research

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[7]Ferguson, Statistical Analysis in Psychology and Education, 105 ff.

[8]Ibid.

[9]Jackson, D.N., A Modern Strategy for Personality Assessment: The Personality Research Form (London: Dept. of Psychology, University of Western, October, 1966) Research Bulletin No. 30, P. 16.

[10]Ibid.

[11]Ibid.

[12]Ibid.

education, and treatment, would be furthered by this study. The accumulation of new data would enhance the research function; the educational component could be utilized in assisting related agencies' patients with the knowledge gained in the treatment data and implications afforded by results of this study.

The study plans could be presented to the Research Director of the A.D.A.R.F., and funds would be allocated from the main budget if it is approved. The procedure followed in presenting the study proposal would, be that procedure used in any other provincial agency.

CHAPTER V

RELEVANCE OF STUDY RESULTS

Relevance to Practice

The data collected, and the future emergent hypotheses resultant from this study could yeild a many faceted benefit to social work practice. The data gathered about the personality of the social worker who chooses to work with alcoholic patients may elucidate significant personality trends about these therapists. Significantly, the profession may learn which therapist traits contributes to "success" or "failure" outcomes with these dependent clients.

The part played by a therapists own personality then in assisting certain clients with these residual infantile traits may become clearer, and as such, elucidate further the postulates put forward by Fromm - Reichmann. For instance, perhaps therapists who are strongly autonomous in their personality makeup will be selected or choose to work with alcoholic and other dependent clients. These therapists may best be able through personality in conjunction with professional training to, as Margaret Cork[1] notes, be a "parent" to these clients, and assist them in their growth toward greater dependence.

If more knowledge were available to the social work supervisors about this inter-relation of patient - therapist personality traits, more effective social worker - client matching could become a reality with a very possible overall improvement in therapy.

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[1]Cork, R. Margaret, Alcoholism and the Family, paper read at the Alcoholism and Drug Addiction Research Foundation Annual Course, May 1964, University of Western Ontario, London.

In addition, the possibility of greater growth potential and flexibility of treatment and face to face interpersonal skills through improved supervision is a possibility. Assisting the social worker to realize his potential with certain clients, and improve his interaction with those with which he is experiencing some difficulty will improve practice and increase the social worker's total potential.

Relation to Theory

The main theoretical contributions of the proposed study are by way of its usage of Murray's theoretical framework, specifically his need concept. Further empirical proof of this concept as operative within the therapeutic situation may be a result.

As well, other concepts operationalized, as has been done in the instrument devised by Jackson, could be utilized to further exemplify as yet theoretical conceptions of behavior. Such work will bridge the gap between theoretical conceptualizations and empirical clinical practice.

Relation to Knowledge

The information gathered in this study will elucidate the inter-relation of the personality traits of the social worker and client operative in the treatment. These inter-relations studied relevant to therapeutic outcome will add to the growing body of knowledge of the total therapeutic situation.

In essence then, this study will hopefully become one small contribution to the questions aroused by the writer's own variable successes with different clients in treatment; and specifically the question to what extent, did she as a person, apart from professional S.W. training, influence treatment "successes" or "failures".

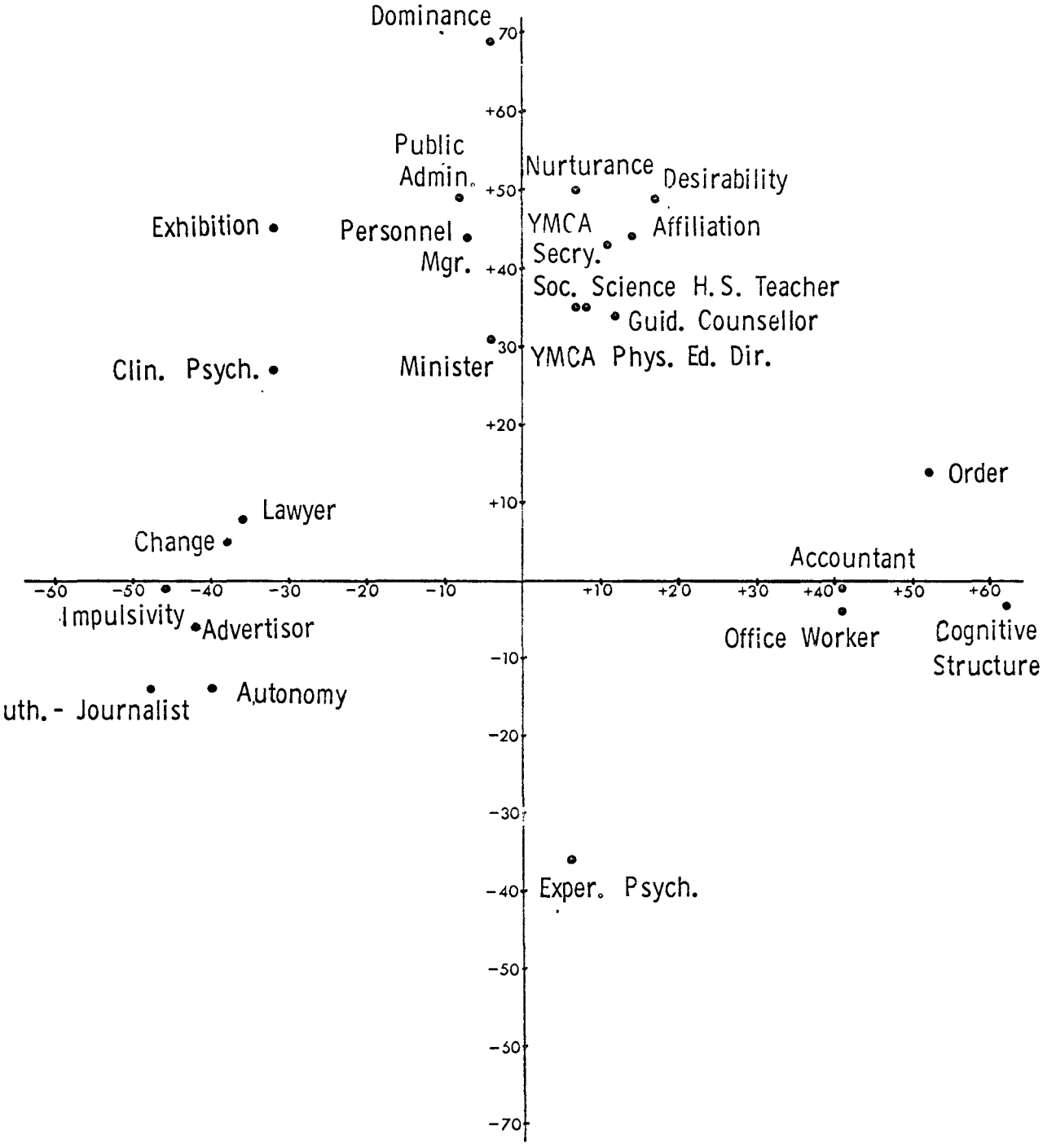
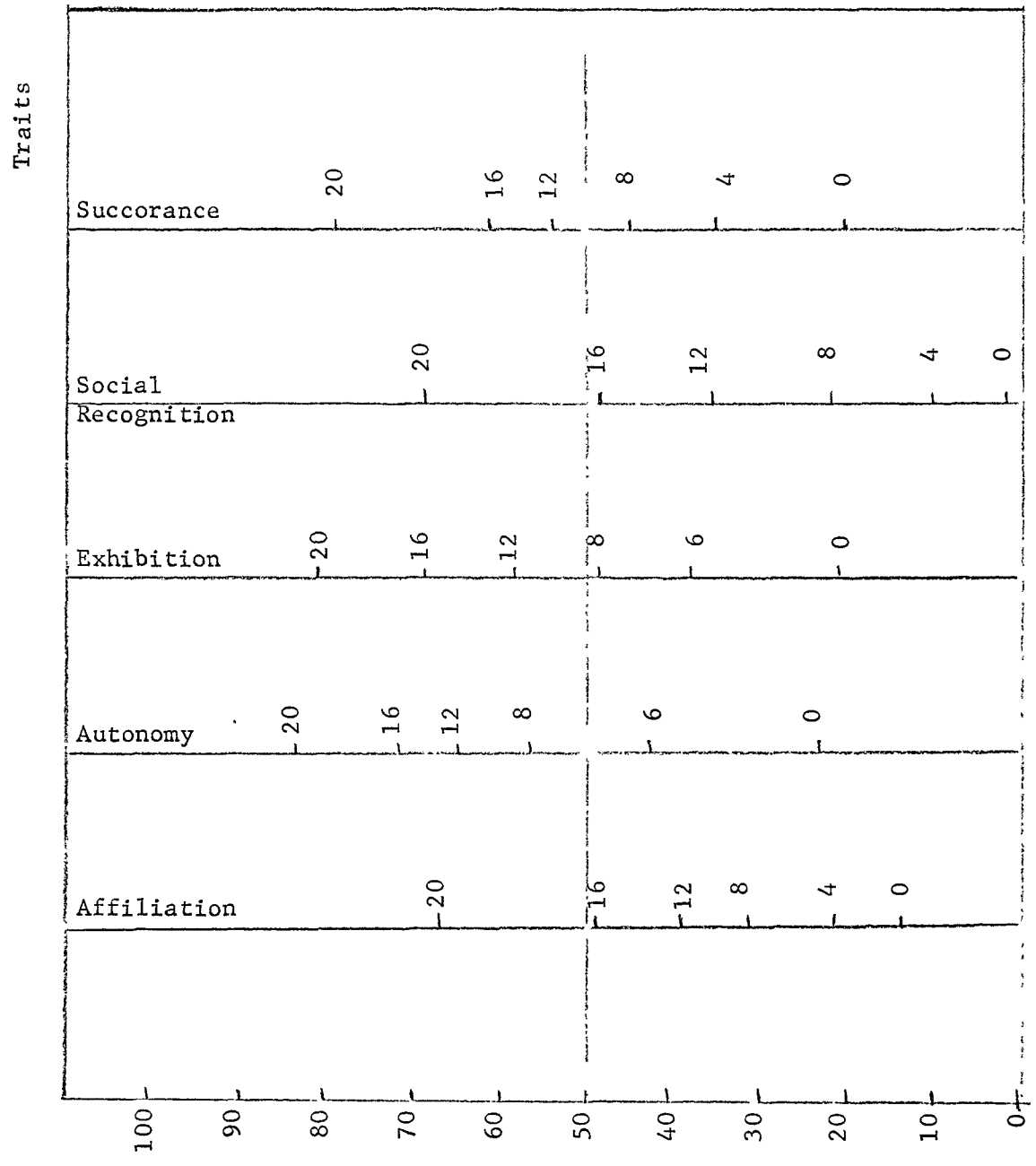


FIG. 10 DIMENSIONS DEFINED JOINTLY BY PERSONALITY TRAITS AND VOCATIONAL INTERESTS

FIGURE TWO

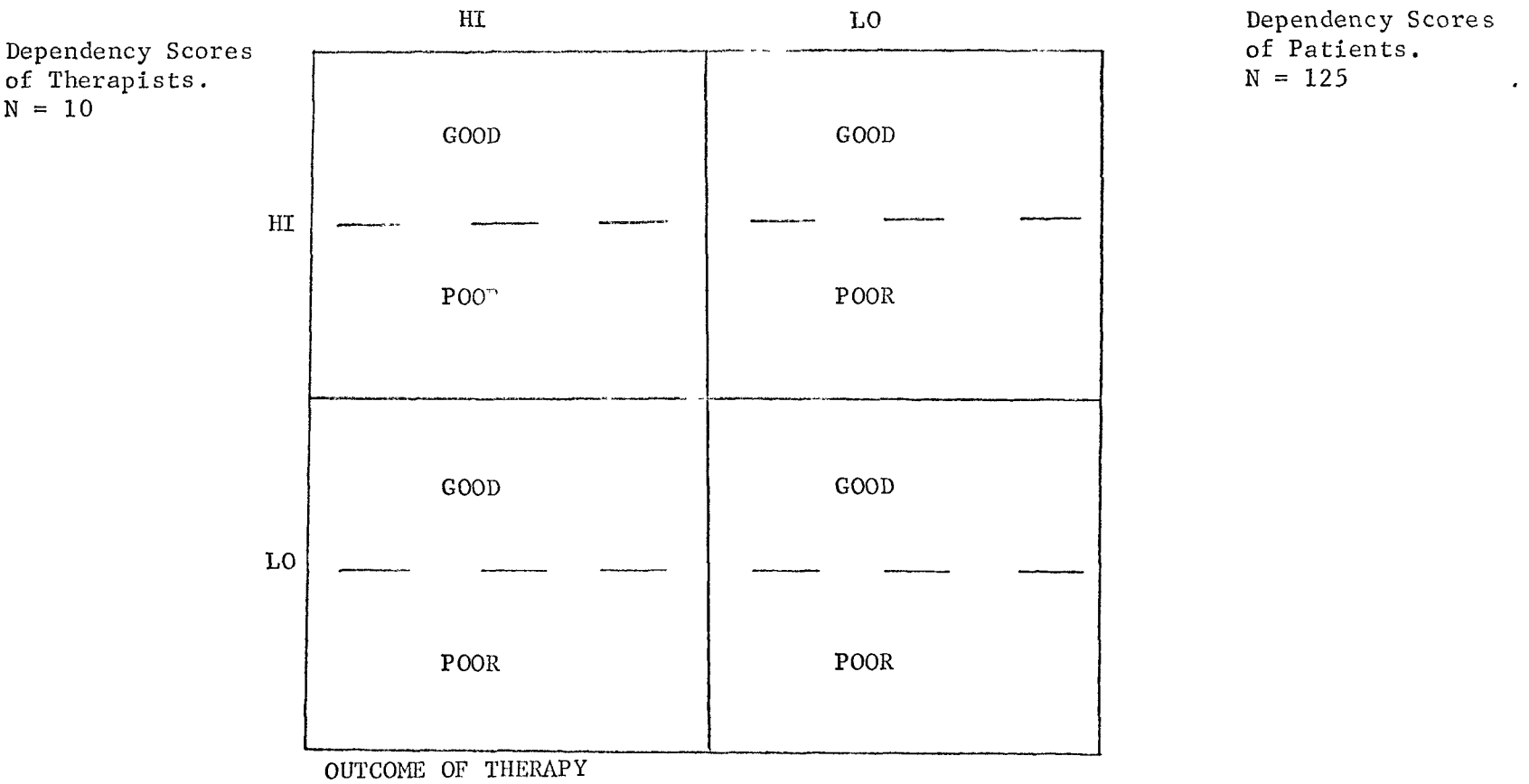
FEMALE NORMS OF THE FIVE PERSONALITY RESEARCH FORM TRAITS OF AFFILIATION, AUTONOMY, EXHIBITION, SOCIAL RECOGNITION AND SUCCORANCE.



Percentiles of Tested Population (1000 College Females)

FIGURE THREE

ANALYSIS OF VARIANCE 2 x 2 x 2 TABLE BETWEEN HIGH AND LOW DEPENDENCY THERAPISTS, PATIENTS, AND GOOD AND POOR OUTCOME.



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