THERAPIST'S SELF-MONITORING STYLE AND CLIENT SATISFACTION

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To the Associate Vice-President for
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I am submitting herewith a thesis written by Greer Garner entitled "Therapist's Self-Monitoring Style and Client Satisfaction." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts with a major in Counseling Psychology.

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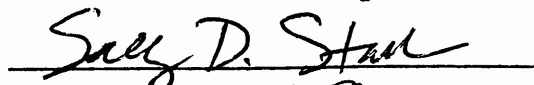

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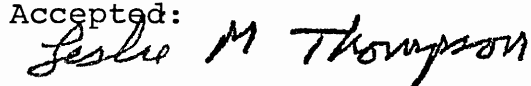

Associate Vice-President for
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AUGUST 1993

The degree to which therapists observe, regulate, and control their appearance with clients is a reflection of their self-monitoring tendency. Different self-monitoring styles of therapists might be related to client's overall satisfaction with the therapist.

Additionally, specific aspects of self-monitoring may be more closely associated with client satisfaction than with others. To investigate this process, 24 therapists completed the Self-Monitoring Scale and three clients of each therapist completed an evaluation form rating their impressions of the therapist. The main hypothesis of the paper suggesting that high self-monitoring therapists would have clients who were more satisfied was not supported. Additionally, no associations were observed between the self-monitoring factors of extraversion and acting and client's rating of satisfaction in the counseling session.

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CHAPTER I

REVIEW OF THE LITERATURE

Most therapists would agree on the importance of clients experiencing a certain level of satisfaction in the treatment setting in order to maximize therapeutic benefits and eventual outcome. The quality of the counseling relationship is seen by many as a significant factor impacting the direction and outcome of therapy. Clients who are comfortable with the therapist and the counseling process are more open to therapeutic strategies and less likely to terminate prematurely (Kokotovic & Tracey, 1987; McNeil, May, & Lee, 1987). Research has illustrated that the level of client reported satisfaction with the therapist is associated with symptom improvement following termination (Nelson & Borkovec, 1989). Additionally, clients who feel comfortable in therapy and who perceive themselves as actively involved in the therapeutic process tend to view the therapist in a positive light (Baer, Dunbar, Hamilton, & Beutler, 1980).

The utilization of client satisfaction levels as an indicator of movement in the therapeutic process has also been explored. Monitoring client satisfaction throughout

therapy provides the therapist with feedback concerning the behavior and affective change in the client (Tracey, 1989). Clearly, clients' perception of their comfort level with the therapist is an influential component contributing to the direction and outcome of therapy.

Counseling as a Social Influence Process

Studies addressing the influences involved in social cognition suggest that many factors, both personal and contextual, interact in a variety of ways to affect perception (Battistich & Aronoff, 1985). Past research has characterized counseling as a social influence process whereby counselor characteristics and influences contribute to attitude change in the client. By enhancing perceived attractiveness, expertness, and trustworthiness, counselors are able to increase client involvement and influence client behavior change (Strong, 1968). Recent research in social influence counseling has expanded this idea to include the contribution of client characteristics to the counseling process. Studies looking at therapy outcome, attitude change, and counseling climate have emphasized the reciprocal process which takes place between client and counselor. The motivation of clients, as well as their ability to process counselor messages, interacts with

therapist characteristics and messages, affecting the quality and direction of counseling (McNeil & Stoltenberg, 1989).

Therapist Contributions to Client Satisfaction

While interactional influences play an important role in determining the quality of the interpersonal process, the unique nature of the therapeutic relationship suggests that counselor influences carry more weight than those of the client. Because a service is being provided, the burden is on the therapist to form an alliance by recognizing the client's attitudes and behaviors. Counselors tailor response modes and strategies around client characteristics, maneuvers that reinforce the importance of counselor style and skill. Such an idea does not lessen the impact of client variables, but rather emphasizes the distinctive nature of the therapeutic relationship. In this respect, the therapist's personal style and interactional skills provide a framework within which clients exercise their own characteristics.

The role the therapist plays in contributing to client satisfaction has received much attention in the research literature. The theoretical orientation of counselors has been suggested as a possible factor impacting successful outcome (Baum, Felzer, D'Zmura, & Shumaker, 1966). In

addition, therapeutic activity, as well as personal characteristics of the therapist, combines with client pre-therapy characteristics to affect the strength of the therapeutic alliance (Strong, 1968). Therapist intentions and resulting response modes have been shown to affect client reactions and behavior in therapy sessions. Investigators have found that therapists must first accurately perceive the client's reaction before the therapist's intentions lead to the desired results (Hill, Helms, Tichenor, Spiegel, O'Grady, & Perry, 1988). In the same vein, specific therapeutic actions such as labeling feelings, offering interpretations, or correcting distortions about reality predict successful outcome in therapy (Jones, Cumming, & Horowitz, 1988). Specific personality attributes of therapists in combination with other influences have been shown to impact client-therapist interaction. Counselors who were more successful at biasing clients toward the desired direction were rated as more dogmatic and nurturing, and they scored higher on the Social Recognition Scale (Harris & Rosenthal, 1986).

Self-Monitoring as a Social Psychological Construct

It seems reasonable to assume that personality characteristics of the therapist play an important role in the counseling session, forming a framework or backdrop for

therapeutic strategies and interactional patterns that will develop over the course of therapy. One such characteristic is self-monitoring which describes the unique ways individuals monitor their self-presentation, expressive behavior, and non-verbal affective displays (Snyder, 1974). An individual's self-monitoring style moderates dispositional and situational influences which interact to produce behavior. The Self-Monitoring Scale was developed to measure individual differences in self-monitoring by distinguishing between high and low self-monitors (Snyder, 1974). High self-monitors are attuned to situational cues in the environment and use these cues to guide them in devising an appropriate self-presentation. These individuals look to the behavior of others as a cue for their own actions in social situations. On the Self-Monitoring Scale they endorse items such as: "In different situations and with different people, I often act like very different persons" (Snyder, 1974, p. 531). In contrast, low self-monitoring individuals care less about their social presentation and more about maintaining congruence between their beliefs and actions, leading them to be more dispositional in their orientation. Low self-monitors would endorse items on the scale such as: "I have trouble changing my behavior to suit different people and different situations" and "I can

only argue for ideas which I already believe" (Snyder, 1974, p. 531). The behavior of low self-monitors tends to be consistent across situations, whereas the behavior of high self-monitors is tailored to each situation, allowing for more cross-situational variability (Snyder & Monson, 1975).

Self-Monitoring and Social Interaction

Self-monitoring styles were evident in studies (Dabbs, Evans, Hopper, & Purvis, 1980; Ickes & Barnes, 1977; Shaffer, Smith, & Tomarelli, 1982) examining the dynamics of social interaction. Videotapes of spontaneous encounters between strangers revealed that high self-monitoring individuals were more inclined to talk first and initiate subsequent conversations. Their partners in the transactions also perceived them as having a greater need to talk. Additionally, high self-monitors were more concerned than low self-monitors with establishing and maintaining a smooth, pleasing flow of conversation. Typical strategies they employed involved talking about the other person instead of themselves, conveying an immediate sense of intimacy, and reciprocating self-disclosures. Low self-monitors took a less active role in the interactions. They felt that their partners had more control over the direction of the conversation

and, in general, felt less invested in the dynamics of the interaction. Such an outcome supports the idea that low self-monitors prefer to remain true to their attitudes and feelings, regardless of the situational context (Snyder, 1987).

Other studies have illustrated that high self-monitors are particularly skilled at expressive self-control. Participants were videotaped reading aloud a neutral paragraph in which they were to convey seven different emotions. Judges rating the tapes indicated which emotions were being expressed. High self-monitors were better able to accurately communicate the desired emotion than were low self-monitors (Snyder, 1974).

Self-Monitoring Orientation of Therapists

Such research suggests that self-monitoring has implications for the therapeutic setting. For counseling to be effective, therapists must be skilled in providing an environment that reflects the unique situation and needs of the client. Therapists who can access a variety of counseling response modes within a flexible framework greatly enhance the nature of the therapeutic process (Tracey, Hayes, Malone, & Herman, 1988). Studies have shown that the therapist's ability to be flexible within a treatment approach maximizes the client's potential for

recovery. Research addressing therapeutic effectiveness with patients suffering from stress-response disorder found that therapists who modified the prescribed treatment in the direction required by the nature of the patient's difficulties were more successful in treatment (Jones et al., 1988). One study found that high self-monitoring therapists were more concerned with finding interventions that fit the specific problem, and therefore subscribed to multiple theoretical orientations. In contrast, low self-monitoring therapists tended to choose a single theoretical orientation which reflected their emphasis on consistency in self-presentation across situations (Matthews & Marshall, 1988).

It seems plausible that therapists' self-monitoring style or preferred mode of self-presentation would influence therapeutic approach. The recognition and understanding of important events in counseling is essential for productive work in therapy. In one study clients and counselors identified specific counseling events involving insight, exploration of feelings, and demonstrations of new behavior as memorable events which had long term impact on the client (Martin & Stelmaczonek, 1988). The self-monitoring propensities of therapists suggest the presence of varying degrees of awareness and sensitivity to environmental events in therapy. Research

has shown that high self-monitors, in attempting to understand situational expectations, invest time and effort exploring the subtleties of interactive behaviors and context, so as to infer the affective and emotional intentions of individuals (Snyder & Cantor, 1980). The well-developed skill of high self-monitors in reading others and assessing the motivational factors behind behaviors, as well as their ability to detect discrepancies between behavior and underlying attitudes, has been born out by research (Geizer, Rarick, & Soldow, 1977). Such attributes would seen to be eminently practical in a therapeutic setting.

One study found that both high and low self-monitoring therapists were adept at conveying empathy. High self-monitors were able to accurately interpret the nonverbal behavior of other people better than were low self-monitors. However, low self-monitoring therapists were perceived as being more genuine in their expressions of empathy as well as more responsive to the person with whom they were conversing (Mill, 1984). Thus, high self-monitoring therapists were more skilled at cognitive empathy; whereas, low self-monitors exhibited skill in affective empathy. Such a finding also parallels that of research addressing the conversational patterns of self-monitors. An examination of self-monitoring styles in

an informal conversational setting found that high self-monitors conversed with other high self-monitors in an easy and sometimes glib manner; while low self-monitors conversed with other low self-monitors in a halting, yet sincere manner (Dabbs et al., 1980).

Dimensions of Self-Monitoring

The Self-Monitoring Scale has been divided into three dimensions which isolate various aspects of the self-monitoring construct. These aspects are Acting, Extraversion, and Other-Directedness (Briggs, Cheek, & Buss, 1980). Acting is the dimension that identifies qualities which are prominent in good actors, such as being entertaining and liking to assume different roles. Extraversion refers to qualities that illustrate how outgoing a person is. This dimension has been shown to correlate highly with the Extraversion Subscale of the Eysenck Personality Inventory (Briggs et al., 1980). Other-Directedness addresses issues of pleasing others, conforming to social situations, and masking one's true feelings. This dimension has correlated significantly with public self-consciousness and neuroticism (Briggs et al., 1980).

The dimension of Acting has particular relevance for high self-monitors. As Snyder (1987) noted, high

self-monitors resemble actors who are able to enact many roles and utilize a wide range of scripts. In contrast, low self-monitors play the same role in every performance, relying on their personality to provide the script. Research has depicted therapy as a process whereby the therapist and client negotiate their respective roles. The therapist strives to alter clients' dysfunctional role expectations so that they more adequately reflect reality (Tracey & Dundon, 1988). The high self-monitoring therapist's awareness of and sensitivity to role expectations suggests they would be adept at identifying client roles and skilled in supplying more productive alternatives. The well-developed acting skills of high self-monitoring therapists also enable them to act as effective role models in therapeutic interventions. Once the high self-monitoring therapist has determined the client's perspective, he or she is then fairly skilled at acting in an appropriate manner, supplying to the client an accurate representation of the problem. Such an ability is supported by Snyder's (1974) claim that high self-monitors are sensitive to other's expressive behavior which enables them to select an appropriate self-presentation that accurately reflects the particular social situation. From another perspective, their acting ability may also allow them to perform well when they must convey greater interest

and concern than they really feel (Snyder, 1987). Such therapeutic skills would enhance clients' feelings of being understood and maximize future, potential interventions, all of which should lead to greater client satisfaction with the therapist and therapy.

The dimension of Extraversion suggests that individuals vary in their capacity to initiate and maintain social interaction. High self-monitors have been described as preferring to take an initiatory and directive role in social contexts, which suggests they would receive high scores on the Extraversion subscale. Therapists fitting this description may be more inclined to reach out and connect with the client in ways that bolster the client's feelings of comfort and satisfaction. Additionally, the Extraversion factor has produced significant correlations with an individual's ability to decode vocal expression (Mill, 1984). Therapists who score high on the Extraversion dimension may possess a well-developed verbal repertoire that enables them to be more sensitive to the verbal styles of others. Such an ability would enhance the probability that client-therapist dialogue would center around relevant issues, leading the client to feel understood.

The Other-Directedness dimension identifies the degree to which individuals direct their attention to others in

social interactions. High self-monitors' sensitivity to others' behavior in a social context suggests that they are strongly focused on those around them. Low self-monitors, on the other hand, are less concerned with others' behavior in social situations and more involved with how the situation fits their own needs and beliefs (Snyder, 1974). While being other-directed has positive connotations in a therapeutic sense, studies have demonstrated that high scores on the Other-Directedness dimension have also correlated positively with Shyness, Public Self-Consciousness, and Neuroticism (Briggs et al., 1980). Having a tendency to focus on others is not negative, per se, but an exaggerated emphasis may be detrimental, not only to therapists who possess such a quality, but to their clients as well.

Other Counselor Characteristics Influencing Client Satisfaction

Additionally, other characteristics of counselors may influence client satisfaction with the therapist. Studies addressing theoretical orientation, experience level, age, and gender of the therapist have been shown to be related to the therapeutic process.

Most of the research addressing theoretical orientation has viewed it as a reflection of the personality of the counselor. One researcher suggested

that counselors choose a theoretical orientation that matches their belief system and has been shown to work (Herron, 1978). Another study found relationships between therapists' self-concept and theoretical orientation. Behaviorists described themselves as low in intuition, and Rational Emotive therapists saw themselves as being high on rationality and low in complexity. Psychodynamic therapists saw themselves as complex as well as high in rationality and intuition. Eclectic therapists perceived themselves as possessing equal amounts of complexity, seriousness, and rationality (Walton, 1978). Another study investigated the relationship between therapeutic orientation and personality in psychotherapists. Therapists were categorized as either Behaviorists, Psychodynamic practitioners or Humanists. Findings revealed that all three groups shared a common core which suggested a focus on the present, strong self-acceptance and self-regard, synergy, and a beneficial view of humanity (Tremblay, Herron, & Schultz, 1986). While the research has not specifically addressed the impact of theoretical orientation on client satisfaction, such an avenue could clarify beneficial aspects of the therapist's strategy. One study found a possible association between self-monitoring style of the therapist and therapist selection of theoretical orientation. Low self-monitoring

therapists preferred a single approach to therapy, usually one that was psychoanalytic or psychodynamic in orientation. High self-monitoring therapists preferred multiple theoretical approaches, with behavioral and systems therapy being the preferred technique (Matthews & Marshall, 1988).

In a study examining client satisfaction with professionally trained therapists and professions in other fields, researchers found that trained therapists were significantly more helpful than those who were not therapists (Gold & Dole, 1989). Another study exploring counselor experience level and client satisfaction found that experience level of the counselor was not related to perceived counselor expertness, attractiveness, or trustworthiness. However, the authors suggest that their findings be regarded as tentative because of the small sample size and contrary findings by other researchers addressing the same variables (Heppner & Heesacker, 1983). In one study researchers observed that therapists with social work degrees had lower self-monitoring scores than those who had degrees in psychology, suggesting a possible association between level and type of graduate training with self-monitoring style (Matthews & Marshall, 1988).

Other research has found that clients' perception of counselor expertness, trustworthiness, and attractiveness

was influenced by gender and experience level of the therapist. In one study, undergraduate psychology students were portrayed to clients as having either a Ph.D. in psychology or a B.A. in another field. Results indicated that expert counselors were rated as more expert than nonexpert counselors. Female experts were seen as more expert than female nonexperts, while male experts and nonexperts were not viewed as different from one another. The authors suggest the observed gender and experience level differences may be attributable to stereotypic impressions of women. A female counselor with an advanced degree may be seen as superior to her male counterparts, whereas a female counselor without a degree is seen as less competent than a male counselor with the same experience level (Merluzzi & Banikiotes, 1978). Another study found that high status male counselors were viewed more favorable by clients than were low status male counselors; whereas, the opposite was true for females (Brooks, 1974). Research exploring and expanding upon this finding demonstrated that experienced paraprofessional counselors were seen as more attractive and trustworthy, but less expert than professional counselors. The authors of the study suggest that clients might have expected paraprofessionals to be more like themselves, and therefore less expert (McCarthy, 1982).

Research addressing the gender and experience level effects of counselors has been mixed. One study investigated the influence of counselor gender and major field of study on nonverbal acuity. The ability to accurately perceive and identify nonverbal information about emotional states has been viewed as an important component of successful counseling. The findings demonstrated that female counselors and noncounselors were more perceptive than males in identifying nonverbal information. No significant differences between counselors and noncounselors in identifying nonverbal information about emotional states were observed. These results suggest that traits characteristic of the female gender could have a direct bearing on counseling skill (Sweeney & Cottle, 1976).

Another study examining counselor expertness looked at counselor gender and training/experience level. Counselors conducted interviews with clients on videotape. Observers assessed counselor expertness on several levels. Only one difference was found with respect to gender. Female observers rated male counselors as significantly more potent than female counselors. Level of counselor experience had no significant effect on observers' ratings of the counselors' performance (Dell & Schmidt, 1976). A study which examined client preferences for therapist sex

role orientation found that clients preferred an androgynous and masculine-oriented therapist to a feminine-oriented therapist (McKinnon, 1990).

The findings regarding age and gender of the therapist have been varied. One study investigating women's preferences for counselors of different gender and age found that women clients preferred women counselors (Simons & Helms, 1976). This finding reflected a shift from earlier findings which concluded that female clients preferred male counselors (Fuller, 1964). Additionally, the women in the Simon and Helms (1976) study demonstrated a preference for female counselors of a specific age. College women preferred counselors in the 34-45 and 55-65 age ranges. Non-college women preferred female counselors in the 55-65 age group.

Age, sex, and title of therapist as determinants of client preferences were investigated in another body of work. "Psychologists" and "psychiatrists" were preferred to "behavioral consultants," "emotional counselors," and "psychoanalysts." Additionally, the subjects in the study preferred male over female therapists. Age preferences indicated that clients preferred 40-year old therapists to 55-year old therapists, while the 55-year old therapists were preferred to the 25-year old therapists (Simon, 1973).

Research addressing the effects of counselor age on the therapeutic relationship has been inconclusive. Counselor age was shown to have no effect on client satisfaction in the therapeutic interview (Robiner & Storandt, 1983). In a follow-up study researchers found that client satisfaction with counselors was related to counselor age only when specific counselor differences within age levels were collapsed and the client's presenting problems considered. Overall, the authors felt that counselor age differences were not a significant factor in client satisfaction (Schneider & Hayslip, Jr., 1986).

The counseling environment is one that is carefully orchestrated by the therapist. By conscious or unconscious intent, counselors' interactional style establishes a mood that surrounds the therapeutic work. The manner in which counselors utilize interventions and strategies will, in large part, be interwoven with their approach to tried and proven ways of interrelating. Studies of self-monitoring in the therapeutic setting offer an opportunity for therapists to identify those aspects of therapy and themselves that produce satisfaction in the client.

Counselors who are comfortable initiating conversations and reciprocating self-disclosures and who

are skilled at expressive self-control provide a comfortable and safe environment for clients. A sensitivity to situational contexts and the motives behind interactive behaviors enables therapists to identify problem areas and explore dysfunctional patterns. Therapists who are sensitive to the verbal and non-verbal cues of those around them are able to access this capability with clients. Additionally, a therapist's tendency to closely monitor situational cues in order to determine the desired behavior translates into a flexible schema when selecting therapeutic approaches that reflect the client's needs. Therefore, therapists who are high in self-monitoring may offer clients a wide variety of talents that contribute to a positive atmosphere. Low self-monitoring therapists, with their attention focused more on internal cues, rather than situational ones, might be at a disadvantage when examining the client's social context and interactive behaviors. While the strength of low self-monitoring therapist's empathic expressions could foster a comfortable working alliance with the client, their restricted awareness of and concern with situational dynamics might delay problem identification and lead to a sense of frustration on the part of the client. Because low self-monitoring therapists have also been shown to

prefer a single theoretical approach in therapy, their therapeutic attempts might not accurately reflect the client's predicament.

Therefore, in order to clarify aspects of therapeutic effectiveness as they relate to client satisfaction in therapy, it is hypothesized that high self-monitors will elicit greater client satisfaction than will low self-monitors. Additionally, so that specific aspects of self-monitoring associated with client satisfaction might be determined, correlations of the three dimensions with client satisfaction levels will be explored. It is hypothesized that the Acting and Extraversion dimensions of the Self-Monitoring Scale will be positively associated with client satisfaction, whereas Other-Directedness will not. Additionally, relationships between counselors' theoretical orientation, experience level, gender, age and client satisfaction will be explored.

Most of the research examining the effects of counselor characteristics has employed analogue designs. Because the present study will utilize data gathered from actual dyadic counseling sessions, it is expected that the findings will provide a clearer picture of those aspects of the therapist associated with client satisfaction.

CHAPTER II

METHOD

Subjects

The therapist sample consisted of 24 counselors from three university counseling centers and three community counseling centers. Counselors from Texas Woman's University, University of Texas at Dallas, and Southern Methodist University counseling centers participated in the study as did therapists from the Galaxy Center, Irving Youth and Family Services, and Catholic Charities. Counselor credentials ranged from graduate student in psychology to those with Ph.D.s. The client population was composed of a random selection of three clients per counselor. The client population was restricted to those who were in individual counseling and who were 18 years of age or older. Clients and therapists were given the option of participating.

Instruments

Therapists completed Snyder's (1974) Self-Monitoring Scale which consists of 25 true-false self-descriptive statements (see Appendix A). The content of the scale addresses the situational appropriateness of

self-presentation, adherence to social cues in determining self-presentation, ability and skill in controlling expressive behavior, and situational shifts in expressive self-presentation (Snyder, 1974, 1987). The statements are scored in the direction of high self-monitoring. For half the items, agreement is keyed as high self-monitoring; for the remainder, disagreement is keyed as high self-monitoring. The categories of high and low self-monitoring are determined by a median split of the sample. Items typically endorsed by high self-monitors include, "I would probably make a good actor," and "In different situations and with different people, I often act like very different persons." Low self-monitors subscribe to statements such as, "I have trouble changing my behavior to suit different people and different situations," and "I would not change my opinion (or the way I do things) in order to please people or win their favor."

Internal consistency was maximized by procedures which selected the 25 items from a larger pool of items (Snyder, 1974). In order to assess whether the Self-Monitoring Scale measured a conceptually distinct construct (discriminate validity), correlations between the scale and six other measures were determined. The measures utilized for this test were Marlowe-Crown Social Desirability Scale, the Minnesota Multiphasic Personality Inventory, the

Machiavellianism Instrument, the Achievement Anxiety test, and Kassarjian's inner-other-directedness scale. Results indicated that the Self-Monitoring scale is relatively independent of other measures.

Construct validity was originally assessed in four separate studies that examined self-monitoring and peer evaluation, prediction of scores on pre-determined groups of individuals, self-monitoring and the expression of emotion, and self-monitoring and attention to social comparison information. Research utilizing the Self-Monitoring Scale since 1974 has confirmed the construct validity of self-monitoring (Snyder, 1987).

The 25-item Self-Monitoring Scale is internally consistent with a Kuder-Richardson 20 reliability of .70, and temporally stable, with test-retest reliability estimates of .83 for a one-month interval, .76 for a two-month interval, and .77 for a 3.5 month interval (Snyder, 1974, 1987). In addition, studies have shown that scores on the Self-Monitoring Scale are independent of social desirability response sets (Snyder, 1987).

Factor analysis of the Self-Monitoring Scale resulted in the identification of three dimensions: Acting, Extraversion, and Other-directedness. The three categories form internally consistent subscales with alpha coefficients in the same range as the full 25-item scale.

Additionally, the three factors demonstrate positive correlations with relevant personality factors.

Several research studies have questioned the psychometric properties of the Self-Monitoring Scale (Ahmed, Garg, & Braimoh, 1986; Briggs & Cheek, 1988; Briggs, Cheek, & Buss, 1980; Lennox & Wolfe, 1984; Miller & Thayer, 1989). Snyder and Gangestad (1986), in reaction to criticism challenging the psychometric properties of the Self-Monitoring Scale, revised the original 25-item scale to one that is 18 items. Latent structural analysis revealed that certain statements on the original scale discriminated poorly between high and low self-monitoring, therefore, those items were dropped. As a result, internal consistency was increased. However, subsequent research has suggested that the 18-item questionnaire is more a reflection of Extraversion and Acting than it is of Other-Directedness, thus suggesting the new scale offers a different meaning of self-monitoring (Briggs & Cheek, 1988). Other researchers felt the original 25-item scale measured variables other than those subsumed by the construct, such as the ability to modify self-presentation and sensitivity to expressive behavior of others (Lennox et al., 1984). Snyder (1987) indicated that the Lennox and Wolfe model shared over 50% of the reliable variance with the 25-item model. The remaining variance was considered

to be not intrinsically valid and therefore not able to demonstrate covariation with significant features of social behavior. Ahmed, Garg, and Braimoh (1986) identified three factors similar to those found by Briggs, Cheek, and Buss (1980). Inter-item correlations were low for the entire scale but moderate for the three factors. Miller and Thayer (1989) performed statistical analyses that challenged Snyder's notion of a binary typology (high and low self-monitors) for self-monitoring. They believed that examination of continuously distributed scores would be more informative and a better source of error variance. Additionally, they found Briggs, Cheek and Buss's (1980) three factor model to be superior, performance-wise, to other factorial versions (Briggs & Cheek, 1988; Lennox & Wolfe, 1984).

While dichotomization of the self-monitoring construct may blur discrimination of individual differences, Gangestad and Snyder (1985) felt that indicating extremity with a continuous distribution of scores was misleading and unnecessary. Self-monitoring determines class membership with external criteria, suggesting that individual differences within classes are not relevant to the self-monitoring criterion. Therefore, this paper utilized the original binary format instead of a multi-point Likert system.

Because of mixed findings regarding the revised 18-item Self-Monitoring Scale, and the possibility that deletion of certain statements may alter the original meaning of the construct, this study used the original 25-item format. In addition to completing the Self-Monitoring Scale, therapists were asked to supply information regarding theoretical orientation, experience level, gender, and age.

Clients completed the Client Evaluation Inventory (CEI) which consists of 21 descriptive statements that are scored on a five point Likert scale (see Appendix B). The purpose of the CEI is to explore client reaction to personal aspects of the counselor. A 68-item CEI (including the Interview Rating Scale) was developed to examine item social favorability (Linden, Stone, & Shertzer, 1965). An intercorrelation matrix for the 68-item responses and a CEI total score was computed. Items loading .40 or greater on one factor, but less than .40 on all the other factors were selected to be criteria on the final 21-item instrument. The three factors identified by the authors are Counseling Climate, Counselor Comfort, and Client Satisfaction. Counseling Climate includes statements such as: "The counselor acted cold and distant," and "The counselor acted as though s/he thought my concerns and problems were important to her/him."

Counselor Comfort refers to descriptions such as: "The counselor gave the impression of 'feeling at ease,'" and "The counselor was awkward in starting our interviews." Descriptive statements associated with Client Satisfaction include items such as: "The counselor's comments helped me to see more clearly what I need to do to gain my objectives in life," and "I feel satisfied as a result of my talks with the counselor" (Linden et al., 1965).

Test-retest reliability on both the long (68-item) and short (21-item) instruments demonstrated that all but three of the 21 critical variables were reliable at the .05 level or beyond for both groups. Estimates of test-retest reliability on the scale scores of the CEI total score ranged from .62 on a 100-day sample to .83 on the 14-day sample. The median coefficient among scale scores was .72 (Linden et al., 1965).

Discriminant validity of the scale was demonstrated utilizing counselor practicum grades as criterion. Validity was shown to be at the .05 level for the factor scales or total CEI score of the 21-item scale. Correlational analyses among the CEI scale scores and total score were significant. Counselor Comfort and CEI total scores for male and females exhibited significant associations with practicum grades. While no significant gender differences were observed for the Counseling Climate

or Client Satisfaction scores, practicum grades did demonstrate significant associations for male counseling climate scores and female client satisfaction scores. Interpretation of the validity findings is limited due to the varied assessment rationales utilized in grading the student's practicum (Linden et al., 1965).

Additional research examining the CEI addressed client-perceived improvement and interscale relationships. The dimensions of the CEI demonstrated congruent validity for self-reported improvements in therapy. Clients rated a positive counseling climate (which entails items focusing on the helper's warmth, patience, sincerity of purpose, acceptance, trustworthiness and lack of authoritarian behavior) as a significant predictor of improvement. Examination of the relationship between questionnaire variables on the CEI revealed moderately high intercorrelations among the dimensions with an average of 25% overlap of variance (Bachelor, 1987).

Procedure

Therapists received an envelope containing the Self-Monitoring Scale and a letter generally outlining the study (see Appendix C). Also included was a form on which they noted their theoretical orientation, experience level, gender and age (see Appendix D). The letter contained

instructions for completion of the Self-Monitoring Scale as well as reassurances regarding the voluntary nature of their participation and other pertinent ethical considerations. The Self-Monitoring Scale was identified by a letter designation (i.e., A, B, C) to insure anonymity.

The random selection of three clients from each therapist's pool of clients occurred in the following way. The therapists received as many sealed envelopes as they had clients. They were instructed to give an envelope to each client. All the envelopes contained a letter (see Appendix E) generally describing the study and outlining ethical considerations; however, only seven of these contained the Client Evaluation Inventory. The letter to the clients stated that if no questionnaire was included in their packet, they were to disregard the letter as they had not been chosen to participate in the study. The number seven was selected to cover for the possibility that some may have chosen not to participate, hopefully leaving at least three clients per counselor who would agree to participate. When more than three clients to a counselor responded, selection of the three forms was determined by the use of a random number table. In the letter clients were instructed that their therapists were not aware of the envelope's contents; therefore, discussion of the contents

was discouraged. Each Client Evaluation Inventory was identified by the therapist's letter designation. This procedure insured anonymity as well as offered a systematic way of keeping track of therapist-client dyads. All participants were informed that the research was an outside study with no connections to the counseling centers. The forms were collected by the researcher as they were completed.

CHAPTER III

RESULTS

The Self-Monitoring Scale scores ranged from 5 to 20 on a 25 point scale with a mean of 11.88 and a median of 13. The 24 scores were divided into 12 high and 12 low self-monitoring categories by a median split of the sample.

Within the sample of 24 counselors, 4 were male and 20 were female. Of that number, 2 males and 10 females fell in the high self-monitoring category while the remaining 2 males and 10 females were in the low self-monitoring category. Because of the small number of males and equal gender distribution in the self-monitoring categories, further gender analyses were not pursued.

Of the 24 therapists, 17 identified family systems as the primary theoretical orientation, while 4 practiced client-centered counseling, 2 preferred behavioral orientations, and one subscribed to a psychodynamic theoretical perspective (Table 1). Because of the skewed distribution among theoretical orientations, client-centered, behavioral, and psychodynamic preferences were collapsed into a category designated as "other" theoretical orientations. A chi-square test of association

between self-monitoring style of the therapist and choice of theoretical orientation indicated no significant relationship was present in the sample [X^2 (1) = .198, $p > .90$].

Table 1

Therapist Theoretical Orientation

	High Self-Monitors	Low Self-Monitors
Family Systems	8	9
Behavioral	1	1
Client-centered	2	2
Psychodynamic	1	0

The average number of years of experience by therapists was 5 years, with high and low self-monitoring therapists having experience levels somewhat similar (high self-monitors: mean = 5.67 years, low self-monitors: mean = 4). Analyses addressing the possibility of a relationship between number of years counseling experience and therapist's self-monitoring approach were examined. A two-sample t-test revealed no significant association between therapists self-monitoring style and number of years of experience [t (22) = 1.10, $p > .20$].

The age range of the counselors extended from 26 to 58 years. The mean age of the 24 counselors was 38 years with high self-monitors having a mean age of 38.17 years and low self-monitors having a mean age of 38.08. Two areas of interest surrounding therapist age were explored. One line of analysis looked at possible associations between therapist age and self-monitoring style. The findings indicated there was no significant relationship between the two areas [t (22) = .0268, $p > .80$]. Another focus was directed towards possible correlations between therapist age and client satisfaction scores in the three groups of clients per counselor. The age of each counselor was correlated with the CEI scores of clients in each of the three groups. The data analyses revealed no significance in this area as well (Table 2).

Table 2

Relationship Between CEI Scores and Counselor Age

Client Groups	r
1	-.048
2	-.182
3	-.285

Note. Alpha = .05; Critical r value = +/- .404.

Apart from counselor demographic characteristics, the possibility that personality attributes of therapists, such as self-monitoring style, might be related to the client's perception of satisfaction with therapy and the therapist was explored. It was expected that therapists with high self-monitoring tendencies would have more satisfied clients. A repeated measures ANOVA was used to evaluate therapist self-monitoring scores and the CEI scores of three clients per counselor. There was no main effect for self-monitoring style of therapists [$F(1, 22) = .48$, $p > .25$], nor was there a main effect with the client satisfaction scores for each therapist [$F(2, 44) = .98$, $p > .25$]. It was expected that client satisfaction scores as a group would remain constant across the three groups of clients since client grouping did not represent meaningful categorization. Additionally, no interaction was observed between self-monitoring style of therapist and the client factor [$F = (2, 44) = .20$, $p > .25$]. (See Table 3.)

Table 3

Repeated Measures ANOVA: Therapist Self-Monitoring Styles and Client Satisfaction

Source	df	SS	MS	F	"p" (a)
A	1	28.12	28.12	.48	.25
B	2	96.58	48.29	.98	.25
AB	2	20.07	10.04	.20	.25
S/A	22	1286.69	58.49		
BS/A	44	2163.41	49.17		
Total	71				

Note: (a) Alpha = .05 [F (1,22) = 4.30; F (2,44) = 3.21]

Previous research surrounding factor analysis of the self-monitoring scale suggested that acting and extraversion factors were positively associated with high self-monitoring, while the other-directedness factor was not. Pearson r correlations addressing the three factor scores and client satisfaction scores did not demonstrate any significant associations (Table 4).

Table 4

Correlation of Self-Monitoring Factor Scores and CEI Scores

Factor	Client Groups	r
Acting	1	.031
	2	-.259
	3	.196
Extraversion	1	.122
	2	-.268
	3	-.291
Other-directedness	1	-.009
	2	.033
	3	.319

Note: Alpha = .05; Critical r value = +/- .404.

CHAPTER IV

DISCUSSION

The main hypothesis of the paper, that self-monitoring aspects of therapists would be associated with satisfaction levels of clients, was not supported. The notion that self-monitoring styles of therapists may be associated with client satisfaction can be challenged from many angles. While high and low self-monitors may utilize their styles differently in session, therapist training may have more of an impact on clients' perception of successful therapy than do therapist personality styles. Additionally, client variables as they impact the therapeutic situation were not addressed. Client expectations, attitudes, preferences, motivation, cognitive capacity, needs, and environmental distractions all factor into the counseling experience and can impact the client's assessment of therapy.

The hypothesis that high self-monitoring therapists will have more satisfied clients than low self-monitors is still open to speculation. The qualities of empathy, warmth, and genuineness characteristic of low self-monitors suggest that they may be able to be more sensitive and responsive to clients in a way that is more therapeutic than the more outwardly-focused style of high

self-monitors. Additionally, therapists utilization of their self-monitoring capabilities may be limited more to social situations and less to the therapy setting in which training may take precedence.

The study utilized data from actual counseling sessions instead of an analogue design. This approach may have contributed to problems centering around timely return of the questionnaires. From the six counseling centers 77 counselors were asked to complete the forms. Of these, only 24 responded. From the therapists' client populations 450 client forms were to be handed out. Of these, only 125 responded, with the final 72 clients randomly selected so that each of the 24 therapists were represented by three of their clients. Had the therapists and clients been required to complete the forms following a staged counseling session, data returns would have been assured.

While the sample population represented three university counseling centers and three community counseling centers, the representativeness of therapists and clients, in general, may be limited. Because of the small number of males, both genders were not adequately represented. Additionally, the large number of therapists subscribing to a Family Systems theoretical orientation may be based, in part, on the therapists having attended one of the local universities where this orientation is prominent.

These factors placed limitations on generalizing the findings to the therapist population at large.

The instruments may have introduced additional confounds as well. Risks reported with self-report personality questionnaires, such as the Self-Monitoring Scale, are a possible factor in that therapists' evaluation of their tendencies might not accurately reflect actual behavior. While therapists were instructed to view the statements on the Self-Monitoring Scale as neither negative nor positive, it is possible some felt answering in a specific direction was preferable, regardless of their own reality. More problematic might be clients' perception of the counseling process and the therapist's role in it as reflected by the CEI. Given the assumption that clients in therapy generally are experiencing a certain amount of stress and the therapist is viewed as someone who will help them to manage the stress, certain demand characteristics arise. Research addressing clients' perception of satisfaction in therapy has identified social desirability as a confounding factor in consumer satisfaction reports (Sabourin, Laferriere, Sicuro, Coallier, Cournoyer, & Gendreau, 1989). Specifically impression-management concerns and self-deception tendencies could be factors influencing individuals' assessing satisfaction with treatment. Impression-management concerns might have been

less of a concern to clients since they were informed that their replies were confidential; but self-deception tactics, wherein the individual denies psychologically threatening thoughts or painful information, could have been an influential factor. Clients generally approach the counseling process with a certain amount of hope that therapy and the therapist will be responsive to their needs. The positive mind-set, while therapeutic, could also contribute to an unrealistic appraisal of the counselor and counseling environment.

While the CEI has been shown to be a valid assessment of client general satisfaction with the therapist and the therapeutic process, for this study it is possible that not enough attention was concentrated on aspects of the therapist as s/he interacted with the client. A questionnaire that was more specific and detailed about therapist attributes might have enabled the clients to be more discriminating in their responses. Additionally, controlling for time factors by specifying that clients complete the form following a particular session could also have helped to lessen the possibility that various stages of the therapy process could be impacting clients and their view of the therapist as well.

Experience level of the counselor was assessed while academic level was not. Again, it is possible that

exploring academic attainment and client satisfaction, as well as academic attainment and self-monitoring style, might have demonstrated interesting connections.

In conclusion, research that explores aspects of therapy, whether it be therapeutic techniques or personality characteristics of the therapist, offers the potential for broadening the therapeutic community's knowledge of what works and what does not work. What does and does not work is a broad category which intuitively must include the personality of the therapist as well as the required knowledge and strategies. It is important to recognize that many aspects of the therapist will be woven into the traditional therapeutic stance, and that some of those aspects may be constructive or destructive to positive movement in therapy. Developing ways of assessing beneficial therapeutic styles can lead to a broader definition of what constitutes a good therapist--not just what s/he knows and can do, but who s/he is.

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APPENDICES

APPENDIX A

HUMAN SUBJECTS REVIEW COMMITTEE STATEMENTS

TEXAS WOMAN'S UNIVERSITY
P.O. Box 22939, TWU Station
OFFICE OF RESEARCH AND GRANTS ADMINISTRATION
DENTON, TEXAS 76204

HUMAN SUBJECTS REVIEW COMMITTEE

Name of Investigator: Greer Garner Center: Denton

Address: 4024 Hanover Date: 2-1-91

Dallas, Texas 75225

Dear Greer Garner,

Your study entitled Therapists' Self-Monitoring Style and Client Satisfaction

has been reviewed by a committee of the Human Subjects Review Committee and appears to meet our requirements in regard to protection of individuals' rights.

Be reminded that both the University and the Department of Health, Education, and Welfare regulations typically require that signatures indicating informed consent be obtained from all human subjects in your study. these are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to DHEW regulations, another review by the Committee is required if your project changes.

Special provisions pertaining to your study are noted below:

____ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

____ Other:

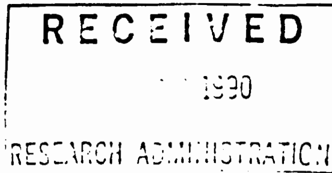
_X_ No special provisions apply.

Sincerely,

Chairman
Human Subjects Review
Committee at Denton

cc: Graduate School
Project Director
Director of School or
Chairman of Department

10/1/87



Date: June 26, 1990

Researcher: Ms. Greer Garner

Department: Psychology

School: n/a because PI is at TWU in Denton, Tx.

SMU Human Subjects Case No. 90177

The chair of the IRB has given the following review status to this project:

exempt ✓ expedited review ___ full review ___

The undersigned members of the Committee for the Protection of Human Subjects have found that the proposed research placed human subjects at

( ) risk (✓) no risk

and verify the following:

( ) The risks to the subject are so outweighed by the sum of the benefit to the subject and the importance of the knowledge to be gained as to warrant a decision to allow the subject to accept these risks;

(✓) The rights and welfare of any such subjects will be adequately protected;

(✓) Legally effective informed consent will be obtained by adequate and appropriate methods in accordance with the provisions of DHHS regulations, and;

(✓) The conduct of the activity will be reviewed at timely intervals.

David Watson ___ Chair, IRB ___

Human Subjects Review Form 3

THE UNIVERSITY OF TEXAS AT DALLAS
P.O. BOX 830688 GR41 RICHARDSON, TEXAS 75083-0688 (214) 690-2057

SCHOOL OF HUMAN DEVELOPMENT

October 17, 1990

TO : Greer Garner

FROM: Duane Buhrmester DB
Chairperson of Human Subjects Committee

RE : Notice of Human Subjects Committee Approval for
Proposal #90-105: Therapists' Self-Monitoring
Styles and Client Satisfaction

The above proposal has undergone an expedited review by the IRB. We deem this proposal to meet human subject guidelines.

APPENDIX B

SELF-MONITORING SCALE

SELF-MONITORING SCALE

The following statements concern your personal reactions to a number of different situations. No two statements are exactly alike, so consider each statement carefully before answering. If the statement is True or Mostly True as applied to you, place a T on the blank to the left of the statement. If a statement is False or Not Usually True as applied to you, place an F on the blank space next to the statement. It is important that you answer as frankly and as honestly as you can. Your answers will kept in the strictest confidence.

_____ 1. I find it hard to imitate the behavior of other people.

_____ 2. My behavior is usually an expression of my true inner feelings, attitudes, and beliefs.

_____ 3. At parties and social gatherings, I do not attempt to do or say things that others will like.

_____ 4. I can only argue for ideas which I already believe.

_____ 5. I can make impromptu speeches even on topics about which I have almost no information.

_____ 6. I guess I put on a show to impress or entertain people.

_____ 7. When I am uncertain how to act in a social situation, I look to the behavior of others for cues.

_____ 8. I would probably make a good actor.

_____ 9. I rarely need the advice of my friends to choose movies, books, or music.

_____ 10. I sometimes appear to others to be experiencing deeper emotions than I actually am.

_____ 11. I laugh more when I watch a comedy with others than when alone.

_____ 12. In a group of people I am rarely the center of attention.

_____ 13. In different situations and with different people, I often act like very different persons.

_____ 14. I am not particularly good at making other people like me.

_____ 15. Even if I am not enjoying myself, I often pretend to be having a good time.

_____ 16. I'm not always the person I appear to be.

_____ 17. I would not change my opinions (or the way I do things) in order to please someone else or win their favor.

_____ 18. I have considered being an entertainer.

_____ 19. In order to get along and be liked, I tend to be what people expect me to be rather than anything else.

_____ 20. I have never been good at games like charades or improvisational acting.

_____ 21. I have trouble changing my behavior to suit different people and different situations.

_____ 22. At a party I let others keep the jokes and stories going.

_____ 23. I feel a bit awkward in company and do not show up quite so well as I should.

_____ 24. I can look anyone in the eye and tell a lie with a straight face (if for a right end).

_____ 25. I may deceive people by being friendly when I really dislike them.

APPENDIX C

CLIENT EVALUATION INVENTORY

CLIENT EVALUATION INVENTORY

The following statements concern your perceptions of the counselor. Each statement has five possible responses: Always, Often, Sometimes, Rarely, and Never. Please check the answer that best expresses your feelings. It is important that you answer as frankly and as honestly as you can. Your answers will be kept in the strictest of confidence.

1. I felt the counselor accepted me as an individual.

Always	Often	Sometimes	Rarely	Never
______	______	______	______	______
1	2	3	4	5

2. I felt comfortable in my interviews with the counselor.

Always	Often	Sometimes	Rarely	Never
______	______	______	______	______
1	2	3	4	5

3. The counselor acted as though s/he thought my concerns and problems were important to her/him.

Always	Often	Sometimes	Rarely	Never
______	______	______	______	______
1	2	3	4	5

4. The counselor acted uncertain of her/himself.

Always	Often	Sometimes	Rarely	Never
______	______	______	______	______
1	2	3	4	5

5. The counselor helped me to see how taking tests would be helpful to me.

Always	Often	Sometimes	Rarely	Never
______	______	______	______	______
1	2	3	4	5

6. The counselor acted cold and distant.

Always	Often	Sometimes	Rarely	Never
______	______	______	______	______
1	2	3	4	5

7. I felt at ease with the counselor.

Always	Often	Sometimes	Rarely	Never
______	______	______	______	______
1	2	3	4	5

8. The counselor seemed restless while talking to me.

Always	Often	Sometimes	Rarely	Never
______	______	______	______	______
1	2	3	4	5

9. In our talks, the counselor acted as if s/he were better than I.

Always	Often	Sometimes	Rarely	Never
______	______	______	______	______
1	2	3	4	5

10. The counselor's comments helped me to see more clearly what I need to do to gain my objectives in life.

Always	Often	Sometimes	Rarely	Never
______	______	______	______	______
1	2	3	4	5

11. I believe the counselor had a genuine desire to be of service to me.

Always	Often	Sometimes	Rarely	Never
________	________	________	________	________
1	2	3	4	5

12. The counselor was awkward in starting our interviews.

Always	Often	Sometimes	Rarely	Never
________	________	________	________	________
1	2	3	4	5

13. I felt satisfied as a result of my talks with the counselor.

Always	Often	Sometimes	Rarely	Never
________	________	________	________	________
1	2	3	4	5

14. The counselor was very patient.

Always	Often	Sometimes	Rarely	Never
________	________	________	________	________
1	2	3	4	5

15. Other students could be helped by talking with counselors.

Always	Often	Sometimes	Rarely	Never
________	________	________	________	________
1	2	3	4	5

16. In opening our conversations, the counselor was relaxed and at ease.

Always	Often	Sometimes	Rarely	Never
________	________	________	________	________
1	2	3	4	5

17. I distrusted the counselor.

Always	Often	Sometimes	Rarely	Never
________	________	________	________	________
1	2	3	4	5

18. The counselor's discussion of test results was helpful to me.

Always	Often	Sometimes	Rarely	Never
________	________	________	________	________
1	2	3	4	5

19. The counselor insisted on being right always.

Always	Often	Sometimes	Rarely	Never
________	________	________	________	________
1	2	3	4	5

20. The counselor gave the impression of "feeling at ease."

Always	Often	Sometimes	Rarely	Never
________	________	________	________	________
1	2	3	4	5

21. The counselor acted as if he s/he had a job to do and didn't care how s/he accomplished it.

Always	Often	Sometimes	Rarely	Never
________	________	________	________	________
1	2	3	4	5

APPENDIX D

THERAPIST LETTER

Dear Counselor,

Besides technical skills and knowledge, counselors bring to the therapy sessions aspects of themselves and their personalities which impact the therapeutic relationship. The present study seeks to explore the self-monitoring tendencies of the counselor and clients' perceived comfort level with the therapist.

Counselors will complete the Self-Monitoring Scale and a Counselor Profile Form while clients will complete a Client Evaluation Inventory. Enclosed in your packet should be three forms: a Counselor Consent Form, the Counselor Profile, and the Self-Monitoring Scale.

The purpose of the Counselor Consent Form is to advise you on the nature of the study. Any risks to you or the counselor-client relationship are seen as negligible, with the benefits to counselors far exceeding any possible drawbacks. More importantly, the findings should provide counselors with a clearer picture of how various aspects of themselves and their personality may contribute to a sense of well-being on the part of the client. Your signature on the consent form indicates understanding and acceptance of any possible risks and benefits that may accrue from the study.

You are also asked to complete the Counselor Profile Form. This information will enable me to consider additional aspects involved in therapeutic interaction. Under the category of Theoretical Orientation, select the approach that best represents your preferred therapeutic approach, even though you may use a combination of several techniques.

The Self-Monitoring Scale is a true-false questionnaire which measures an individual's preferred style of self-presentation and mode of expressive behavior. Scores categorize individuals into two categories: high self-monitors and low self-monitors. This categorization is merely a convenient way to distinguish the different interactional strategies employed by individuals. So as to insure anonymity and confidentiality, the Self-Monitoring Scale will be identified by a letter designation.

Some of your clients will receive an evaluation form accompanied by a letter describing the study. These packets will be distributed from the office as your clients come in or handed out by you if this is preferred. In order to secure a random selection of four clients per counselor, only four of the clients' envelopes will contain an evaluation form, the rest will have just a letter notifying them that if no evaluation form is enclosed, they are to disregard the letter as they have not been chosen to participate.

When you have completed the Self-Monitoring Scale, Counselor Profile Form, and Consent Form, please leave them in the envelope with the secretary in the counseling office. Your prompt attention to this matter is greatly appreciated.

If for any reason you should have cause for concern regarding your participation in the study, please contact me at (214) 373-0239. I want to thank you for taking the time to participate in the study. Your input will help counselors clarify aspects of their interactional style as well as identify personal qualifications that are associated with client satisfaction.

On completion of the study, the findings will be available to you in your counseling office.

Sincerely,

Greer Garner

APPENDIX E

COUNSELOR PROFILE

COUNSELOR PROFILE

THEORETICAL ORIENTATION

Please indicate your primary theoretical orientation. We realize you use a variety of techniques, but for the purposes of this study, select only one.

Client-centered__________

Behavioral_______________

Psychodynamic____________

Family Systems___________

EXPERIENCE LEVEL

Please indicate the number of years you have been counseling.

____

AGE

Indicate your age:

____

GENDER

Indicate your sex:

female___________

male_____________

APPENDIX F

CLIENT LETTER

EXPLORING THE CLIENT-THERAPIST RELATIONSHIP

The purpose of this letter is to invite you to participate in an experimental study which will look at aspects of the therapy session and personal characteristics of the counselors as they relate to client satisfaction.

One aspect of the counseling experience that therapists view as crucial is the establishment of a caring and trusting relationship with the client. In order for counselors to be aware of those aspects of themselves that may contribute to or detract from a satisfying relationship, client feedback is essential. By answering the accompanying questionnaire, you will provide counselors with valuable information that can be used to improve client-therapist interaction. The present study will assess your general satisfaction level with the therapist.

Enclosed you will find a Client Evaluation Inventory which addresses such issues as counselor's interactional style and other general aspects of the therapy session. The instructions given at the top of the inventory describe how you are to score the statements.

Also enclosed you will find a Client Consent Form. If you decide to participate, this paper needs to have your signature. The purpose of the consent form is to advise you of any risks and/or benefits that may result from your participation in the study. Your counselor will not have access to your responses on the inventory, and anonymity and confidentiality will be strictly enforced. Any discussion of the inventory with your counselor is discouraged since such action might compromise the findings. On completion of the study, the results will be available for you to read in the counseling center.

When you have completed the Client Evaluation Inventory and signed the Consent Form, please leave it with the secretary in the counseling center office. If you should have any questions regarding the enclosed information, leave word at the counseling center and I will respond. If you prefer not to participate, please leave your form at the counseling center office so that I may pick them up as soon as possible. Your prompt action on this matter will be greatly appreciated.

Your participation in the study will enable therapists to better understand aspects of themselves and the counseling environment that contribute to a satisfying, working relationship between client and therapist. Once the data is collected, the general findings will be available for your perusal in the counseling center office.

Please Note: If there is no Client Evaluation Inventory and Client Consent Form enclosed in your envelope, please disregard this letter as you have not been selected to participate in the study. (This selection procedure was used to insure a random selection of clients for each counselor.)