What Therapists Feel: Personal and Professional Factors in Therapists' Affective Experience.

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ABSTRACT

In recent years there has been increasing recognition of the importance to psychological therapy of the therapeutic relationship. As acknowledgement has grown that, regardless of theoretical approach to therapy, a good relationship between therapist and client is fundamental to the ultimate success and outcome of psychological therapy, there has been greater theoretical and research interest in the qualities that contribute to the making of an effective relationship.

Although it differs in a number of its dimensions from other, more prototypical, relationships, the therapeutic relationship shares with them several defining features. One such feature is that both participants experience emotions in the course of therapy. This contravenes the long-held view that the therapist is a benign and objective participant in the therapeutic process, one who is not subject to the emotions normal to membership of most other types of relationships. This stereotype has been hard to break and even now, when the relationship itself receives plentiful recognition, there lingers a belief that the therapist should not feel. To do so is implicitly held to render the therapist unprofessional, unscientific, and vulnerable, and perhaps because these beliefs persist unchallenged, some clinical training programmes still fail to more than cursorily deal with the issue of therapist emotion.

In the first study of this thesis, male and female undergraduate students of psychology first completed self-report measures of personality and trait affect, and then assumed the mental set of therapist to observe simulated interviews with four female clients presenting a variety of affect-inducing behavioural styles. At the conclusion of each interview participants reported what they felt about each client using an eleven item

adjective checklist. Responses were aggregated across the four client interviews and mean negative and positive affect scores were obtained. Both the gender and personality of the participants were found to contribute to the variance in state affective response. Specifically, male participants responded with more state negative affect than did female participants, and female participants showed a trend to respond with more state positive affect, even when trait affect was controlled for.

Of the five broad personality dimensions measured, only Neuroticism showed a relationship to state affective experience, with high Neurotic participants reporting experiencing more negative affect than low Neurotic participants. However, the effect did not persist when trait negative affect level was taken into account, suggesting that the affective response to the interviews was trait- rather than situationally-based. One unpredicted result was that high Neurotic participants reported less positive affect than low Neurotic participants.

The second study essentially replicated the first with a large group of practising therapists from a range of professional backgrounds. The results showed that male and female therapists reported similar levels of both state negative and positive affect, even when trait affect was controlled for, and again, the only personality dimension to show a significant relationship to state affect was Neuroticism, with therapists high in Neuroticism reported experiencing more negative affect than therapists low in Neuroticism. However, in contrast to the study using student participants, when trait negative affect was included as a covariate, the significant difference between the low and high Neuroticism groups persisted. This suggested that, for practising therapists, at least some of the negative affect

experienced by more neurotic therapists was a response to the specific context of the task and not just a reflection of enduring trait levels of affect.

The final phase of this research was to consider the effects of factors intrinsic to the role of therapist for their association with affect experienced in psychological therapy; specifically, theoretical orientation, and the professional affiliation of the therapist. When these two variables and the personality dimension Neuroticism were analysed for their effects on global affective experience, only personality was found to have an independent relationship to state negative affect. However, theoretical orientation interacted with level of Neuroticism, as did also professional affiliation. Specifically, high Neurotic occupational therapists responded to the interviews with more positive affect than high Neurotic members of other professional groups. Moreover, low Neurotic occupational therapists reported the lowest levels of positive affect. In other words, occupational therapists showed an opposite positive affective response to other professional groups at both low and high levels of Neuroticism.

In sum, each of the variables examined in this research showed some relationship to affective experience. Implications of these results for theory and therapy are discussed, and it is argued, in particular, that if the results of this research accurately reflect the way in which personality, gender, professional orientation, and role impact on therapists' affective experience of clients, then it is critically important for training programmes to incorporate components in their programs that alert and educate trainee therapists to these potential effects.

Chapter 1

OVERVIEW AND PLAN OF THESIS

This thesis considers one aspect of the therapist's contribution to the process of psychological therapy. Specifically, it addresses therapist affective experience and considers what factors, both those intrinsic to the person of the therapist and those wrought by the assumption of a professional therapeutic role, determine or modify therapist affective experience.

Psychological therapy is a definitively interpersonal undertaking, notwithstanding the varying emphasis given to the therapeutic relationship by different theoretical approaches (Derlaga, Winstead, & Berg 1991; Strupp, 1978). As such, the emotional experiences and reactions of both participants are inextricably bound up in the way therapy proceeds and also, therefore, in its outcome. Despite a common assumption that therapists are able to control affective experience and expression, or are even devoid of affect in their therapist role, there is ample anecdotal and research evidence that such is not the case. In therapeutic encounters therapists experience a range of affects that may be positive or negative, appropriate or inappropriate, expressed or unexpressed. The manner in which the therapist monitors, understands, and manages his or her affective experience has the potential to influence the events and course of therapy and is therefore integral to outcome.

Therapy orientations vary widely in the extent to which they acknowledge the presence of therapist affect, and also in the degree to which a plan for affect management is advocated or prescribed. In recent years, as focus on the therapeutic relationship has grown, more attention has been paid to the sequelae of therapist affect. This has, however,

been largely incidental to the study of other aspects of the relationship and little research has considered therapist affect in its own right. The result has been a dissipation of information about therapist affect across a range of therapy disciplines, relationship components, and theoretical orientations.

This research will focus on therapist affect as a pan-therapy phenomenon and will limit itself neither to a particular theoretical construction of the therapy exchange, nor to a particular component of the therapy process. Rather, it will consider the broad occurrence of therapist affect in dyadic therapeutic relationships and how this varies among individuals. Its particular focus will be to investigate how personal and professional characteristics of the therapist mediate between the client as stimulus and therapist's reported affective experience, and it will do so within a framework that is accessible to all theoretical orientations and disciplines.

Affect in the Therapeutic Process

As a therapist negotiates his or her way through the complexities of a relationship that is at the one time personal and professional, the intricate interplay of thought processes, affects and behaviours requires sustained vigilance. Much of the therapist's mental processing occurs at a consciously rational and intellectual level. The therapist is continually processing the client's communication, relating it to a theoretical framework and to clinical knowledge, considering it in the context of the client's history, planning an appropriate response and working towards a therapeutic goal. At a more personal level, but still rationally and intellectually, the therapist is aware of relating the client's communication to his or her own experiences and history, particularly in the empathic

process, and uses this knowledge to enhance understanding of, and empathy with, the client's experience.

Conscious thought is, however, underpinned by a deeper level of thought that is not as readily identified, but that also requires therapist vigilance. In both the personal and professional intellectual exercise there is a gestalt, in which the client and the therapeutic work stand in the foreground and the therapist's beliefs, values, attitudes, attributions, goals and motivations form a background to consciously monitored and immediate thought. These beliefs, values, attitudes and the like are not always fully in awareness, but nevertheless contribute both directly and indirectly to understanding the client's communication (Strupp, 1993). The therapist's awareness of these mental "positions" is instrumental in determining the response to the client. Professional training teaches the necessity of vigilance about personal and professional values, beliefs and other thoughts; on-going professional development, supervision and/or personal therapy help to maintain this vigilance in later work. However, both initial training and later use of professional resources vary widely among therapists and it is, for many, a matter of individual responsibility and choice, how fully such matters are examined for their contribution to therapy.

For many therapists the first indication that the professional domain has been penetrated by personal values, attitudes and beliefs may be through awareness of affect. Theory continues to debate which of cognition and emotion occurs first in human functioning. In actual experience, however, the two are often virtually fused in experience. Frequently, first awareness will be of a feeling, a flash of emotion, an emerging mood, which can give pause to explore what cognitions have occurred. At other times a discrete

emotion, or perhaps a developing mood, will closely follow a thought or sequence of thoughts. Often the two processes will be indivisible in experience. Thoughts are rarely unitary and usually will comprise an interconnected chain. In the therapy process, the therapist's alertness to the on-going flow of data places great demands on the here-and-now in cognitive processing, and awareness of an affective event may often be the front line indicator of developing thought patterns. Sensitivity to affect and affective change can therefore be the pivotal event in a therapist noting and pinpointing underlying thought processes, particularly where these are attitudes or evaluations.

Because many factors, both personal and professional, contribute to the therapist's thoughts, and because thoughts can co-occur, overlap or even merge, the capacity to accurately monitor thoughts can easily be exceeded. Here again, affect represents a front line signalling system for the recognition of thought processes salient to the therapeutic process. Emotions in this context can be seen as indicators that attention needs to be paid to thoughts accompanying therapy events. Attention to an emotion or mood can alert the therapist to thought patterns before they are translated into behaviour. The vicissitudes of therapist emotion during a therapeutic encounter represent, therefore, a significant means by which the therapist is able to monitor and manage both consciously deliberated thoughts and the "ground" of personal and professional beliefs, attitudes and attributions against which these thoughts occur.

Affect can critically influence behaviour. Some therapeutic approaches acknowledge this through their advocacy of therapists' self-monitoring and processing of affective experience as a means of comprehending the subtleties of client communications, and of appropriately modifying therapist behavioural response (Dawes, 1985; Najavits et

al. 1995; Racker, 1957; Safran & Segal, 1996). Thus, decisions about interventions may be informed by attention to affect. Conversely, inattention to affect may lead to behaviours that are detrimental, and even destructive, to the goals of therapy. The outcome of inattention to affect can be far-reaching and impact negatively on both client and therapist. The greater is the therapist's awareness of affect and its determinants, the better is the therapist equipped to make informed and productive decisions in the therapy process.

Determinants of Therapist Affect

Surprisingly little research has directly addressed the affective experience of the therapist, albeit that some therapy approaches give it considerable theoretical weight. In research, therapist affect is usually considered as an accompaniment to, or corollary of, therapy events and, if studied directly, its operationalisation is generally as therapist behaviour. As a result, understanding of the nature and determinants of therapist affect has been fragmented across theoretical approaches, therapy disciplines and discrete components of the therapeutic process. In its dispersal the recognition of therapist affect as a pivotal event in therapy is diminished and its determinants and modifiers are more difficult to define.

In this thesis it will be argued that therapist affect serves important functions in the therapeutic process and merits independent investigation. Affect influences behaviour in its own right; it acts as a trigger for subsequent thoughts and thence behaviour, and it signals the occurrence of more complex underlying cognitive events that may not reach full awareness in their own right (Planalp & Fitness, 1999). Theory and research in psychological therapy, and in the wider domain of general emotion research, consistently point to a number of factors that are significantly associated with affect and that occur at a

personal and/or a professional level. An obvious stimulus to affect is the client's behaviour and this constitutes a body of research in its own right. This thesis, however, takes as its topic a concern with characteristics within the therapist that mediate affective experience of the client's behaviour as stimulus.

This thesis selects for investigation a number of therapist characteristics that have been hypothesised in general emotion and therapeutic relationship research to be significant contributors to the direction and intensity of affective experience. In order to investigate these variables a series of videotapes was made depicting interviews with clients displaying different behaviours. In a first study, these were presented to undergraduate psychology students to investigate the effects of personality and gender on their affective reactions. A second study presented the same videotapes to a group of practising health professionals from four professional disciplines and, in addition to personality and gender, considered the effects of theoretical orientation and training on affective experience.

PLAN OF THESIS

In the second chapter of this thesis, psychological therapy will be conceptualised and defined, and the nature and structure of the therapeutic relationship, in which therapist affect is most readily identified, considered. Chapter 3 will outline general emotion theory and its terminology, and give a brief consideration of the role of affect in interpersonal relationships generally, and therapeutic relationships in particular. Chapter 4 will review the empirical evidence for the impact of therapist affect on psychological therapy and, in particular, on the therapeutic relationship. Chapter 5 will specify the therapist variables to be examined in relation to affective experience and present the argument for the approach

taken to the investigation of therapist affect in the present research. Chapter 6 will report the construction and validation of experimental materials, and Chapters 7 to 10 report the two studies. Finally, in Chapter 11 a general discussion will integrate the results of the research with the wider research literature and make recommendations for future research strategies.

Chapter 2

CONCEPTUALISING THERAPY AND THE THERAPEUTIC RELATIONSHIP

What makes psychological therapies work? A prolific theoretical and research literature attests to the commitment to answering this question. Thus far, however, rather than the answer having been revealed, the question seems to have become more complex. As theorising and associated empirical evidence builds, psychological therapy is increasingly revealed as an intricate interweaving of theoretical, technical, personal and temporal factors. This chapter summarises how psychological therapy has been conceptualised, with attention to the importance of the therapeutic relationship that has particular significance to the current research.

Defining Psychological Therapy

Psychological therapy is used here as a generic term to encompass the literally hundreds of approaches now practised to help those in psychological distress (Kendall, 1998). The form that psychological therapy takes is determined by the reasons that a client seeks therapy, the theory embraced by the therapist, the therapy techniques derived from that theory, and by the identities of the participants in psychological therapy. Clients seeking therapy vary in the origins, symptoms, duration, and intensity of their problems, in their demographic characteristics, their personality structure and their interpersonal style. Therapists vary in their personal characteristics, professional affiliation, adherence to a theoretical position, experience and even in the demands of their work environment. It is

small wonder, then, that the business of determining what contributes to successful psychological therapy has proven complex.

Process and Outcome in Psychological Therapies

As therapeutic approaches, professional training programmes, and treatment facilities diversify and compete, there is greater demand for the demonstrated effectiveness of therapy and therapists. In the past three decades a complex network of research has grown that explores the association between the significant components, events and processes of therapy, and their relationship to outcomes. Attesting to the major role now attributed to process in psychological therapy, a review by Orlinsky, Grawe and Parks (1994) classified and summarised well over 2,000 studies of process and outcome.

In their Generic Model of Psychotherapy, Orlinsky, Grawe and Parks (1994) conceptualised psychological therapy as both a system and its environment. The model organises psychological therapy variables by their contribution as inputs to, processes of, or outputs from, the therapeutic system, or as combinations of these three. The model acknowledges the internal and external milieux of both participants as significant contributors to the overall system, and includes the reciprocal roles of therapist and patient, and participants' actions and experiences as attributes of the system. The participants' extended, "non-role" selves contribute to the milieu of therapy also, so that psychological therapy occurs as a convergence of therapy events with the wider context of the participants' lives.

The model describes six aspects of process that can be identified in all forms of psychological therapy. The formal, technical, interpersonal, intrapersonal, clinical and temporal aspects of process give structural cohesion to interrelated characteristics of

participants, therapeutic milieu, and wider social and cultural context. Overall, the model highlights that psychological therapy entails both theoretical and technical factors, while also acknowledging that the therapeutic endeavour, through the therapeutic relationship, is essentially a human and interpersonal undertaking (Orlinsky, Grawe & Parks, 1994; Safran & Segal, 1996; Strupp, 1986; Mallinckrodt, 1997).

Specific and Non-Specific Factors in Psychological Therapies

Process-outcome research has often reported that no apparent advantage accrues to any one model of therapy, although some psychological therapies are claimed to be more effective in the treatment of specific disorders (Cornsweet, 1983; Lambert & Bergin, 1994; Luborsky, Singer & Luborsky, 1975; Norcross, 1986, Stiles, Shapiro & Elliott, 1986;). One consequence of this repeated assertion that specific approaches and techniques cannot adequately explain therapy success, has been an increased interest in so-called nonspecific, or common, factors in the psychotherapy process (Kazdin, 1979).

Specific factors refer to techniques unique to an approach to therapy and include "...the particular theoretical orientation adopted by the therapist as well as the technical maneuvers (techniques) based on the theory" (Butler & Strupp, 1986; p.31). Nonspecific factors refer to those core aspects of therapy, common across therapeutic modalities, which encompass a range of personal and collaborative experiences, expectations, and responses in the therapeutic encounter. Nonspecific factors are deemed to add significantly to patient improvement, and the variance in outcome attributable to the nonspecific factors of therapy has been set as high as 45% (Lambert, Shapiro & Bergin, 1986).

There is debate about what constitute the commonalities among common factors (Grencavage & Norcross, 1990) and, indeed, whether common factors are so inextricably

related to specific factors as to be empirically indistinguishable from them (Waterhouse & Strupp, 1984; Safran, 1990). Indeed, Strupp (1986) argued strongly against differentiating specific from nonspecific factors claiming that the "...therapist's personal and technical skills are inextricably woven into every aspect of the structure and process of his or her relationship with the patient." (p.519). Attempts to identify the elements common to therapeutic modalities consistently include the therapeutic relationship as one of the most influential. Frank (1971), in an early discussion of nonspecific elements of therapy, emphasised the emotionally charged relationship and the agreed therapeutic rationale shared by therapist and client. Garfield and Bergin (1994) named a number of broad common factors such as hope, emotional release and interpretation of problems, but placed as first the relationship that is developed in virtually all psychological therapies. Karasu (1986) identified affective experiencing, cognitive mastery and behavioural regulation as factors common to psychological therapies, and noted that such was the importance of the therapeutic relationship as a nonspecific factor that it formed a separate category requiring independent investigation.

This factor of the relationship between therapist and client thus obtains consistent attention as a principal variant in the therapy process (Karasu, 1986; Frank, 1971; Hylan, 1981; Strupp, 1986; Strupp & Hadley, 1979). Although the emphasis given to the role of the therapeutic relationship differs across therapeutic modalities (discussed in Chapter 5), there is general agreement that a positive relationship between therapist and client is a requirement for therapeutic change to occur (Strupp, 1996; Marziali & Alexander, 1991; Safran,1990). The characteristics that contribute to a "good" therapeutic relationship have

therefore received particular attention and the literature provides a rich source of information relevant to the current research.

The Nature of The Therapeutic Relationship

The therapeutic relationship can be viewed as a close personal relationship, sharing the basic structural features of prototypical close relationships such as friendship and marriage (Christensen, 1983; Derlega, Hendrick, Winstead & Berg, 1991). Kelley et al (1983) described a close relationship as "...one of strong, frequent and diverse interdependence that lasts over a considerable period of time" (p.38). In their model of close relationships Kelley et al determined that interdependence results from the causal interconnections between interpersonal event patterns of participants' lives. Kelley et al specified eight properties as important to the analysis of this interdependence: the kinds of events that comprise the two interconnected chains of participants; the patterns, strength, frequency, diversity and symmetry of interconnections; the facilitation/interference between chains; and the duration of the relationship.

Although the interaction between therapist and client is agreed to be a relationship, it is often termed a "special" relationship to signify that its members interact in somewhat different ways from members of other, more prototypical relationships. The properties of interdependence between close relationship members prove a useful means by which to identify the unique properties of the therapeutic relationship and also point to significant conceptual differences between theoretical approaches to the therapeutic relationship.

Arguably the point of greatest divergence from other forms of close relationship occurs in the asymmetry of the therapeutic relationship (Christensen, 1983; Derlega, Hendrick, Winstead and Berg,1991). In prototypical relationships there is reasonable

symmetry of roles, power, self-disclosure, obligation and personal benefit. In therapeutic relationships these dimensions may differ markedly among participants, and therefore may impact on the nature of the relationship. The asymmetry in the relationship between therapist and client, particularly concerning issues of gender and power, has been identified as a defining feature of some psychological therapies (Brown, 1986; Schaverien, 1996; Sesan, 1988;).

Like other relationships, the therapeutic relationship occurs as a series of interactions that are extended over time. However, there is a variation from the prototypical conceptualisation of the close relationship that typically extends over months, if not years (Kelley et al., 1983). Unlike prototypical relationships, in which duration is generally open-ended, a therapeutic relationship exists for a finite and often clearly specified period. Temporal boundaries may be set explicitly (e.g., contracted to extend for five sessions) or implicitly (e.g.,until the client has achieved resolution of the presenting problem), but there is agreement that the relationship will ultimately terminate. The time over which a therapeutic relationship is agreed to extend, and the constraints upon tasks and goals that this imposes, forms one of the principal characteristics discriminating among approaches to psychological therapy.

The patterns, strengths, frequency and diversity of interconnections in prototypical relationships normally develop through a progressively negotiated exchange between participants. In therapeutic relationships, however, at least some of these properties are defined from the outset. Thus the pattern and frequency of interconnections are determined by a contractual agreement between therapist and client according to the nature of the particular approach to psychological therapy. Similarly the strength and diversity of

interconnections will be specified, albeit sometimes implicitly, by the theoretical approach taken to therapy. Testing of, and strains on, such negotiated agreements form a central working dynamic in many forms of psychological therapy (Safran, Crocker, McMain & Murray, 1990).

In prototypical relationships the roles, goals, and tasks ascribed to each participant are frequently not clearly delineated at the outset and may be negotiated and re-negotiated throughout the relationship. In a therapeutic relationship, which Derlega et al. (1991) described as both personal and professional, there is a shared "professional" goal (the client's wellness) which may be more or less clearly defined and agreed at the outset. The tasks employed to achieve the professional goals of therapy vary with the theory of therapy and, again, form an identifying characteristic between theoretical approaches. Each participant also has unique personal goals and motivations (for the therapist, for example, to be an effective therapist, or to obtain a livelihood; for the client, to achieve self-understanding or control over problem behaviours) which may also be more or less explicitly stated. Although there is ideologically a confluence of personal with professional goals, this does not always occur in practice; nor, indeed, may personal goals (and their conflict with stated professional goals) necessarily even be personally acknowledged.

Another potential difference between prototypical and therapeutic relationships is the relevance of individual characteristics to the relationship. In most close relationships individual characteristics such as personality, physical attractiveness, age, race, gender, marital status and religious and other belief systems may be determinants of whether initial interaction progresses to a sustained relationship, and all may act to facilitate or interfere with interconnectedness (Auhage & Hinde, 1997). In the therapeutic relationship the

relevance of such characteristics is, at least in theory, suspended at the initiation of the relationship, and asymmetry in these characteristics may be suppressed for the duration of the relationship. Despite their assumed irrelevance such characteristics may impinge on the relationship, and such a view is reflected in the therapeutic literature which has considered the relevance of client-therapist "matching" for characteristics such as ethnicity, race and gender (Lambert & Bergin, 1994).

The fundamental properties of close relationships described by Kelley et al. (1983) serve as a means of identifying factors that are likely to significantly affect the form and quality of the therapeutic relationship. To date, theorising and research in psychological therapy has been slow to take advantage of developments in the broader domains of psychology, and in the highly complex area of relationships there may be an advantage in adopting a less parochial stance (Safran & Greenberg, 1991). The proliferation of research into the therapeutic relationship attests to the importance now attached to it. However, understanding of relationship factors and their outcomes is hindered by the fact that almost all research is conducted within the parameters of a particular theoretical framework, and therefore a particular view of the therapeutic relationship. The consequent esoteric view of the relationship makes difficult a shared knowledge base. To consider the therapeutic relationship from a perspective of fundamental characteristics such as those described by Kelley et al. (1983) may help to unravel its complexities.

Finally, a key characteristic of close relationships is that they are "...characterised by emotional investment of the participants in the relationship" (Berscheid, 1983, p.148). Indeed, emotion forms so intimate a part of all relationships that emotions have been considered *as* social relationships if emotion is seen as always relative to an other (de

Rivera, 1977; de Rivera and Grinkis, 1986). However, it is a not uncommon assumption about psychological therapy that the therapist can maintain sufficient professional distance in the therapeutic relationship that he or she need not experience emotion, or else can effectively suppress, contain or otherwise manage his or her emotion so that the relationship is unaffected. In part this ostensibly is achieved through the adoption of a theoretical orientation, and also in part by training and experience. It is the overall aim of this thesis to examine individual differences in therapists' affective experience and also to consider the contribution of a number of therapist characteristics that might contribute to individual differences in affective experience.

Theoretical Approaches to Psychological Therapy

The therapist's theoretical orientation, and the assumptions that underpin it, will to some degree shape the character of the relationship that develops between therapist and client. Cornsweet (1983, p.309) defined a theory of psychological therapy as "...an organizing principle for the clinician which, ideally, encompasses most aspects of clinical experience and provides guidelines for assessment and treatment, but is not so rigid as to preclude creativity in application and development of theory and research." Norcross (1985), using the terms theory, orientation and system interchangeably, considered that a theoretical orientation provides a consistent theory of normal and dysfunctional human behaviour, a theory of psychotherapy and the mechanisms by which change is accomplished. However, as both these authors have pointed out, there is not necessarily exact accord between the principles of an espoused theory and the way that they are translated into clinical practice. Both at a deliberate and an inadvertent level, therapists may diverge from the principles of a designated theory.

The assumptions that underlie a theory of therapy are subject to verification, re-interpretation or variation according to the experience and beliefs of the therapist. It has been reported, for example, that with increasing experience therapists may move from a strict adherence to the theoretical principles in which they were first trained to an adapted or modified theory that reflects their expanding clinical experience and their own personalities (Schwartz, 1978; Lazarus, 1978). Although principles may not stringently reflect the original theory, therapists will hold, either implicitly or explicitly, theoretical formulations about both human nature and therapy practices. Indeed, Norcross (1985) disavowed that therapy can be atheoretical, maintaining that therapy is always guided by theory, no matter that this is sometimes imperceptible even to the therapist.

As approaches to psychological therapy have proliferated, and attention has turned to the relative efficacy of differing orientations, there have been attempts to classify the many available approaches into broad categories according to their fundamental assumptions. The basis on which classifications of theoretical orientation are made appears to rest on broad historic paradigms but method of classification is rarely specified in therapy research. The most frequent classification is tripartite, by psychoanalytic, behavioural/cognitive behavioural, and person-centred/experiential principles. In earlier research into differences between theoretical orientations, the distinction was often a dichotomy, with either psychoanalytic and behavioural, or psychoanalytic and client-centred approaches compared with each other (see, for example, Patterson, Levene & Breger, 1971; Strupp, 1955; Weiss, 1973). More recent research appears to include more extended combinations of categories.These are, however, still related to the broad paradigms of psychology's history, although a growing minority now advocate an

integrative approach to psychological therapy. In the past, integrative approaches have been viewed with disfavour for being without a clear theoretical foundation. More recently, however, the possibility of blended theoretical principles have been more readily accepted by some.

In a comparison of perspectives on the therapeutic alliance which, as will later be discussed, forms a cornerstone of the therapeutic relationship, Gaston et al. (1995) discussed cognitive-behavioural, psychodynamic and experiential approaches and found that, while all agreed on its importance, there were differences of emphasis. Murdock, Banta, Stromseth, Viene and Brown (1998) investigated counsellors' choice of theoretical orientation and asked participants to choose their primary theoretical orientation from a list of eight. These were later collapsed into five categories of psychoanalytic, systems/interpersonal, person-centred, cognitive-behavioural and existential/gestalt theoretical orientation, which were best predicted by philosophical assumptions, personal control and supervisor orientation.

The reported finding that specific factors account for little of the difference in outcome from therapies of differing theoretical orientation implies that it is in the nonspecific, or common, factors that dimensions of difference are to be identified. Cornsweet (1983) elected the therapist-client relationship, the cognitive set provided by the therapist, and the personality of the therapist as three basic categories of nonspecific factors. Karasu (1977), also focussing on the nonspecific elements of psychological therapy, nominated three themes - dynamic, behavioural and experiential - and grouped over 50 approaches to psychotherapy by these three themes. The themes were then contrasted on a number of underlying and interrelated dimensions. "Each theme represents

something of a unity, that is, one's conceptual framework or belief system regarding the nature of man and his ills will have a bearing on one's concept of therapeutic modes or curative processes and the nature of the therapeutic relationship between patient and therapist and, ultimately, on one's methods or techniques of treatment." (Karasu, 1977, p.853). In most comparisons of theoretical orientation, therefore, the therapeutic relationship is consistently cited as one way in which orientations may be differentiated. However, theoretical orientation is also closely related to the cognitive patterns (beliefs, values and attitudes) of the therapist and the three factors of theory, relationship and therapist cognition are therefore integrally related with each other.

What remain unclear are the fundamental dimensions on which categories of theoretical orientation differ, and numerous factors have been proposed that constitute the differences between theoretical orientations. Poznanski and McLennan (1995) reviewed and evaluated measures of counselling psychologists' theoretical orientation. Acknowledging first the consensual finding that differing approaches to psychological therapy are generally found to be equally effective, the authors cited research indicating that there exist observable differences between therapists of different theoretical orientations and that such differences reflect variations in the therapists' underlying conceptual assumptions. From the many different dimensions that have been proposed as characterising different orientations, Poznanski and McLennan concluded that analytic versus experiential and objective versus subjective dimensions proved most useful in differentiating between major theoretical approaches. The analytic-experiential dimension opposes planned approach, focus on unconscious processes, limited therapist spontaneity and conceptualising, with unplanned approach, therapist spontaneity and therapist

personality. The objective-subjective dimension contrasts preference for the observation, objectivity and factual data with preference for the subjective, introspective and experiential.

Although the two dimensions identified as basic by Poznanski and McLennan (1995) are a useful means of identifying central differences between approaches to psychological therapy, the nature of the dimensions fails to fully reflect the characterstics of the therapeutic relationship, which is acknowledged as central to therapy. Other attempts to identify characteristics of theoretical approaches have acknowledged the therapeutic relationship as an important differentiating characteristic and in this context specify affect as a feature. For example, McNeilly and Howard (1991) used The Therapeutic Procedures Inventory-Revised (TPI-R; Orlinsky, Lundy, Howard, Davidson, & O'Mahoney, 1987) to identify dimensions most salient to theoretical orientations and recovered three factors that included an affective dimension. Most items relevant to this dimension were derived from the scale measuring the therapeutic relationship. However, the majority of these items refer to working with the patient's affect and only few to the therapist's own affective reactions in therapy.

To summarise this chapter, psychological therapy has been conceptualised in terms of specific and nonspecific factors, of which the therapeutic relationship is identified as a significant nonspecific factor that contributes to process and outcome in all modalities of psychological therapy. The therapeutic relationship possesses properties identifying it as a form of close relationship, although one in which there are specifiable differences from other close relationships.The therapist, as a participant in a close relationship, will necessarily experience affect in response to the other participant, the client. That affective

experience is not simply a response to the stimulus of client behaviour, but is shaped by personal characteristics of the therapist and is partially modified by training, experience and adherence to a theoretical position. The next chapter considers theories of emotion, emotion in relationships, and the approach to emotion adopted by three major approaches to psychological therapy.

Chapter 3

CONCEPTUALISING AFFECT

After decades of relegation to the backwaters of psychology, the tide of interest in emotion theorising and research has swelled to flood proportions in recent years. Emotion has become the "hot" topic, and personality, biological, developmental, social and social-cognitive psychology in particular have turned their attention to the relationship of emotion to these areas of knowledge. As yet an integrated theory of all aspects of emotion has not evolved. Rather, theoretical perspectives have addressed different aspects of emotion and a network of approaches now exists. Within a psychological perspective, for example, Carlson and Hatfield (1992) identified three traditional approaches to theorising about emotion as experiential, physiological and expressive. Metts and Bowers (1994), taking a communication perspective, grouped theories of emotion according to three principal themes of language analytic, psychosocial and psychophysiological.

The concern of the present research is with the therapist's internal, emotional experience within the interpersonal context of therapy. Therefore, of the three approaches described by Carlson and Hatfield (1992), it is to experiential, rather than physiological or expressive, theories that this thesis turns for theoretical ground. Within the experiential approach, Carlson and Hatfield identified two basic approaches of psychodynamic/motivational and cognitive theories of emotion. Of these, it is perhaps the cognitive approach that has greatest relevance here, in that this approach emphasises the links between emotion and cognitive activities such as evaluation, appraisal and attribution. From Metts and Bowers' (1994) perspective, the psychosocial approach is also

relevant since psychological therapy is a quintessentially interpersonal enterprise. Although Carlson and Hatfield, and Metts and Bowers, use different methods of identifying common themes among theories, the theorists included within these groupings overlap to some degree, and it is a mark of the indistinct boundaries between such theories that different approaches can be taken to their categorisation.

The use of emotion terminology varies considerably in its meaning across the different areas of theorising and research. Thus, the first section of this chapter delineates the ways in which emotion terminology is employed in the present research. The second section then considers briefly the contribution of the cognitive and psychosocial approaches to the understanding of emotion, and relates each to the process of psychological therapy.

Emotion Terminology

As interest in emotion has spread throughout psychology there has been a concomitant proliferation in the way in which emotion-related terminology is used. Terms such as affect, feelings, mood and emotion have been employed by different paradigms with little commonality of usage, and it is as well to identify at the outset the ways in which these terms are employed.

The problem of what constitutes an emotion has bedevilled psychological study for years and at its most elemental reduces to which of physiological, mental or behavioural elements is basic to emotion. For every definition of emotion that gives priority to one of these, there exist exceptions; thus Fehr and Russell (1984) have argued against classically defining emotions by necessary and sufficient conditions, suggesting instead that emotions are best understood in terms of their prototypicality, or characteristic features of concept

membership. By adopting this view, the "basic" emotions often sought in emotion theory become those judged to be prototypical of the concept (Shaver, Schwartz, Kirson & O'Connor, 1987). Fundamental to this approach to the definition of emotion is that it specifies events that are discriminable , and it is this way that the term is used here. Emotion is frequently used as a collective noun to refer to the broad phenomenon of emotional experience and expression. It is used here, however, to refer to the discrete emotional episodes characterised by a cluster of physiological, experiential and expressive features that are brief (from seconds to minutes), reasonably sharply defined, and reactive to a prevailing condition (Watson & Clark, 1994).

Affect

In this thesis the approach to therapist emotional experience is a broad one, and for that reason the term "affect" is used in preference to emotion. To speak of emotions implies a specificity that is not addressed in this research. Indeed, the aim of the present research is to provide a generic view of therapist affective experience in psychological therapy that does not seek to differentiate discrete emotions. "Affect" is therefore used to signify the generic construct, one intended to include the gamut of emotional parameters, from broad to narrow (Fitness & Strongman, 1991). Thus affect refers to all nature of emotional phenomena and, to use Averill's (1997) framework for the analysis of emotion, includes emotional syndromes (anger), states (angry), and reactions (attacking), as well as the emotional traits (choleric) that are superordinate to these three. In distinguishing a hierarchical relationship, from broad emotional syndromes, through states, to reactive levels of emotion, Averill's framework points to another affect term that is perhaps one of the most loosely (and consequently confusingly) used emotion terms, that of mood.

Mood

Mood is generally used to indicate more or less enduring affective states which are of low intensity and which are pervasive in their effects (Forgas, 1991). In the sense that it is used in this definition, affective "state" refers to a condition. However, two mood conditions are commonly referred to – trait moods and state moods – and it is to this distinction that the "more or less" of mood would appear to refer, and from which at least some of the confusion about mood appears to arise. In the wider domain of psychology, Allen and Potkay (1981) have argued that the state-trait distinction is an arbitrary one and that the two cannot effectively be distinguished. The response by Fridhandler (1986) to this argument is useful in the present context in identifying what defines a trait and a state mood.

Fridhandler (1986) specified four distinguishing characteristics of state and trait: duration, continuity, concreteness and causality. These are applied here to differentiate between a state mood and a trait mood. The duration of traits is assumed to be long-lived or enduring, and of states is assumed to be short-lived or transitory. However, while most would agree on this distinction between trait and state moods, the continuity of the mood qualifies its duration. Fridhandler asserted that traits are discontinuously apparent and states continuously apparent. Thus, while trait moods may last for a lifetime, they need not always be expressed and are therefore discontinuously manifest, whereas state moods only exist for a relatively short time and are continuously manifest for that period. Thirdly, traits are abstract and can only be identified by inference; the individual possessing a trait mood need not have here-and-now awareness of a trait mood, nor can a trait mood be directly observed from one occasion but must be inferred from its discontinuous but repeated

occurrence. On the other hand, state moods are concrete, can be directly observed by others, are in the awareness of the individual, and often can be related to a contingent event. Thus, as Fridhandler (1986, p.170) stated, "...one can term a state a *concrete* entity and a trait an *abstract* one." Finally, trait and state moods can be distinguished by their causality. Whereas, according to Fridhandler, traits have a causal context intrinsic to the individual, states have as their causal context an immediate situation. Thus a trait mood is one arising principally through factors distal to the situation and a state mood is one arising principally from proximal and current factors.

Trait and state moods are sometimes also distinguished by the manner in which discrete emotions are associated with them, although this difference may be more apparent than real. Indeed, Lazarus (1991a), among others, has asserted that traits do not constitute emotions but that states do. Traditionally the discrete emotion events associated with state moods appear to be more sharply defined and intense than those associated with trait moods. However, this difference may be an effect of the shorter duration, continuity and concreteness of state mood that throws them into sharper contrast with the individual's prevailing or non-mood state. Because state moods are usually associated with particular circumstances or events, discrete emotions may also be more acute and out of the ordinary, whereas the emotional events occurring as a consequence of trait mood may be more chronic and therefore be less sharply defined. This characteristic is likely to be manifest in both experience and behaviour, as is reflected in Fridlander's (1986) concrete-abstract dimension. Thus, for example, irritability attributed to trait mood may present as generalised, predictable and chronic bad temper and with less sharply defined outbursts of

discrete emotion. The irritability attributed to state mood may appear more as an uncharacteristic outburst and therefore be more apparent and seem more intense.

In this research, both trait and state mood are viewed as potential independent and interacting influences on the therapist's affective experience in psychological therapy. Trait mood, as an enduring but discontinuous propensity to experience some affects more than others, sets the backdrop of affective tone against which more context-specific affect is played out. State mood, more situation-dependent, and therefore more likely to be triggered by the events of therapy, is also more concrete and more likely to be within the conscious experience of the therapist. However, the backdrop trait propensity for moods of a particular valence enhances the likelihood that state moods of the same valence will occur. Discrete emotions, direct responses to specific events of therapy, will also occur. The manner in which these events and their contingent emotions are evaluated and interpreted by the therapist will, to some degree, reflect the effects of trait propensity to experience affect of a particular valence. For example, if a series of like-valence discrete emotions is experienced (e.g., annoyance, hostility, disgust, and anger) these may accumulate to become a situationally determined state mood that is continuous for part or all of the consultation (or beyond) and is consciously felt by the therapist. The propensity for a like-valenced trait mood may contribute to the development of state moods and also to discrete emotions.

Thus, although the presence of both discrete emotions and state moods may be observable, it is not always possible to attribute these solely to the events of therapy. Rather, they occur as a continuous interaction between trait mood, state mood and the context of therapy. In short, discrete emotions, state moods, and trait moods may all occur

during therapy, depending on the characteristics of the stimulus situation (that is, the client's behaviour), the therapist's enduring underlying trait propensity to experience certain affects, and the therapist's state susceptibility to the situation.

Having outlined the manner in which emotion terminology is employed, the next section describes emotion theories that help to explain the causes and functions of affective phenomena. These will then be applied to the events of psychological therapy.

Theories of Emotion

Two related emotion theories, cognitive and psychosocial, have been chosen for their particular relevance to the understanding of therapist affect in psychological therapy. Cognitive theories acknowledge the role of physiological, perceptual, cognitive and behavioural processes in emotion but place these in varying emphasis to each other. All, however, take as their premise that affect and cognition (attributions, appraisals, judgements or evaluations, for example) are intricately tied to one another, one virtually always accompanying the other to at least some minimal degree. This begs the question that was hotly debated for some years (see Zajonc 1980, 1984; Lazarus 1982, 1984) as to which, of emotion and cognition, has primacy and this has some relevance to the present research.

The view taken here is that appraisal and other cognitive activities accompany every emotional event (although this does not include a presumption that cognition will necessarily precede all affect). Not every cognitive activity, however, need be accompanied by affect. Sometimes cognition will lead to affect; always affect will lead to cognition as appraisal or re-appraisal (Lazarus, 1991a, 1991b). However, the two systems are so closely articulated that, in actual experience, often no distinction can be made as to

which resulted in the other. Such a view accords with a systemic approach such as that of Leventhal (1979) in which parallel systems operate simultaneously to produce emotional experience upon which the individual acts according to environmental demands.

Cognitive Theories

Cognitive theories of emotion have focussed on different aspects of the cognition-emotion connection, although most acknowledge a role for both physiological arousal and cognition as the foundations for emotion. In recent years the particular emphasis has been on the role of cognitive attributions and appraisals, and their adaptational significance for the individual. In particular,Lazarus (1991a, 1991b) made the distinction between "cold" and "hot"cognition: the former involves impersonal knowledge, without significance for the well-being of the individual, and therefore does not include an emotional element; the latter involves a personal evaluation (appraisal) of events for their significance to the well-being of the individual and therefore involves emotion. Smith, Haynes, Lazarus and Pope (1993) tested the hypothesis that the original causal attribution made about situations did not necessarily directly cause emotion, and found that it was with the ensuing appraisal concerning well-being that emotion was related.

The distinction between non-emotional cognitive knowledge and emotional cognitive appraisal is an important one in considering the therapist's responses to the therapy situation. "Knowledge consists of what a person believes about the way the world works in general and in a specific context. Without a personal stake in a transaction with the environment, knowledge is relatively cold or non-emotional." (Lazarus, 1991b). When the further step is taken to appraise knowledge and determine its significance for well-being and goals, then emotion must be necessarily result.

Thus, the therapist who operates without personal stake in the (therapeutic) transaction will be (relatively) non-emotional. However, immediately that there is significance for goals, plans, and well-being, the (therapeutic) transaction must be emotional at some level. Moreover, the extent of emotional involvement will entail the extent to which goals, plans and well-being are seen as potentially benefited or threatened.

According to the cognitive perspective, situations are perceived and appraised not only in terms of current knowledge, but also in terms of past experience and future expectations. In his or her transactions with the environment, the individual must make decisions about how to act, and these decisions are based in how the current situation is perceived, how past experience informs present perceptions, and what is anticipated from the situation. The emotion that accompanies a current transaction with the environment, therefore, emanates from a complex processing and appraising of past experience, present needs and future goals, and is determined also by the individual's affective and cognitive styles (traits) that are established early in life.

In the therapeutic relationship, as in other close relationships, there is a continuous stream of affect, which both requires and results from the therapist's attributions and appraisals as he or she interacts with the client. The view taken here of the association is that, in its primary informational and communicative function, affect interacts bi-directionally with cognition. That is, affect both generates and signals the presence of cognitions, and also arises in response to cognitions. The process is potentially facilitative in both directions in that either may give access to information contained in the other. Either may occur at conscious or preconscious levels and frequently, when one is available at a conscious level, it may be used to access a preconscious event in the other modality.

Because attributions, appraisals and other evaluative processes draw not only on the factual information available about the situation, but also are integrally tied to the therapist's own memories, beliefs, needs and goals, the examination of affect is a central tool in the tasks of therapy. Affect, acknowledged as the result of appraisal of personal significance, is the means by which the therapist can become aware of personal values, judgements, wishes and fantasies that have entered the therapeutic process.

Psychosocial Theories

The group of emotion theorists labelled by Metts and Bowers (1994) as psychosocial also includes, perhaps not surprisingly, the work of Lazarus. Metts and Bowers grouped Lazarus' theory of emotion with that of Averill and de Rivera and identified as their common ground that emotional experience is viewed as a social phenomenon, in which the individual's "....social knowledge and subjective appraisal channelize interpretations of experience as emotions". (Metts & Bowers, 1994, p.519). Theorists within this group thus emphasise the role of affect within a social framework, finding evidence of social values, norms and aspirations in the types of appraisals that individuals make in their transactions with the environment. For example, Parkinson and Manstead (1992) have commented on the vital role of social, cultural and institutional factors in the causation of emotion and have argued that these are sufficiently integral to everyday interpersonal interactions that they do not necessarily occur as deliberate appraisals. Much of our interpretation of interactions with others include ingrained and continuous social attunement to the situation that involves no direct appraisal. There is frequently a shared social meaning that also contributes to emotional reaction. As Parkinson and Manstead stated: "...society often affects social interactions quite directly,

prescribing legitimate modes of action via implicit and explicit rules that structure the possible channels of action and shape their interpretation for people ocuupying different roles" (p. 145).

For the therapist, therefore, the affect experienced in the therapeutic setting reflects both a response to the reality of therapy and an evaluation of that reality in terms of its meaning for the therapist. A large part of the reality is the relationship with the client and is represented by the actuality of the client and the therapist as separate individuals and in interaction with each other. How that reality is appraised, interpreted and given meaning by the therapist will involve the social values, beliefs, norms and aspirations of the therapist, which may have been inculcated over a lifetime and may not be fully in awareness. Even the theoretical orientation adopted by the therapist entails something of the therapist's own values and belief systems, and therefore will not necessarily be sufficient to over-ride or contain the personal meanings applied by the therapist in responding to the therapy situation.

Thus within the context of what has already been stated of Lazarus' theory of emotion, the evaluation of relative well-being signalled by the occurrence of emotions includes not only physical well-being, but psychological and social well-being also. The beliefs, values, principles, goals and wishes that an individual holds will be determined by past experience in interpersonal interactions and the social environment in which the individual exists and will to some extent predict the nature of future interactions. Inevitably, therefore, emotions must accompany most, if not all, the individual's interpersonal transactions since so much of what occurs in interpersonal relationships does so within the framework of values and beliefs learned in a particular social environment.

For therapists, exchanges in the therapeutic context will frequently contain affect that results from the therapist's personal appraisals and understandings of the interaction and also from social factors "....that interpenetrate individual action at all levels, with culturally defined relations representing themselves in every interpersonal transaction so that differential social positions are involved even in our 'personal' intepretations of the world" (Parkinson & Manstead, 1992, p.146). The research reported in this thesis takes some of the variables most likely to be identified with personal and social meanings and examines their relationship to affective responses in an analogue therapy situation. In the next chapter evidence is presented for the presence of therapist emotion in psychological therapy and, in particular, relates it to components of the relationship with the client.

Chapter 4

THERAPIST AFFECT AND THE THERAPEUTIC RELATIONSHIP

One of the marked differences between therapeutic and other relationships is the manner in which participants' emotions are experienced and expressed. In prototypical relationships there is the potential for, although not necessarily the practice of, an equal exchange of emotion. The same potential for equality of emotion expression does not exist in the therapeutic relationship. In most psychological therapies it is increasingly accepted that the client participant will experience and express a range of emotions and that these will be explored with the therapist (see, for example, Greenberg & Safran, 1984). As a symptom of specific dysfunction, a sample of behaviour occurring in other interpersonal interactions, a response to the therapy itself, and as a source of insight into the client's problems, client affect is grist for the mill of therapy. However, for most psychological therapies this same expectation of experienced and expressed affect does not extend to the therapist. Indeed, the converse could be said to be true. In most major therapeutic approaches there is an expectation that affect range and intensity will be contained by the therapist in experience as well as in expression .

Therapist affect presents a paradox for therapy. On the one hand an emerging consensus is that the establishment of an emotional bond with the client is central to productive therapy (Bordin, 1979; Gelso & Carter, 1985; Horvath & Greenberg, 1994). On the other hand, however, the therapist must also maintain a professional relationship with the client and therefore monitor and limit what affect is experienced and expressed. Therapist affect must be subject to continual examination and decision-making in order to

determine its relevance to the therapeutic process. Thus the therapist must both offer an emotionally genuine, spontaneous and "personal" presence in the relationship with the client, but at the same time maintain a relative emotional distance that permits appropriate "professional" perception and evaluation of the client.

Although the therapeutic relationship can be considered common to all psychological therapies, it nevertheless also shows variation across therapies, reflecting the theoretical assumptions on which therapy is based. The theories upon which therapies are founded provide, more or less explicitly, guidance and recommendation as to the form of the therapeutic relationship established with the client. Because affect is inherent in the relationship, the theory embraced by the therapist will therefore also provide a perspective on the relevance and role of therapist affect and this will direct the manner in which the therapist understands, manages and uses his or her own emotions.

An extensive and diverse literature refers to the therapeutic relationship, its component parts and its contribution to therapy process and outcome. The effects of both therapist and client affect in the relationship are implicit in much of this literature, but surprisingly little direct attention has been given to the role of therapist affect or its impact on process and outcome. Recent attempts to present a more integrated construction of relationship components enable a clearer view of how therapist affect contributes to the relationship.

A Model of the Therapeutic Relationship

In 1985 Gelso and Carter published an article intended to stimulate thinking about, and research into, the therapeutic relationship in individual psychological therapy. Their tripartite model of the relationship was proposed as one relevant to all therapeutic orientations, although the emphasis given to components might differ. Gelso and Carter

acknowledged their own therapy orientation to be psychoanalytic and perhaps there is some partisanship in the way in which the relationship components are discussed. In the present discussion some aspects of the relationship are reconceptualised in order to avoid a bias to the more psychoanalytic view taken by these authors.

Gelso and Carter (1985) defined the therapeutic relationship as "...the feelings and attitudes that counseling participants have toward one another, and the manner in which these are expressed" (p.159) They identified three interrelated components of the therapeutic relationship, the working alliance, the "real" relationship, and the "unreal", or transference, relationship. In a later elaboration of their model, Gelso and Carter (1994) stressed that the three components are overlapping and in continuous interaction with each other, although their characteristics and functions are usually described as distinct and independent. This has re-kindled interest in the indistinct separation between these three ostensibly independent aspects of the relationship (see Greenberg, 1994; Patton, 1994; Beutler and Sandowicz, 1994; Hill, 1994 for contributions to this discussion). Although the issue has been debated in the psychoanalytic literature for many years (Greenson, 1965; Langs, 1979; Adler,1980), in the wider domain of theorising and research, the intimate relationship between these three constructs has been neglected, with the result that each is usually independently defined and researched.

Using the model proposed by Gelso and Carter (1985;1994) consolidates the extensive literature on the relationship and therapist affect, illustrating the overarching role of therapist affect in the therapeutic relationship. The following discussion of the three components acknowledges the difficulties in making a clear separation between the

components but proposes that a focus on therapist affect can assist in clarifying their distinct, but overlapping, natures.

The Working (Therapeutic) Alliance

Few therapists would disagree that, regardless of the context of therapy, the type of relationship formed, or the techniques deployed, some union of interest between therapist and client is required in order for the work of therapy to proceed. The concept of the working, or therapeutic, alliance (the terms are used here as equivalents) encapsulates this sense of union and collaboration and constitutes a major aspect of the therapeutic relationship.

The concept of an alliance between therapist and client was part of early psychoanalytic thought. Freud pointed to its importance in his discussion of such concepts as resistance, and the distinction between distorted transference reactions and the collaborative analytic pact. However, it was later psychoanalytic writers such as Sterba (1934), Zetzel (1956) and Greenson (1965) who more fully developed the concept of the working, or therapeutic, alliance. Sterba (1934) referred to the "ego alliance", or the alliance between the reasonable, rational aspects of both the client and the analyst, which permits the formation of a therapeutic contract. Zetzel (1956), the first to use the term "therapeutic alliance", focussed on the distinction in transference between the attachment to, and identification with, the analyst, and the more distorted transference reactions.

Greenson (1965) incorporated these earlier authors' work into an influential paper in which he proposed that the alliance be distinguished from the real and transference relationship. He emphasised a requirement for the patient to work purposefully with the therapist as central to the concept of an alliance between therapist and client, and claimed

that this was possible even when transference effects were at their most powerful. Thus, in psychoanalytic theory, the concept of the alliance has gradually evolved to represent the concept of cooperative, goal-directed work between therapist and client that is distinct from either the real (non-transference) relationship, or the unreal (transference) relationship. Each constitutes a different aspect of relating between therapist and client but necessarily, because each forms part of the larger whole, there is overlap between them.

Bordin (1979) recommended the importance of the alliance to a wider group of psychological therapies, and gave the impetus for future research when he proposed that the concept was generalisable to all forms of therapy. His aim was to provide a framework that could accommodate differences in emphasis between therapy genres while maintaining the key importance of the alliance to therapy generally. Bordin formulated the working alliance as comprising three features of agreement on goals, assignment of tasks and the development of relational bonds between therapist and client. Unlike earlier conceptualisations, Bordin's view permits the alliance to stand independently of such analytically based concepts as divisions of the ego and transference, and therefore, theoretically, makes it acceptable to orientations not embracing such concepts.

Bordin's (1979) paper proved to be a pivotal incentive to considering the role of the working alliance, but it provided only a relatively brief explanation of each of the three features and, despite his emphasis that the alliance was one of mutuality between therapist and client, Bordin made relatively few comments on the therapist's contribution. Gelso and Carter (1985; 1994) extended Bordin's conceptualisation of the alliance, describing it as "...an emotional alignment that is both fostered and fed by the emotional bond, agreement on goals, and agreement on tasks" (Gelso & Carter, 1985; p.163). Gelso and Carter's

formulation expanded on the meaning of the alliance by giving detailed attention to the activities of both participants, and by placing a greater emphasis on the emotional aspects of the alliance.

Affect in the Working Alliance

Gelso and Carter (1985;1994) stressed that, in addition to the positive affective tone that the therapist contributes to a "good" working alliance, "...therapists often experience strong reactions to their clients; here the therapist's job is to understand such feelings..." (Gelso & Carter, 1985; p.163-4). This formulation identifies two interrelated affective aspects of the alliance. The first involves offering professional concern, compassion and interest, together with client-centred conditions of empathy, genuineness and respect. The second concerns monitoring and managing the range of potentially strong emotional reactions that may accompany interactions with the client and that could contaminate the alliance. The latter appears to reflect a personal side of the therapist, connected with the "real" relationship (discussed below), that requires the therapist's observing, professional side for its management. Gelso and Carter (1994) emphasised that realistic therapist perceptions may vary on a continuum from extremely positive to extremely negative emotions, which may diminish or enhance the working alliance.

A number of other authors have also referred to the importance of therapist emotion to the working alliance. For example, Strupp (1980), in a comparison of two patients treated with time-limited dynamic psychotherapy, commented that a major factor in the formation of a good working alliance is the therapist's capacity to deal with his or her own responses to hostility and negativism from the client. Counter-responses involving negative emotional reactions such as hostility and coldness may become major deterrents to a strong

working alliance. Strupp's research efforts have for many years focussed on the therapeutic relationship and he has continued to advocate that personal qualities of the therapist are central to the relationship generally, and the alliance in particular (Strupp 1955; 1958). In a similar vein, Safran, Crocker, McMain and Murray (1990) identified several ways in which the therapist's awareness of his or her own feelings is important to the resolution of ruptures in the alliance. They suggested that therapist feelings attune the practitioner to the quality of the relationship, provide information useful in meta-communication with the client, and help the therapist to accept responsibility for his or her role in the therapeutic process.

An adequate review of the extensive research conducted on the working alliance is beyond the scope of the present discussion. However, it is noteworthy that, of the plethora of instruments devised to measure the working alliance, most include scales intended to tap the affective aspects of the alliance (eg. Horvath & Greenberg, 1989; Marmar, Horowitz, Weiss & Marziali, 1986) and stand as testament that therapist affect is formative in the working alliance. In the establishment of an emotional environment that is conducive to cooperation and unity of purpose between participants, the therapist's own affective state is instrumental in contributing to the tone of trust and collaboration between participants. It also serves as a powerful signalling system as to the strength of the alliance or to potential ruptures. The therapist's sensitivity to his or her own affective experience is therefore necessary to development and maintenance of the working alliance.

The Transference-Countertransference Relationship

The second component of the Gelso and Carter (1985) model is dually represented by transference and countertransference phenomena in the client and therapist respectively.

It is termed the "unreal" relationship to mark its basis in experiences that are shaped by perceptions, feelings and attitudes that disregard or distort current reality, and that are often outside awareness. Countertransference, which forms the focus of this discussion, is a concept founded in its client counterpart, transference, which has a more evolved theoretical history. Therefore a brief outline of transference is discussed first.

Transference

Early in the development of his psychoanalytic technique, Freud (1895) referred to the tendency of patients to make a false connection between early objects and the person of the analyst, so that significant childhood relationships were "recapitulated" in the relationship with the analyst (Gitelson, 1952). Emotion-laden ideas and wishes were unconsciously transferred on to the therapist so that psychological experiences were revived, "...not as belonging to the past, but as applying to the person of the physician at the present moment" (Sandler, Dare & Holder, 1970, p.667). The concept of transference was gradually developed and differentiated by Freud until it became a cornerstone of his psychoanalytic treatment. It was Freud's conviction that, through the therapist's recognition and interpretation of transference, the means was obtained by which early conflicts could be identified, brought to consciousness and worked through.

The essential concept that an individual's response to another is shaped by early experience is not unique to the therapy situation. An individual's early learning in significant relationships will determine both the individual's experience of him- or her-self, as well as experience of the other in all relationships. Freud (1912) referred to this as a stereotype plate by which the individual fitted current experience with the past. What sets apart the transference experience in therapy is that it is seen as reflecting those areas of

unresolved conflict that interfere with the individual's capacity to respond flexibly to the real world. Transference therefore is identified by its inappropriateness to the present situation and by its repetition of past experience (Greenson, 1965). The therapist's recognition, and interpretation, of these inappropriate recapitulations of past experiences opens a window on the patient's inner world.

The term transference is used by theorists with varying degrees of specificity. For example, some theorists hold that transference includes only those responses to the therapist that are inappropriate recapitulations of the patient's early experiences. For other theorists, any and all of the patient's responses to the analyst will be founded in early experience and will therefore be considered transference. Sandler, Holder and Dare (1970) identified several other senses in which the term transference is used, although the two just described seem of particular importance here since they mirror an equivalent debate in conceptualising countertransference. Sandler, Holder and Dare take the view that the most appropriate use of the term is to a specific "illusion" experienced by the patient towards the therapist that is at least partially determined by repetition of an earlier significant relationship. Further, they specify that the association with past experience is not recognised by the patient and, in its unconscious repetition, is experienced as real and appropriate.

The task of the therapist who embraces the concept of transference therefore entails two essential skills. First, the therapist must differentiate reality-based from inappropriate, "unreal" patient perceptions, emotions and attitudes. This skill entails a second, more subtle, skill: the therapist must have sufficient self-awareness and impartiality to recognise that some patient responses are to the therapist's real person, and are therefore not

inappropriate. In classical psychoanalysis, the analyst aims to efface his or her own personality so that the patient's transference reactions can be reliably identified. In many of the therapies developed in more recent years, however, there has been a shift to attributing greater importance to the "true" relationship between therapist and client, in which the therapist will allow more of his or her personal style to emerge. In such therapies the identification of transference from non-transference may be made even more difficult and it is perhaps for this reason that more recent therapies have placed greater store on the use of the identification of countertransference as a tool of therapy.

Countertransference

Like transference, the history of countertransference has been an evolving one. Its definition, comparative importance to therapy, and the manner in which it is utilised, vary with the theoretical perspective of the therapist. In Freud's original formulation, countertransference was the unconscious reaction of the therapist to material produced by the client. Freud viewed it as a negative occurrence in therapy and one to be guarded against: "We have become aware of the 'counter-transference' which arises in the physician as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize his counter-transference in himself and overcome it. (Freud, 1910; p.144).

As Davis (1991) pointed out, however, Freud was not entirely consistent in his expectation of emotional neutrality from the therapist, since he also recommended that the therapist attend to the effects of the patient on his unconscious feelings. Nevertheless, Freud was consistent in his belief that countertransference feelings should be overcome and that the most reliable route to doing so was that the therapist undergo regular analysis

in order to rise above the intrusion of instinctual demands from his own unresolved childhood conflicts. This view remained unchallenged for several decades. Despite attempts by some authors, notably Deutsch (1926 as cited in Reich 1951) and Racker (1957), to draw attention to the importance of the therapist's own response to the patient, the presence of countertransference reactions in therapy was little discussed until the 70s and 80s. As Tansey and Burke (1989) have commented, this may reflect the negativity and disapprobation with which countertransference was viewed, and which effectively rendered it a taboo subject.

In recent decades, a conceptual shift away from the pathological and potentially harmful process described by Freud has occurred for some theorists, so that two positions have been established regarding countertransference. One, termed the "classical" approach because of its relative adherence to Freud's original position, continues to regard countertransference as the therapist's conflict-based, and therefore distorted, emotional and attitudinal responses to the patient. The second, "totalist" position considers all the therapist's emotional responses to the patient, conscious and unconscious, and incorporating "real" and distorted perceptions of the client, to be countertransferential (Kernberg, 1965; Kernberg, 1975; Blanck & Blanck, 1979). With this new definition comes the acknowledgement that countertransference is a normal process that has potential as a tool in aiding the therapist's understanding of the client. Such a definition appears to make no distinction between the therapist's real and distorted emotions and attitudes and places greater emphasis on internal reactions rather than external behaviour (Peabody & Gelso, 1982). All emotions and attitudes have the potential to benefit or interfere with therapy, and their effects depend on the therapist's recognition and understanding of their

occurrence and meaning. The pejorative connotation attached to countertransference is therefore denied in this view, since self-examination of feelings and thoughts should enhance understanding of the client and prevent the therapist acting out those thoughts and feelings in behaviour .

While the concept of countertransference remains principally the domain of psychoanalytic psychotherapy, there has been an increased acknowledgement in other therapies of the importance of the therapist's emotional and attitudinal experience of the client and its consequences for psychological therapy. Perhaps because of its ties to psychoanalytic therapies, however, and its parallels with transference, countertransference is not always viewed as a valid construct by which to encapsulate the therapist's emotions and attitudes. Consequently much of the useful research on therapist affect and attitude is made inaccessible to psychological therapies that do not embrace the concept of countertransference in its traditional meaning.

In their model of the therapeutic relationship, Gelso and Carter (1985; 1994) included transference-countertransference feelings under the rubric of the "unreal" relationship. Their definition of countertransference identifies transference-based feelings, attitudes and behaviours of the therapist that are displaced on to the client's material, but the emotional reactions of the therapist appear to attract particular attention. Therefore, their view of countertransference is aligned with a more classical view of countertransference, but recommends that the therapist's awareness of countertransference emotions in particular is useful in the therapeutic relationship. Gelso and Carter (1994) acknowledge the strong overlap of the unreal relationship with other aspects of the

relationship, drawing particular attention to the importance of therapists' monitoring and understanding their countertransference reactions to avoid damage to the alliance.

Affect and Countertransference

Although countertransference is usually observed in therapist behaviour, it is well acknowledged that these behaviours are sourced in therapist feelings and attitudes. The psychoanalytic literature abounds with commentary on the emotions experienced by the therapist (Winnicott, 1949; Maltsberger & Buie, 1974; Adler, 1972; Gitelson, 1952) and their potential effects on behaviour. In addition to negative emotional or behavioural responses to the patient (for example, feeling and expressing dislike, withdrawal, anger, ambivalence or rejection) countertransference may also be seen in positive feelings, and over-identification or over-involvement with the client (McClure & Hodge, 1987). Hence the therapist may feel and express liking, warmth, love, compassion, and sexual attraction. While inappropriate positive reactions may occur with equal frequency to inappropriate negative reactions, they appear less readily acknowledged by the therapist, and are less frequently commented on by colleagues (Carr & Robinson, 1990).

"Negative" thoughts and feelings about the client, when left unchallenged and uncomprehended, have negative sequelae in the therapist's behaviour: withdrawing, distancing or rejecting behaviour (eg avoiding the client, lateness for appointments, failing to keep regular contact, loss of concentration during therapy sessions, neglect of suicidal signals from the client) controlling, hostile, and critical behaviour (eg over-zealous interpretation of rules, angry or hostile responses to requests, refusal of requests, critical comments of the client's statements or behaviour, disagreements with colleagues about the

client), tiredness and boredom (attention lapses, restlessness, discontinuation of therapy) are all behaviours that may have their origins in unacknowledged therapist emotion.

"Positive" thoughts and feelings about the client, when left unchallenged and uncomprehended, may also have negative sequelae in behaviour, usually seen as over-involvement. Nurturing behaviour that displays bias (inappropriately making extra appointments, acting on behalf of the client to resolve difficulties outside of therapy, granting special privileges, 'rescuing' client in disputes with other clients or colleagues); friendship behaviour (self disclosure, accepting or giving gifts, meeting on social occasions, seeking out client for informal conversations); sexual behaviour (flirting, touching, intercourse) are instances in which unacknowledged therapist feelings may be interpreted as inappropriate and countertransferential.

Countertransference Research

The concept of countertransference contains one of the principal sources of information about therapist affect. Nevertheless there is a surprising lack of research dealing with countertransference, partly perhaps because of its original ties to psychoanalytic theory and partly also for the difficulties in isolating a phenomenon that is to a large extent internal, unconscious and not directly observable. Approaches to measuring countertransference usually adopt one of its three principal components of feelings, cognitions and behaviours as their focus. Countertransference is usually first identified through affect about the client, followed by an awareness of such affect. The degree to which the therapist is then able to cognitively evaluate his or her emotions determines the manner and degree to which emotions are acted out in behaviour. Thus, some studies have elected to measure the feelings experienced by the therapist, others have

elected to seek evidence of misperception or attitudinal bias, and still others to seek the acting out of feelings and attitudes in behaviour.

For researchers embracing a position that countertransference results from unconscious, unresolved conflict one method of measurement has been to assess therapist misperception. Thus, one of the earliest studies of countertransference by Cutler (1958) considered the influence of the therapist's needs and conflicts on perception of client and self behaviour. Fiedler (1951) measured the discrepancy between therapist's and client's personality self-description on the assumption that the separation of real from perceived represented the degree to which perceptions were unconsciously distorted.

A number of studies have explored the therapist's behavioural defense against anxiety experienced in the therapeutic setting. Most of these have assumed a dynamic model in which anxiety results from unconscious conflict, although Bandura (1956) investigated the relationship of therapist's self-insight and defensive avoidance of anxiety without invoking psychoanalytic constructs. Yulis and Kiesler (1968), employing an influential methodology later adopted by a number of other researchers, measured countertransference behaviourally as withdrawal of personal involvement. (See also Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Hayes & Gelso, 1991). Their rationale for this measure was that countertransference responses resulted from patients' touching on unresolved conflicts in the therapist, from which resulted anxiety, and against which the therapist would defend by excluding the threatening material by (among other tactics) withdrawal of involvement.

Despite the primacy of emotion as the initiating factor in the occurrence of countertransference few studies have attempted measure it. Recent studies by Hayes and

Gelso (1993) and Gelso, Fassinger, Gomez and Latts (1995), however, took a multivariate approach to countertransference, in which affective, cognitive and behavioural measures were obtained. In each case the affective measure was of state anxiety (resulting from conflict), the cognitive measure was of inaccuracy in recalling client material, and the behavioural measure one of approach or avoidance verbal responses. In addition, the second study by Gelso et al (1995) attempted to address the failure of previous countertransference research to consider "positive" countertransference reactions by measuring over- as well as under-involvement by the therapist. Thus, these studies address some of the deficits in previous countertransference measurement.

Although the approach to affect taken in this research is very broad it has particular relevance for countertransference, in which affect plays such a major part. It is argued that a broad approach to therapist affect addresses a number of the problems encountered in countertransference research. The assumption here is that therapist affect is a natural concomitant of the interpersonal nature of the therapy and, no matter how skilled the therapist, will inevitably arise. It is further argued that the affects experienced by the therapist may be diverse, of both positive and negative valence, and of varying intensity. However, emotions (and accompanying attitudes and evaluations) need only be considered countertransferential in the sense of being detrimental to the process of therapy when they are unexamined and allowed inappropriately to influence behaviour. When appropriate awareness and processing of affect occurs, understanding of the client will be enhanced and the therapy aided.

Clearly, then, countertransference is a concept that holds therapist emotion at its core. It encompasses the idea that emotions can be appropriate and inappropriate to the

context, but also suggests that whether they are appropriate or not, the therapist's emotions can have profound impact on behaviour. Viewed from a totalist perspective, even when a therapist's emotions are an appropriate, and even conscious, reaction to the client behaviour, they may be considered countertransferential if the therapist acts on them without due thought for their implications for the therapeutic relationship. Such events are well recognised by most therapeutic approaches, but the confusion over what is considered to be countertransference , and the usual interpretation of countertransference as requiring assumptions based in psychoanalytic theory, has made it difficult for useful research to be accessed by all therapy orientations. The use of a broad approach to therapist affect, not tied to a particular theoretical construct, allows greater accessibility of research results and overcomes many of the boundary problems that limit attention to therapist affect.

The Real Relationship

The concept of the real relationship has proven the most contentious component of the model proposed by Gelso and Carter (1985). Indeed, the issue of whether real relationship transactions can be differentiated from unreal (transferential-countertransferential) transactions has dogged discussion of the therapeutic relationship in psychoanalytic theory throughout its history (Langs, 1979; Greenson & Wexler, 1969).

In Gelso and Carter's (1985; 1994) model, the real relationship represents those aspects of the relationship that are non-transferential, that is, that are based in participants' real and undistorted perceptions and this accords with psychoanalytic approaches to therapy. However, for some, the real relationship can also mean "real" in the sense of a genuine and personal relationship between therapist and client. In this latter sense, Gelso and Carter (1994) commented the real relationship is most usually associated with

humanistic, and particularly person-centred, approaches to therapy, in which the emphasis is upon therapist-offered conditions of genuineness and authenticity. In their review of the counselling literature, for example, Sexton and Whiston (1994) saw the real relationship as embodying the interactive nature of the personal relationship between therapist and client.

Possibly some of the confusion surrounding the concept of real relationship stems from attempts to integrate these two meanings of absence of transference-based relating, and a personal relationship between therapist and client. While sharing conceptual ground, their theoretical bases are essentially different. To speak of perceptions as undistorted assumes that, for example, the therapist's perceptions of the client are founded in actual characteristics rather than filtered through the lens of the therapist's own experience. Hill (1994) has maintained that undistorted perceptions are not possible, since all "reality" is a subjective construction and cannot be free of the individual's own interpretation, an echo of an information processing view of transference and also of intersubjective approaches to therapy (Stolorow, 1990). Hill's view is that the real relationship is more clearly conceptualised if defined as genuineness and freedom to be oneself in the relationship. Such a conceptualisation more nearly approximates Rogers' view of the optimal relationship between therapist and client.

For psychoanalytically oriented therapists, the existence of a real relationship has been repeatedly acknowledged, but in practice "real" transactions are given less theoretical significance because transference forms the central vehicle of therapy. However, what is deemed to be transference depends on the evaluations of the therapist and therefore cannot stand alone as fact. Hence the therapist has need to bear in mind the effects of his or her own self in the relationship, both in how the patient realistically perceives the therapist and

in how the therapist's own attitudes and judgements impinge on the therapy. "It is necessary to know many things quite objectively about ourselves, our patients, our culture, environment, etc., before we are able to determine whether we are dealing with a transference or a realistic reaction." (Greenson & Wexler, 1969, p.32). Such a view would seem to be a fundamental of an intersubjective, or social constructivist view of psychological therapy (Stolorow, 1990, 1995; Hoffman, 1991).

The importance of this point for the present discussion is that, in acknowledging the therapist as an individual who experiences and appraises the therapeutic process from his or her own perspective, affect must necessarily accompany that perspective and the therapist be subject to its influence if the affect is not openly acknowledged.

The real relationship would seem to have particular significance for client-centred therapies in that the necessary and sufficient conditions for therapeutic change identified by Carl Rogers (1957) all have a strong link to the idea of a genuine and personal relationship between therapist and client. Those of the conditions that pertain specifically to the therapist place very high demands on the therapist to contribute to the formation of a particular type of real relationship. Rice (1983), in discussing the role of the relationship in client-centred therapy, focussed on the three essential qualities to which the therapist contributes. Unconditional positive regard, state of congruence, and empathic understanding, all of which possess a clear affective component, each have a powerful bearing on the real (that is, genuine) relationship with the client.

According to Rogers (1957/1992) unconditional positive regard is evident when the therapist experiences a warm acceptance of the client, achieved through an absence of evaluative attitude and freedom from the counselor meeting his or her own needs.

Elsewhere, Rogers (1961, p 47) equated unconditional positive regard with "...the degree of positive affective attitude..." of the counselor but also suggested that the counselor's function was to impart a sense of acceptance, without emotion (Rogers, 1951/1981; p.39). As Rogers himself readily admitted, achieving acceptance and an absence of other than positive attitudes and feelings is not easy. Rogers' belief was that the acceptance and warmth for which the client-centred therapist should strive was "....closely related to the therapist's own struggle for personal growth and integration. He can be only as 'nondirective' as he has achieved respect for others in his own personality organization." (Rogers, 1951/1981, p.21). Thus, as the therapist acknowledges and resolves his or her own conflicts, any negative attitudes and feelings about the client are more likely to be understood and resolved and, with this, the condition of congruence between internal experience and external expression also can be achieved.

It is perhaps in this sense that that the overlap between the dynamic and client-centred views of the real relationship is observed. Both approaches acknowledge that resolution of past conflicts is important to the establishment of the real relationship. However psycho-dynamically oriented theorists identify this as an issue of transference, and its resolution, in the therapist. Client-centred theory, which does not embrace transference as the source of judgement or evaluation in distorted perceptions, asserts the importance of a genuine and congruent relationship with the client but give little guidance to the therapist as to how this will be achieved.

To achieve authenticity and genuineness with the client means a matching of internal experience with external behaviour so that verbal and non-verbal communication with the client are congruent. Inevitably there are occasions on which the therapist will

experience negative reactions to a client that may be either be based in actual negative behaviours of the client, or in negative evaluations by the therapist. If the therapist experiences negative feelings about some aspect of the client's behaviour, the requirement is that these feelings be recognised, processed and understood so that the therapist can retain a state of non-evaluative acceptance. The capacity to recognise and accept that feelings about the client emanate from personally held attitudes and beliefs, hinges on the therapist's own maturity and self-awareness. This suggests that to fail to do so would render the real relationship unreal, and therefore countertransferential. The concept of congruence versus incongruence, therefore, appears to mirror some the ideas encapsulated in the pyschodynamic concept of countertransference without recourse to unresolved, unconscious conflicts. It assumes that the therapist has conscious awareness of his or her own attitudes and evaluations and that non-judgemental acceptance and congruence between inner experience and out expression can be achieved.

The above discussion of affect in components of the therapeutic relationship highlights the very clear contribution of therapist affect in the formation of a constructive milieu for therapy. The view espoused is that therapeutic alliance, unreal and real relationships are overlapping and indistinct aspects of the therapeutic relationship, each of which is imbued with affect. That affect operates to fundamentally affect the strength or weakness of all three components. Despite Gelso and Carter's (1985; 1994) assertion that their conceptualisation of the therapeutic relationship is accessible to all therapy approaches, there remain strong ties to a dynamic perspective that require a conceptual leap of faith that not all therapists may be prepared to take. To view affect as a phenomenon common to, and linking, all these components of the relationship, and to view

changes in affect as a reflection of the appraisals and evaluations (both personal and professional) made by the therapist, requires none of the assumptions of a particular theoretical approach. Furthermore, the difficult distinction between a real and an unreal relationship need not be necessary when affect is taken as the basis of these components. When a model is adopted that affect occurs in relation to evaluations and appraisals that are inherently a result of the individual's own personal values, beliefs, goals and motivations, then affect occurring in the therapeutic relationship depends on the degree to which the therapist has awareness of the evaluative nature of his or her interpretation of the relationship. The extent to which the therapist is able to monitor, understand and manage affect provides a powerful tool for therapy since it provides a means by which evaluations based in personal beliefs and values can be brought into full awareness for examination.

Chapter 5

FACTORS CONTRIBUTING TO THERAPIST AFFECTIVE EXPERIENCE

Throughout the hundred or so years in which psychological therapy has been conducted, an increasingly sophisticated understanding has developed of the many factors that contribute to its course and outcome. The model of the therapeutic system described by Orlinsky, Grawe and Parks (1994) identified inputs, processes, and outcomes as levels of the system and acknowledged that the individual and interacting characteristics of therapist and client contributed to psychological therapy at all these levels. This thesis takes as its topic characteristics of the therapist that are extrinsic and intrinsic to the therapeutic system and considers these through the lens of the therapist's affective experience.

Affect is woven into the fabric of psychological therapy through the essentially interpersonal nature of the therapeutic enterprise. Because the therapist enters the relationship with the client both as an individual and in a professional role, the interaction will contain both "cold" and "hot" cognitions. That is, although the therapist ostensibly operates from a position of impartiality that involves "cold" knowledge and reasoning, he or she also has a personal investment in the transaction that will result in evaluations and appraisals which will generate affect. Even in the role of professional therapist there is some personal stake, in that there are goals and plans associated with the role of competent and effective therapist. When personal investment is thwarted or facilitated, some at least minimal affect must result. Lazarus (1991a, 1991b) has argued that appraisals of potential harm or benefit to the individual and his or her goals, beliefs, plans and motivations, must

be accompanied by affect, which itself can be re-appraised to produce further affect. Thus, affect will be experienced by the therapist in the appraisal of the therapeutic interaction.

Through training, professional experience and the adoption of a theoretical approach, the therapist acquires a framework within which to structure the events of therapy. Because these professional factors provide a knowledge and theoretical base on which to found perception, evaluation and understanding of the events of therapy, they will to some degree assist the therapist in reducing personal involvement and evaluation of the client. However, the therapist must maintain a personal presence with the client, and appraisals reflecting the personal motivations, beliefs, values and wishes will inevitably impinge upon the therapist's perceptions and evaluations of the client. The evidence for an association between affect and the therapist's characteristics extrinsic and intrinsic to the therapeutic role are considered in the next two sections of this chapter. In the final section of the chapter, a rationale for the research to be conducted is offered.

Therapist Extrinsic Characteristics

Because psychological therapy necessarily takes place within the context of an interpersonal relationship, the same individual characteristics that are pertinent in other interpersonal relationships will also be pertinent to the therapeutic relationship. The therapist's verbal and non-verbal communications, mannerisms, gender, personality traits, personal history, beliefs, attitudes and values convey the person of the therapist to the client, and also contribute to the way in which the therapist responds to the therapy situation.

The complex interplay among these characteristics makes it a difficult task for the therapy researcher to tease out the specific effects of individual characteristics, and this

thesis therefore elects to investigate dimensions that are broad and within which other, more specific, factors may be nested. Two characteristics of the person consistently investigated for their impact on therapy, and also investigated for their association to emotional experience and expression, are personality and gender. Each of these is considered for its association with psychological therapy and is then considered for its association with affect.

Personality and Affect

At a time when both personality and emotion have independently experienced a resurgence of interest in psychology, there has also been increased interest in the relationship between these two phenomena. Indeed, the concepts of emotion and personality are so strongly related that it is difficult to determine whether emotion determines personality or whether the reverse is true (Pervin, 1991). In different domains of psychology, affect has been considered for its association with a variety of human functions that collectively define personality as a general construct. In particular, affect has been considered in relation to cognition, motivation, perception, communication and other interpersonal behaviour, with consistent evidence that it is implicated in a diverse range of human functions.

Increasingly, researchers who espouse a trait view of personality have turned their attention to a consideration of how affect and personality are related. Affective (or emotional) traits have been linked to broad personality dimensions, and level of affective arousal has been asserted as representing a central defining characteristic of at least some personality domains. Affective traits, or trait moods, are represented in personality through a sensitivity to positive or negative affective arousal that is sustained over time and that has

the potential to infiltrate the individual's perceptual, cognitive, emotional and behavioural functioning (Strelau, 1987).

Trait moods are not necessarily directly expressed, but have the enduring potential to manifest in the way the individual engages emotionally, cognitively and behaviourally with the environment. In fact, the term "trait mood" may be misleading since mood implies an actualised and observable disposition when it is in actuality not continuously apparent, and can only be identified by inference. The propensity bestowed at a trait level to experience positively or negatively valenced affect does, however, increase the likelihood of the individual experiencing transitory state moods of that valence, in which like valenced discrete emotions are also likely to occur. Against the background of trait mood, therefore, occur more transient mood states that are shorter term (lasting from minutes to hours) and that are more connected with contiguous events than trait mood.

It can be expected, therefore, that the state mood elicited within a particular context will reflect both the effects of enduring mood orientation and also a response to the particular context. Although the individual may be biased to respond affectively by the trait emotional component of personality, other factors within personality will also impose an effect on state response to the situation. In interpersonal situations, in particular, this will be evident because other aspects of personality such as motivations and goals, perception of self in relation to others, and cognitive style will direct perception and appraisal of the situation. Thus, it is to be expected that personality factors will contribute to state affective experience at the trait affect level, but will be tempered by other factors pertinent to the particular situation in which the individual experiences affect.

In models of the affect-personality association, debate continues as to their hierarchical relationship, with some theorists placing trait mood, and others trait personality, at the highest level of the hierarchy (Nemanick & Munz, 1997). Still other researchers view some emotional and personality traits to be interchangeable constructs (Tellegen, 1985; Watson & Clark, 1992). Both trait mood and trait personality are, however, viewed as occurring at a higher level of explanation than state mood. In the present research, the view is taken that affect and personality are closely interrelated, and that affective traits are determined initially by biological differences that are then shaped by environmental experience. Personality, with its attendant emotional bias, provides a dispositional backdrop that tends individuals to respond with a particular emotional bias at both a trait and a state level. However, other factors relating to how the individual experiences and interprets the particular context will also contribute to affective state response. The beliefs, values, attributions and appraisals that the individual makes will in some part blend with dispositional characteristics, but will also reflect current concerns, needs and wishes and these will also be adaptive to immediate circumstances.

Personality and Therapy

The history of theorising and research about the relationship between therapist personality and therapy is almost as long as the history of therapy itself. The influence of therapist personality is linked in two major ways to psychological therapy. First, through the therapist's personality contributes to the type and style of the therapeutic relationship, principally through the real relationship and also through the working alliance. Second, the therapist's own characteristic strengths and weaknesses, and the degree to which the

therapist has awareness of these, impact on therapy through the unreal or countertransference component of the therapeutic relationship.

One of the ways in which therapist personality has been evaluated is through the intermittent, but continued, interest in the impact of therapist personal therapy on therapist effectiveness. From Freud's (1937) advocacy that analysts themselves undergo regular personal analysis, the assumption has been made that through personal therapy the therapist gains greater understanding and integration of his or her own personality, which has beneficial effects on the therapy process. However, as Beutler, Machado and Neufeldt (1994) have pointed out therapists enter into personal therapy for a variety of reasons, of which the development of self-awareness is only one. These same authors reported that the evidence for benefit from personal therapy was not clearly demonstrable. Some early studies of the effects of personal therapy found it unrelated to effectiveness as a therapist (Katz, Lorr & Rubenstein, 1958; Garfield & Bergin, 1971; Strupp, 1958). However, MacDevitt (1987), in a more limited context, compared receipt of personal therapy and awareness of countertransference and found a positive relationship. Kernberg (1973) also found a positive effect from personal therapy although, as Beutler, Machado and Neufeldt (1994) have pointed out, Kernberg did not take into consideration experience as a therapist, which may have confounded the results.

Many dimensions of therapist personality have been considered for their influence on psychological therapy. Beutler, Machado and Neufeldt (1994), in their review of therapist variables contributing to therapeutic change, identified locus of perceived control, conceptual level and dominance as relevant to therapeutic outcome. Orlinsky, Grawe and Parks (1994) identified personality dimensions such as therapist self-congruence, self-

acceptance, credibility (versus unsureness), expressiveness and detachment as variables for which there were consistent positive findings of a relationship to both process and outcome. In the Penn Psychotherapy Project, which studied predictability of outcomes of psychotherapy, field dependence-independence and the discrepancy between self and ideal concept were included for evaluation among therapist characteristics (Luborsky et al, 1980).

Therapist personality has particular relevance to some components of the therapeutic relationship. Indeed, therapist personality can be considered integral to the concept of countertransference, and in particular to the classical conceptualisation, in which the unconscious conflicts in therapist personality that are seen as causal in the process. Most definitions of countertransference include both affect and attitude as central components and these also, of course, form central components of personality.

In a survey of psychologists who were identified as authorities on countertransference, Hayes, Gelso, Van Wagoner and Diemer (1991) found that self-insight and self-integration were judged important in the management of countertransference and these authors commented that "...management of countertransference is predominantly a function of the personality composition of the therapist..." (p.146). Rosenkrantz and Morrison (1992) studied countertransference from within an object relations framework and found support for their hypothesis that therapist personality characteristics affected the development of countertransference. In an early study Cutler (1958) investigated countertransference using Bruner's three-step perception process and identified therapist conflict areas by comparison of self- and rater-reports of therapist personality on 16 traits, many of which were affect-related. McClure and Hodge

(1987) assessed the personality of both therapist and client on nine bipolar dimensions, such as active-social/quiet, hostile/tolerant and sympathetic/indifferent. They used the congruence between perception of self and perception of client as a measure of the level of countertransference in the relationship.

The concept of a real relationship is also intimately connected with therapist personality in that the properties of openness, congruence and authenticity salient to this concept are all dependent on therapist personality dimensions. The real relationship, related as it is to interpersonal processes, has a clear association to the interpersonal dimensions of personality. It is somewhat surprising, therefore, that following the early research conducted by Carl Rogers and his associates, aspects of the relationship such as genuiness, authenticity and positive regard have not continued to receive research attention, particularly since the relationship has again become a focus of interest in recent years. Empathy, however, which plays a central role in client-centred and other approaches to therapy has been extensively investigated over the years.

Regardless of the position taken as to whether it is considered a disposition, or an acquired skill (Davis, 1983; Hornblow, 1980; Marangoni, Garcia, Ickes & Teng, 1995), personality must be considered central to the concept of empathy. Davis and Kraus (1997) conducted a series of meta-analyses of the literature pertaining to personality and empathic accuracy, and identified factors from five classes of individual difference variables that showed a consistent relationship with empathic accuracy. Their conclusion from their meta-analyses was that it was the combined and overlapping effect of several personality traits that contributed to interpersonal accuracy rather than any one class. In summary, a good judge of others is likely to be intelligent, to have a cognitively complex and

sophisticated view of the world, to be more field-independent and flexible in thought, to be psychologically well-adjusted, mature and well socialised. It is noteworthy also, that Davis and Kraus found affective sensitivity to be of greater influence on accuracy than cognitive sensitivity, although they noted that neither had a significant absolute effect.

Specific to the context of psychological therapy, Peabody and Gelso (1982) investigated empathic ability and its relationship to countertransference behaviour on the premise that both involve partial identification with the client. Their study found that empathy was negatively related to countertransference behaviour but noted that this was dependent on the client's presentation; a positive relationship was also found between the therapist's openness to countertransference feelings and empathic ability. Miller, Taylor and West (1980) reported that level of accurate empathy predicted client outcome in a study of treatment approaches to problem drinking and that years of experience as a therapist was unrelated to accurate empathy.

There is ample theoretical, if uncertain empirical, support for assuming that therapist personality should be related to therapy process and outcome. However, the diverse approaches taken to personality and the instruments used to measure it, have contributed to a fragmented literature and this is compounded by tendency to consider personality for its association to particular components of therapy, particularly the therapeutic relationship. It is logical, therefore, to consider personality from a broader and more integrated perspective, one that is independent of specific components of the therapy process. To do so may give the opportunity to evaluate the contribution of personality in a more inclusive and integrated manner.

A Model of Personality

In theory and research, the personality of the therapist has received consistent attention as an influential variable in psychological therapies. For the most part personality has been conceptualised and investigated in this context as comprising discrete elements. Typically, these elements are selected for their theorised relevance to the component or mechanism of therapy that forms the focus of research, and the theoretical perspective of the researcher. The use of multiple theoretical approaches to personality and multiple personality characteristics has meant that an integrated view of how personality contributes to therapy process, and thence to outcome, has been difficult to formulate. Instead, a diverse array of discrete personality constructs has been related to an equally diverse group of therapy factors, so that studies do not cohere to give an integrated picture of the contribution of therapist personality to psychological therapy.

In the present research, personality was conceptualised in terms of a hierarchical trait model, the Five Factor Model (FFM), with which repeated associations have been made to trait and state dimensions of affect. The assumption of a broad approach to personality as a preliminary investigative tool has several advantages for this research. The first of these is that the use of a broad model of personality permits the integration of otherwise diverse personality constructs into a comprehensive framework (McCrae & John, 1992). Secondly, the atheoretical nature of the model makes it accessible across all theoretical models of therapy. Thirdly, on the basis of research into the relationship between the FFM and affect, predictions can be made about the likely associations between personality and affective experience in psychological therapy.

Many of the personality constructs previously investigated in psychological therapy research are incorporated at the second, more specific, facet level of the FFM. The model therefore provides a convenient means by which personality can be assimilated into one model and, at the same time, provides a theoretical link between personality and affect that is independent of theoretical approach to therapy and its component parts. Thus, in this research, the view of personality is a general one, intended to generate an integrative framework for understanding the relevance of therapist personality to psychological therapy at a broad level.

The five domains of the FFM vary in the degree to which they have been associated with affect. Neuroticism and Extraversion, included in almost every trait model of personality, have received greatest attention. The evidence for an association between affect and the model's three remaining domains, Openness, Agreeableness and Conscientiousness, is more tenuous but some research evidence of associations is now emerging for these (Watson & Clark, 1992). The hypothesised associations between affect and the five domains of the FFM are discussed in a later chapter.

Gender and Affect

The relationship between gender and affect has been discussed in Chapter 3. In that chapter both biological and socio-cultural factors were discussed as possible contributors to the persisting belief that males and females differ in their emotional experience and expression. As Brody and Hall (1993) have suggested, differences between men and women in their expressivity, particularly of specific emotions such as anger or sadness, have been proposed as gender-stereotypic beliefs that may be sufficiently well entrenched as to become self-fulfilling prophecies. Beliefs about gender-appropriate

affective experience and expression may therefore lead males and females not only to respond affectively to others in accord with these beliefs but may also behave in a way that expectations are reciprocated.

Gender and Therapy

Gender differences in emotional experience and expression have direct relevance to a number of important issues in psychological therapy, both in training and practice. For example, therapist differences in affective experience are implicated in gender matching of therapist and client, the capacity to empathise, behavioural expectations of self and other, coping with stress, countertransference issues and sexual attraction to clients. Reports of gender differences in therapists' affective experience are numerous although, as has already been noted, these are not necessarily reported about emotion per se, but are often operationalised as behavioural responses to particular aspects of the therapeutic relationship. Some few studies, however, have reported more directly on gender differences in affective experience.

Howard, Orlinsky and Hill (1969) investigated therapists' feelings in psychotherapy and how these related to patients' experiences. They identified nine feeling dimensions (e.g., feeling good; uneasy intimacy; sense of failure) on a number of which male and female therapists differed in their endorsement. Overall, male therapists reported more unpleasant feelings about female patients than did female therapists and female therapists generally reported more positive feelings than did male therapists. When therapists' feelings were compared with their patients' experiences the authors reported significant relationships that led them to conclude that "...therapists' feelings during

psychotherapy sessions do provide some important clues to what their patients are experiencing concurrently" (Howard, Orlinsky & Hill, 1969, p.92).

A more recent study by Pope and Tabachnik (1993) investigated therapist feelings of anger, fear, hate and sexual arousal and associated client and therapist behaviours, but found no differences between male and female therapists in their reported experience. Sharkin and Gelso (1993) also failed to find gender differences in trainee counsellors' anger proneness and discomfort in responding to an angry client.

Sharkin and Gelso's (1993) study of anger-proneness in trainee counsellors founded its hypotheses in countertransference theory. This is an area of research in which, not surprisingly, gender differences have frequently been proposed. Thus, affect resulting from and defending against, unconscious conflicts provides a rich ground for hypothesising possible therapist gender differences. Gender has been considered in the context of countertransference both from the differing countertransference reactions of male and female therapists and also for therapist-patient cross-sex countertransference (see, for example, Gelso et al, 1995; Peabody & Gelso, 1982)

The changing face of opinion about whether male-female differences in emotion are dispositional or socially determined is well exemplified in the area of empathic ability. Here women have traditionally been seen as more sensitive to, and better "intuiters" of, others' emotions, but as recent research has shown, when empathic accuracy is broken down into component tasks, women do not possess clearcut advantage over men. Ickes and his research team have proposed an alternative to women's native ability to read others' emotions in suggesting that differences in empathic accuracy may be explained by a combination of social roles and evolutionary theory (Graham & Ickes, 1997). Thus, as in

other areas of emotional experience and expression, differences between males and females may be attributed to a mix of biological, evolutionary and socio-cultural factors (Brody, 1999).

Clearly, then, the gender of the therapist is an important variable to be considered in affect-based therapy research and was therefore included as an independent variable in the present research. The aim was to identify potential differences in males' and females' reported broad affective experience and to consider this as potentially both a trait- and state-based phenomenon. Based on current general emotion, and therapy, literature it was hypothesised that males would report more negative and less positive affect than females in response to videotaped vignettes of therapeutic interviews. It was further hypothesised that controlling for self-reported trait affect would not diminish differences between males and females in their state affective response.

Therapist Intrinsic Characteristics

Theoretical Orientation

In the present research, in which the focus of interest was the characteristics of the therapist that contribute to affective experience, the theoretical orientation adopted by the therapist was expected to relate to how the therapist experienced the client affectively. In Chapter 2, theoretical orientation was discussed in the context of psychological therapy in general and three principal theoretical approaches of psychodynamic, cognitive-behavioural and client-centred were identified as broad categories used in research to incorporate a number of specific, but related, approaches to therapy. Most dimensions

used to identify salient properties of different theoretical approaches specify these as having core features that differentiate them from each other.

Commitment to a theoretical orientation can be related to affective experience in two major ways. First, choice of theory must in some degree reflect a compatibility of values and beliefs for the individual with that theoretical approach (Barron, 1978; Chwast, 1978; Norcross, 1985). A theoretical orientation includes an at least basic acknowledgement about fundamental human experience and functioning. In adopting a theoretical stance, the therapist therefore aligns him- or herself with a view of human functioning that reflects a philosophical worldview. In assuming this, it follows that the theoretical orientation preferred by a therapist will in some respects also reflect the therapist's social expectations and values and that these will be in turn reflected in how the therapist structures his or her understanding of the client. The appraisal process that ensues in psychological therapy will be reflected in the affects experienced by the therapist. .

Theory also forms a basis for constructing the techniques and goals of therapy and this will include a theory (more or less specified by different approaches) of the interpersonal relationship and, associated with this, a model for managing therapist affect. Theories of therapy vary in the degree to which such guidelines are enunciated. Psychoanalytic psychotherapy, in its early years, made quite explicit the form of therapeutic relationship to be entered into. So, also, did client-centred therapy specify a model for the therapeutic relationship. Cognitive-behavioural approaches to therapy are perhaps less explicit in their explication of the nature of the therapeutic relationship,

although in more recent times, more attention has been paid to this aspect of cognitive-behavioural therapy (Goldfried & Davidson, 1994).

Professional Affiliation

Therapists' affiliation to a professional group is a variable less usually investigated than, for example, theoretical orientation. However, in the present research, this variable was considered to be of interest for several reasons. Therapists' professional affiliation has been shown to relate to attitudes to clients. For example, Stein, Del Gaudio, Carpenter and Ansley (1978) investigated the effects of therapist profession on the attitudes and assumptions about patients from differing socioeconomic groups, levels of insight and severity of disorder. These authors reported that therapist attitude was related to profession. If there is an association between attitudes and values of members of different professional groups, then this may be played out in the affects experienced about clients.

Professional role, both in its selection and in its execution, makes assumptions about the relationship between therapist and client that may have relevance to the affect experienced by the therapist. Furthermore, professional role determines the type and extent of contact between therapist and client and this also may influence affective experience. Medical practitioners, for example psychiatrists, usually meet with their clients by appointment and for a specified period and in a designated setting. Nurses, on the other hand, often have no specifiable contact times with their patients and must deal with whatever issues are occurring at the time of intervention. The relative lack of control that nurses experience over their contact with their clients, in comparison with psychiatrists or clinical psychologists, may subtly alter the nature of the relationship between therapist and client.

More direct evidence for an association between professional role and affective experience comes from Colson et al (1985, 1986) who investigated hospital staff countertransference reactions to difficult psychiatric patients. Affective response ratings were found to differ for psychiatrists, social workers, nurses and activity therapists. In a now classic article, Neill (1979) also described the different affective reactions of professional groups to the management of patients with demanding and difficult behaviours. On these various grounds it was therefore considered appropriate to include professional affiliation as a variable intrinsic to the therapeutic environment that might impinge on therapist affective experience.

Experience

Intermittent attention has been paid to the experience level of the therapist and there is appeal to the notion that therapists with greater experience may prove to be more effective in the treatment of clients. The topic, however, has not proven easy to address, not the least because of the confronting results that have sometimes been obtained from research. A further obstruction to obtaining clear evidence for the effects of therapist experience on psychological therapy is that experience level confounds with a number of other factors. For example, age of therapist and years of experience are usually positively correlated and therefore difficult to differentiate in their effects. Level of experience as a therapist is also not necessarily a guarantee of extensive training, so that highly experienced therapists may have had little training and vice versa. Moreover, therapists at different stages of their professional life rely differently on factors such as technique, with less experienced therapists tending to rely more heavily on structure and technique than those with greater experience (Wogan & Norcross, 1985). Vasco and Dryden (1997) also

pointed to the confusion between experience and expertness, emphasising that years of experience as a therapist are not necessarily an affirmation of depth of knowledge.

A number of reviews have considered therapist experience in relation to outcome with conflicting conclusions. Stein and Lambert (1984) conducted a review of the area and concluded that therapist experience is not necessarily a significant contributor to outcome in psychotherapy, although the methodological difficulties encountered in research make firm conclusions difficult. They suggested that future research needs to consider the effects of factors such as age, social status, and degree of training and supervision before the effects of experience on outcome can be better elucidated.

In the context of the current research, the experience of the therapist may have some impact on affective response to the client. Experience exposes therapists to a larger range of client behaviours and potentially generates a larger knowledge base on which to base evaluation of the client. As experience increases, therapists may develop a greater capacity to anticipate and interpret client behaviours and this may have consequent effects on affective experience in the therapeutic relationship. Familiarity with the ways in which clients present and what treatment approaches are effective in different client presentations may lead to greater self-assurance for the therapist. Viewed from another perspective, however, greater experience may also lead to more negative affective outcomes for the therapist, in that previous negative experiences may lead to unwarranted negative appraisals, particularly in dealing with more challenging client behaviours. Acknowledging that differences in experience level of therapists may impact on affective experience, years of experience as a therapist was included as a covariate in the current research. In the light of what has been reported in the literature about the difficulties in

isolating experience as a factor, it is acknowledged that years of experience represents only a rough quantitative measure of a complex variable. However, inclusion years of experience as a covariate represents a compromise to ignoring what may be an influential variable in considering therapist affective response.

The contention of this thesis is that therapists' characteristic affective style will continue to manifest in the therapist's emotional experience of the client, and morevover, that therapist's appraisals and evaluations are reflected in their choice of theoretical orientation and also by their professional affiliation. The likely affect attached to such appraisals and judgements may be only partially modified by the adoption of a theoretical orientation. As has already been discussed, certain personal characteristics of individuals have been associated with direction and intensity of emotional experience and expression. This research aims to examine whether such characteristics contribute to therapists' emotional experience of their clients, and to what degree theoretical orientation, training and experience help to modify that emotional experience.

PLAN FOR THE RESEARCH

In the chapters that follow a series of studies are reported that investigated therapist characteristics of gender, personality, theoretical orientation and professional affiliation for their effects on therapist affective experience. Personality was measured employing a broad, dimensional trait model of personality, the Five Factor Model, with which relationships have been found to broad level affective experience (Church, 1994; Nemanick & Munz, 1997; Watson & Clark, 1997).

Theoretical orientation was described according to three of the more commonly used categories of psychodynamic, cognitive-behavioural and client-centred orientation.

These were selected on the basis of the literature already discussed in Chapter 3, which shows these to be historically and conceptually distinct orientations that differ in their underlying dimensions. A fourth category of theoretical orientation, human occupation, was also included that represents a frequently applied framework in the field of occupational therapy. This orientation in some respects resembles a client-centred approach to psychological therapy, in that it adopts an interpersonally based and humanistic view of the individual. The human occupation model represented an appropriate theoretical choice for a group of occupational therapists who participated in the study.

In the professional groups selected to test for the effects of professional affiliation on affective experience, a group of occupational therapists was included as a comparable occupation against which three mental health professions could be compared. The three professional groups working within a psychological health framework were nurse, psychologist and medical practitioner, the latter including both psychiatrists and psychiatric registrars. Occupational therapists also work within an intensive therapeutic relationship and an individual basis, although the focus of their work differs in its aims. It was intended that this group offer the opportunity to observe for differences in affective experience between mental health professionals and a professional group, working in similar conditions, experienced in the therapeutic interaction, but lacking direct experience with clients presenting with psychological problems.

Chapter 6

CREATING AND VALIDATING THE STIMULUS MATERIALS

The aim of this research was to measure therapist affective experience in an experimental setting, and to assess the degree to which therapist characteristics, extrinsic and intrinsic to the therapeutic milieu, might modify that experience. The intention was to create an analogue of the therapist's experience in psychological therapy by constructing vignettes that depicted situations typical of the therapy setting. The affects experienced by therapists in the therapeutic milieu are potentially unlimited. The plan was therefore to create several vignettes, so that the analogue was sufficiently representative of the therapy experience to evoke the potentially broad range of affects that therapists might experience.

Vignettes have a long tradition of use as stimulus materials in psychological research, and have been presented in written, photographic, audio, and audio-visual form (Hughes, 1998). For the present research, videotaped vignettes were selected as the preferred stimulus. In actual therapy sessions, both verbal and non-verbal client behaviours contribute to the interaction and to therapist affective experience. Videotaped presentation of the clients' behaviour most nearly approximated the conditions encountered in therapy by permitting form and content of speech, vocal and facial expression, and postural behaviour to be depicted. Videotaped presentations also more nearly approached the immediacy of the therapy setting and the moment-to-moment processing of verbal and non-verbal communication.

Vignette content in psychotherapy research has used both simulations by actors and excerpts from actual therapy sessions, and each of these methods has advantages and

limitations. In recent years, a vignette approach to the study of emotion and appraisal has also been both advocated and criticised (Parkinson & Manstead, 1993; Roseman, 1991). In the present research actors were recruited to simulate clients' behaviour for the vignettes. The principal advantage in using actors to portray client behaviour was in the greater control obtained over the multiple variables that may impact on the therapy situation and, more specifically, on therapists' affective experience. Particularly in this research, where client variables were not a primary focus of the research, but might impact on therapist affective experience, there was advantage in controlling for as many extraneous variables as possible.

Another reason for using actors concerned the potential ethical problems in using extracts from genuine therapy sessions, since the material was to be shown to a large numbers of participants and over a relatively extended period. Respect for the clients' right to privacy and confidentiality, and for their right to withdraw permission to use the material during the study, placed limitations on the use of excerpts from genuine therapy sessions. Furthermore, because undergraduate psychology students were to act as participants in one of the studies, there were ethical concerns about showing genuine material that was intentionally affect-inducing to participants who were untrained in psychological therapy. Client simulations were, therefore, considered a more appropriate choice for the vignettes. This chapter describes the creation, construction and validation of the vignettes used in the research project.

Selecting Client Variables as Stimuli

A considerable amount of psychological therapy research has explored the relationship between specific client and therapist variables. In the present research,

however, client characteristics served as the stimulus to therapist affect, and it was not intended to examine their relationship to experimental variables. The aim in creating the vignettes was therefore to select client characteristics shown in other research to evoke different emotional responses from therapists. The literature on process and outcome variables, the therapeutic relationship, and on difficult and liked-disliked patients, points to client characteristics that might be expected to evoke differences in therapists' affective experience. The vignettes were designed to depict a variety of client behavioural styles and to control other client variables that might evoke more idiosyncratic responses in the therapist. The following discussion specifies how client variables were taken into consideration in creating the vignettes, and then describes how the vignettes were constructed, recorded and validated

Demographic Characteristics

Outcome and therapeutic relationship research have consistently directed attention to the potential impact of client demographic factors on psychological therapy (Garfield, 1994). The gender, ethnicity, race, social status, marital status, age and educational level of the client have all been investigated and, albeit with conflicting results, reported as having a potential impact on the outcome of psychological therapy. Client gender and ethnicity have received increased attention in recent years, and these two demographic factors have been discussed in particular for the relative merits of therapist-client matching (Atkinson & Schein, 1986). There is also evidence of the pertinence of such variables to affect-saturated components of psychological therapy such as empathy, countertransference, and the therapeutic relationship generally. On the assumption that therapist affect is an integral part of these aspects of psychological therapy, it was

considered that the portrayal of clients in the vignettes designed for this research should take such characteristics into account.

Gender. There has been extensive debate about how client gender might impact on the therapy process and the therapeutic relationship, particularly in regard to issues of therapist-client matching in gender. Therapists' reactions to their clients are generally assumed to be neutral and unaffected by client gender, but it is axiomatic that same-sex/opposite-sex dyads will vary at least somewhat in their interactions through the effects of socialisation on individuals' perceptions and expectations of themselves and others. Thus, not only may gender differences in therapist affect occur as a consequence of male-female differences in affective experience, but also because same-sex/opposite-sex interpersonal interactions will generate different affects. Ideally, therefore, stimulus materials for the present studies should include both male and female clients. However, because of the number of therapist variables to be considered in the studies, the decision was made to portray only female clients. Therapist variables were the principal focus of the research and to have also included client variables would have further complicated an already complex design and taxed the available power in the analyses.

Ethnicity and Culture. Although there has been sporadic interest in the effects of ethnicity and culture in psychological therapy, it is in relatively recent years that these client variables have been the subject of greater discussion and research. In part this may reflect the wider range of cultural and ethnic backgrounds of those now seeking psychological therapy, and also the greater awareness of often unconsciously held attitudes regarding ethnicity. Ethnic and cultural aspects of the client's presentation may impinge on the process and outcome of psychological therapy in a number of ways, and may enter

significantly into the affective experience of the therapist. Therapists' values and attitudes regarding their own and others' ethnic origins, and their depth of understanding of other cultures, can lead to a variety of both positive and negative affects, although negative affects are most frequently discussed in the literature. For example, Comas-Diaz and Jacobsen (1991) discussed ethnocultural factors within a psychodynamic framework and gave illustrations of countertransferential feelings of guilt, anger, hope and despair in therapy encounters with clients of different ethnic groups.

Ethnocultural factors may impinge upon the affective tone of the therapeutic relationship at a number of levels, particularly in respect to the formation of an emotional bond in the therapeutic alliance and in the capacity to sustain an empathic stance towards the client. The capacity to maintain empathic contact with a client of different ethnic or cultural origins may be compromised by a therapist's lack of understanding of, or indeed over-compensation for, such factors. Despite efforts in therapist training programmes to increase awareness of the potential impact of such variables, the probability remains that therapists will differ in their response to ethnocultural factors. These variables were therefore controlled for in creating the vignettes for this research.

Social Status. Social class, or social status, has been considered for its relevance to both process and outcome in psychological therapy. Psychological therapy, in the form of psychoanalytic therapy, has tended to be the domain of the middle- to upper-classes until relatively recent times. In more recent years, however, as public awareness of psychological therapy has widened, as styles of therapy, particularly more short term therapies, have diversified, and as public programmes have been instituted for the

management of specific disorders, therapists may work with clients from a variety of social backgrounds.

Research shows that therapists report a preference for clients who are verbal, well-educated, intelligent and motivated to succeed, all characteristics correlated with social class. Such characteristics can be understood as making a contribution to both the process and outcome of psychological therapy. Therapists are themselves more likely to be educated, intelligent and verbal and, because research suggests that therapist-client similarity contributes to a stronger therapeutic relationship, this may enhance positive feelings to clients of similar background. Furthermore, clients who are verbal, intelligent, well-educated and motivated to succeed enter therapy with characteristics that enhance their capacity to gain from the process, and this may account for the reported higher retention rate in therapy of clients from at least a middle class background.

With the widening in availability of different forms of psychological therapy over the past 20 years or so, there has no doubt been a widening of usage across social classes. Therapists in this research project were drawn from a variety of clinical settings and represented a range of professional disciplines. It is probable therefore that contact with clients from different social classes would be quite broad. In the present research there was advantage in controlling social class by portraying that group with whom most therapists were likely to be familiar. Clients were therefore portrayed to be of middle class origins, with similar levels of education and verbal skills.

Age. The "Yavis" cluster described by Mintz (1972), in addition to social factors such as education, verbal skills and success, indicated that therapists showed a preference for young (and attractive) clients. There is little hard evidence as to why client age should

be considered relevant to psychological therapy. Logically it would seem that the nature of the therapeutic relationship may vary with the age of the client, since a quite different relationship is likely to evolve with different aged clients, particularly where transference is considered an important component of the therapy process. Therapists' attitudes about, and expectations of, clients of different ages are also likely to vary and may result in different feelings about the client. Furthermore, therapists' liking for, and capacity to empathise with, clients of different ages may well vary depending on the therapists' own age and experience level. Because age has the potential to impact on therapist affective experience, because of factors such as the therapist's own age, experience with clients of different ages, and attitudes and theoretical perspective, age was controlled for as a variable in the vignettes.

Education. Education has been discussed in relation to social class, the educational level attained by the client may have a bearing on psychological therapy. The educational levels attained can be affected by a wide variety of factors, including opportunity, motivation, family expectations and intelligence. Educational level in itself is not likely to directly affect either process or outcome of therapy, although perhaps those having received a higher level of education are perhaps likely to be more aware and accepting of the aims and benefits of psychological therapy. However, once again therapists' perceptions, expectations and attitudes to clients with different educational levels may result in different affective experiences. For example, a therapist may experience more negative affect with a client of higher educational attainment who fails to make the expected gains from therapy. In creating the vignettes, therefore, all clients were portrayed

as having undertaken the same level of education (at tertiary level), albeit in different arenas.

Diagnostic and Behavioural Characteristics

Another group of client variables researched for their significance in psychological therapy is concerned with the type, duration and severity of the presenting problem, the associated symptoms, and the personality of the client (Garfield, 1994). These variables have the potential to impact on the therapist in a number of ways, and are particularly likely to affect the nature and quality of the relationship formed with the client. Thoughts and behaviours accompanying some disorders inevitably impinge on interpersonal interactions, and the therapy interaction is no exception. For example, therapist affective experience may be modified by the client's interpersonal style, by the demands made upon the therapist's expertise, and also by therapist assumptions about the nature of the client's disorder. Therapists' personality traits can be expected to bear some relationship to interpersonal style and response to stress as well as affective experience. Moreover, theoretical orientation can be expected to shape both the assumptions made about the disorder and the way in which the therapist manages his or her response to the client's behaviour. Behaviours associated with client disorder were therefore selected as the stimulus material for the vignettes.

It should be noted that client behaviours were represented in the vignettes, rather than specific diagnoses. For a number of reasons it was preferable that symptom behaviour depicted in the vignettes was not pronounced. Studies have consistently shown that diagnostic labels can influence therapists' perceptions of, and attitudes to, their clients and may often elicit negative feelings and pejorative judgements about certain diagnoses

(Herbert, Nelson & Herbert, 1988; Lewis & Appleby, 1988). In the present studies, this could prove a confound, in that experienced therapists' affective experience could reflect undetected preconceptions about a diagnostic label. In obtaining participants for the studies it was not possible to control for clinical expertise, and it was expected that there would be wide variability in participants' exposure to, and experience with, different diagnostic groups. If diagnosis were a distinguishing feature in vignettes there was the likelihood that affective variation might be attributable to familiarity with diagnoses, and the therapists' experience in managing such disorders. Further, not all behaviours associated with a diagnosis are necessarily affect-inducing. By referring to the literature about difficult, and liked-disliked, clients it was possible to identify the behaviours that were most likely to be affect-inducing without allowing these to cluster at a level at which a diagnosis was clearly defined. In this way it was hoped to avoid responding to labels but rather to focus on the behaviours likely to evoke an affective response from participants.

Another consideration arbitrating against a focus on diagnosis was that some participants were not practising mental health professionals and were unlikely to have accurate knowledge of diagnostic criteria. If diagnosis, rather than behaviours, were the distinguishing criterion, inexperienced participants might be distracted, or confused, by some behaviours. This again could possibly confound results obtained in the studies.

The task, therefore, was to focus on affect-inducing behaviours, and to depict those behaviours at a level of severity and symptom aggregation that did not clearly delineate a diagnosis. Severity of disorder and associated symptoms have been shown to influence therapists' responses to clients, with more severe disorders evoking strong negative reactions in some therapists (Colson, 1990; Colson et al., 1985; Merbaum & Butcher,

1982; Rosenbaum, Horowitz & Wilner, 1986). Behaviours displayed in the vignettes therefore intentionally did not reach extremes of severity and were held constant at a moderate level, as has been explained above. In selecting interviews, those most nearly matched in symptom severity ultimately chosen. (See the section in this chapter concerning validation of interviews for further information.)

Selecting Client Behavioural Styles

On the basis of the evidence from the literature about behaviours perceived as difficult or disliked, three broad categories of client behaviours were selected: depressed style, psychotic style and personality disordered style (Colson et al, 1985, 1986; Kelly & May, 1982; Neill, 1979). Some behaviours associated with these disorders have been found particularly to be associated with negative affective experience, although in some cases also positive affective experience has also been reported. To these three behavioural styles, a fourth category of 'neutral" style was added.

A behavioural description was drafted for each of these categories to serve as a behavioural guide for the actors portraying clients in the vignettes. Information from a number of sources, including the diagnostic criteria and associated features from the relevant sections of the Diagnostic and Statistical Manual, Fourth Revision (American Psychiatric Association, 1994), were used to create behavioural descriptions. "Behaviour", here, is used to include form and content of speech, as well as physical behaviours and mannerisms. A panel of three psychiatrists and one clinical psychologist met with the researcher to consider what behaviours might best characterise each of the four categories in young male or female clients. All members of the panel were experienced clinicians, with a mean of 9.2 years clinical experience.

The criteria for including a behaviour were that it should frequently associated with either depressive, psychotic, personality or no disorder, should not represent an extreme and should not accrete with other behaviours to a level at which a disorder was necessarily clearly present. From the draft descriptions the panel selected the following as likely to be associated with each of the four behavioural styles:

Neutral Style:

- Maintain high eye contact with interviewer
- Open, relaxed posture
- Articulate and spontaneous speech
- Cooperative and responsive to interviewer
- Active, involved participation in interview
- Motivated to obtain help
- Emotional expression appropriate to interview content
- Insightful, "psychologically-minded" commentary
- Openness and willingness to explore issues

Depressed Style:

- Reduced eye contact
- Sad facial expression
- Subdued motor activity
- Reduced spontaneity in speech
- Restricted emotional range
- Interpersonal withdrawal
- Loss of interest in usual activities
- Apathetic; passive
- May show dependent or "helpless" behaviour

Psychotic Style:

- Reduced eye contact

- Reduced facial expression
- Reserved, oblique or slow in answering questions
- Limited expression of emotions
- May make obscure or cryptic comments
- Withdrawn, guarded or remote interpersonal style
- Non-cooperation with interview

Personality Disordered Style:

- Spontaneous speech
- Some manipulative or seductive behaviour
- Demanding, hostile or intrusive behaviour
- Labile emotions
- Responsive to questions but may be uncooperative
- Attention-seeking
- Mentions self-destructive behaviours

Scripting and Filming the Vignettes

Four vignettes were devised for use in this research, one for each of four behavioural styles (neutral, depressed, psychotic and personality disordered) and these were portrayed by four different female actors. As discussed above, clients were matched as nearly as possible for characteristics of age, ethnicity, education, socioeconomic status, presenting problem, severity and length of problem, physical attractiveness and likeability.

Client Histories

A life history was devised for each of the clients that included details of age, family of origin, education, current employment, relationship history and the reason for seeking

consultation with a therapist. It was not intended that all of the information would be used during the interviews, but that the creation of a full history would allow the actors to better conceptualise their characters, and to maintain and express that identity during the interview. It also ensured that both interviewer and actor worked from a common knowledge base to increase consistency during the interview.

Histories were constructed so that all clients were described as seeking consultation as an out-patient rather than as an in-patient, and the interview content was designed to suggest that the consultation was an early one. None of the characters was depicted as having a chronic disorder, or having consulted a therapist for an extended period. Clients were portrayed as undertaking, or having completed, a tertiary education and were described as employed either full- or part-time, depending upon whether tertiary education was completed. This, to some degree, was prescribed by the age of the actor. For example, the actor portraying the neutral behavioural style was aged 27 years and was therefore described as having completed her tertiary education. The actor portraying the personality disordered behavioural style was, however, somewhat younger (aged 23 years) and was therefore described as studying at a tertiary institution and working part time.

Interview content needed to centre on a common problem area that was plausible and acceptable to both untrained and trained participants. All clients were therefore described as reporting difficulties in a "romantic" relationship. Because therapists have been found to differ in their responses to gay and lesbian clients (Gelso, Fassinger, Gomez & Latts, 1995; Hayes & Gelso, 1993) the relationship was in each case portrayed as heterosexual. Relationship difficulties, frequently encountered in all types of psychological therapy, constituted an appropriate focus for the interviews. However, it was

considered that participants inexperienced in psychological therapy would not be precluded from identifying with, and understanding, the clients' difficulties. Thus the interview content would be relevant to both the first study, in which participants were undergraduate students, and the second study, in which participants were trained therapists of varying professional disciplines and theoretical orientation.

Actors

A limited research budget precluded the employment of professional actors to portray the clients in videotaped vignettes. There was, however, an advantage in using non-professional actors for the project since it reduced the likelihood of actors being familiar to any of the large number of participants in the study. Acting competence was required to ensure convincing portrayal of characters and it was therefore decided to approach drama departments of tertiary education institutions to canvass the voluntary participation of acting students in the project.

The Faculty of Visual and Performing Arts at the University of Western Sydney, Nepean Campus, was approached and its cooperation obtained in inviting students to voluntarily participate in making the videos. The project was explained to a meeting of students who were midway through their undergraduate training, and seven students volunteered to take part in making the videos. At the time of making the videos all of the students had completed 18 months of their three-year undergraduate degree and none had professional acting experience.

The actors' ages ranged from 20 years to to 27 years. Six of the actors were of Anglo-Australian origins. In order to comply with the requirement of matched ethnicity, the seventh actor, of Asian origin, was not included in the group. Two more actors were

available than there were clients to be portrayed. A second interview was therefore recorded for each of the two client roles likely to be most demanding. A decision was later made as to which of these interviews was the most convincing and consistent, and these ultimately were used in the study.

An appointment was made with each of the actors to discuss the project and to explain the character each actor was to portray. At this first interview, the background to the research was outlined and the plan for constructing the interviews discussed. Each actor signed a document agreeing to participate without payment in the project, and to allow the edited interviews to be used for a limited time for research purposes only.

At this first interview each actor was given a detailed written history for her character. Each actor was also given a selection of reading material, such as case histories taken from textbooks. Where possible, actors were also referred to fictional and non-fictional sources that gave accounts of the thoughts and behaviours of individuals experiencing problem behaviours similar to those of the characters the actors were to portray. It was explained that, since the interviews were to be spontaneous and unscripted, the actors should familiarise themselves with the history of their character and consider their likely thoughts, feelings and behaviours during the interview. The actors were then given time to review their characters, and appointments were made to further discuss the characters. At this second interview, the character was developed through discussion and explanation, and any questions regarding behavioural style were answered. An appointment was then made to videotape the interview at the studios of the university.

Interview Structure

The intention was to produce vignettes that reflected a natural and believable portrayal of client behaviour during a therapy interview. Therefore no set script was used, and a spontaneous unrehearsed interview was videotaped, adhering to the parameters set by the previously arranged life history and behavioural style. The researcher, a registered psychologist with extensive experience in clinical interviewing, took the role of therapist and conducted all the interviews. It was assumed that all interviews took place at an early stage in the formation of the therapeutic alliance. The style of the interviews did not adhere to one theoretical approach, and techniques associated with a specific therapy orientation were not employed. Interview content steered a course between identification of the perceived problem area, information gathering, empathic listening and reflection, and clarification of client comments. To ensure that participants were distracted as little as possible by the therapist's character, speech and behaviour, the therapist did not appear on-camera and the therapist's speech was later edited out and replaced by sub-titles.

The unedited interviews were each approximately 30 minutes to 45 minutes in length and were then edited down to meet the requirements of the studies. Interviews needed to be short enough for viewers' attention to be well sustained within each interview, and across the series of interviews, but sufficiently long to gain a clear impression of the client's history and behavioural style. In other studies using videotaped clinical material, viewing time has varied from three to fifteen minutes. For this research, various interview lengths, ranging from three to eight minutes, were tested by a panel of three judges and a unanimous decision was reached that six minutes was an optimal length. Less than six minutes did not allow sufficient time for an observer to absorb the content

and behavioural style of the client. When interviews extended for more than six minutes it was difficult to maintain consistency of content, and total viewing time proved too long when all eight tapes were viewed consecutively. In total, then, viewing time for all four interviews was 24 minutes and, in terms of the planned second study in which participants were to be practising therapists, this was considered likely to be a maximum time expenditure permissible for the study by some institutions. Nevertheless, it was considered that to employ briefer excerpts compromised a consistent and meaningful portrayal of characters and therefore a six-minute interview length was adopted.

Recording and Editing Vignettes

Interviews were filmed using a Sony Video 8 camera mounted on a tripod, and with a free-standing Electret Condenser microphone positioned close to the client. Each interview was filmed in the same manner with the therapist seated out of shot beside, and to the left of, camera so that clients spoke, and faced, to a point just off-camera. This was considered to produce a more realistic and convincing portrayal than speaking directly to the camera. The client sat in a comfortable chair, or couch, against a plain background. The camera was trained to frame the head and torso of the actor, rather than a fully body shot, in order to allow a relatively close up picture that permitted clear registration of facial expression as well as body posture. Camera position remained the unchanged throughout the interview.

Filming was conducted in one sitting and, with few exceptions, as one continuous interview. Interviews were then transposed onto editing tape and the tapes edited down to the required length of six minutes using a Sony U-Matic Editing System. When edited, the tapes gave the appearance of a single segment taken from a longer interview. Thus an

interview commenced apparently when the client had been speaking for some time and when the introductory formalities had been passed. This was intended to increase the realism of the simulations. Between five and seven segments were selected from the full interview that comprised a coherent extract from the client's story when they were combined. Interviewer comments or questions were used to link the segments to each other to produce an apparent continuous extract from the full interview.

Once the film had been edited into a coherent extract, appropriate interviewer comments were composed. These were up to ten words in length, and were either a question or a statement that was affectively neutral in tone. Still frames of the client were selected at a natural pause in the client's speech. Interviewer comments were superimposed in yellow type at the bottom of the still frame in a size sufficient to be easily read from a distance. An Amiga computer was used to generate the sub-titles and to superimpose them onto the still frames. A Genlock synchroniser connected to the computer synchronised the still frames with the U-Matic editing tape at the appropriate point in the interview. The effect was that the interview commentary paused, changed to the still frame, then re-commenced with as little interruption to visual continuity as possible. The length of time that a still frame was exposed was determined by the length of the interviewer comment but generally was between three and six seconds in length. This permitted comfortable time to read the sub-title without undue distraction from the action content of the interview.

An interview commenced with a screen displaying the client's name, in the same yellow type as was used for interviewer comments. This was exposed for three seconds, followed by a two-second, blank screen before the interview proper commenced. The tape

concluded with a further two seconds of blank screen. Once editing had been completed, interviews were transposed onto individual VHS videotapes so that interview order could be varied as required.

Once all six interviews had been recorded and edited, a decision was made as to which of the duplicated behavioural styles should be used. Two interviews were discarded, one on the grounds that the behaviours portrayed were too extreme to be comparable to other interviews, and the other on the grounds that the behaviours were not adequately identifiable with one diagnosis.

Validating the Vignettes

The validity of the vignette content was assessed for the consistency of behavioural style with diagnosis, the comparability among behavioural styles, the believability of the portrayals, and the physical attractiveness and likeability of client presentation. In the sections that follow each of these validation procedures is described.

Behavioural Style

The behavioural styles depicted in the vignettes were intended to portray behavioural characteristics associated with, but not necessarily diagnostic of, three categories of disorders (depressed, psychotic and personality disordered) and one category neutral for disorder. As has been stated previously it was not intended that these behavioural characteristics necessarily reached a level at which a disorder would clearly be present, but that the behaviours be those reported as difficult or affect-inducing for the therapist. Behaviours depicted in the vignettes had been agreed upon by a panel of expert clinicians as those likely to be seen in clients presenting as out-patients.

METHOD

In order to determine the accuracy with which the four actors displayed behaviours associated with a specific disorder, the vignettes were shown to expert clinicians who were asked to decide with which of a number of diagnostic categories each client's behaviour was most consistent. Ten psychiatrists and three psychologists with extensive clinical experience (mean of 14.4 years) in adult mental health were approached to participate in this validation study. The participants were not personally know to the investigator and did not have any prior knowledge of the research. They were accessed with the assistance of a senior psychiatrist who was acquainted with the aims of the research and the purpose of the validation studies. The twelve clinicians participated voluntarily and anonymously in the study.

Packages containing a VHS videotape of the vignettes, an explanatory letter and a set of data sheets were sent to each of the participants. The letter explained the purpose of the study as the validation of simulated interview material to be used in a larger study. The contents of the videotape were summarised, and it was specified that actors portrayed the client interviewees. The letter also specified that the behaviours did not necessarily reach a level at which a formal diagnosis would be warranted. A stapled set of data sheets, one page for each of the four interviews, was compiled in the order in which the interviews appeared on the videotape. Each sheet was printed on an A4 page and was headed with the name of the client. The one-paragraph history intended for future use in the studies then followed in bold type. The following instructions were then given:

> Please indicate to what degree (client's name) behaviour is consistent with **each** of the seven diagnostic categories listed below. Do this by ticking the appropriate

column for **each** category on a scale from 1 to 5, where 1 indicates the absence of that diagnosis and 5 indicates the definite presence of that diagnosis. Remember that the behaviour portrayed in this excerpt will not necessarily warrant a formal diagnosis. Your response should represent the degree to which, in your opinion, the behaviour portrayed is consistent with each diagnosis.

A table listed, in its left-hand column, the seven diagnostic categories of "No disorder", "Substance-related disorder", "Psychotic disorder", "Mood disorder", "Anxiety disorder", "Adjustment disorder", and "Personality disorder". Five further columns were headed by the scale numbers and descriptions: 1: Not at all consistent; 2: A little consistent; 3: Quite consistent; 4: Mostly consistent; 5: Entirely consistent. Thus participants rated each behaviural style for its consistency with each of the seven diagnostic categories.

The diagnostic categories were labelled using six general headings given in the diagnostic classification system of the DSM-IV (American Psychiatric Association, 1994). The categories included the three that formed the focus of behaviour in the vignettes (mood disorder, psychotic disorder and personality disorder) plus three further categories of anxiety disorder, adjustment disorder and substanced-related disorder. These three further categories were selected alternative disorders in which some of the behaviours depicted in the vignettes might also occur, and were included as a means of further checking accuracy and specificity of behaviours depicted in the vignettes. A seventh category labelled "no disorder" was also included. Those general DSM classifications not

included in the list were ones unlikely to have been associated with the clients' presentations, such as dementias, developmental disorders, and eating disorders.

RESULTS AND DISCUSSION

The criterion for an acceptable level of consistency of behavioural style with diagnostic category was set at a modal rating of "Quite consistent. A further criterion was set that only one diagnostic category should reach criterion, that is, that there be a clear preference for one diagnostic category over others. Modal responses to the seven diagnostic categories for each of the four behavioural styles are given in Table 6.1.

Table 6.1. Modal Consistency Responses to Seven Diagnostic Categories for Four Behavioural Styles

Diagnostic Category	Personality Disorder	Neutral	Psychotic	Depressed
No Disorder	1	4*	1	1
Substance-Related Disorder	1	1	1	1
Psychotic Disorder	1	1	3*	1
Mood Disorder	1	1	2	3*
Anxiety Disorder	1	1	1	1
Adjustment Disorder	2	1	1	2
Personality Disorder	4*	1	1	1

Note Values marked by an asterisk represent the modal responses for each category.

The modal responses for all the behavioural styles met both consistency criteria. The personality disordered and neutral behavioural styles were judged to be mostly consistent with the appropriate categories, and the psychotic and depressed behavioural styles to be quite consistent with the appropriate categories. Personality disordered, depressed and psychotic behavioural styles were judged to be a little consistent with a second category, with only the judgement of the neutral category indicating a clear preference for only one diagnostic category.

Most behavioural styles were judged to be a little consistent with a second diagnostic category, and this is not an unlikely outcome. In reality, secondary or differential diagnoses are a frequent occurrence and, particularly because the vignettes were designed to not represent clear templates for diagnoses, some equivocality of judgement was to be expected . The secondary judgements in each case represent an appropriate and not inconsistent alternative to the preferred diagnosis and, in the case of the personality disordered behavioural style, can be viewed as a relevant Axis I diagnosis. In conclusion, therefore, the four vignettes met satisfactory levels of consistency with the intended diagnostic categories.

Believability

Another factor in determining that the vignettes were valid was that the characterisations be believable. This once again required the judgement of expert judges, since believability in this context was determined both by the believability as individuals and believability as clients consulting a therapist.

METHOD

To obtain a measure of believability, a section was included at the end of the data sheets described above for behavioural style asking psychiatrists and psychologists to make a judgement on whether the actors' characterisations were believable. A sentence read:

"(Client's name) character is portrayed by an actor. Please indicate how believable you found this character by circling one of the numbers below." There

followed a scale 1: not at all believable; 2: not very believable; 3: quite believable; 4: very believable; 5: entirely believable.

RESULTS AND DISCUSSION

Once again the criterion was set in the mid-range, here "quite believable", although in this instance the mean was used as a measure of central tendency. All actors were rated as being quite, to very, believable in their characterisations. The actor portraying the personality disordered client was judged most believable ($\underline{M}$ = 4.08, $\underline{SD}$ = 0.52), followed by the neutral ($\underline{M}$ = 3.83, $\underline{SD}$ = 0.58) and the depressed ($\underline{M}$ = 3.67, $\underline{SD}$ = 0.65) clients. The actor portraying the psychotic behavioural style obtained the lowest score for believability ($\underline{M}$ = 3.08, $\underline{SD}$ = 0.90) but this remained within the acceptable limit.

This is not, perhaps, a surprising result since the accurate and believable portrayal of low level psychotic behaviour is difficult to achieve. As has already been noted, in reality psychotic behaviour is at times difficult to identify without an extended interview, even when expert clinicians make the assessment. In this case, the expert judges had only the evidence of a six-minute excerpt and under these circumstances a rating of moderate believability is deemed satisfactory. All other ratings easily reached the required level of believability, with the actor portraying the personality disordered behavioural style being rated highest in believability.

Physical Attractiveness and Likeability: Video Excerpts

Physical attractiveness has been related to individuals' evaluations and

judgements of others. Observers can impute internal characteristics to an individual on the basis of unrelated, external characteristics such as competence, personality type and responsibility for transgression (Dion, 1972; Forgas, 1988). In psychological therapy, the physical attractiveness of clients has been hypothesised as impacting on the relationship between therapist and client (Garfield, 1994). In the present context, physical attractiveness of the clients portrayed in the vignettes may be relevant to affective experience. Patrick and Lavoro (1997) discussed the structure of affective response to pictorial stimuli such as film clips and slides. They found that, with slide presentations of pleasant, neutral and unpleasant stimuli, positive affect was highest for pleasant slides and negative affect was highest for unpleasant slides. If pleasantness is assumed to be a concomitant of physical attractiveness, then it is reasonable to assume that positive and negative affect may vary with level of attractiveness. For the purposes of the present study, therefore, it was desirable that clients portrayed in vignettes should be comparable in physical attractiveness.

Similarly, the likeability of clients may influence therapists' affective response to their clients. As has already been discussed, therapists can experience greater difficulty with less liked clients in the therapeutic relationship. Management practices such as appointment keeping, medication use and attentiveness, have been found to be affected with less liked clients (Robbins, Beck, Mueller & Mizener, 1988). In creating vignettes for this research, likeability was therefore also a consideration.

In making the vignettes, matching for physical attractiveness and likeability presented some challenges. Although evaluations of both physical attractiveness and likeability are to some extent predictable by social and cultural norms, they are also

idiosyncratically determined. It is to be expected that individuals will hold differing views of what constitutes physical attractiveness and likeability, and therefore matching cannot necessarily be readily achieved. Furthermore, in creating the vignettes, the limited availability of actors meant that there was little scope for selection on the basis of physical attractiveness and likeability. Nevertheless it was desirable to establish a measure of the comparability of the clients portrayed in the vignettes for these variables. Two studies of physical attractiveness and likeability were conducted, one using extracts from the vignettes and the other using black and white photographs of the actors.
Brief extracts from each interview were presented to a group of undergraduate students and ratings obtained for the physical attractiveness and likeability of the characters.

METHOD

The researcher reviewed the unedited interviews and selected a ten-second extract from each interview for its neutral behavioural and speech content. These extracts were then transposed in random order onto a single VHS videotape. Permission was obtained from the Psychology Department at Macquarie University to attend the closing stages of an undergraduate psychology lecture and to ask students to make judgements of characteristics of individuals portrayed in the extracts. At the lecture the purpose of the study was briefly explained and those students not wishing to participate were given the opportunity to leave the room. Seventy-six students agreed to participate.

A set of stapled data sheets, one page for each interview extract, was distributed and participants were asked to indicate their sex at the top of the first sheet. Each sheet was titled with the name of the character, followed by a summary of the verbally delivered instructions and a scale (1=not at all; 2=a little; 3=moderately; 4=a lot; 5=extremely).

There followed two questions, each on a separate line – "How attractive is (client's name)? "How likeable is (client's name)?" followed by the numbered scales. Instructions to the participants were as follows:

> You will be shown four, ten-second segments extracted from interviews to be used in a larger study. Your participation is anonymous and your willingness to participate is indicated by completing the task. Your participation is appreciated, but if you decide not to participate simply leave the forms blank. Please use the data sheet to indicate how physically attractive and how likeable you consider each person to be, on the basis of the interview segment. Use the criteria that are *personally relevant to you* (e.g. appearance, speech, manners) and that you might normally employ in making such judgements in everyday life. Use a scale from 1 (not at all) to 5 (extremely) to record your judgements. Turn to the next page in the booklet as soon as you have made your judgement. Should you recognise, and know personally, any of the people shown please indicate this by making a circle around the name of the person.

The videotape was then run and projected onto a large screen at the front of the lecture theatre. The tape was paused between extracts to allow participants time to make their judgements. After all four extracts had been shown, the data sheets were collected, and the participants thanked for their participation.

RESULTS AND DISCUSSION

No actor was known personally by a participant. Fifteen participants failed to record their sex on the data sheet. Of the remaining 61 participants, 16 were male and 45 were female. Data were first analysed for the entire group and then by gender. Mean attractiveness and likeability ratings for the combined group of 76 participants, and for male and female participants, are shown in Table 6.2. Male participants' mean scores were consistently higher than those of female participants. There was also a quite large range in standard deviations, indicating that some ratings were more internally consistent than others. Greatest variability occurred within the smaller male sub-sample.

Table 6.2. Mean Attractiveness and Likeability Ratings of Four Behavioural Styles: Vignette Extracts

Behavioural Style	Combined Sample Participants (N=76)		Male Participants (n=16)		Female Participants (n=45)	
Attractiveness Ratings	M	SD	M	SD	M	SD
Personality Disordered	2.11	.90	2.25	1.18	2.09	.82
Neutral	2.78	.87	2.56	96	2.91	.76
Psychotic	2.67	.74	2.88	.62	2.64	.74
Depressed	2.34	.76	2.00	.73	2.51	.73
Likeability Ratings	M	SD	M	SD	M	SD
Personality Disordered	2.83	1.00	3.00	1.16	2.73	.96
Neutral	3.11	.97	2.88	1.09	3.31	.85
Psychotic	2.61	.82	2.81	.91	2.51	.76
Depressed	2.57	.79	2.25	.93	2.73	.78

Mean ratings of physical attractiveness and likeability were highest for the neutral behavioural style for both the combined sample and female participants. Male participants judged the actor portraying the psychotic behavioural style to be highest in physical attractiveness, and the actor portraying the personality disordered behavioural style to be highest in likeability. T- tests were then conducted to establish whether any significant differences existed among means for the various behavioural styles. The results of the t-tests are summarised in Table 6.3.

Physical Attractiveness.

T-tests for differences between the four behavioural styles in independent samples of male and female participants revealed no significant differences for any of the comparisons, indicating that male and female participants made comparable attractiveness ratings for each of the behavioural styles.

Table 6.3. Summary of Paired t-test Comparisons of Physical Attractiveness Ratings Female Actors and Four Behavourial Styles – Vignette Extracts

Behavioural Style	Combined Sample (N=76) t	Male Participants (n=16) t	Female Participants (n=45) t
PD vs Neutral	- 4.65**	- 0.69	- 5.74**
PD vs Psychotic	- 4.39**	- 1.67	- 3.77**
PD vs Depressed	- 1.74	0.62	- 3.09*
Neutral vs Psychotic	0.81	- 1.43	1.63
Neutral vs Depressed	4.52***	2.52	3.90**
Psychotic vs Depressed	3.19	4.34**	0.97

Notes: Behavioural Styles: PD = Personality Disordered Behavioural Style; Psychotic=Psychotic Behavioural Style; Neutral=
Neutral Behavioural Style; Depressed=Depressed Behavioural Style
Two-tailed t-tests with significance level at .01
* p < .01 ** p < .001 *** p < .0001

However, differences emerged when behavioural styles were compared with each other, and the directions of these differences varied with the gender of the participants. Considering first the combined group of 76 participants' ratings of characters, the actor depicting a depressed behavioural style was judged to be significantly less attractive than the actors depicting a neutral behavioural style, $t(75) = -4.52$, $p<.0005$, and a psychotic behavioural style, $t(75) = -3.19$, $p<.002$. Further, the actor depicting a personality disordered style was judged to be significantly less attractive than the actors portraying a neutral behavioural style, $t(75) = -4.65$, $p<.0005$, and a psychotic behavioural style, $t(75) = -4.39$, $p<.0005$. The differences in attractiveness ratings between depressed and

personality disordered, and neutral and psychotic, behavioural styles were both non-significant.

When two-tailed paired t-tests were conducted to test for differences between male participants' attractiveness ratings between behavioural styles, only one pair was found to be significantly different. The actor depicting the depressed behavioural style was judged significantly less attractive than the actor depicting the psychotic behavioural style, $t(15) = -4.34$, $p<.001$. Female participants' attractiveness ratings, however, revealed a larger number of differences between behavioural styles. The actor depicting the personality disordered behavioural style was judged by female participants to be significantly less attractive than the actors depicting either the neutral, $t(44) = -5.74$, $p<.0005$, psychotic, $t(44) = -3.77$, $p<.0005$ or personality disordered, $t(44) = -.3.09$, $p<.003$ behavioural styles. The actor depicting the depressed behavioural style was also judged to be significantly less attractive than the actor depicting the neutral behavioural style, $t(44) = -3.90$, $p<.0005$. The differences between psychotic and depressed, and psychotic and neutral behavioural styles were non-significant

Summary and Conclusion

Actors portraying the different behavioural styles were not judged as comparable in physical attractiveness, and the differences in rated attractiveness varied according to whether male or female participants made the judgements. A percentage of the overall sample of participants failed to indicate their sex on the data sheets (19.7%), and there was a disparity in the numbers of identified males and females participating in the study, with almost three times the number of female to male participants. It is possible that the larger number of significant differences between behavioural styles in the combined sample and

female participants sub-sample may have been a result of the relatively large sample sizes for these groups. Nevertheless, the disparity in judged physical attractiveness of the actors should be borne in mind when interpreting the results of studies using the vignettes.

Likeability

Mean likeability ratings and standard deviations are summarised in Table 6.4. A series of t-tests was conducted to test for differences between mean likeability scores for the four interview extracts. T-tests for independent samples by sex of participants indicated there were no significant differences between males and females in overall ratings of actors portraying the four behavioural styles.

The four behavioural styles portrayed by actors were then compared with each other for differences in mean likeability ratings, and these were tested for the total sample of participants, as well as the sub-sample of male participants and female participants. Likeability was rated somewhat differently from physical attractiveness. For the full sample of 76 participants, the actor portraying the neutral behavioural style was judged to be more likeable than the actor portraying the depressed behavioural style, $t(75) = 4.77$, $p.<.0005$ and the actor portraying the psychotic behavioural style, $t(75) = 3.40$, $p.<001$. All other comparisons of actors were non-significant.

When the sample was divided by sex of participants, paired t-tests of the differences in likeability between behavioural styles once again showed some variation. For male participants none of the paired t-test comparisons of behavioural style reached significance. That is, male participants judged the actors to be comparable in likeability. For female participants' judgements, the actor portraying the neutral behavioural style was judged to be significantly more likeable than the actors portraying the depressed

behavioural style, $t(44) = 4.48$, $p<.0005$, the psychotic behavioural style, $t(44) = 4.79$, $p<.0005$, and the personality disordered behavioural style, $t(44) = 3.41$, $p<.001$. That is, the actor portraying the neutral behavioural style was judged to be more likeable than other actors. Differences between other behavioural styles were all non-significant. A summary of the results of paired comparisons t-tests is given in Table 6.4.

Table 6.4. Summary of Paired t-test Comparisons of Likeability Ratings Four Behavioural Styles: Vignette Extracts

Behavioural Style	Combined Sample (n=76) t	Male Participants (n=16) t	Female Participants (n=45) t
PD vs Neutral	-1.61	0.25	-3.41*
PD vs Psychotic	1.62	0.42	1.46
PD vs Depressed	-1.70	1.66	0.00
Neutral vs Psychotic	3.40*	0.19	4.79*
Neutral vs Depressed	4.77*	2.18	4.48
Psychotic vs Depressed	0.32	2.06	1.53

Notes: Behavioural Styles: PD = Personality Disordered Behavioural Style; Psychotic=Psychotic Behavioural Style: Neutral=
Neutral Behavioural Style; Depressed=Depressed Behavioural Style
Two-tailed t-tests with significance level at .01
* $p < .001$

Summary and Conclusion

The results of these t-test comparisons indicate that, on the basis of short extracts from the videotaped vignettes, likeability was not comparable across the characters. It is of particular note that the actor portraying the neutral behavioural style was judged by female participants to be more likeable than other actors. Since likeability has been related to positive affective experiences, there existed the possibility that, when used in the studies, the vignettes depicting a neutral behavioural style might be experienced more positively on the basis of likeability rather than on the basis of behavioural style.

A somewhat similar bias in physical attractiveness was found towards the actor portraying the neutral behavioural style. These results may have reflected genuine

differences in physical attractiveness between actors. It was also possible that physical attractiveness was included as a personally relevant criterion in making judgements of likeability, as has been shown to be the case in some studies of social interactions, particularly dating behaviour (Berscheid, Dion, Walster & Walster, 1971; Walster, Aronson, Abrahams & Rottman, 1966). In this case, however, this seems unlikely since there was no clear relationship between the order of ratings for physical attractiveness and likeability.

Another possibility was that, despite the precaution that only neutral segments were selected from the videotaped interviews, the clients' characters "leaked" into the segments. This would account for the relatively consistent higher ratings for the client with neutral behavioural style since this character portrayed more open and spontaneous non-verbal behaviour, made more eye contact with the interviewer and using a more open and confident posture. Although relatively little was said in each ten-second segment, the more articulate and modulated speech of the neutral behavioural style client may also have been apparent and affected likeability ratings. A more valid measure of physical attractiveness and likeability may have been obtained if participants had made judgements of actors when they were not "in character".

In order to evaluate the physical attractiveness and likeability of actors without leakage from the characters portrayed in the vignettes, it was decided to attempt to obtain further videotaped footage of each of the actors when they were not enacting a role and to obtain judgements of this "neutral" material. Results could then be compared with those obtained from the excerpts from vignettes to ascertain whether the relative attractiveness and likeability of the actors remained the same when they were not in character.

Physical Attractiveness and Likeability: Photographs

Attempts were made to obtain brief videotape segments of each of the actors when they were not acting a part, but not all of the actors who participated in making the vignettes could be contacted. However, when their university was contacted, black and white publicity photographs of the actors were available and permission was obtained to use these photographs to obtain a further set of judgements of physical attractiveness and likeability.

METHOD

The black and white photographs were scanned on an Hewlett Packard C25 20B scanner, and reproduced at a size of 4 mm. x 4.75 mm. Each photograph was photocopied at the top centre of a separate A5 page, on which were printed the same instructions and rating scale used in the previous study (adapted for a still, rather than an action, stimulus). The four pages were compiled into a booklet, at the front of which was attached a demographics sheet on which the participants were asked to indicate their sex and age. The pages were collated in a random order (see Appendix A).

Permission was once again obtained from the Psychology Department of Macquarie University in Sydney to enlist the participation of second year undergraduate students of a psychology course in making judgements of the photographs. Students were approached at their tutorial classes and were asked, if they had not participated in the previous study, to complete the task of rating the photographs. The task explained to participants as follows:

> This study is part of the validation of a larger study on relationships. Your participation is anonymous and your willingness to participate is indicated by

completing the task. Your participation is appreciated, but if you decide not to participate simply leave the forms blank. Before proceeding please indicate your sex and age on the front page of the booklet. On each of the following pages is a black and white photograph. Please look at each photograph in turn and decide how attractive and likable you consider the person to be. Use the criteria that are personally relevant to you and that you might normally make in making such judgements in everyday life. Use the scale, from 1 (not at all) to 5 (extremely) shown on the page to make two judgements, one about how attractive the person is and another about how likeable the person is. Once you have made a judgement of a photograph, go on to the next page and do not refer back to your previous judgements. If you recognise, and know personally, any of the people in the photographs please place a circle around that person's photograph.

When the task was completed, the booklets were collected and the participants thanked for their time.

RESULTS AND DISCUSSION

The data were analysed in the same way as for the study using vignette extracts. None of the actors was known personally to a participant. 161 students participated in the study, of whom 41 were male and 120 were female. Mean age was 22.5 years (SD 6.87), with a range from 19 to 60 years. Means scores and standard deviations for physical attractiveness and likeability for the actors who had portrayed the four behavioural styles are shown in Table 6.5.

Table 6.5. Mean Attractiveness and Likeability Ratings of Four Behavioural Styles: Black and White Photographs

Behavioural Style	Combined Sample (N=161)		Male Participants(n=41)		Female Participants (n=120)	
	M	SD	M	SD	M	SD
Attractiveness						
Personality Disordered	2.46	0.81	2.08	0.69	2.53	0.81
Neutral	2.70	0.79	2.39	0.74	2.81	0.78
Psychotic	2.83	0.87	2.73	0.81	2.86	0.90
Depressed	3.53	0.76	3.39	0.67	3.57	0.79
Likeability						
Personality Disordered	2.92	0.82	2.55	0.75	3.04	0.80
Neutral	3.49	0.71	3.37	0.66	3.53	0.72
Psychotic	2.83	0.87	2.71	0.81	2.86	0.90
Depressed	3.58	0.95	3.39	0.77	3.49	0.77

Physical Attractiveness. Female participants generally gave higher ratings for physical attractiveness than did male participants. In contrast to the judgements made of vignette extracts, the actor portraying the depressed behavioural style obtained considerably higher ratings than did other actors. T-tests for differences between the four behavioural styles in independent samples of male and female participants revealed significant differences between male and female participants' judgements in two cases. Female participants judged the actor who had portrayed the neutral behavioural style to be significantly more attractive than did male participants, $t(158) = 3.00$, $p<003$ and also judged the actor who had portrayed the personality disordered style to be more attractive than did male participants $t(158) = 3.85$, $p<.0005$.

When paired t-test comparisons were made of the four behavioural styles for the combined sample, and for the male and female sub-samples, a number of significant differences were found. These are summarised in Table 6.6. For the combined sample, the actor portraying the depressed behavioural style was judged to be significantly more attractive than the personality disordered, $t(160) = 12.77$, $p.<.0005$, the neutral, $t(160) =$

11.86, p.<0005 and the psychotic, t(160) = 9.56; p.<0005 behavioural styles. The actor portraying the psychotic behavioural style was judged to be more attractive than the personality disordered behavioural style, t(160) = 4.28, p.<.0005.

Table 6.6. Summary of Paired t-test Comparisons of Physical Attractiveness Ratings for Four Behavourial Styles: Black and White Photographs

Behavioural Style	Combined Sample (N=161) t	Male Participants (n=41) t	Female Participants (n=120) t
PD vs Neutral	- 3.25**	- 2.22	- 2.51
PD vs Psychotic	- 4.28**	- 3.84**	- 2.80*
PD vs Depressed	- 12.77**	- 9.99**	- 9.69**
Neutral vs Psychotic	- 1.62	- 2.47	- 0.55
Neutral vs Depressed	- 11.86**	- 7.94**	- 9.28**
Psychotic vs Depressed	- 9.56**	- 4.63**	- 8.34**

Notes: Behavioural Styles: PD = Personality Disordered Behavioural Style; Psychotic=Psychotic Behavioural Style: Neutral=
Neutral Behavioural Style; Depressed=Depressed Behavioural Style
Two-tailed t-tests with significance level at .01
* p < .01
** p < .001

For the sub-sample of male participants, the actor portraying the depressed behavioural style was found significantly more attractive than either the psychotic, t(40) = 4.63, p.<.0005, neutral, t(40) = 7.94, p.<.0005, or personality disordered, t(40) = 9.99, p.<.0005, behavioural styles. The differences between the neutral and personality disordered behavioural style, and the neutral and psychotic behavioural styles were not significant. For the sub-sample of female participants, the actor portraying the depressed behavioural style was once again found to be significantly more attractive than either the neutral, t(119) = 9.28, p<0005, personality disordered t(119) = 9.69, p<.0005, or the psychotic, t(119) = 8.34, p<.0005 behavioural styles. The actor portraying the psychotic behavioural style was judged to be significantly more attractive than the personality disordered behavioural style t(119) = 2.80, p<.006. However, there was no significant

difference between judgements of attractiveness of the neutral and personality disorder behavioural styles, or the neutral and psychotic behavioural styles.

CONCLUSION

When judgements of physical attractiveness were made on the basis of excerpts taken from the vignettes, the actor portraying the neutral behavioural style was judged to be more attractive than other actors. However, when the judgements were made from black and white photographs when the actors were not "in character", the actor who had portrayed the depressed behavioural style was considered more physically attractive than other actors. When the vignettes were filmed, actors did not significantly alter their appearance by the use of make-up, clothing or other alterations in appearance. The major obvious difference between vignette extracts and photographs was that, in the photographs, all actors were smiling. It seems probable that judgements of physical attractiveness were made on characteristics other than simple appearance.

The first conclusion to be drawn from this outcome is that, irrespective of the nature of the material on which judgements were based, there were differences in the perceived physical attractiveness of the four actors. Furthermore, it would seem that attractiveness ratings of vignette extracts were also affected by the characterisations. Despite the fact that every attempt was made to ensure excerpts from the interview material were neutral in tone and presentation, some aspects of the characterisation may have "leaked" through to colour participants' perceptions of the actors. Thus the actor portraying the neutral behavioural style, who used an open communication style, was judged more attractive than other actors whose less open behavioural styles may have interefered with their apparent attractiveness. This "leakage" of character may also

explain the discrepancy between judgements of the actor portraying the depressed behavioural style in vignette excerpts and photographs. On the basis of the black and white photograph this actor was judged more attractive than other actors, but on the basis of the vignette extract she was rated low for physical attractiveness. Thus, the lowered voice, reduced eye contact and passive posture adopted for the characterisation may have negatively affected judgements.

In itself, the possibility that mood and interpersonal style may influence judgements of physical attractiveness is hardly surprising. Indeed, it could well be assumed that a covert factor such as this may operate in the therapeutic relationship. Nevertheless, the evidence from the study employing photographs is that there are differences in "natural" levels of physical attractiveness. The characters portrayed in the vignettes cannot be considered matched for physical attractiveness, even when out of character, and this should be taken into account when interpreting results of studies in which the vignettes are used. Since an individual's perceived physical attractiveness may influence broad affective experience, this may be a factor in determining the kinds of affect participants report to different vignettes.

Paired t-test comparisons of the means for the combined sample, and for the male and female sub-samples showed a number of significant differences. For the combined sample of 161 participants, all but two comparisons showed a significant difference. The actor depicting the depressed behavioural style was judged to be more likable than the actors depicting the psychotic, $t(160) = 7.99$, $p.<.0005$, and personality disordered, $t(160) = 6.55$, $p.<,0005$ behavioural styles, but to be equal in likeability to the actor depicting the neutral behavioural style. The actor portraying the neutral behavioural style was also

judged to be significantly more likeable to the actor portraying the psychotic $t(160) = 8.33$, $p.<.0005$, and the personality disordered, $t(160) = 7.46$, $p.<.0005$ behavioural style. The actors portraying the psychotic and personality disordered behavioural styles were judged not to differ from each other in likeability.

For both the male and female sub-samples, the same directions of difference were found. Male participants judged the actor portraying the depressed behavioural style to be significantly more likeable than the psychotic $t(40) = 4.55$, $p.<.0005$, and the personality disordered $t(40) = 5.30$, $p.<.0005$ behavioural styles. The actor depicting the neutral behavioural style was judged to be significantly more likeable than the actor depicting the psychotic, $t(40) = 4.15$, $p.<.0005$, and the the personality disordered, $t(40) = 6.18$, $p.<.0005$ behavioural styles. Actors portraying depressed and neutral behavioural styles were not judged to be significantly different in likeability. Similarly, actors portraying psychotic and personality disordered behavioural styles were judged to be equal in likeability.

Female participants also judged the actor portraying the depressed behavioural style to be significantly more likeable than either the actor portraying the psychotic behavioural style $t(119) = 6.57$, $p.<,0005$, or the personality disordered behavioural style, $t(119) = 4.64$, $p.<.0005$, but equivalent in likeability to the actor portraying the neutral behavioural style. The actor portraying the neutral behavioural style was judged to be significantly more likeable than either the actor portraying the psychotic behavioural style, $t(119) = 7.20$, $p.<.0005$, or the actor portraying the personality disordered behavioural style $t(119) = 5.36$, $p.<.0005$. Again, the actors portraying the psychotic and personality disordered behavioural styles were judged not to differ in likeability.

Table 6.7. Summary of Paired T-test Comparisons for Likeability Ratings of Four Behavourial Styles: Black and White Photographs

Behavioural Style	Combined Sample (n=161) t	Male Participants (n=41) t	Female Participants (n=120) t
PD vs Neutral	- 7.46*	- 6.18*	- 5.36*
PD vs Psychotic	0.95	- 0.70	1.55
PD vs Depressed	- 6.55*	- 5.30*	- 4.64*
Neutral vs Psychotic	8.33*	4.15*	7.20*
Neutral vs Depressed	0.46	- 0.20	- 0.62
Psychotic vs Depressed	- 7.99*	- 4.55*	- 6.57*

Notes: Behavioural Styles: PD = Personality Disordered Behavioural Style; Psychotic=Psychotic Behavioural Style: Neutral= Neutral Behavioural Style; Depressed=Depressed Behavioural Style Two-tailed t-tests with significance level at .01
* $p < .001$

CONCLUSION

Most actors portraying the four behavioural styles were considered to differ in levels of likeability by male and female participants, even when they were not in character for the vignettes. However, for judgements of likeability based on black and white photographs quite different results were obtained from those based on vignette extracts. Whereas the actor depicting the neutral behavioural style was judged to be more likeable than the actor portraying the depressed behavioural style on the basis of vignette extracts, there was no difference in likeability based on black and white photographs. This held for the combined sample and sub-samples of male and female participants when judgements were made for black and white photographs, but not for vignettes extracts.

Thus, it would seem likely that, even when brief and ostensibly neutral extracts were obtained from the vignettes, the characterisations were sufficient to influence judgements of likeability. Although there were obviously differences relating to different modes of presentation between photographs and filmed segments, for example voice and mannerisms, it is difficult to conceive how presentation differences might account for such

large discrepancies in the direction of likeability ratings, particularly since actors did not significantly alter their appearance in the vignettes. The most likely explanation of the differences between vignette extracts and photographs is in the parts played by the actors.

It is interesting to note that male participants, when making judgements based on photographs, found greater differences in likeability between the actors than they did based on vignette extracts. Female participants made distinctions in likeability between actors regardless of whether photographs or vignette extracts were used. It is possible that the larger number of male participants in the study using photographs was sufficient to account for the increased number of significant results. However, when the order of means for likeability between male and female participants' judgements for the two modes of presentation are compared, it is clear that males found actors to be different in likeability than did female participants. Thus, it would seem that male and female participants used different criteria for judging likeability.

Summary of Validation Studies

Vignettes were assessed for the consistency and comparability of the behavioural styles portrayed, the general believability of the portrayals, and the physical attractiveness and likeability of the actors performing the roles of clients. The panel of expert clinicians were also asked to make judgements of the general believability of the clients portrayed in the vignettes. All vignettes were deemed to meet the set criterion of at least moderate believability. Portrayal of the personality disordered behavioural style was judged to be "very believable". The portrayal of the psychotic behavioural style, although judged to be moderately believable, obtained the lowest mean score. This probably reflects the considerable difficulties in depicting this diagnostic category at a low level of severity. In

actual clinical settings clients seen in early sessions who display some, but not all, symptoms of psychosis are often difficult to relate to, and to empathise with, because of their guarded behaviour and at times puzzling thought patterns. A differential diagnosis is often hard to make in actuality and the result obtained here is therefore quite consistent with actual clinical practice. Furthermore, clients displaying possible early signs of psychosis may have a remote and "unreal" quality in their interpersonal interactions and therefore are difficult to portray convincingly by an actor. The fact that the actor was deemed to reach a moderate level of believability was considered here to be an adequate result. All vignettes were therefore considered to be comparable in, and meet the required levels of, believability.

Finally, vignettes were assessed for the physical attractiveness and likeability of the actors. This was a necessary consideration since both these characteristics have been found to influence therapists' evaluations of their clients and, in other research domains, self-report of affective experience has been found to fluctuate with these variables. Excerpts from the vignettes were not judged by undergraduate students to be equal in physical attractiveness and likeability, and differences were also found between judgements made by male and female participants.

Because the actor portraying the neutral behavioural style was consistently and significantly judged to be more physically attractive and more likeable than other behavioural styles, it was felt that there may have been some "leakage" of characterisation into the ostensibly neutral excerpts. For this reason a further study was conducted using black and white publicity shots of the four actors, that is, when they were not enacting a role. Judgements of the actors for their physical attractiveness and likeability remained

discrepant, although the direction of the differences varied from those of vignette extracts. In this case, the actor portraying the depressed behavioural style was judged to be the most physically attractive, although equal in likeability to the actor portraying the neutral behavioural style. In this study, there were no differences in the judgements of attractiveness and likeability between male and female participants.

There are inherent difficulties in controlling for the physical attractiveness and likeability of individuals. To some extent characteristics by which physical attractiveness, and to a lesser extent likeability, are judged are likely to be socially and culturally determined. However, both such evaluations are also likely to reflect personal evaluations and preferences. Ideally, as has been the case in many other studies of psychological therapy using simulations, each actor should have portrayed each of the behavioural styles and these shown to different groups of participants. In the present research, however, large numbers of participants were required to ensure adequate numbers of participants were obtained for the numerous independent variables to be considered. Furthermore, one study asked practising clinicians to respond to the vignettes and it was not possible to guarantee to the availability of adequate numbers of participants. To have attempted to obtain samples of participants to respond to four behavioural styles portrayed by four different actors would have been prohibitive in terms of time, availability and numbers of participants. No doubt there would also have been difficulties in ensuring equivalent performances between actors of the four behavioural styles for consistency and believability.

It was not intended to examine individual client characteristics for their effects on affective experience. Participants' characteristics of personality, gender, theoretical

orientation and professional affiliation were the independent variables of focus. The effects of differences in physical attractiveness and likeability were therefore likely to be of less importance than if client characteristics were of central interest. Because different samples of participants made the judgements of physical attractiveness and likeability from those self-reporting affective experience in the studies proper, it was not possible to control for attractiveness and likeability ratings by including these variables as covariates. Finally, the four simulated interviews were not treated separately in the analysis but a mean rating of positive and negative affect was taken across the four behavioural styles. Thus, differences in physical attractiveness and likeability, although important if the vignettes had been compared with each other, was not likely to critically affect the outcome of judgements.

Chapter 7

PERSONALITY, GENDER AND AFFECTIVE EXPERIENCE IN A SIMULATED THERAPEUTIC TASK INTRODUCTION AND METHOD

Theory and research consistently denote that therapist affect plays a distinctive part in psychological therapy. In particular, an increased research focus on the non-specific factors of psychological therapy, and the therapeutic relationship, has highlighted therapist affect as a significant marker of the robustness, or otherwise, of the relationship. The therapist's affective experience, and the manner in which that affect is managed, has been shown to significantly impact on all relationship components. Well-monitored and -managed therapist affect contributes positively to the therapeutic relationship, to the process of therapy and thence to outcome. Denial, or misuse, of therapist affect may lead to negative effects that can permeate the relationship and therefore impact negatively on outcome.

In other fields of psychology, emotion researchers have considered a number of individual characteristics for their relevance to emotional experience in general. In therapy research there has been consistent investigation of a highly similar set of variables for their salience to the therapist's contribution to therapy. A further set of variables, intrinsic to the therapist's role, has also been investigated and it can be expected that both these sets of therapist characteristics, intrinsic and extrinsic to the therapy setting, will contribute to variability in therapist affect during therapy sessions.

In this thesis, it is argued that therapist affect is a pervasive and influential factor in all aspects of psychological therapy. The impact of therapist affect is considered to be bi-

directional; that is, affect is both a reaction to the therapeutic encounter and also acts to influence the encounter itself. Because the therapist enters both a personal and a professional relationship, the process of understanding the client must necessarily involve at least a modicum of affect. To some degree the therapist's personal and also professional beliefs, goals, values and motivations must impinge upon his or her interpretation and evaluation of the client and affect will therefore be present. This affect may in turn also be appraised, and may give rise to revised understandings and possibly also revised affects. The extent to which the therapist is able to monitor and manage these affects depends on both personal and professional style.

The principal aim of the present study was, therefore, to first investigate how broad affective experience varies among individuals in a simulated therapy setting, and to examine the degree to which affective experience can be predicted by individual difference characteristics that are extrinsic to psychological therapy. Two such characteristics, personality and gender, were investigated for their effects on emotional experience. Both of these variables have been extensively investigated in general emotion and psychological therapy research, and represent key variables at the emotional interface between therapist as experiencing person and therapist as experiencing professional. It was expected that these two factors would contribute to explaining individual differences in self-report of positive and negative affect in a simulated therapy setting.

The Relationship of Gender to Affective Experience

Popular belief holds that women are more emotional than men and, indeed, this has received some support from research into the experience and the expression of emotion, and in sensitivity to emotion in others. However, the evidence is by no means unequivocal

(Manstead, 1992; Brody & Hall, 1993; Shields, 1991). Where once greater emotionality of females was held to lie in biologically based differences between the sexes, it is now acknowledged that socialisation plays a powerful role. Socially determined gender roles attribute to men greater control over their emotions and the expectation that they will experience more muted emotions and also be less expressive of their emotions, particularly the more nurturant, or "soft", emotions that have become identified with the female gender role. The female gender role, on the other hand, encourages a generally greater sensitivity to experienced emotions and, concomitantly, an expectation that nurturant and affiliative emotions will be expressed in behaviour.

Therapist gender has long been considered for its effects on psychological therapy in general and the therapeutic relationship in particular. In recent years, with the greater social and cultural awareness of the ways in which gender roles infiltrate the individual's beliefs about themselves and others, attention has been focussed on the ways in which the therapeutic relationship may be affected by such beliefs. The different affective roles ascribed to men and women might be expected to be evident in the manner in which therapists of different genders respond to the therapeutic environment. Specifically, it might be expected that female therapists will be more prone to experience positive emotions while male therapists might be expected to experience more negative emotions. These hypotheses were tested in the present study.

The Relationship of Personality to Affective Experience

In recent years there has been considerable interest among trait personality researchers of the relationship between global affective experience and personality traits. However, although broad trait personality dimensions predict the general affective,

cognitive, interpersonal and behavioural responses of the individual, the situational conditions to which the individual responds will also affect these responses. In the therapy situation, in which the therapist intentionally attempts to make a rational and relatively impartial appraisal of the client's presentation, it might be expected that trait affective responses will be present but will at least partly be over-ridden by the demands of the situation and how it is interpreted. The greater the therapist's awareness of how personal and professional beliefs, values and attitudes direct evaluations of the therapeutic encounter, the better will the therapist be able to understand and benefit from the affective information which is sourced in these beliefs, values and attitudes. Although no therapist is (or should be) able to maintain an entirely unemotional stance to therapy, greater awareness of the source and meaning of affective experience should permit the therapist to stand back from both the objective and subjective events of therapy and to obtain a well informed and reasoned evaluation.

Therapy research has investigated a variety of discrete personality variables for their relationship to processes and stages of psychological therapy. Despite the common sense notion that therapist personality will influence behaviour in therapy, the evidence for an association has not been unequivocally demonstrated. In this research it is reasoned that the intimate relationship between personality and affect offers an opportunity to re-evaluate the role of therapist personality in therapy from a different vantage point. Further, the use of a broad model of personality that organises many of the discrete personality characteristics previously investigated in therapy research may assist in predicting the domains of personality significant in affective experience.

In this research a trait model of personality, the Five Factor Model, was used to conceptualise the breadth of personality and to examine its relationship to two broad affective dimensions, positive and negative affect. The FFM proposes that five enduring and relatively stable characteristics of personality are sufficient to describe the consistency and predictability with which the individual interacts with his or her world. For two of these dimensions, Extraversion and Neuroticism, consistent evidence suggests that positive and negative affect respectively, are central defining features of the individual's characteristic response. Thus, individuals high in Extraversion are found to respond to their world with higher levels of positive affect, and individuals high in Neuroticism are found to respond with higher levels of negative affect. Other, although less well defined, relationships between positive and negative affect and Openness, Agreeableness and Conscientiousness have also been proposed. These relationships between personality domains and affective experience were used to generate hypotheses about the ways in which affect and each of the five personality domains would be related in an analogue therapeutic setting. Each of the five personality domains and its relationship to affect is considered below.

Neuroticism and Affect

Neuroticism (N) has repeatedly been associated with the propensity to experience more negative, but not more positive, affect. Individuals high in N, have a dispositional tendency to experience distress, insecurity and negative self-esteem, are more disposed to negative emotional experiences and to respond to situations with negative state emotions such as anxiety, guilt, sadness and even anger or hostility, particularly when self-esteem is threatened. In contrast, individuals low in N are disposed to a greater equanimity,

calmness and stable self-esteem, and are less sensitised to negative affective experiences. In general consequence they experience the environment as less stressful and generally are less likely to experience negative state emotions. The tendency for N to be linked to affect does not extend to positive affect and neither high- nor low-N individuals are theorised to show differential experience of positive emotions, such as joy or excitement.

In the therapeutic setting, high levels of Neuroticism, or emotional instability, have been reported as detrimental to optimal functioning as a therapist. The capacity to tolerate at times ambiguous and stressful interactions, and to maintain a stable presence in the face of another's discomfort would seem essential characteristics of the well-functioning therapist. Despite good training and adequate therapeutic technique, it is plausible to assume that the therapist who is high in N will experience more negative state affect as a result of their trait propensity for negative affectivity. In the present study, it was hypothesised that individuals high in N would experience more negative affect than those low in N when viewing simulated client interviews. It was also hypothesised that high-N individuals would not differ from low-N individuals in their propensity to experience positive affect.

Extraversion and Affect

High levels of Extraversion (E) have been associated with the trait propensity to experience positive affect. Extraverts are depicted as active, sociable and cheerful individuals whose disposition is to respond with enthusiasm, attentiveness and optimism to their environment. Introverts, more inward-looking, socially reserved and independent than their counterparts, are less disposed to positive affective experiences, although this does not denote a tendency to experience negative affect.

It is more difficult to identify specific positive state emotions associated with E, and those most frequently associated with positive affect – for example, love, happiness and excitement – are not always readily acknowledged as appropriate to the therapist's emotional repertoire, although of course they may occur. Extraversion tends to denote an orientation to an active and pleasurable engagement with the environment, one that is likely to enhance in the extraverted therapist a positive affective state of benevolence, friendliness and attentiveness. It might be assumed that the high E therapist will respond with high energy to the demands of therapy, maintaining a confident and positive attitude, and will enter the relationship with greater self-assurance and cheerfulness. Introverted therapists, although not experiencing higher levels of negative affect, may respond with greater reserve and inhibition than their counterparts, may reflect more of their own experience, and may also therefore experience lower levels of positive affect. Those high in E should experience higher levels of positive affect because of their positive orientation and active engagement with the therapy situation. In this study it was therefore hypothesised that individuals high in E would experience more positive affect than those low in E. It was also hypothesised that low and high E individuals would not differ in the level of negative affect experienced.

Agreeableness and Affect

Agreeableness (A) is an essentially interpersonal domain subsuming, in Costa and McCrae's interpretation of the FFM, six facets of Trust, Straightforwardness, Altruism, Compliance, Modesty and Tender-Mindedness (Costa & McCrae, 1993). Its interpersonal orientation therefore makes A highly relevant to the therapeutic setting, and its facets call to mind characteristics associated with the client-centred approach to therapy, where

genuineness, openness and positive regard are emphasised. The relationship of affect to A is less clear than that identified for E and N. However, some theoretical links have been proposed and these find some support in the limited empirical research conducted to date.

Theory suggests that high A individuals may be more prone to suppress negative emotions, and to feel more positive emotion towards others in, for example, feelings of greater warmth, acceptance and nurturance. Conversely, individuals low in A who adopt a more distant and analytic interpersonal stance might be expected to experience more negative affect such as hostility and aggression, and to experience greater difficulty in empathising with a client's negative feelings. Also, because of their more distanced interpersonal stance, individuals low in A may experience less positive affect in their interpersonal interactions and this may be evident in therapeutic interactions.

In the present study it was hypothesised that, when participants viewed simulated therapeutic interviews, those high in Agreeableness would experience more positive affect, but not negative affect. It was also hypothesised that individuals low in Agreeableness would experience more negative affect, but not positive affect.

Openness and Affect

Open individuals are described as likely to have a rich feeling and fantasy life, to be adventurous in their thinking and their enjoyment of new ideas and experiences. Those low in Openness are seen as more prone to social and political conservativism, and less likely to fully experience and attach meaning to their feelings. Although feelings play a strong part for high Openness individuals in their experience of the world, this does not necessarily incline them to experience either more positive or negative affect. Rather, because of their receptiveness to their environment, and their enjoyment in dwelling on

and exploring their emotional experience, these individuals may experience both more positive and more negative affect. Similarly, it cannot be assumed that individuals low in Openness would experience either more positive or negative affect. Because of their inclination to greater conservatism in the experience of their own emotions, low Openness individuals might be expected to experience somewhat reduced but equivalent levels of positively and negatively valenced affect compared with high Openness individuals. In this study, it was hypothesised that when viewing simulated client interviews, high Openness individuals would report experiencing both more positive and negative affect than those individuals low in Openness.

Conscientiousness and Affect

Conscientiousness in the FFM describes those individuals who are well-organised, determined, self-controlled, orderly and highly principled. At its extreme such a personality dimension can be marked by over-control to the point of compulsiveness and rigidity in moral thinking. At its low pole Conscientiousness may be evidenced by carelessness in both moral codes, and work and personal practices. There is scant evidence for an affective component to C, although some research has suggested that some markers of C are related to aspects of Neuroticism and if this is the case, there may be an association with the negative emotions of the N domain. For example, the tendency for high C individuals to be reliable, self-controlled, well-socialised and with a personal sense of competence and responsibility, are all characteristics that overlap with the lower pole of N. There may be reason, therefore, for proposing that low C will be associated with a reduced susceptibility to negative affect and greater self-confidence.

In their research Watson and Clark (1992) found that C was positively related to Positive Affect and attributed this relationship to a propensity to greater attentiveness, one of the three positive affects included in their study. Furthermore, Watson and Clark found the Achievement facet of the C domain to have a quite strong correlation with PA, whereas facets of Dependability and Orderliness did not. Although Achievement is included as a facet of C in some models, in others this is seen as more appropriately placed in the Extraversion domain, and this would explain its greater association with positive affect in the FFM.

In the context of the therapeutic interaction, it is difficult to predict how C might relate to the propensity to experience positive or negative affect. High C individuals who experience themselves as competent, effective, and with a strong internal locus of control may be expected to react with reduced levels of negative affect in the therapy setting, whereas low C individuals might be expected to experience more negative affect. At its extreme, however, the high principles of C may lead to difficulty in accepting divergence in others from socially prescribed moral codes. Conversely, where Achievement is emphasised as a component of C, positive affect might be more likely to be associated with high C. In the Costa and McCrae interpretation of the FFM used in this study, both Competence and Achievement are included as traits of Conscientiousness. In view of the equivocal evidence for an association between this domain and affective experience, no experimental hypotheses were proposed for the relationship between Conscientiousness and either positive or negative affect.

In the therapy situation it has been suggested that both trait and state contribute to the manner in which the therapist responds affectively. Trait personality characteristics,

including trait affect, bias the individual to perceive and interpret the therapy interaction in a predictable way. The therapeutic encounter, however, provides a specific environment and set of conditions to which the individual will make a specific response. While trait characteristics will guide the direction of that response, there must be some interaction between trait and state to temper the therapist's response. It is proposed here that while trait affect characteristics will to some degree predict the affective response to therapy, the therapist's idiosyncractic interpretation of the therapy situation will also influence affective response. It is therefore hypothesised that when trait affect is taken into account, there will remain evidence of a state negative or positive affective response to the therapy analogue presented in the study.

The Contribution of The Client's Behaviour

Inevitably, because psychological therapy represents an interpersonal exchange, the characteristics of the other member of the therapeutic dyad, the client, will also contribute to therapist's affective experience. In this research, however, client characteristics were employed only as the stimulus to therapist affect and the therapist's affective response to specific client behaviours was not considered. Rather, a range of behaviours was depicted that potentially might evoke different affects in the therapist.

A series of four videotaped interviews, described in Chapter 6, were recorded in which actors portrayed a variety of client behavioural styles. On the basis of the literature relating to therapist affective response to clients found to be "difficult" to manage, three behavioural styles were identified as most likely to evoke the required range of affective responses from therapists. These behavioural styles were of depressed, psychotic and personality disordered behaviours, and they were portrayed so that behaviours associated

with these disorders did not necessarily achieve clear diagnostic levels so as to reduce the possibility that experienced therapists would show a bias to respond negatively to diagnostic labels. A fourth interview with a client showing no behaviours related to a clinical disorder was also recorded to provide a comparison condition. The expectation was that observers would differ in their affective experience of the clinical and non-clinical behavioural styles, although no predictions were made regarding the direction of these differences for either of the therapist characteristics of gender and personality type.

Affect was conceptualised also using a hierarchical trait model, in which the superordinate level of affect was represented by two general affective dimensions of positive affect (PA) and negative affect (NA). Both personality and affect models propose superordinate dimensions that represent general traits, or dispositions, each of which subsumes lower, and increasingly specific, levels of state behaviour, mood or discrete emotions.

Summary of Hypotheses

To summarise, the following hypotheses were tested in this study:

1. That male participants would report experiencing more negative affect in response to the client videos than female participants.
2. That female participants would report experiencing more positive affect in response to the client videos than male participants.

3a. That participants high in Neuroticism would report experiencing more negative affect in response to the client videos than participants low in Neuroticism.

3b. That low and high Neuroticism participants would report no differences in their experience of positive affect in response to the client videos.

4a. That participants high in Extraversion would report experiencing more positive affect in response to the client videos than will participants low in Extraversion.

4b. That low and high Extraversion participants would report no differences in their experience of negative affect in response to the client videos

5a. That participants high in Agreeableness would report experiencing more positive affect in response to the client videos than participants low in Agreeableness.

5b. That participants low in Agreeableness would report experiencing more negative affect in response to the client videos than participants high in Agreeableness.

6a. That participants high in Openness would report experiencing more negative affect than participants low in Openness in response to client

6b. That participants high in Openness would report experiencing more positive affect than participants low in Openness in response to client

7. No specific hypotheses were made in relation to Conscientiousness. However, an exploratory question was asked as to whether there was any effect of Conscientiousness participants' reported affective experience.

8. That the inclusion of a measure of trait affect as a covariate would diminish or eliminate any gender- or personality-related differences in reported state positive and state negative affect in response to the client videos.

METHOD

Participants

Students of an introductory psychology course at Macquarie University in Sydney elected to participate in the study in partial fulfilment of their course requirements. Students indicated their willingness to participate by selecting this study from a number of other available advertised studies and choosing a convenient attendance time. 157 students participated in the study of whom 111 (70.7%) were female and 46 (29.3%) were male. This approximates the proportions of male and female students enrolled in the introductory psychology course. Participants' ages ranged from 18 years to 45 years, with a mean age of 21.61 years (SD = 6.67). One hundred and twelve participants (71.3%) were aged from 18 to 20 years, 24 (15.3%) were aged between 21 and 25 years, and 21 (13.4%) participants were 26 years or older.

All students who agreed to participate were given the option of repeating the study for further course credit after a three week interval. A small group of 28 students accepted this option, of whom 17 (39.3%) were males and 11 (60.7%) were females. The age range of this group was from 18 to 42 years, with a mean age of 21.82 years (SD = 6.23). Nineteen repeating participants (67.9%) were aged from 18 to 20 years, three aged from 21 to 25 years, and six (21.4%) were aged 26 years or older. None had a history of employment in allied health. The data from the group repeating the study were used to assess reliability of the measures used in the study.

Measures

Demographic Variables. Participants provided demographic information regarding their sex, age and any health-related work history. For the latter, participants were asked to record if they had "ever worked as a health professional" in either a voluntary or paid capacity. For participants checking "yes" to this question, details were requested about the position held, the length of time (estimated in whole years) the participant had worked in that capacity and if such work was current.

Ten participants (6.3%) had worked in a paid or voluntary capacity as allied health workers: six as nurses, two as voluntary lay counsellors, one as a "youth worker" and one as a dental health nurse. The mean number of years worked was 4.1 years (SD=3.2) with a range of one to twelve years. No participant was currently employed in an allied health position.

Dependent Variables

Affect Measures. The means by which participants rated their emotional experience of the stimulus material consisted of a concise list of emotion terms that could be combined to give global measures of positive and negative affect. Clearly the potential range of therapist affect experienced in a therapeutic encounter is extensive. Although a number of frequently occurring therapist emotions can be identified from the literature (eg. frustrated, overwhelmed, drained, protective, attracted) it was difficult to ensure that any list of words constructed from the literature was valid in both its comprehensiveness and specificity. Furthermore, the task for participants of selecting and checking an extensive list of adjectives would be too cumbersome and lengthy to ensure minimal distraction from immediate emotional experience. The list therefore needed to encompass the broad range

of emotions that might be expected to occur in a therapeutic setting but also be sufficiently brief to capture the immediacy of emotional experience.

In order to meet these requirements of brevity and comprehensiveness it was decided to employ a model of primary emotions, a number of which have been identified in recent years (Plutchik, 1980; Izard, 1977; Watson & Tellegen, 1985). Such models propose between six and twelve primary emotions and, although there is not complete agreement among these models as to which discrete emotions should be deemed primary, there is considerable overlap in the adjectives included in such lists. The model proposed by Watson and Tellegen (1985) identifies eleven discrete emotional states that factor analytic studies have associated with two higher order dimensions of positive and negative affect. This model has the benefit of incorporating both global and discrete measures of emotions, and at the same time affording coverage of the areas acknowledged as primary by several other models.

The PANAS-X (Watson & Clark, 1994) is a scale created to reflect the taxonomic scheme of emotion proposed by Watson and Tellegen (1985). The PANAS-X measures both the valence (positive and negative) and the content (individual qualities) of emotions. Its 60 adjectives combine to give measures of both higher and lower order affect dimensions. Global negative affect comprises 23 adjectives forming four primary scales labelled Fear, Hostility, Guilt and Sadness. Global positive affect comprises 18 adjectives forming three primary scales labelled Joviality, Self-assurance and Attentiveness. Four further scales, Shyness and Fatigue (four adjectives each) and Serenity and Surprise (three adjectives each) are included in the PANAS-X and these terms reflect subjective

perceptions of cognitive states that are strongly related to affective experience (Watson & Clark, 1992).

The eleven scale terms employed in the PANAS-X adequately met the requirements of brevity and comprehensiveness sought for this study, and of reliable and valid measures of global positive and negative affect. The terms and rating scales employed by the PANAS-X were therefore adapted to construct a checklist appropriate to the requirements of the present study. The terms most appropriate to the intended task were selected from those scoring first or second highest in the factor loadings for each of the eleven scales (Watson & Clark, 1994). The final adjectives selected were Scared, Hostile, Guilty, Sad (together forming a higher order negative affect measure) Happy, Self-assured, Attentive (global positive affect), Shy, Tired, Relaxed and Surprised.

Adjectives were printed in three columns, on plain A5 paper, in one of three randomised orders. A fully anchored five point scale, the same as that employed by the PANAS-X, was used (1- not at all; 2- a little; 3- moderately; 4- quite a bit; 5- extremely). Separate checklists were printed for each vignette and were headed by the name of the client to be rated. Instructions were printed at the top of each page and directed the participant to think about the client they had just observed and to mark each adjective with the rating that best described the degree to which that emotion had been experienced while viewing the relevant client interview. The booklets of four checklists were then collated in the order in which the four stimulus tapes were to be presented. The checklists are included in Appendix B.

Independent Variables

Trait Affect Measure. Participants first completed a measure of trait affect, the Positive and Negative Affect Schedule-Expanded Form (PANAS-X; Watson & Clark, 1994), which has been described above. This 60-item adjective checklist provides mood measurement at two levels, two broad dimensions of Positive Affect and Negative Affect, and eleven lower order specific affects. The PANAS-X may be used to measure long-term, stable trait mood or more short-term fluctuations in mood, that is, state mood.

The PANAS-X employs a five point Likert scale (1: not at all; 5: extremely)and gives eight different time instruction options, from "moment" to "general". "General" instructions were used on this occasion. Data collected from student, adult and psychiatric patient samples indicate low correlations between positive and negative affect scales that range from -.05 to -.35, indicating relative independence of the two scales. Factor analytic studies to establish the validity of the two broad scales suggest that these are accurate measures of global positive and negative emotion (Watson & Clark, 1994).

Personality measure. There are now available several instruments for assessing the Five Factor Model of personality (Briggs, 1992; Widiger & Trull, 1997), and of these the NEO Personality Inventory-Revised (NEO-PI-R; Costa & McCrae, 1992) was selected for use in this study. The NEO-PI-R is a 240 statement self-report inventory assessing normal adult personality. It comprises scales for each of the five major domains of Neuroticism, Extraversion, Openness, Conscientiousnss and Agreeableness (48 items each), and for each of the six lower order facets (eight items each) of the major domains. Facets for the five broad domains are listed in Table 7.1. The inventory is available in observer-rated (Form R) and self-rated (Form S) form, of which the latter was used in this study. Respondents

indicate their level of agreement with the 240 statements on a five-point Likert scale (0=strongly disagree; 1=disagree; 2=neutral; 3=agree; 4=strongly agree). There is no time restriction on responding to the inventory. There is also available a short form of the inventory, the NEO-FFI (Costa & McCrae, 1992), which measures only the five superordinate domains.

Table 7.1. Facet Scales for The Five Domains of NEO-PI-R *

Neuroticism	Extraversion	Openess	Agreeableness	Conscientiousness
Anxiety	Warmth	Fantasy	Trust	Competence
Angry Hostility	Gregariousness	Aesthetics	Straightforwardness	Order
Depression	Assertiveness	Feelings	Altruism	Dutifulness
Self-Consciousness	Activity	Actions	Compliance	Achievement Striving
Impulsiveness	Excitement-Seeking	Ideas	Modesty	Self-Discipline
Vulnerability	Positive Emotions	Values	Tender-Mindedness	Deliberation

*Source Professional Manual: Revised NEO Personality Inventory (Costa & McCrae, 1992).

For Form S of the NEO-PI-R the 240 statements are printed in a question booklet and this is accompanied by a self-scoring answer sheet for recording responses. For this study permission was obtained from the publishers to create an alternate answer sheet and for a computerised scoring system to be devised for use with the alternate answer sheet.

The inventory incorporates no formal validity scales although the answer sheet includes, as a validity check, three simple statements referring to accuracy and honesty of responding intended as a basic validity check The manual accompanying the NEO-PI-R includes information for the scorer on the means by which to check for acquiescence, nay-saying and random responding (Costa & McCrae, 1992).

The NEO-PI-R is a relatively new inventory and has undergone several revisions since its first appearance as the NEO-PI (Costa & McCrae, 1985). For these reasons there are as yet relatively little reliability data available for all five scales of the inventory. Considerable data are available for the original NEO-PI, and these confirm it as a stable and consistent test. The NEO-PI-R has been shown to have good internal consistency, with coefficient alpha reported between .86 and .92 for the five domains, and between .56 and .81 for the facet scales (Costa & McCrae, 1992). The manual reports a small study of test-retest reliability of the NEO-PI over a short period at satisfactory levels and also reports long term stability over several years for the major scales at levels between $\underline{r}$=.63 and $\underline{r}$=.81. Good convergent and discriminant validity of the NEO-PI-R with both adjective and phrase-based inventories has been reported (Costa & McCrae, 1988).

Materials

Videotaped Interviews. The videotaped vignettes used in the study have been described in Chapter 6. Four simulated interviews were videotaped in which four female actors portrayed clients displaying normal, depressed, psychotic and personality disordered behavioural styles. Each interview ran for approximately six minutes and were shown to groups of participants in a randomised order.

Procedure

Ethics approval for the study was obtained from the Macquarie University Ethics Committee (Human Subjects). A large room, in which the floor rose in three low tiers to the back, was allocated for testing sessions. In accordance with the number of participants attending the testing session, seats with detachable tables were arranged on the tiers so that

each participant had an uninterrupted view of the front of the room. At least one metre was allowed between adjacent seats. At the front and centre of the room a video playback monitor with a 68cm screen and a videotape player were positioned so that the monitor was at a height of about 1.5 metres and was clearly visible to all participants. Testing sessions were designed for a maximum capacity of ten participants at one session. Actual numbers of participants attending a session ranged from four to ten participants per session.

Participants were welcomed by the researcher, shown to a seat and asked to read an explanatory letter that outlined the purpose of the study, the conditions of participation and that also gave contact information of the principal researcher and her supervisor. The researcher then verbally reiterated the contents of the letter, informing participants that their attendance was wholly voluntary and anonymous, and that they were free to terminate their participation without penalty at any time. The purpose of the study was explained as an investigation of therapists' emotional experience in therapy sessions.

Individually coded packages containing the demographics data sheet, PANAS-X Affect Schedule, NEO-PI-R question booklet and answer sheet, sample affect checklist and the assembled booklet of client histories and adjective checklists were distributed to participants. Participants were first instructed to complete the demographics data sheet and then to select the PANAS-X Affect Scale and to complete the scale according to the instructions printed at the top of the sheet. These instructions were those given in the PANAS-X Manual (Watson & Clark, 1994) for obtaining a trait measure of affect and read as follows:

"This scale consists of a number of words and phrases that describe different feelings and emotions. Read each item and then mark the appopriate answer in the space next to that word. Give an answer for each of the items. Indicate to what extent you generally feel this: that is, how you feel on average."

Completion of the PANAS-X took approximately 10 minutes, after which participants were instructed to put the checklist aside and to move next to the NEO-PI-R question booklet and answer sheet. In accordance with the directions of the test constructors instructions were then given to participants on the procedure to be followed in completing the test. Participants then completed the form. This took approximately 30-40 minutes, after which participants were instructed to check carefully that they had responded to all items. All forms were then collected and the participants given a short break before viewing the interviews.

Before viewing the interviews the affect checklist was explained to participants in the following words:

"I am going to show you videotaped interviews with four different clients, each of whom is talking about a problem in a relationship. The interviews are all about six minutes long. These clients were interviewed as out-patients either at a university counselling centre or at a psychologist's private rooms. As you watch and listen to each client, imagine that you are the therapist whom the client is consulting, and that you will be the client's therapist in the future. Attend to the client from that perspective. On the videos any speech by the actual interviewer has been edited out of the interview and replaced with sub-titles at the bottom of the screen, so that you are not distracted by the characteristics of the interviewer.

Now look at the printed booklets you have been given. These contain a brief history of the clients and an affect checklist for you to complete about that client. You will

read the history for the first client, then view the videotaped interview with that client. At the end of the interview I will stop the video and ask you to complete the affect checklist to record the feelings you experienced about that client as you watched the video. Your task is to record your own feelings **about** the client, **not** what you think the client herself, or the interviewing therapist, may be feeling.

Please look at the sample affect checklist at the front of your booklet. At the top of the sheet is a scale numbered from one, not at all, to five, extremely. Use the scale to indicate to what extent you felt **each** of the eleven emotions listed on the sheet as you watched the video. You are to give a number to all of the emotions listed. For example, if you felt quite a bit sad as you watched an interview you should put the number 4 next to "sad". If you did not feel a listed emotion you should indicate this by assigning it the number one. Remember that each emotion should receive a number. Now check through the emotions listed on the sheet and ask for clarification if you are not sure of the meaning of any of the words used.

We will follow the same procedure for each of the four interviews. After you have completed the affect checklist for the first interview, you will turn the page, read the history for the next client and then we will watch the next video. When the interview is ended you will again complete an affect checklist and so on, for all four videos. Once we have progressed to the next interview in the series please do not turn the pages back to review what ratings you gave adjectives in the previous interviews.

When you have completed your participation in this study please do not discuss the clients, or the subject matter of the interviews, with other people. If you recognise, or know personally, any of the clients interviewed, please place an asterisk on the relevant sheet and inform me at the end of the testing session that you knew that client."

Participants were then given an opportunity to ask questions and, when these had been answered, they were requested not to ask further questions until the end of the testing session. Instructions were deliberately phrased in such a way as to enhance the likelihood

that the client interviews would be seen as genuine. On three occasions a participant asked if these were actual, or simulated, clients. This question was answered by repeating that all the interviews had been conducted with a psychologist at one of the stated out-patient clinics. No further information was given. (On one occasion the participant asked for further information and the group was then informed that the clients were actors. The data for all five participants in this group were later dropped from the study. A further two participants' data were also dropped after they informed the researcher at the end of testing sessions that the actors were known to them.)

Participants then read the first of the client histories and watched that interview. The researcher then stopped the videotape and instructed participants to complete the appropriate checklist in the booklet. Once all participants had completed this task, they were instructed to turn to the next client history and the entire procedure was repeated for each of the remaining interviews. In order to be available to change the videotapes the researcher remained in the room while the interviews were shown but sat at a desk at the side of the room with her back to the participants.

At the conclusion of the testing session participants were asked if they were prepared to repeat their participation in the study for further credit. Those participants agreeing to do so were asked to enlist for a second testing session in two to three weeks' time, a record of their code numbers was made, and the participants advised that they would receive a final debriefing after their second participation. They then left the room and the remaining participants were informed that the clients were actors who had been trained to enact a fictional client history. Participants were then given the opportunity to ask any questions about the clients' behaviour or other aspects of the study. After all

questions had been answered, participants were asked not to divulge the nature of the study to other potential participants to prevent contamination of any future data collected. When participants had departed, the experimenter collected all materials and re-assembled them for participants by matching the code numbers of personality inventories with those of the affect checklists.

Chapter 8

PERSONALITY, GENDER AND AFFECTIVE EXPERIENCE IN A SIMULATED THERAPEUTIC TASK: RESULTS AND DISCUSSION

Results

Descriptive Statistics

Trait Affect Measure. The PANAS-X Affect Schedule (Watson & Clark, 1994) was employed as the measure of trait affect and entered as a covariate in the analysis. Table 8.1 reports mean positive and negative trait affect scores and standard deviations obtained on this scale for the full sample and broken down by gender. Means for the combined sample are comparable to those given in the PANAS-X Manual for like instructions and population, although standard deviations from the normative sample are slightly higher. Means and standard deviations for male and female participants show negligible differences between genders, as has been reported by Watson and Clark.

A bivariate correlation between positive and negative affect scales was calculated from this study's data to test the independence of the two scales. As expected, the two trait affect scales were not significantly correlated with each other ($r = -.135$, $p < .093$). The internal reliability of the two scales was also tested and found to be acceptable, with coefficient alpha for the negative affect scale =.87 and for the positive affect scale at =.86. These data are highly similar to those reported in the scale's manual and support the assumption that the scale at this administration retains properties reported by Watson and Clark (1994).

The positive and negative affect scores obtained for this sample were also correlated with participants' scores on the NEO PI-R personality scale and these correlations are reported below, together with other data relating to the personality scale.

Trait Personality Measure. The NEO-PI-R (Costa & McCrae, 1992) was employed as a measure of the Five-Factor model of personality. The data obtained for this measure were first examined for their comparability with normative data reported in the test manual. Means, medians and standard deviations obtained for the five factors in the combined, and in the male and female, samples are reported in Table 8.2. The means and standard deviations for the comparable normative sample of college-age individuals are shown in italics in the same table (Costa & McCrae, 1992; p.77). Although the facet scores for each of the five factors were obtained in the present study, these were not included in the data analysis and are therefore not reported here.

A comparison of the means and standard deviations of participants' scores on the NEO-PI-R indicates that they are generally similar to those for the comparable normative groups for both males and females. However, two deviations from this similarity are noted: both male and female participants' scores for the Openness factor were considerably higher than those of the normative group (129.3 and 131.6 respectively for male and female participants in the present study, versus 113.9 and 118.6 respectively for males and females in the normative sample); male and female participants' scores on the Conscientiousness factor were lower than those of the normative sample (103.8 and 103.1 respectively for males and females in the present study, versus 113.5 and 115.1 in the normative sample).

Table 8.1. Mean Trait Affect Scores and Standard Deviations for Total Population and Two Levels of Five Personality Factors: Negative and Positive Affect Measure (General Instructions)

	TRAIT NEGATIVE AFFECT						TRAIT POSITIVE AFFECT					
	Combined (N=157)		Males (n=46)		Females (n=111)		Combined (N=157)		Males (n=46)		Females (n=111)	
Personality Factor	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
TOTAL POPULATION	20.16 *(19.5)*	5.33 *(6.2)*	19.94	5.20	20.25	5.40	33.50 *(35.7)*	5.57 *(6.2)*	33.54	6.12	33.48	5.36
NEUROTICISM -												
Low	17.19	3.65	16.30	2 92	17.54	3.87	34.83	5.40	34.04	6.79	35.14	5.39
High	23.25	5.05	23.56	4.39	23.11	5.34	31.12	5.44	33.04	6.79	31.72	4.77
EXTRAVERSION												
Low	20.61	5.72	20.61	5.49	20.60	5.85	31.75	5.65	31.96	6.50	31.67	5.34
High	19.68	4.88	19.26	4.92	19.87	4.89	35.36	4.87	35.13	5.40	35.45	4.67
OPENNESS												
Low	20.74	5.81	19.96	5.25	21.50	5.92	33.70	4.92	33.38	5.10	32.41	4.86
High	19.56	4.74	21.00	5.05	18.98	4.52	34.33	6.10	33.73	7.19	34.56	5.66
AGREEABLENESS												
Low	20.63	5.45	19.39	5.70	21.14	5.31	33.48	5.44	33.13	6.26	33.63	5.12
High	19.68	5.20	20.48	4.72	19.35	5.39	33.51	5.74	33.96	6.09	33.33	5.63
CONSCIENTIOUSNESS												
Low	20.62	5.21	20.31	5.51	20.75	5.13	31.42	5.46	30.52	6.36	31.789	5.06
High	19.69	5.44	19.57	4.97	19.75	5.67	35.60	4.87	36.58	4.13	35.20	5.13

Note. Values enclosed in parantheses are normative values for equivalent instructions and sample taken from PANAS-X Manual (Watson & Clark, 1994; p.3). (Separate statistics for male and female subjects are not reported in the Manual.)

Table 8.2. Means, Standard Deviations and Median Scores for Personality Measure (NEO PI-R)

Personality Factor	Combined (N=157)			Males (n= 46)			Females (n = 111)		
	M	SD	Mdn	M	SD	Mdn	M	SD	Mdn
N	97.6 *(96.3)*	22.3 *(21.9)*	99.0	93.5 *(90.5)*	22.3 *(22.1)*	93.5	99.3 *(99.8)*	22.7*(20.9)*	101.0
E	116.3 *(121.2)*	17.5 *(18.2)*	119.0	111.9 *(116.7)*	17.9 *(18.3)*	116.0	118.1 *(123.9)*	17.1*(17.7)*	120.0
O	130.9 *(116.8)*	16.4 *(17.8)*	135.0	129.3 *(113.9)*	17.0 *(18.5)*	134.0	131.6 *(118.6)*	16.2*(17.1)*	135.0
A	117.5 *(113.5)*	16.9 *(16.6)*	119.0	113.6 *(107.4)*	18.2 *(16.2)*	116.0	119.1 *(117.2)*	16.1*(15.7)*	121.0
C	102.8 *(114.5)*	20.5 *(21.1)*	104.0	102.3 *(113.5)*	21.8 *(22.0)*	104.5	103.1 *(115.1)*	20.0*(20.6)*	102.0

Note: N=Neuroticism; E=Extraversion; O=Openness; A=Agreeableness; C=Conscientiousness.
Values enclosed in italics are normative data for college-age sample:
n=148men and 241 women aged 17-20 years (Costa & McCrae, 1993;p.77)

Table 8.3. Bivariate Relationships of Trait Affect, State Affect and Five Personality Factors

	Trait PA	State NA	State PA	N	E	O	A	C
Trait Negative Affect	- .135	.196	- .219*	.659***	- .14	- .042	- .150	- 185
Trait Positive Affect		.026	.320***	- .437***	.489***	.201	.066	.495***
State Negative Affect			- .163	.136	.004	- .109	- .130	- 005
State Positive Affect				- .204*	.145	.167	.138	.133
Neuroticism (N)					- .258**	.079	-.222**	- 450**
Extraversion (E)						.192*	- .055	.103
Openness (O)							- .034	.179*
Agreeableness (A)								.208*

*p<.01;**p.<.001; **p.<.0005

Table 8.3 depicts bivariate correlations among the five factors using Pearson's Product Moment correlation, together with their significance levels. Also included in the table are the bivariate correlations with trait and state affect variables. Neuroticism correlated negatively with Conscientiousness (r= -.45, p=.0005), and also with Extraversion (r= -.26, p=.001) and Agreeableness (r= -.22, p=.005). Extraversion correlated positively with Openness (r=.19, p=.016) and Agreeableness correlated positively with Conscientiousness (r=.21, p=.009). These intercorrelations closely parallel those reported in the test manual for the five domains (Costa & McCrae, 1992; p.100), although the correlation between Extraversion and Openness is somewhat lower for the present data.

As a check on the reliability of NEO-PI-R scores, 28 participants agreed to return three weeks after their first participation to complete the inventory for a second time. The test-retest correlations for the five factors are shown in Table 8.4. Generally reliability was satisfactory, with correlations ranging from .94 for Agreeableness to .85 for Openness. At this second assessment, Neuroticism was found to correlate negatively with Conscientiousness (r = -.63, p = .0005). (This latter correlation mirrors the high intercorrelation found between these two factors as reported above.)

The internal consistency of the items forming each of the five personality factors was also calculated as a further check on the reliability of the instrument. Coefficient alphas for each of the five factors were: Neuroticism α =.93; Extraversion α = .88; Openness α=.87; Agreeableness α=.87; Conscientiousness α=.92. Generally, therefore, the reliability of the test was satisfactory and closely approximated the values reported in the test manual (Costa & McCrae, 1992).

Table 8.4. Correlations among Five Personality Factors Scores at Test and Three-Week Retest

Personality Factor	N	E	O	A	C
Neuroticism (N)	.911	.012	.158	- .383	- .630
Extraversion (E)	- .046	.948	- .104	.128	- .006
Openness (O)	- .047	- .175	.850	.131	- .322
Agreeableness (A)	- .320	.035	.408	.938	- .024
Conscientiousness(C)	- .644	- .158	- .238	.249	.906

Note: N=11 men and 17 women aged 18-24 years

Tests of The Hypotheses

In this study there were two dependent variables, negative affect (NA) and positive affect (PA), and two independent variables, participant's personality score, as measured by the NEO PI-R, and participant gender. Each of the personality factors was divided into low and high levels by a median split. Medians were determined separately for male and female participants, because differences have been noted previously among males and females in normative data provided for the personality instrument used in the study (Costa & McCrae, 1992). As the medians displayed in Table 8.2 demonstrate, gender differences were also detected in the present study's data. Trait affect scores, as measured by the PANAS-X (Watson & Clark, 1994), were entered as a covariate in a second analysis of the data. Mean negative and positive trait affect scores and standard deviations are displayed in Table 8.1 for combined, male and female samples and for each of five personality factors.

Analysis was conducted in two stages, by Analysis of Variance and Covariance. The first set of analyses tested for the effect of two independent variables, gender and personality, on state positive and negative affect. This set of ten analyses tested the basic hypothesis that personality and gender are related to state affective experience. Each of the five personality factors was tested in separate analyses because the FFM assumes its domains to be largely independent of each other. Similarly, separate analyses of positive and negative affect were conducted, since positive and negative affect are hypothesised to be independent of each other. In the second stage, trait affect was included as a covariate in each of the above ten analyses. This allowed for an examination of state affective response and its relation to gender and personality independent of the effects of trait affect.

Tests of significance were determined using unique sums of squares because no greater significance was attributed to effects from any of the independent variables. Because of the large number of participants in the study, and the resultant relatively large power available, significance was set at the more stringent level of .01 to reduce the possibility of a Type 1 error.

Hypothesis 1 was that male participants would report experiencing more negative affect than female participants.

Table 8.5. Mean Scores and Standard Deviations for Two Levels of Five Personality Factors – State Negative and Positive Affect

	STATE NEGATIVE AFFECT						STATE POSITIVE AFFECT					
	Combined (N=157)		Males (N=46)		Females (N=111)		Combined (N=157)		Males (N=46)		Females (N=111)	
Group	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
TOTAL POPULATION	1.59	.41	1.73	.49	1.53	.36	2.58	.57	2.42	.57	2.64	.56
NEUROTICISM -												
Low	1.52	.40	1.60	.47	1.49	.37	2.66	.60	2.60	.55	2.69	.63
High	1.66	.41	1.87	.47	1.58	.35	2.49	.52	2.25	.55	2.59	.47
EXTRAVERSION												
Low	1.60	.41	1.78	.51	1.53	.34	2.59	.57	2.34	.62	2.69	.52
High	1.58	.42	1.69	.47	1.54	.39	2.56	.57	2.51	.53	2.59	.59
OPENNESS												
Low	1.63	.44	1.78	.57	1.56	.36	2.53	.48	2.50	.53	2.54	.47
High	1.56	.37	1.68	.37	1.51	.36	2.63	.64	2.34	.62	2.75	.62
AGREEABLENESS												
Low	1.62	.41	1.75	.49	1.57	.36	2.53	.57	2.97	.50	2.63	.57
High	1.57	.41	1.72	.49	1.50	.36	2.63	.57	2.55	.62	2.66	.55
CONSCIENTIOUSNESS												
Low	1.58	.40	1.73	.51	1.52	.34	2.53	.48	2.34	.53	2.60	.45
High	1.61	.42	1.74	.47	1.55	.39	2.63	.64	2.50	.62	2.68	.65

Mean state negative affect scores and standard deviations as given in Table 8.5 and the Analysis of Variance is summarised in Table 8.6. (Note that this table summarises the ANOVA for Neuroticism. The F values and significance levels for the main effect of gender varied very slightly across the ANOVAs depending what personality variable was entered in the analysis. Overall significance of results was, however, not affected by these variations. This can be observed by a comparison of F values for gender in later tables reporting ANOVAs for the other four personality variables. For convenience, therefore, it is to the first reported table that the reader is referred.)

There was a significant main effect for gender, with male participants reporting more state negative affect than female participants ($F_{1,153} = 8.08$, $p.<.005$). The gender x Neuroticism interaction was not significant.When trait negative affect was entered as a covariate, the main effect for gender remained significant ($F_{1,152} = 8.52$, $p.<.004$), with male participants reporting significantly more state negative affect than female participants. Again, there was no significant gender x Neuroticism interaction.

Table 8.6.Analysis of Variance for State Negative and Positive Affect by Neuroticism and Gender, without and with Trait Affect as Covariate

	NEGATIVE AFFECT				POSITIVE AFFECT			
	Without Covariate		With Covariate		Without Covariate		With Covariate	
Source	df	F	df	F	df	F	df	F
Regression			1	2.43			1	16.88**
Gender	1	8.08**	1	8.52**	1	4.88	1	5.57*
Neuroticism (N)	1	6.62*	1	1.63	1	5.29	1	2.61
Gender x N	1	1.90	1	1.54	1	1.81	1	3.33
Within Group Error	153	(0.16)[a]	152	(0.16)	153	(0.31)	152	(0.28)

Notes: [a] Values enclosed in parentheses represent mean square errors.
*p < .02; ** p < .01; *** p < .0005

Hypothesis 2 was that female participants would report experiencing more state positive affect than male participants.

Mean state positive affect and standard deviations are given in Table 8.5 and the Analysis of Variance is summarised in Table 8.6. The main effect of gender failed to reach significance, although there was a trend in the predicted direction, with female participants reporting experiencing more positive affect than male participants ($F_{1,153} = 4.88$, $p.<.029$).

Again, there was no significant gender x Neuroticism interaction, indicating that the tendency for female participants to report experiencing more positive affect than male participants was not qualified by differences in Neuroticism. When trait affect scores were entered as a covariate, the main effect for gender was non-significant, although the previously noted trend in the predicted direction for female participants to experience more state positive affect than male participants was still evident ($F_{1,152} = 5.57$, $p.<.020$).

Hypothesis 3a was that participants high in Neuroticism would report experiencing more negative affect than participants low in Neuroticism.

Mean levels of state negative affect and standard deviations obtained for gender and two levels of Neuroticism are given in Table 8.5 and the analyses of variance (without and with covariate of trait negative affect) are summarised in Table 8.6. The main effect for Neuroticism failed to reach significance at the stringently set level of $p.=.01$ ($F_{1,153} = 6.62$, $p<.011$). However, the F value failed to reach significance by a very narrow margin and indicated a strong trend for participants high in Neuroticism to report more negative affect than those low in Neuroticism. As previously reported, the gender x Neuroticism interaction was not significant. When the covariate of trait negative affect was entered into the analysis, the trend for differences between participants low and high in N was no longer apparent ($F_{1,152} = 1.63$, *ns*), suggesting that the greater part of the variance in N was

accounted for by variance in trait levels of negative affect. The gender x N interaction was not significant.

Hypothesis 3b was that low and high Neuroticism participants would report no differences in their experience of positive affect.

Mean affect scores and standard deviations are again given in Table 8.5 and results of the analysis of variance are summarised in Table 8.6. The main effects of Neuroticism and gender were not significant, although a trend was noted for low-N participants to report more positive affect than high-N participants ($\underline{F}_{1,153} = 5.29$, $\underline{p}.<.023$). The gender x N interaction was not significant. Controlling for the effect of trait positive affect removed the trend towards a significant difference between low and high Neuroticism groups, indicating that the variance in N was largely accounted for participants' dispositional level of positive affect. There was no gender x N interaction.

Hypothesis 4a: That participants high in Extraversion would report experiencing more positive affect than will participants low in Extraversion.

Table 8.7.Analysis of Variance for State Affect by Extraversion and Gender, without and with Trait Affect as Covariate

	NEGATIVE AFFECT				POSITIVE AFFECT			
	Without Covariate		With Covariate		Without Covariate		With Covariate	
Source	df	F	df	F	df	F	df	F
Regression			1	6.68*			1	22.16**
Gender	1	7.85**	1	8.52**	1	4.72	1	5.34
Extraversion (E)	1	0.31	1	0.11	1	0.11	1	1.03
Gender x E	1	0.40	1	0.33	1	1.83	1	2.46
Within Group Error	153	(0.16)[a]	152	(0.16)	153	(0.32)	152	(0.28)

Notes: [a] Values enclosed in parentheses represent mean square errors.
* $\underline{p} < .02$** $\underline{p} < .01$ *** $\underline{p} < .0005$

The mean positive affect scores and standard deviations are reported in Table 8.5 and the analysis of variance is summarised in Table 8.7. The analysis of variance with state positive affect as the dependent variable revealed no significant main effect for Extraversion ($F_{1,153}$=0.11, *ns*). Thus participants low and high in Extraversion reported equivalent levels of state positive affect. The gender x Extraversion interaction was not significant. When trait positive affect was entered as a covariate, there remained no significant differences between levels of state positive affect reported by participants low and high in Extraversion.

Hypothesis 4b was that low and high Extraversion participants would report no differences in their experience of negative affect.

Mean affect scores and standard deviations are again given in Table 8.5 and results of the analysis of variance are summarised in Table 8.7. The main effect for Extraversion was not significant, indicating that participants low and high in E did not differ in their state negative affective experience. Nor was there a significant gender x Extraversion interaction. When trait negative affect was entered as a covariate the main effect of E was non-significant.

Hypothesis 5a was that participants high in Agreeableness would report experiencing more positive affect than participants low in Agreeableness.

Mean negative affect scores and standard deviations are shown in Table 8.5 and a summary of the analysis of variance for Agreeableness is given in Table 8.8. With state negative affect as the dependent variable, there was no significant main effect for Agreeableness ($\underline{F}_{1,153} = 0.41$, ns), nor was there a significant gender x Agreeableness interaction. Results were not altered by the inclusion of trait negative affect as a covariate.

Hypothesis 5b was that participants low in Agreeableness would report experiencing more negative affect than participants high in Agreeableness.

Mean positive affect scores and standard deviations for Agreeableness are given in Table 8.5. The analysis of variance is summarised in Table 8.8. The main effect of Agreeableness was again not significant ($F_{1,153}$=0.45, *ns*) and the gender x Agreeableness interaction was not significant. These results were unaffected by the inclusion of trait positive affect as a covariate. Thus, participants low and high in Agreeableness did not differ in the reported levels of state negative affect.

Table 8.8.Analysis of Variance for State Affect by Agreeableness and Gender, without and with Trait Affect as Covariate

	NEGATIVE AFFECT				POSITIVE AFFECT			
	Without Covariate		With Covariate		Without Covariate		With Covariate	
Source	df	F	df	F	df	F	df	F
Regression			1	6.46*			1	17.91***
Gender	1	7.90**	1	8.57*	1	4.85	1	5.49*
Agreeableness (A)	1	0.45	1	0.26	1	2.09	1	2.05
Gender x A	1	0.06	1	0.00	1	1.28	1	0.99
Within Group Error	153	(0.16) [a]	152	(0.16)	153	(0.31)	152	(0.28)

Notes: [a] Values enclosed in parentheses represent mean square errors.
*p < .025 **p < .01 *** p < .0005

Hypothesis 6a was that participants high in Openness would report experiencing more negative affect than participants low in Openness.

Mean negative affect scores and standard deviations for Openness are given in Table 8.5, and the analysis of variance is summarised in Table 8.9. There was no significant main effect for Openness, nor was there a significant gender x Openness interaction. Thus participants low and high in Openness did not differ in their reported levels of negative affect. When trait negative affect was entered into the analysis as a covariate, Openness remained non-significant as a main effect, indicating that trait negative affect was unrelated to Openness. The gender x Openness interaction was not

significant. Participants low and high in Openness did not differ in their reported levels of state negative affect.

Hypothesis 6b was that participants high in Openness would report experiencing more positive affect than participants low in Openness.

Mean positive affect scores and standard deviations for Openness are shown in Table 8.5 and a summary of the analysis of variance is given in Table 8.9. With positive affect as the dependent variable there was no main effect for Openness, nor was there a significant gender x Openness interaction. Results were not altered by the inclusion of trait positive affect as a covariate. Thus, participants low and high in Openness did not differ in their reported levels of state positive affect.

Table 8.9.Analysis of Variance for State Affect by Openness and Gender, without and with Trait Affect as Covariate

	NEGATIVE AFFECT				POSITIVE AFFECT			
	Without Covariate		With Covariate		Without Covariate		With Covariate	
Source	df	F	df	F	df	F	df	F
Regression			1	7.03*			1	16.27***
Gender	1	7.72**	1	8.37**	1	5.11*	1	5.72*
Openness (O)	1	1.30	1	1.22	1	0.06	1	0.02
Gender x O	1	0.15	1	0.82	1	3.53	1	2.77
Within Group Error	153	(0.16) [a]	152	(0.16)	153	(0.31)	152	(0.28)

NoteS: [a] Values enclosed in parentheses represent mean square errors.
* p < .025 ** p < .01*** p < .0005

Research Question: What, if any, is the effect of Conscientiousness on participants'reported affective experience.

Mean negative affect scores and standard deviations for Conscientiousness are presented in Table 8.5 and the analysis of variance is summarised in Table 8.10. The analysis of variance revealed no significant main effect for Conscientiousness ($F_{1,153}$ =

0.10, *ns*), nor an interaction between gender and Conscientiousness. These results were not significantly altered by the inclusion of trait negative affect as a covariate. Thus, participants low and high in Conscientiousness did not differ in their reported experience of state negative affect.

Table 8.10Analysis of Variance for State Affect by Conscientiousness and Gender, without and with Trait Affect as Covariate

	NEGATIVE AFFECT				POSITIVE AFFECT			
	Without Covariate		With Covariate		Without Covariate		With Covariate	
Source	df	F	df	F	df	F	df	F
Regression			1	7.13**			1	16.70***
Gender	1	7.83**	1	8.55**	1	4.83	1	5.41*
Conscientiousness (C)	1	0.10	1	0.28	1	1.46	1	0.17
Gender x C	1	0.02	1	0.03	1	0.17	1	0.00
Within Group Error	153	(0.16) [a]	152	(0.16)	153	(0.32)	152	(0.29)

Notes: [a] Values enclosed in parentheses represent mean square errors.
* $p < .025$ ** $p < .01$ *** $p < .0005$

The mean positive affect scores and standard deviations for Conscientiousness, gender and behavioural style are shown in Table 8.5, and the analysis of variance results are summarised in Table 8.10. Conscientiousness was not significant as a main effect ($F_{1,153} = 1.46$, ns), nor was there a significant gender x Conscientiousness interaction. The results were not significantly altered by the inclusion of trait negative affect as a covariate. Participants did not differ in their reported levels of state positive affect.

Summary of Results

As had been predicted, male participants reported experiencing significantly more negative affect in response to the simulated client interviews than did female participants. This result was unaffected by the inclusion of a covariate to control for trait negative

affect. However, the prediction that females would report experiencing higher levels of positive affect than males was not supported, although there was a trend for this to be the case. This result was also unaffected by the inclusion of trait positive affect as a covariate.

When the five personality factors of the FFM model, Neuroticism, Extraversion, Openness, Agreeableness and Conscientiousness, were tested for their relationship to reported levels of state negative affect, only level of Neuroticism was found to be significant. As predicted, participants high in N reported experiencing more state negative affect than participants low in N. When trait negative affect was controlled for, however, this effect was no longer evident. Contrary to expectations, a trend was also noted for Neuroticism to be related to positive affect, in that low-N participants reported experiencing slightly more positive affect than high-N participants. Again, this effect was removed by the inclusion of the covariate of trait positive affect.

None of the four remaining personality variables was found to be related to either state positive or state negative affect, and this was also the case when the effect of the relevant trait affect was controlled for. Unexpectedly, high-E participants did not report experiencing more positive affect than low-E participants. Levels of Agreeableness, Openness and Conscientiousness were found to have no significant effect on mean reported state negative or positive affect. Inclusion of the covariate for trait negative or positive affect did not alter these results.

DISCUSSION

This study investigated two therapist characteristics, personality and gender, for their influence on self-reported affective experience of simulated client interviews. The participants, who were without training as therapists, were instructed to assume the role of

therapist as they observed videotaped interview excerpts in which actors simulated sub-clinical and non-clinical client behaviours. Results from the study suggest that both gender and personality may influence state positive and negative affect. Although gender differences in affect were largely as had been predicted on the basis of previous research, variations in affect mediated by the five personality dimensions of the FFM were not always in accord with the relationships reported in previous research.

Gender and Affect

The results of the study are consistent with general emotion and therapy research that have reported gender differences in self-reported affective experience. Male participants reported experiencing significantly more negative affect while attending to the videotaped interviews than did than female participants. Although it failed to reach significance, there was also a trend towards the predicted converse effect, that female participants would report more state positive affect than male participants. Controlling for level of trait negative or positive affect did not appreciably alter either of these results, and this was as expected based on the assumption that gender differences would not be apparent at a trait level.

In this analogue situation, the participants' mean positive and negative affect scores can be considered a state mood response, in that their adjective ratings were a summation of their affective experience of the total interview. State mood comprises a relatively broad transitory response to a particular context that increases the probable occurrence of emotions of the same valence. State moods are likely to persist beyond the original context, and to spill over to colour the experience of thoughts and feelings in neighbouring contexts and events.

Why might males have experienced the clients more negatively? Current explanations for differences in affective experience between males and females favour the effects of socialisation rather than a biologically based sex difference. Indeed, if the effect were due to a biologically based difference there might be greater reason for expecting a relationship between trait based affect and state affective response. From an early age, children learn through parental, peer and others' behaviours that certain emotions are more appropriate to one gender than to another, and by adulthood these attitudes appear to be well entrenched. While both sexes may be actively discouraged from directly expressing negative emotions, there is evidence that the expression of externalised negative emotions is more associated with the male gender role and that expression of nurturant, affiliative positive emotions is more associated with the female gender role. Such attitudes may, over time, become internalised to the extent that affect is actually experienced in this way and is not selectively manipulated to be gender role appropriate. The gender differences observed in this study fit with what might be expected on the basis of socialised gender roles in that differences persisted even when trait affect levels were controlled by the inclusion of a covariate.

Another explanation of male-female differences in self-reported state affective experience is that social desirability may incline males and females to bias their responding in keeping with expectations of gender-appropriate affective experience. Males, for whom a gender role norm is of relative impassivity in their positive interpersonal emotional expression, may over-compensate against positive feelings by attending more to their negative feelings. Females, on the other hand, for whom negative affects are not part of the gender role norm, may suppress negative affects and enhance positive affects, in order

to comply with the stereotype. Such may have been the case in the present context. It is unknown how participants interpreted their instructions to assume they were to be the therapists managing the clients. There may have been socialised gender differences in interpretation of these instructions so that males viewed the therapist's role in a more analytic and relationally distant light, whereas females may have viewed the therapist's role as one based in a nurturant and caring relationship. A future study of this kind should perhaps attempt to specify the parameters of the therapist's role more clearly in the instructions given to participants.

There are a number of further comments regarding the design of this study that warrant discussion. The first, and most obvious, of these is that male participants may have felt less sympathetic to the stories recounted by the female clients portrayed in the videotapes. In each of the interviews the problem presented was one of a female client's difficulty in a heterosexual relationship. While the stories were divided with respect to whether the problem was implied as originating with the female client or her male partner, it is possible that the inexperienced participants in this study may have been biased to emotionally "align" themselves with one or other party. Male participants may have felt more negatively about the female clients because they were biased against female clients' behaviour, or because they were less able to empathise with the female clients' stories, and not because of a general tendency for males to respond with more negative affect.

Likewise, the tendency for female participants to experience a somewhat more positive mood as they attended to the videos could reflect an emotional and attitudinal bias towards same-sex clients, or a perhaps a greater tendency to empathise. The relative youth of the participants (mean age 21.6 years) may also have affected participants' capacity to

emotionally distance themselves from the clients' stories, particularly since they may have identified more strongly with the like-aged characters in the vignettes. Of course, in an actual therapeutic encounter, a gender-based bias of affect could well be corrected by the training received by the therapist. However, in this study, where participants were inexperienced in therapeutic encounters, such a bias might be more apparent, despite the instruction to participants to assume the mental set of a therapist in attending to clients' stories.

Personality and Affect

The second therapist characteristic to be considered in this study was the personality of the participant. It was predicted that trait-related differences in broad personality variables would influence participants' state affective response when viewing the client interviews and that these differences would be in accord with reported assocations between personality, trait and state affect. Not all of these predictions were borne out and, indeed, some indications were for quite opposite effects than that which had been predicted.

Generally, affective experience was found to vary only with the two personality traits most frequently associated with affective variation, Neuroticism and Extraversion. These will be discussed first, before considering why other personality factors did not show an association with state negative and positive affect.

As predicted, participants high in N reported more state negative affect than those low in N. The disposition of high N individuals to experience more negative affect, both in terms of mood and discrete emotions, across time and situation may therefore incline them to a more negative experience in the therapy setting. This supports therapy research

findings that therapists with neurotic personality characteristics are more likely, in several respects, to experience difficulty in therapeutic encounters. As it has been argued here, the participants' aggregated responses to positive or negatively valenced adjectives represent a state mood existing for the duration of the videotaped interviews. The relationship between personality, and trait and state moods is still unclear, but the argument here is that trait mood is a strong contributing factor to personality, and that state moods are determined both by an association with trait mood and with the contextual precipitants. In this case, high N participants were found to experience the precipitating behaviours of the clients more negatively. However, when participants' trait level of mood was controlled for, the differences between low and high N participants were no longer apparent. This would suggest that habitual mood bias was the major contributor to the way in which Neurotic individuals experienced the client interviews and was sufficient to override the individual's idiosyncratic interpretation of the situation.

Inconsistent with the theoretical assumption of independence of Neuroticism from positive affect, in this study there was a trend for those high in N to also report lower levels of PA, that is to experience less positive engagement when viewing the vignettes. Based on the adjectives included in the measure of PA this suggests that participants high in N are less attentive, less self-assured and/or less happy in the presence of the client.

Contrary to predictions from trait personality theory, the propensity of extraverted individuals to experience more positive affect was not borne out in this study. Participants low and high in Extraversion reported the same levels of positive affect in response to clients. It would seem unlikely that the previously consistent reports of a strong relationship between level of Extraversion and the propensity to experience positive

emotions have been ill founded. Rather, it would seem more appropriate to assume that some pertinent aspect of the stimulus situation acted to suppress the normally more optimistic, sociable and ebullient affective response of the highly extraverted individual.

The use of an analogue enforced an inherently more passive role of observer and this may not have allowed full play for the extravert's natural propensity for interpersonal engagement and gregariousness, so that their response was more similar to the conservative response to be expected from their introverted counterparts. Nevertheless, it would seem reasonable to assume that other qualities associated with the extraverted personality, such as enthusiasm, positive engagement and interest, should be apparent in the affective response to the task. The positive emotion terms employed in this study (attentiveness, happiness and self-assuredness) have been found to be more frequently endorsed by extraverted individuals and should have been adequate to tap such characteristics. However, the vast majority of studies in which a relationship has been reported between Extraversion and positive affect have required participants to report on their mood during everyday activities, or have asked participants to imagine themselves in situations likely to evoke positive affect. Possibly, the failure to support the usual findings of an Extraversion-positive affect relationship was related to the immediacy and novelty of the task assigned to participants. Participants in this study were naïve to the therapeutic environment, and the unfamiliar and sometimes challenging behaviours displayed by the clients may have acted to suppress the extravert's more outgoing, gregarious and confident personality style. This may have resulted in a suppression of active positive engagement with the characters depicted in the videotapes.

The conclusion from this study is that both gender and personality can affect the ways in which naïve individuals respond affectively to client behaviours. However, training and experience as a therapist, should to some degree act to ameliorate such differences by educating the therapist to adopt a more impartial and emotionally controlled response to the client. In the study reported in the next chapter, trained therapists acted as participants in the same analogue therapy task and the effects of gender and personality once again examined for their impact on state affective response.

Chapter 9

THE EFFECTS OF GENDER AND PERSONALITY ON THERAPIST AFFECTIVE EXPERIENCE

When untrained participants assumed the mental set of therapist while observing videotaped, simulated client interviews there was evidence that both gender and personality contributed to affective experience. These personal characteristics (that is, extrinsic to the therapeutic system) of the individual have potential relevance to all the individual's interactions with his or her environment through their contribution to patterns of perception and appraisal. However, training and the adoption of a theoretical orientation to psychological therapy should act to modify therapists' perceptions and appraisals. Because of the relationship between appraisal and affect, affective experience should also therefore be modified.

To test this hypothesis, practising therapists from a variety of professional training backgrounds and theoretical orientations observed the same videotapes used in the previous study and their reported affective experience was evaluated for the effects of both personal and professional characteristics. This chapter reports the effects of extrinsic characteristics of gender and personality on therapists' affective experience; the effects of theoretical orientation and professional training on affective experience will then be reported in the next chapter.

Therapist Gender

A maze of theoretical discussion and empirical research signals the importance attached to therapist gender in many aspects of psychological therapy. Therapist gender has been considered as a variable in areas as broad and as narrow as outcomes of therapy (Orlinsky & Howard, 1980; Jones, Krupnick & Kerig, 1987)), countertransference phenomena (Hayes & Gelso, 1991; Latts & Gelso, 1995), empathy (Marangoni, Garcia, Ickes & Teng, 1995), clinical assessment interviews (Brown, 1986; 1990) sexual attraction to clients (Pope, Keith-Spiegel & Tabachnik, 1986; Schaverien, 1996), sex-role stereotyping (Davidson, 1983; Sesan, 1988) and treatment of depression (Zlotnick, Elkin & Shea, 1998). Although the literature recognises the potential for therapist gender effects in both process and outcome of psychological therapy, research has not produced unequivocal evidence for gender differences (Beutler, Machado and Neufeldt, 1994). However, as Orlinsky and Howard (1980) indicated in relation to outcome research, it is the social, cultural and psychological accompaniments to gender that are significant in psychological therapy, rather than the demographic variable itself.

As has been discussed in earlier chapters, one facet of potential difference between men and women is in their experience and expression of affect. Gender differences in affect have been attributed to both biological and socialisation processes and, of these, socialisation is seen here as having a major impact on gender differences in affective experience in the context of psychological therapy. From an early age, children are socialised to an expectation of differences in emotional experience between males and females and these seem, by adulthood, to have achieved the status of "natural" characteristics of men and women. Such socialised beliefs extend not only to an

understanding of one's own appropriate affective experience and behaviour, but also to the appropriateness of others' (for example, the client's) experience and behaviour. Thus, where therapists' social and cultural beliefs regarding gender remain unchallenged, there will be consequent effects on how therapists evaluate their clients. This must have inevitable consequences for affective experience. Furthermore, because such beliefs are relevant also to the therapist's beliefs about self, the affects experienced about the client may also be evaluated in the light of beliefs about what is affectively appropriate to the therapists' own gender.

Although most therapy training programmes discuss how therapists' personal beliefs, values, attitudes and evaluations, including those relating to gender, can impact on the practitioner's behaviour in therapy it is apparent that this discussion is not always adequate. For example, Rieker and Carmen (1983) described a model for clarifying values and attitudes about gender and psychotherapy, and stated of psychiatry residents that: "When confronted with the extent to which sex role socialization has shaped not only their own values but also the values and behaviors of their mentors, patients, and intimates, they respond with intense anxiety." (p. 410). Pope, Keith-Siegel and Tabachnick (1986) surveyed a large group of psychotherapists about their feelings of sexual attraction towards clients and also the adequacy of the training they had received in understanding and managing such feelings. Results indicated that, although only few therapists acted on such feelings, a majority had experienced feelings of attraction to clients, which had resulted in subsequent feelings of guilt and anxiety. Only 9% of the sample reported that they believed their training had been adequate in regard to such feelings. Hence, not only do therapists

experience specific emotions (in this case, sexual attraction) about their clients, but also experience emotions resulting from their appraisal of those emotions.

In the study reported in Chapters 7 and 8, male and female undergraduate students were found to respond differentially to simulated client behaviours, and these differences were not accounted for solely by dispositional, or trait, differences in affect. Thus, male participants experienced more state negative affect and less state positive affect than did female participants, and this appeared to reflect a response to the particular context rather than a dispositional difference, since entry of trait affect score as a covariate did not alter the effect. In the present study, using practising therapists as participants, it was hypothesised that male-female differences in affective experience would continue to be manifest despite the effects of training and orientation. This hypothesis is based on the evidence of the previous study in which affective experience was found to differ among males and females, and also on the literature that has reported differences between men and women therapists in a number of areas in which affect is implicated. The evidence points to the likelihood that gender differences will persist in how male and female therapists experience the clients portrayed in the videotaped interviews and that training and theoretical orientation will not be adequate to alter perceptions and appraisals of the clients.

Therapist Personality

Therapist personality has long been considered a significant variable in psychological therapy, particularly in those therapies in which the therapeutic relationship is considered central. Thus, both Freud and Rogers acknowledged the importance of therapist personality to the therapy process in their writing. Over the years, interest has

continued in examining the ways in which therapist personality contributes to the course and outcome of therapy. Despite the long history of this literature, the evidence for therapist personality effects in therapy remains erratic and unclear.

This lack of clarity about therapist personality effects can be attributed to a number of factors. As Rorer and Widiger (1983) have remarked in a more general context, the tendency is for consideration of personality to be more disparate than integrative. In therapy research, the preference has been to seek the relationship between personality and therapy in discrete units of personality, usually in the context of a particular aspect of the therapy process, with the result that research findings have remained disparate and fragmented. Because almost all theories of therapy are associated with theories of personality, research findings are further divided by researchers' adoption of a theoretical perspective on personality that may make assumptions not recognised by other models. Further, because therapist personality has been related to specific therapy components, results have been confined to its implications for that component and therefore there is also difficulty in forming a cohesive view of the contribution of personality to the therapy process generally. Although there is some evidence to support the commonsense notion that therapist personality is relevant to therapy, there has been little opportunity to integrate that research into a cohesive picture of how therapist personality impacts on psychological therapy.

In the previous study, the Five Factor Model was used to provide a global and integrated conceptualisation of the major dimensions of personality. The basis of the FFM is that it provides a hierarchical description of personality whose five broadest levels can together incorporate at lower, more discrete, levels, the major characteristics of

personality. Most of the personality characteristics that have been investigated within the context of the therapist's contribution to psychological therapy can therefore be incorporated within this model. Thus, personality facets such as self-integration, nervousness, depression, anxiety and other negative affects fall within the scope of Neuroticism; activity, expressiveness and openness to others can be subsumed under Extraversion; detachment and interpersonal warmth are included in Agreeableness; and self-acceptance, subjectivity and empathy have been associated with Openness to Experience.

The use of the FFM, although sacrificing specificity, allows an opportunity to encompass within one framework many of the diverse areas of therapist personality thought to contribute to therapeutic process and outcome. In particular, because theoretical links have been made between the FFM and affect, the model allows some hypotheses to be made about how therapist affect might be predicted on the basis of personality. In this study, specific hypotheses and more general research questions were generated based on the earlier discussion of the relationship between personality and affect described in Chapter 7.

Thus, it was hypothesised that therapists who scored high on Neuroticism would experience more negative affect in observing the stimulus interviews than therapists who scored low on Neuroticism. This is based on the inclusion of facets such as anxiety, self-doubt, poor personal adjustment and within the dimension of Neuroticism. Research evidence suggests that years of experience as a therapist and personal therapy are not necessarily adequate to modify the effects of personality and therefore the finding of the

previous study that high Neurotic individuals do indeed experience more negatively the clients portrayed in the interviews, is expected to persist.

In the previous study no clear evidence was apparent for an association of the other four broad dimensions of the FFM with affective experience of the stimulus materials. However, there are conceptual ties between these personality variables and those previously asserted important in psychological therapy. Therefore, the same hypotheses as were tested in the previous study were again tested here.

Trait and State Affect

In this research, a case has been made for considering trait and state affect as separate variables in these studies. Although trait affect and personality are acknowledged to have an intimate relationship to each other, the view taken here is that the two are not equivalent, as some theorists have proposed and that other aspects of personality contribute to the state affect experienced in particular contexts. Thus, trait affect is seen as contributing through personality to affective experience in the therapeutic setting but other aspects of personality, such as motivations and interpersonal style will also impinge on how an individual responds in a particular context. Strupp (1955, p.97) commented, for example, "...that the therapist's personality, attitudes, past interpersonal experiences, and emotional blind spots are among the prime determiners of his therapeutic operations." Furthermore, although to some degree the therapist's perception and appraisal of the environmental context will reflect their affective disposition, other factors will also contribute. In particular, the manner in which the therapist draws on past experience, training in their professional role and the theoretical approach adopted to therapy, should also serve to direct the therapist's attention and appraisal to different aspects of the

therapeutic context and should partially modify dispositional characteristics. A number of the authors contributing to the special issue of Psychotherapy: Theory, Research and Practice (1978) that addressed the issue of therapist personality and theoretical orientation argued that personality influenced selection of, and allegiance to, a particular theoretical orientation.

One way of attempting to evaluate the relative contribution of trait and state factors to the therapist's affective response is to partial out the effects of trait levels of negative affect. In this study, therefore, it was planned to first examine the effects of gender and personality on state affective response, and then to repeat the analysis including a measure of trait affect as a covariate. It was hypothesised that state affective response would only partially be explained by differences in trait levels of the relevant affect.

Summary of Hypotheses

A summary of the hypotheses for this study is as follows:

1. That male therapists would report experiencing more state negative affect than female therapists in response to the client videos
2. That female therapists would experiencing more state positive affect than male therapists in response to the client videos

3a. That therapists high in Neuroticism would report experiencing more state negative affect in response to the client videos than therapists low in Neuroticism.

3b. That there would be no differences between therapists low and high in Neuroticism in their reported levels of state positive affect in response to the client videos

4a. That therapists high in Extraversion would report experiencing more state positive affect in response to the client videos than therapists low in Extraversion.

4b. That there would be no differences between therapists low and high in Extraversion in their reported levels of state negative affect in response to the client videos.

5a. That therapists high in Agreeableness would report experiencing more state positive affect in response to the client videos than therapists low in Agreeableness

5b. That therapists low and high in Agreeableness would not differ in their reported experience of state negative affect in response to the client videos.

6a. That therapists high in Openness would report experiencing both more state positive and more negative affect in response to the client videos than therapists low in Openness.

7. That therapists low and high in Conscientiousness would not differ in their reported experience of either state negative or state positive affect in response to the client videos.

9. That the inclusion of a measure of trait affect as a covariate would only partially diminish gender- or personality-related differences in reported state positive and state negative affect in response to the client videos.

METHOD

Procedure

Ethics approval was first obtained for the study from the Macquarie University Ethics Committee (Human Subjects). Government and private hospitals, community health centres and group private mental health practices in the Greater Sydney region were approached through their department heads to obtain in-principal approval for clinical staff members to participate in the study. Four professional groups, identified by basic training, were sought: psychology, nursing, medical and occupational therapy. Requests were submitted to the Ethics Committees of the facilities for formal approval to conduct the study and, once ethics approval was obtained, appointments were made for group testing sessions at the participants' workplace. At some major government hospitals more than one department (eg. psychiatry, medical psychology, occupational therapy) were included in the study and in these cases, the departments were approached and tested separately; participants were therefore of the same professional group. At other, smaller facilities, such as community health centres, members of more than one professional group were sometimes present at one testing session.

In all, 27 facilities participated in the study and, in some of these, more than one testing session was held. The number of participants at a session varied from three to a maximum of 15 at one session. In some instances testing sessions were included as part of facilities' in-service education, grand rounds, or colloquia programmes. In these cases testing was conducted first and was followed by a 30-minute presentation explaining the project, and including a summary of the results of a previous study (described in Chapter 9). In other instances staff volunteered to attend testing sessions outside working hours.

These sessions were followed by an informal debriefing session, in which participants were informed of the nature of the study and any questions addressed .

The same general procedure was followed at each facility. An appointment was made for the session, the probable numbers of participants were ascertained, and packages of printed materials (described below) were prepared. Arrangements were made with a representative of the facility for a room to be set aside for testing. Most facilities made teaching or meeting rooms available for testing, and these rooms were already equipped with a television monitor and videotape player. Where this equipment was not available, or where the television monitor had an inadequate screen size, the researcher provided the equipment and set it up appropriately before the testing session. At all sessions the television monitor and videotape player were placed at the front and centre of the room, and seats were placed in the available space so that each afforded an uninterrupted view of the television monitor. To allow for maximum privacy of response during testing, the separation between seats was at least one metre and, if rows of seats were required, these were placed at least 1.5 metres apart.

As participants entered the room, the researcher handed them a set of test materials and participants took a seat. When the complete group was assembled, participants were welcomed to the testing session and asked to read an introductory letter that explained the purpose of the study, conditions of participation, and gave contact details for the researcher. The same procedure as for the previous study, as described in Chapter 7, was then followed, except that no arrangements were made for any participants to return to repeat the study at a later date. (Re-test was not conducted as the majority of facilities

indicated that time could not be made available for further staff participation. Sufficient numbers of participants therefore could not be obtained to ensure an adequate sample size.)

Where arrangements had been made with the facility to make a presentation about the research, this was conducted after all testing materials had been collected and participants had been debriefed. About one week after a testing session had been conducted, a letter was sent to the facility thanking staff for their participation and offering to inform participants of the results of the study when these became available

Participants

In all, 187 practising therapists took part in the study. However, the data from nine participants were incomplete and were therefore not included in the study. Of the remaining data a number of participants' stated theoretical orientation or professional affiliation did not fall within the required categories. Participants' professional affiliations other than those required by the study included Social Worker (four participants), Drug and Alcohol Counsellor (six participants), Counsellor (one participant), Welfare Officer (four participants) and Nurse's Aide (one participant). Six participants gave their theoretical orientation as "eclectic", three participants gave a theoretical orientation of "biological", three participants gave a theoretical orientation of "systems approach", and three participants gave their theoretical orientation as "other". Four participants failed to record a theoretical orientation. Those data not fitting with a required category were grouped in categories labelled "Other" for the two variables, but were not included as levels of these factors in the analysis. Data from a further three participants were excluded because they failed to complete a full set of adjective checklists. Two participants failed to

indicate their sex, but since the data from these two participants was otherwise complete, they were included in all analyses but those involving gender.

The demographic description of the final sample of 179 participants included in the study is given in Table 9.1. As will be seen from an inspection of the first column of the table, numbers of participants in the various groups were uneven. In part, the uneven numbers resulted from the manner in which participants were recruited for the study. Although a broad and representative spectrum of facilities was approached, from which it might have been expected that adequate numbers of participants from each professional affiliation would be obtained, a number of facilities declined to participate. Furthermore, within the facilities that agreed to participate, it was at times not possible to limit which therapists agreed to attend the testing sessions. This was because participation was determined by constraints on which staff could be freed from their work, and also by individual staff member's willingness to volunteer. For example, psychiatrists and psychiatric registrars, whose professional numbers are lower in many facilities than, for example, mental health nurses, proved less easy to attract to testing sessions. Within professional affiliations there is also an inherent gender imbalance, such that there are larger numbers of mental health nurses and occupational therapists who are female, and larger numbers of psychiatrists and psychiatric registrars who are male. Theoretical orientation also could not be anticipated, as participants could not be canvassed for this information prior to their participation. The limitation of these uneven numbers in the data set was recognised from the outset, but was considered a necessary sacrifice in order to obtain the participation of practising therapists, rather than the trainee therapists often employed in studies of this kind.

Table 9.1.Numbers of participants selecting membership of four groups for each of Theoretical Orientation and Professional Affiliation

		Psychodynamic	Cognitive Behavioural	Client-Centred	Human Occupation	Total
Nurse	Male	0	4	7	0	11
	Female	3	10	16	0	29
	Total	3	14	23	0	40
Psychologist	Male	4	4	1	0	9
	Female	4	24	3	0	31
	Total	8	28	4	0	40
Medical	Male	12	4	1	0	17
	Female	5	2	0	0	7
	Total	17	6	1	0	24
OT	Male	0	0	0	1	1
	Female	0	0	17	24	41
	Total	0	0	17	25	42
Total		28	48	45	25	146

Materials

Demographic Variables. A single, coded A4 sheet was prepared, on which was requested basic demographic information. This included the age and gender of the participant, the name of the facility at which the participant worked, professional affiliation, the number of years working in that profession, and principal theoretical orientation. (Two participants failed to record their gender and therefore are not included in any analysis in which gender was included as a variable. However, the data for these two participants were included in all other analyses for which gender was not a variable.) (Note that the participant stated his or her age in years, and this was later recoded into groups of 20-30 years, 31-40 years, 41-50 years and more than 50 years. The facility at which the participant worked was requested by name, but these were later recoded into four groups of "hospital, community health service, rehabilitation centre and private practice". These data were not used in the analyses.)

Dependent Variable: Measures of state negative and statee positive affect were obtained using the same procedure described in Chapter 8. No changes were made to the structure of the adjective checklist. Thus participants rated eleven adjectives on a scale of one to five to indicate the extent to which they experienced each affect when viewing videotaped interviews. The state negative affect scale consisted of four adjectives (Sad, Scared, Hostile and Guilty) and the state positive affect scale consisted of three adjectives (Happy, Self-assured and Attentive). A further four adjectives (Shy, Tired, Relaxed and Surprised), included in the affect model described by Watson and Clark (1994) in the PANAS Affect Schedule, were also given in the checklist but were not used in the present study.

Independent Variables

Trait Affect Measure: As in Study 1, the PANAS-X (Watson & Clark, 1994) was used as a measure of trait affect in this study. The PANAS-X, and its method of administration, was presented to participants in exactly the same form as previously described (See Chapter 8).

Personality Measure: On this occasion a short version of the NEO-PI-R, the NEO-FFI (Costa & McCrae, 1993), was used as a measure of the FFM. The decision was made to employ the shorter version of this test because of the necessary time constraints in testing therapists in their workplace. The NEO-FFI takes approximately 10-15 minutes to complete in comparison with 30-40 minutes for the NEO-PI-R.

The NEO-FFI consists of 60 statements, 12 for each of the five personality factors, which render a global measure for each of the domains. Individual facet scores for the domains are not obtained from the NEO-FFI. Reliability and validity of the NEO-FFI have been reported as satisfactory (Costa & McCrae, 1992).

Theoretical Orientation

Four categories of theoretical orientation were used in this research. As was discussed in Chapter 3, theoretical orientation has been categorised in a number of ways in studies of psychological therapy. Based on the rationale described earlier, three categories relevant to psychological therapy were identified and fourth category included for occupational therapy. The three categories relevant to psychological therapy were named psychodynamic, cognitive-behavioural and client-centred and that for occupational therapy was named human occupation. Participants' elected theoretical orientations were coded according to these four categories and any participants who indicated a different theoretical orientation were allocated to an "other" category. On the demographics data sheet instructions asked participants to indicate their preferred theoretical orientation and although several examples were given, a forced choice was not necessary. Thus participants were free to elect the orientation most appropriate to their practice.

Responses coded in the Psychodynamic category were: psychoanalytic, dynamic, self psychology, and object relations. Responses coded in the Cognitive-Behavioural category included cognitive and cognitive-behavioural. Responses coded in the Client-Centred category included Rogerian, person-centred and client-centred. Only preferred orientation of human occupation was included in that category. Two occupational therapists elected Human Performance Model as their preferred theoretical orientation and

these were included in the "Other" category. It should be noted that this, and the next variable of professional affiliation, were not employed in the study reported in this chapter, but are examined in the results reported in Chapter 10.

Professional Affiliation

Participants selected their professional affiliation from a list of terms including psychiatrist, psychiatric registrar, psychologist, nurse, occupational therapist and "other". Responses were coded into five categories of medical (psychiatrist, registrar), psychologist (clinical, counselling, generalist), registered nurse, occupational therapist and other.

Professional Experience

Participants were asked to indicate the number of full years in which they had worked in their specified profession. Where some of their work had been part-time, participants were asked to round these periods into the nearest full year.

Materials

Videotaped Interviews

The same videotaped interviews employed in Study 1, and described in Chapter 6, were employed in this study. That is, simulated interviews with four female clients were shown to participants. The interviews depicted depressed, personality disordered, psychotic and normal behavioural styles and each interview excerpt was six minutes in length. Thus, total viewing time was 48 minutes.

RESULTS

Descriptive Statistics

Trait Affect Measure. The PANAS-X Affect Schedule (Watson & Clark, 1994) was employed as the measure of trait affect and this score entered as a covariate in some of the analyses. Table 9.2 reports mean trait negative and positive affect scores and standard deviations obtained on this scale for the full sample, and for male and female sub-samples. (This table also shows a breakdown of trait negative and positive affect scores by levels of five personality variables.) One-way Analyses of Variance performed to test for differences between scores of male and female samples were not significant for either negative affect ($F_{1,177}$=0.728; ns) and positive affect ($F_{1,177}$=1.187; ns). Thus male and female therapists did not differ in their trait levels of negative and positive affect.

Bivariate correlation of trait positive and negative affect scales was used to test the independence of the two scales. As expected, the two trait affect scales were not significantly correlated with each other (r=.0603; p.<.423). The internal consistency of the two scales was also tested and found to be acceptable, with coefficient alpha for the negative affect scale of .783 and for the positive affect scale of .799. These values are slightly lower than those reported in the PANAS-X Manual (Watson & Clark, 1994), and those obtained for the sample of undergraduate students in Study 1, but are still within acceptable limits.

Trait Personality Measure. The NEO-FFI (Costa & McCrae, 1992) was employed as the measure of personality. The data were examined for their comparability with the normative data provided in the test manual. Means, medians and standard deviations obtained for the five factors of personality in the combined, and the male and female

samples are reported in Table 9.3, with the comparable data for the normative sample of adults shown in italics in the same table. The data were similar to those reported in the manual, with some minor variations although these were not as large as those found with the student population reported in Study 1. Mean Neuroticism scores for the combined sample and for females were slightly lower than those reported in the manual, as were Conscientiousness scores for combined, male and female samples. Mean scores for Extraversion, Agreeableness and Openness were slightly higher for all three groups.

Table 9.2. Mean Trait Negative and Positive Affect Scores and Standard Deviations for Two Levels of Five Personality Factors

	TRAIT NEGATIVE AFFECT						TRAIT POSITIVE AFFECT					
	Combined (N=179)		Males (n=48)		Females (n=131)		Combined (N=179)		Males (n=48)		Females (n=131)	
Group	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
TOTAL POPULATION	17.11	4.33	17.56	5.36	16.94	3.89	34.79	5.08	34.10	6.35	34.84	4.35
NEUROTICISM -												
Low	15.23	3.24	15.00	3.85	15.31	3.04	36.08	5.11	35.33	6.60	36.33	4.53
High	19.18	4.45	20.13	5.50	18.80	3.95	33.37	4.68	32.88	6.00	33.56	4.11
EXTRAVERSION												
Low	17.56	4.28	17.46	5.16	17.59	3.94	32.67	5.01	31.58	6.58	35.04	4.54
High	16.59	4.35	17.68	5.71	16.21	3.73	37.18	4.02	37.09	4.62	33.09	4.25
OPENNESS												
Low	16.96	4.33	17.12	5.36	16.90	3.69	33.33	5.21	31.32	6.48	34.01	4.55
High	17.28	4.57	17.12	5.31	16.98	4.17	36.56	4.34	37.13	4.67	36.33	4.22
AGREEABLENESS												
Low	18.08	4.53	18.04	5.83	18.10	3.98	34.59	5.11	33.92	6.79	34.84	4.35
High	16.00	3.82	17.00	4.92	15.65	3.37	35.01	5.08	34.32	5.92	35.26	4.77
CONSCIENTIOUSNESS												
Low	17.56	4.21	17.96	5.00	17.41	3.91	33.51	5.05	32.65	6.71	33.83	4.28
High	16.60	4.43	17.09	5.88	16.42	3.83	36.24	4.75	35.82	5.55	36.39	4.47

Table 9.3. Means, Standard Deviations and Median Scores for Personality Measure (NEO-FFI)

Personality Factor	Combined (N=179)			Males (n = 48)			Females (n = 131)		
	M	SD	Median	M	SD	Median	M	SD	Median
N	18.4 *(19.1)*	7.33 *(7.68)*	18.0	17.7 *(17.6)*	7.43 *(7.46)*	16.5	18.64 *(20.5)*	7.31 *(7.61)*	18.0
E	31.0 *(27.7)*	5.61 *(5.85)*	31.0	29.7 *(27.2)*	5.45 *(5.85)*	30.0	32.42 *(28.2)*	6.06 *(5.82)*	33.0
O	32.9 *(27.0)*	5.78 *(5.84)*	33.0	34.3 *(27.1)*	4.72 *(5.82)*	34.0	31.41 *(27.0)*	5.62 *(5.87)*	31.0
A	34.2 *(32.8)*	5.14 *(4.97)*	34.0	32.0 *(31.9)*	5.50 *(5.03)*	32.0	35.02 *(33.8)*	4.77 *(4.74)*	35.0
C	32.8 *(34.6)*	6.25 *(5.88)*	33.0	31.7 *(34.1)*	6.14 *(5.95)*	32.0	33.21 *(36.8)*	6.14 *(5.78)*	34.0

Notes: N=Neuroticism; E=Extraversion; O=Openness; A=Agreeableness; C=Conscientiousness.
Figures in italics are normative data for college-age sample:
N=148 men and 241 women aged 17-20 years (Costa & McCrae, 1993;p.77)

Table 9.4. Bivariate Correlations among Trait Affect, State Affect and NEO-FFI Personality Factor Raw Scores

	Trait PA	State NA	State PA	N	E	O	A	C
Trait Negative Affect	.060	.131	-.017	.594**	-.074	.100	-.249*	-.096
Trait Positive Affect		-.064	.300**	-.205*	.522**	.215*	.100	.313**
State Negative Affect			-.267**	.208*	-.018	.011	.044	-.084
State Positive Affect				-.093	-.019	.127	.002	.041
Neuroticism (N)					-.286**	-.059	-.275**	-.270**
Extraversion (E)						.246*	.235*	.132
Openness (O)							.054	-.155
Agreeableness (A)								.104

Notes: * p.<.001
** p.<.0005

Table 9.4 shows the bivariate relationships among the scores for the five factors of the NEO-FFI. Also included in this table are the bivariate relationships among trait and state negative and positive affect scores and the five personality factors. Neuroticism correlated negatively with Extraversion (r= -.286, p.=.0005), with Agreeableness (r= -.275, p.=.0005) and with Conscientiousness (r= -.270, p.=.0005). Extraversion correlated positively with Openness (r= -.246, p.=.001) and with Agreeableness (r= -.235, p.=.001). Intercorrelations among NEO-FFI factor scales are not reported in the manual. However, the correlations obtained here are similar to those reported for the NEO-PI-R, with the exception that the negative correlation between Neuroticism and Conscientiousness, although still significant, was not as high in this case.

Trait negative affect was positively correlated with Neuroticism (r = .594, p.<.0005) and negatively correlated with Agreeableness (r= -.249, p.<.001). Trait positive affect was negatively correlated with Neuroticism (r= -.205, p.<.001) and positively correlated with Extraversion (r= .522, p.<.0005), Openness (r= .215, p.<.001) and Conscientiousness (r=.313, p.<.0005). State negative affect was positively correlated with Neuroticism (r=.208, p.<.001). Trait positive affect was positively correlated with state positive affect (r=.300, p.<.0005). Contrary to expectations, trait negative affect was not correlated with state negative affect. Also contrary to expectations, there was a negative correlation between state positive and negative affect (r= -.267, p.<.0005).

Tests of the Hypotheses

The analysis for this study was conducted in the same manner as that reported for Study 1, with negative affect (NA) and positive affect (PA) as the dependent variables and gender and personality score as the independent variables. For the latter variable, a median

split (determined separately for each gender) was once again used to differentiate low and high levels for each of the five personality variables. Two Analyses of Covariance were conducted for each of the two dependent variables: in the first study, years of experience as a practising therapist was included as a covariate; in the second analysis both years of experience and trait affect were included as covariates. Mean negative and positive trait affect scores and standard deviations (PANAS-X) are displayed in Table 9.2 for the combined, male, and female samples, and for each of five personality factors.

Hypothesis 1 was that male therapists would report experiencing more negative affect than female therapists.

Mean state negative affect and standard deviations are given in Table 9.5 and the Analyses of Covariance are summarised in Table 9.6. (This table summarises the ANCOVA for gender and Neuroticism. As in the previous study, the F values for the main effect of gender showed slight variation across the analyses, depending on which personality variable was entered in the analysis. The significance of results was, however, not affected by these variations. For convenience, therefore, it is to the table reporting the first ANCOVA that the reader is referred.)

The main effect of gender was not significant. That is, there were no significant differences between male and female therapists in their reported state negative affect. However, inspection of the means in Table 9.5 illustrates that there was a slight trend in the expected direction of male therapists reporting more state NA than female therapists. No significant gender x personality interaction was obtained. When trait negative affect was entered into the analysis as a covariate, the main effect for gender remained non-

significant; that is, when trait level of negative affect was taken into account male and female therapists did not differ in their reported levels of state negative affect.

Table 9.5. Mean State Negative and Positive Affect Scores and Standard Deviations for Two Levels of Five Personality Factors

	STATE NEGATIVE AFFECT						STATE POSITIVE AFFECT					
	Combined (N=179)		Males (n=48)		Females (n=131)		Combined (N=179)		Males (n=48)		Females (n=131)	
Group	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
TOTAL POPULATION	1.48	.37	1.57	.39	1.45	.38	2.74	.56	2.66	.49	2.77	.58
NEUROTICISM -												
Low	1.38	.32	1.47	.31	1.35	.31	2.82	.55	2.72	.45	2.85	.58
High	1.60	.42	1.66	.44	1.57	.41	2.65	.56	2.53	.53	2.68	.58
EXTRAVERSION												
Low	1.51	.40	1.53	.33	1.50	.42	2.74	.55	2.62	.49	2.78	.56
High	1.46	.37	1.61	.45	1.40	.32	2.74	.58	2.70	.49	2.76	.61
OPENNESS												
Low	1.48	.37	1.58	.41	1.45	.35	2.67	.57	2.55	.56	2.82	.54
High	1.48	.40	1.55	.37	1.46	.41	2.82	.54	2.77	.39	2.84	.59
AGREEABLENESS												
Low	1.48	.33	1.55	.32	1.46	.34	2.74	.57	2.73	.52	2.75	.59
High	1.48	.43	1.59	.46	1.45	.42	2.74	.55	2.57	.45	2.80	.57
CONSCIENTIOUSNESS												
Low	1.54	.39	1.61	.31	1.52	.43	2.69	.56	2.58	.55	2.73	.56
High	1.42	.35	1.52	.47	1.38	.30	2.79	.56	2.74	.40	2.82	.61

Table 9.6.Analysis of Variance for State Negative and Positive Affect by Neuroticism and Gender, without and with Trait Affect as Covariate

Source	STATE NEGATIVE AFFECT				STATE POSITIVE AFFECT			
	With One Covariate		With Two Covariates		With One Covariate		With Two Covariates	
	df	F	df	F	df	F	df	F
Regression	1	0.69	3	0.36	1	0.44	2	6.82**
Gender	1	3.72	1	3.73	1	0.95	1	0.64
Neuroticism (N)	2	9.92**	1	8.30**	1	2.33	1	0.48
Gender x N	1	0.00	1	0.00	1	0.12	1	0.07
Within Group Error	172	(0.13)	171	(0.13)	172	(0.31)	171	(0.29)

Note: Values enclosed in parentheses represent mean square errors.
**p < .01

Hypothesis 2 was that female therapists would experiencing more positive affect than male therapists.

Mean state positive affect and standard deviations are given in Table 9.5 and the Analyses of Covariance are summarised in Table 9.6. The main effect of gender failed to reach significance, nor was there any trend in the predicted direction for female therapists to report more state positive affect than male therapists. There was no significant gender x personality interaction, and this was consistent across all analyses, irrespective of the personality factor included in the analysis. Thus, male and female therapists did not vary significantly in their state positive affect according to their personality description. When trait positive affect score was entered into the analysis as a second covariate, these results were unaltered. That is, controlling for level of trait positive affect did not appreciably alter the reported state positive affect of male or female therapists.

Hypothesis 2 was that therapists high in Neuroticism would report experiencing more negative affect therapists low in Neuroticism.

Mean state negative affect ratings and standard deviations obtained for two levels of Neuroticism, and for male and female therapists are reported in Table 9.5, and the analyses of covariance (without and with covariate of trait negative affect) are summarised in Table 9.6. The main effect of Neuroticism was significant ($r^2 = .091$) ($F_{1,172}=9.92$, $p<.002$). Therapists high in Neuroticism reported experience significantly more state negative affect than did therapists low in Neuroticism. As previously reported, the interaction between gender and level of Neuroticism was not significant. When the covariate of trait negative affect was entered in the analysis, there remained a significant main effect for Neuroticism ($r^2 = .092$) ($F_{2,171}=8.30$, $p<.004$). That is, after trait level of negative affect had been accounted for, level of state negative affect reported by therapists high in Neuroticism remained greater than that reported by therapists low in Neuroticism. It was noted, however, that the regression value was non-significant, indicating the previously noted non-significant correlation between trait negative affect and state negative affect. The gender x Neuroticism interaction remained non-significant. Thus therapists low and high in Neuroticism differed in their reported state negative affect, with high N therapists reporting more negative affect than low N therapists. Furthermore, some difference remained between low and high N therapists, even after trait levels of negative affect had been accounted for.

Hypothesis 3b was that there would be no differences between therapists low and high in Neuroticism in their reported levels of positive affect

Mean state positive affect scores and standard deviations are reported in Table 9.5, and the Analyses of Covariance are summarised in Table 9.6. The main effect of Neuroticism was not significant. That is, therapists low and high in Neuroticism did not

differ in their reported levels of positive affect. The Neuroticism x gender interaction was also not significant, indicating that gender of therapist did not differentially affect state positive affect for high and low Neuroticism participants. When trait positive affect was entered as a covariate, the main effects of Neuroticism and gender, and the interaction between Neuroticism and gender, remained non-significant. The F value for the regression was significant ($F_{2,171}=6.82$, $p<.001$), indicating that there was a significant relationship between trait and state positive affect.

Hypothesis 4a was that therapists high in Extraversion would report experiencing more positive affect than therapists low in Extraversion.

Mean state positive affect scores and standard deviations are given in Table 9.5, and the analyses of covariance are summarised in Table 9.7. The main effect of Extraversion was not significant, indicating that therapists low and high in Extraversion did not differ in their reported experience of state positive affect. Nor was there a significant gender x Extraversion interaction. When trait positive affect score was entered as a covariate, the main effects of Extraversion and gender, and the Extraversion x gender interaction remained non-significant. The F value for the regression was significant ($F_{2,171}=10.23$, $p<.0005$), again indicating that there was a significant relationship between trait and state positive affect.

Hypothesis 4b was that there would be no differences between therapists low and high in Extraversion in their reported levels of negative affect.

Table 9.7.Analysis of Variance for State Negative and Positive Affect by Extraversion and Gender, without and w.ith Trait Affect as Covariate

Source	STATE NEGATIVE AFFECT				STATE POSITIVE AFFECT			
	With One Covariate		With Two Covariates		With One Covariate		With Two Covariates	
	df	F	df	F	df	F	df	F
Regression	1	1.09	2	1.31	1	0.16	2	10.23**
Gender	1	4.43	1	4.01	1	1.09	1	0.66
Extraversion (E)	1	0.00	1	0.00	1	0.09	1	2.73
Gender x E	1	1.74	1	1.49	1	0.30	1	0.10
Within Group Error	172	(0.14)	171	(0.14)	172	(0.32)	171	(0.29)

Note: Values enclosed in parentheses represent mean square errors.
**p < .01

Mean state negative affect scores and standard deviations are given in Table 9.5, and the analyses of covariance are summarised in Table 9.8. The main effect of Extraversion was not significant, indicating that therapists low and high in Extraversion did not differ in their levels of state negative affect. There was also no significant gender x Extraversion interaction. When trait negative affect score was entered as a covariate, the main effects of Extraversion and gender, and the Extraversion x gender interaction remained non-significant. That is, when trait negative affect was controlled for there were no differences between therapists low and high in Extraversion in their levels of state negative affect.

Hypothesis 5a was that therapists high in Agreeableness would report experiencing more positive affect than therapists low in Agreeableness.

Mean state positive affect scores and standard deviations are given in Table 9.5, and the analyses of covariance are summarised in Table 9.8. The main effect of Agreeableness was not significant, indicating that therapists low and high in Agreeableness did not differ in their reported levels of state positive affect. There was also no significant

gender x Agreeableness interaction. When trait positive affect score was entered as a covariate, the main effects of Agreeableness and gender, and the Agreeableness x gender interaction remained non-significant. That is, when trait positive affect was controlled for there were no differences between therapists low and high in Agreeableness in their reported levels of state positive affect.

Table 9.8.Analysis of Variance for State Negative and Positive Affect by Agreeableness and Gender, without and with Trait Affect as Covariate

	STATE NEGATIVE AFFECT				STATE POSITIVE AFFECT			
	With One Covariate		With Two Covariates		With One Covariate		With Two Covariates	
Source	df	F	df	F	df	F	df	F
Regression	1	1.46	2	1.60	1	0.14	2	8.27**
Gender	1	4.38	1	3.85	1	1.37	1	0.87
Agreeableness (A)	1	0.00	1	0.06	1	0.36	1	0.56
Gender x A	1	0.34	1	0.22	1	1.16	1	1.29
Within Group Error	172	(0.14)	171	(0.14)	172	(0.32)	171	(0.29)

Note: Values enclosed in parentheses represent mean square errors.
**p < .01

Hypothesis 5b was that therapists low and high in Agreeableness would not differ in their reported experience of negative affect.

Mean state negative affect scores and standard deviations are given in Table 9.5, and the analyses of covariance are summarised in Table 9.8. The main effect of Agreeableness was not significant, indicating that therapists low and high in Agreeableness did not differ in their levels of state negative affect. There was also no significant gender x Agreeableness interaction. When trait negative affect score was entered as a covariate, the main effects of Agreeableness and gender, and the Agreeableness x gender interaction remained non-significant. That is, controlling for trait negative affect did not affect the

absence of differences between therapists low and high in Agreeableness in their levels of state negtive affect.

Hypothesis 6 was that therapists high in Openness would report experiencing both more positive and more negative affect than therapists low in Openness.

Mean state negative and positive affect scores and standard deviations are given in Table 9.5, and the analyses of covariance are summarised in Table 9.9. The main effect of Openness was not significant for either positive or negative state affect, indicating that therapists low and high in Openness did not differ in their reported levels of state negative or positive affect. There was also no significant gender x Openness interaction for either dependent variable. Entering trait negative affect score as a covariate did not alter these results. That is, when trait affect was controlled for there were no differences between therapists low and high in Openness in their levels of state negative positive affect, nor were these results qualified by the gender of the therapist.

Table 9.9. Analysis of Variance for State Negative and Positive Affect by Openness and Gender, without and with Trait Affect as Covariate

	STATE NEGATIVE AFFECT				STATE POSITIVE AFFECT			
	With One Covariate		With Two Covariates		With One Covariate		With Two Covariates	
Source	df	F	df	F	df	F	df	F
Regression	1	1.33	2	1.66	1	0.31	2	6.56**
Gender	1	4.08	1	3.64	1	1.18	1	0.75
Openness (O)	1	0.00	1	0.01	1	3.33	1	0.22
Gender x O	1	0.10	1	0.13	1	0.17	1	0.02
Within Group Error	172	(0.14)	171	(0.14)	172	(0.31)	171	(0.29)

Note: Values enclosed in parentheses represent mean square errors.
**p < .01

Hypothesis 7 was that therapists low and high in Conscientiousness would not differ in their reported experience of either state negative or positive affect

Mean state negative and positive affect scores and standard deviations are given in Table 9.5, and the analyses of covariance are summarised in Table 9.10. The main effect of Conscientiousness was not significant for either dependent variable, indicating that therapists low and high in Conscientiousness did not differ in their levels of state negative or positive affect. There was also no significant gender x Conscientiousness interaction for either dependent variable. When trait negative affect score was entered as a covariate, the main effects of Conscientiousness, gender, and the Conscientiousness x gender interaction remained non-significant. That is, when trait affect was controlled for, gender did not qualify the reported state negative or positive affect scores of therapists low and high in Conscientiousness.

Table 9.10. Analysis of Variance for State Negative and Positive Affect by Conscientiousness and Gender, without and with Trait Affect as Covariate

	STATE NEGATIVE AFFECT				STATE POSITIVE AFFECT			
	With One Covariate		With Two Covariates		With One Covariate		With Two Covariates	
Source	df	F	df	F	df	F	df	F
Regression	1	1.27	2	1.38	1	0.14	2	7.43**
Gender	1	4.14	1	3.76	1	1.11	1	0.69
Consciousness (C)	1	2.77	1	2.38	1	1.39	1	0.05
Gender x C	1	0.00	1	0.00	1	0.12	1	0.08
Within Group Error	172	(0.14)	171	(0.14)	172	(0.32)	172	(0.29)

Note: Values enclosed in parentheses represent mean square errors.
**$p < .01$

Hypothesis 8 was that the addition of a measure of trait affect as a covariate would partially reduce differences in reported positive and negative affect accounted for by gender and personality.

A preliminary observation was made that, contrary to expectations on the basis of the theorised relationship between trait and state affect, the bivariate correlation between trait negative affect and state negative affect scores was not significant ($r = .131$, ns). That is, state negative affect did not covary with trait negative affect. For positive affect, a significant positive correlation was evident between trait positive affect and state positive affect ($r = .300$, $p<.0005$). However, contrary to the theorised relationship between trait and state affect, trait positive affect was found to have a significant negative correlation with state negative affect ($r = -.267$, $p<.001$).

Results obtained when trait negative or positive affect was entered into the analyses as a covariate have been reported above for each of the hypotheses for gender and personaity. The effects of the covariates are summarised below. Without the addition of the covariate of trait affect, the only significant result for personality factors was obtained for Neuroticism. In this case, participants high in Neuroticism reported experiencing more negative affect than did participants low in Neuroticism. When the covariate of trait negative affect was included in this analysis, the main effect of Neuroticism remained significant. That is, trait negative affect did not account for all the variance observed between participants low and high in Neuroticism.

All other analyses of personality variables found a non-significant relationship between high and low levels of the personality factor and state negative or positive affect, whether or not the appropriate (negative or positive) trait affect covariate was included in the analysis.

Summary of Results

In this study, male and female therapists did not differ in their reported experience of either state negative or positive affect and the inclusion of trait negative or positive affect as a covariate did not alter this outcome. Although the direction of differences in the means was as predicted for both negative and positive affect, these differences were not sufficient to reach significance.

The relationship of each of the five personality factors to state negative and positive affect again showed a significant effect only for Neuroticism. Therapists high in Neuroticism reported experiencing more state negative affect than did therapists low in Neuroticism. The difference between low and high Neurotic therapists remained significant after the inclusion of trait negative affect as a covariate. The remaining hypotheses regarding personality were not supported. None of the remaining four personality factors of Extraversion, Agreeableness, Openness and Conscientiousness showed a relationship to state negative or positive affect. The inclusion of the appropriate trait affect score as a covariate also did not alter these results.

DISCUSSION

In this study, practising therapists were asked to observe the same videotaped interview excerpts that had been used in the previous study and to report their affective experience of the clients portrayed in the interviews. It had been hypothesised that the same gender- and personality-related differences in affect would obtain with practising therapists as had been observed with untrained undergraduate students. Results in the present study suggest that, when participants are trained therapists personality, but not gender, may influence affect.

Gender and Affect

In this study, male therapists showed a trend to report more state negative affect than female therapists but the difference was not sufficient to reach significance and the trend did not persist after trait negative affect was added as a covariate. In the previous study, differences between male and female naïve observers were evident whether or not trait negative affect was controlled for, and the differences were therefore suggested to have resulted from differences in affective experience to the context to which they were responding. In this study, the trend for male therapists to respond more negatively than female therapists was only apparent when trait levels of negative affect were not taken into account.

In the first analysis, in which trait affect scores are not included, affective response is considered to include both dispositional affect and affect relating to the particular context. In the second analysis, in which dispositional affect has been partialled out, it can be considered that any persisting affect difference must represent a response to the particular situation. Viewed in this way, practising therapists appeared to have modified their affective experience with the clients. In other words, therapists appear to have adapted to the therapy situation so as not to respond affectively in the same manner as usual. A tendency for male therapists to respond in a more negative way does not appear to apply in the therapy situation. This can be explained in a number of ways.

The most simple explanation of these results is to consider that adoption of a professional role permits therapists to stand back more from the interaction with the client and to perceive and appraise the client differently from usual. Therapists appear able to adopt an impartial affective stance in relation to clients and to limit their general

propensities in affective responding when they adopt a professional role. It is argued in this thesis that the response to any situation includes a combination of both a general propensity and a state response to the context. Dispositional affect can be said to colour the response to the environment both by providing the low level tendency to respond in a particular affective direction and the increased probability that the tendency will be manifested in state response to the particular situation. However, dispositional affect is not the only factor to determine affective response in a specific situation. The demands of the situation itself may also contribute to affective experience and, in effect, can over-ride the general disposition to respond in a particular affective direction. Thus, for therapists, the demands of the situation of observing a client appear to be different from the demands of a situation for untrained observers, and therapists may be better able to manage their personal affective responses to the client.

One of the limitations of the current study is that the effects of the age of the participants was not controlled for. The mean age of therapists was 36.7 years, compared to a mean age for the student population of 21.6 years. Thus the results might be explained in terms of the greater maturity of the therapist sample rather than their adoption of a professional stance. It is feasible that greater maturity enables individuals to adopt an at least temporarily impartial stance to a situation, and this may have been the case with the study of therapists. In this study, although years of experience as a therapist was controlled, it was not possible to control for age because of the way in which the sample was obtained. A future study should attempt to control for age of therapist in order to test whether different affective responses are attributable to age, adoption of a professional role, or both.

Personality and Affect

In this study, of the five personality variables tested, significant levels of variance were only found to exist between those low and high in Neuroticism. As had been predicted, therapists high in Neuroticism reported more state negative affect than did therapists low in Neuroticism. This accords with previously reported differences in levels of state negative affect reported in the personality literature and also lends support to the notion that therapists with more neurotic personality characteristics are more likely to experience the therapy situation negatively. Therapists who generally experience more negative affect, such as worry, anxiety, self-doubt or even depression are likely also to do so in the therapeutic setting.

Moreover, when trait level of negative affect was controlled for, the difference between low and high Neuroticism therapists remained significant. That is, when therapists' general level of trait negative affect was taken into account, those high in Neuroticism continued to experience more negative affect than their low-Neuroticism counterparts. As was discussed in relation to gender differences in affect, the state affective response to the stimuli used in this study is assumed to reflect both the prevailing tendency of Neurotic individuals to experience more negative affect and also the tendency to react to specific contexts more negatively. If differences in negative affect persist after trait levels of negative affect have been controlled for, then it would suggest that high-Neurotic are not able to draw upon their professional role to adequately distance themselves from their general negative reactions, and that these spill over to colour the contextually related state mood experienced in relation to the client. This suggests that

high-Neurotic therapists are more prone to perceive and evaluate the therapy situation in more negative terms than their low-Neurotic counterparts.

As in the previous study, no relationship was found between Extraversion and the propensity to experience more positive affect. This was an unexpected result since the Extraversion-positive affect relationship has been reliably reported in personality research. Although it is recognised that some characteristics of the extraverted individual may not be brought into play in the therapy situation, there is no reason to assume that characteristics of greater interpersonal engagement, attentiveness and self-assuredness would not obtain in the therapeutic setting. One explanation for the failure to find the expected relationship here may lie in the type of task to which the individual responds in the general personality literature and that used in the present study.

Most studies of the Extraversion-positive affect relationship ask participants to self-report on their overall mood over a specified period of time. Thus, extraverts in these studies report greater positive affect over the range of situations and environments encountered in everyday life. In the present study, the context to which participants were asked to respond was a specific one and it may be that when state positive affect is measured in relation to a particular situation, the expected association is not necessarily apparent. Thus, in the study using naïve undergraduate students, it was argued that the novelty of the situation might have suppressed the extraverts' usually positive and engaged response. In the current study, however, such an explanation seems less likely since participants were all practising therapists for whom the presentation of clients would have been less novel.

None of the other three personality variables of Agreeableness, Openness and Conscientiousness was found to be associated with differences in levels of either positive or negative state affect. Although the association of these three personality variables to affect is not yet as clearly defined as that for Neuroticism and Extraversion, it was still expected that some differences would be found, particularly for Agreeableness. This personality characteristic, which has a strong interpersonal component, was expected to show variation with both positive and negative affect. It was to be expected that the inherently interpersonal nature of the therapeutic encounter would present a situation to which the highly Agreeable therapist would respond with greater positive affectivity. Perhaps the fact that an analogue setting was used for these studies contributed to the failure to find the expected result. Although the assumption was made that participants would be sufficiently engaged by the task to reflect their natural interpersonal reactions, it may well be that unless the task involves actual interpersonal interactions, a propensity for more positive responding cannot be detected. In other words, because the participants' role in the task was a relatively passive observer role, rather than the interactive one of the actual therapy task, affective response may have been more muted and therefore insufficient to reveal differences between low and high Agreeableness.

Since in both this, and the previous study, differences were found for negative affect but not positive affect, there is the possibility that the state affect measure employed was generally inadequate. Global measures of positive affect have a more uncertain history than do global measures of negative affect and it may be that the three adjectives used in these studies to assess state positive affect were either inappropriate or insufficient to tap differences in global positive affective experience.

The conclusion from this study is that gender and personality may both contribute to the manner in which therapists respond affectively to the therapy situation. Moreover, there is evidence that it is not only the therapists' general dispositional characteristics that influence their affective experience, but that the situation itself also has some bearing on affective experience. It seems likely that, over and above what can be attributed to general propensity to experience negative or positive affect, there may be a context specific perception and appraisal of the situation that contributes to affective experience. Thus, therapists' gender and also their level of Neuroticism may have an effect on how therapists respond to clients in psychological therapy, and that training and theoretical orientation do not ameliorate these effects. In the next chapter, therapists' theoretical orientation and professional affiliation were considered for their effects on state negative and positive affect.

Chapter 10

EFFECTS OF THEORETICAL ORIENTATION AND PROFESSIONAL AFFILIATION ON THERAPIST AFFECTIVE EXPERIENCE

In the previous chapter, two therapist characteristics extrinsic to the therapeutic system were considered for their relationship to therapist affective experience. The gender and personality of a group of practising therapists were found to influence the therapists' affective response to simulated interviews with four different clients. In the model of therapy described by Orlinsky, Grawe and Parks (1994), a further set of therapist variables that may impact on the therapeutic system are those intrinsic to the therapist's professional role. In this chapter, two such intrinsic factors, theoretical orientation and professional affiliation are considered for their association with affective experience.

Theoretical Orientation

The theoretical orientation adopted by the therapist is central to the approach to therapy in several ways. Firstly, it signifies something of the way in which the therapist views the world and the way in which human beings develop, survive, function and dysfunction in their world. In the adoption of a theoretical stance (providing, that is, that a theory is chosen rather than imposed) the therapist aligns him- or herself to a worldview and this has implications for the therapist's own system of beliefs and values. In Lazarus' (1991a, 1991b) conceptualisation of emotion as bi-directionally tied to appraisals, the beliefs, values and motivations of the individual are intimately connected to the affective responses they will experience to their environment. In the context of therapy and theoretical orientation, then, therapists embracing a similar theoretical perspective might

be expected to share some common ground of appraisal and evaluation of the therapeutic environment.

Furthermore, theoretical orientations suggest with varying explicitness the manner in which the therapeutic relationship is to be understood and managed. Even when explicit recommendations are not made, a theoretical approach to human relating can provide the guidelines by which the therapist conducts him- or herself in the therapeutic relationship. In the adoption of a theoretical orientation, therefore, the therapist may also adopt an understanding of the therapist-client relationship that will guide behaviour and also affective response.

METHOD

Participants, materials and procedure used in this study have been reported in the previous chapter dealing with therapist gender and personality. To summarise, 179 practising therapists of four professional affiliations (psychologist, nurse, medical and occupational therapist) participated in the study. The therapists belonged to one of four categories of theoretical orientations of psychodynamic, cognitive-behavioural, client-centred and human occupation. Following the same procedure described previously, therapists observed the four videotaped simulations of client behaviours and recorded their affective experience of the clients using an adjective checklist.

RESULTS

Descriptive statistics for the sample have been given in the previous chapter.

Tests of the Hypotheses

The analysis for this study was conducted in the same manner as that reported for the previous analysis of gender and personality. State negative affect and state positive affect were the dependent variables, and personality, theoretical orientation and professional affiliation were the independent variables. Separate Analyses of Covariance were conducted for each of the two dependent variables, with years of experience as a therapist as the covariate. The analyses were then repeated including a second covariate of trait negative or positive affect.

Four research questions were posed

1. What, if any, differences in state affect would be apparent as a result of therapists' theoretical orientation?
2. What, if any, effect would the inclusion of a trait affect measure as a covariate would have on results?
3. What, if any, differences in state affect would be apparent as a result of therapists' professional affiliation and theoretical orientation?
4. What, if any, differences in state affect would be apparent as a result of an interaction between Neuroticism, theoretical orientation and professional affiliation?

Negative Affect

Mean state negative affect scores and standard deviations are reported in Table 10.1 and the Analyses of Covariance (without and with trait negative affect) are summarised in Table 10.2. The main effect of Neuroticism was significant ($F_{1,122} = 10.54$, $p.<.002$), with therapists high in Neuroticism reporting significantly more state negative affect than therapists low in Neuroticism. The main effects of theoretical orientation and professional

Table 10.1. Mean State Negative and Positive Affect Scores and Standard Deviations for Theoretical Orientation and Professional Affiliation

	STATE NEGATIVE AFFECT								STATE POSITIVE AFFECT							
	Nurse		Psychologist		Medical		O.T.		Nurse		Psychologist		Medical		O.T.	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
CBT																
Low Neuroticism	1.29	0.38	1.38	0.39	1.83	0.19			2.69	0.76	3.12	0.47	2.13	0.42		
High Neuroticism	1.50	0.37	1.48	0.20	1.69	0.51			2.45	0.60	2.85	0.51	3.06	0.54		
Dynamic																
Low Neuroticism	1.44	0.09	1.38	0.15	1.38	0.18			2.71	0.88	2.88	0.31	2.61	0.57		
High Neuroticism	1.44								2.17							
Client Centred																
Low Neuroticism	1.45	0.39	1.03	0.04	1.19		1.39	0.32	2.66	0.28	2.50	0.12	2.58		3.26	0.78
High Neuroticism																
Human Occupation																
Low Neuroticism							1.34	0.23							2.71	0.56
High Neuroticism																

affiliation were not significant. That is, there were no significant differences in reported negative affect among therapists of the four theoretical orientations, or among therapists of four professional affiliations.

Table 10.2. Analysis of Variance for State Negative and Positive Affect by Neuroticism, Theoretical Orientation and Professional Role, without and with Trait Affect as Covariate

	STATE NEGATIVE AFFECT				STATE POSITIVE AFFECT			
	With One Covariate		With Two Covariates		With One Covariate		With Two Covariates	
Source	df	F	df	F	df	F	df	F
Regression	1	1.18	2	0.90	1	0.50	2	4.96**
Neuroticism (N)	1	10.54***	1	10.21	1	3.46	1	1.10
Theory	3	2.19	1	2.16	3	1.86	3	2.29
Profession	3	1.66	3	1.76	3	1.82	3	1.82
N x Theory	3	3.12*	3	3.02	3	0.36	3	0.36
N x Profession	3	0.06	3	0.10	3	4.91***	3	3.64*
Theoryx Profession	4	1.29	4	1.25	4	0.54	4	0.74
N x Theory x Profession	3	0.56	3	0.52	3	0.54	3	0.64
Within Group Error	122	(0.13)	121	(0.12)	122	(0.32)	121	(0.29)

Note: Values enclosed in parentheses represent mean square errors.
*p. <.05 **p < .01 ***p.<.001

Two- and three-way interactions between Neuroticism, theoretical orientation and professional affiliation all failed to reach significance at the stringently set level of p.<.01. However, there was trend towards an interaction between Neuroticism and theoretical orientation. Specifically, across theoretical orientations high Neuroticism therapists tended to report experiencing more negative affect than low Neuroticism therapists. Moreover, state negative affect reported by low Neuroticism therapists differed very little across theoretical orientations, whereas among high Neuroticism therapists, therapists adopting a theoretical orientation of Human Occupation reported experiencing more negative affect than all other theoretical orientations.

When trait negative affect was included as a covariate, the main effect of Neuroticism remained significant (F 1,121 = 10.21, p.<.002) and the trend to an interaction between Neuroticism and theoretical orientation was still apparent. That is, controlling for therapists' trait levels of negative affect did not appreciably alter reported levels of state negative affect.

Positive Affect

Mean state positive affect scores and standard deviations are reported in Table 10.1 and the Analyses of Covariance (without and with trait positive affect) are summarised in Table 10.2. The main effects of Neuroticism, theoretical orientation and professional affiliation were not significant. However, these results were qualified by a significant interaction between level of Neuroticism and professional affiliation ($F_{1,122} = 4.91$, p.<.003).

Examination of the means showed that low Neuroticism therapists of nursing, medical and psychology professions all reported experiencing more positive affect than their high Neuroticism counterparts, with low and high Neuroticism psychologists showing the greatest differences between mean values. Occupational therapists, however, reported an opposite pattern, with low Neuroticism occupational therapists reporting less state positive affect than their high Neuroticism counterparts. That is, for all professional groups except occupational therapists, low Neuroticism therapists to reported more state positive affect than high Neuroticism therapists. Occupational therapists low in Neuroticism reported less state positive affect than occupational therapists high in Neuroticism.

When trait positive affect was entered as a covariate the main effect of Neuroticism was no longer significant. Theoretical orientation and professional affiliation were also not significant. The interaction between Neuroticism and professional affiliation was no longer significant, but a trend was still evident for this interaction to be present. Inspection of the means indicated that the direction of the differences remained unchanged by the addition of trait positive affect as a covariate.

In summary, these results suggest that Neuroticism and theoretical orientation were related to state negative affect. Inclusion of trait negative affect as a covariate did not appreciably alter these results. Moreover, there was a significant Neuroticism x professional affiliation interaction, with occupational therapists reporting the opposite in levels of state positive affect to other professional groups for both low and high Neuroticism. Inclusion of trait positive affect as a covariate only marginally altered these results.

CONCLUSIONS

In this study, it was suggested that two factors intrinsic to the role of the therapist might be associated with differences in therapists' affective experience during therapy. Theoretical orientation and professional affiliation are two variables that have been linked to aspects of psychological therapy in which affective experience is implicated. Research questions were posed that, when practising therapists of differing theoretical orientations and professional affiliations observed simulated client interviews, differences might be apparent in their affective responses and that these might be qualified by level of Neuroticism.

Three major professional affiliations trained in psychological therapy were considered, and a fourth professional group of occupational therapists were included as a

comparison group. Occupational therapists represent a professional group who also work in a close therapeutic relationship with their clients, but that does not address the psychological problems that are the domain of therapists working in mental health fields. The theoretical orientation adopted by occupational therapists, although providing a framework for the interpersonal aspects of the working relationship, is otherwise oriented to conceptualising a different group of human problems.

The results of this study suggest that, in interaction with level of Neuroticism, therapists of differing theoretical orientation and professional affiliation do indeed show some differences in both their positive and negative affective responses.

Neuroticism and Professional Affiliation

Differences in reported positive affect were apparent between the occupational therapists and the professional groups whose training is directed towards psychological therapy. Although the groups did not differ significantly among each other, when level of Neuroticism was taken into account, differences were apparent in the levels of state positive affect that therapists experienced. Whereas therapists trained in psychological therapy and high in Neuroticism reported less positive affect, occupational therapists (that is, therapists without training in psychological therapy) reported more positive affect.

It is difficult to conceptualise why this group of therapists might respond more positively when their level of Neuroticism is high. In the first study reported in this thesis, naïve participants observing the same client interviews showed the same tendency for high Neurotic participants to report more positive affect. One way to explain the current results is, therefore, to consider that these therapists were unfamiliar with, or less practised in working with, clients presenting with psychological problems. There may be a tendency

for therapists with more unstable personality characteristics who are less familiar with the client population to feel more engaged by, and attracted to, the clients than those whose daily work involves such client presentations. It could be speculated that when personality is less stable, and the therapist is less experienced in confronting the negative emotions expressed by clients, there is a greater tendency to feel sympathy for, and become over-involved with the experience of the client.

Viewed from the perspective of the therapeutic relationship, the results may suggest that training as a psychological therapist differs with respect to the issues that are addressed regarding the therapeutic relationship. Although occupational therapists work in equally close relationship to their clients as other professionals, it would seem that either inexperience with clients with psychological problems or the basic training received as a therapist contributes to a different affective experience of the client. Studies comparing professional with paraprofessional therapists have sometimes reported that paraprofessional therapists are more effective than professional therapists (Hattie, Sharpley & Rogers, 1984). A more conservative view expressed by Berman and Norton (1985) was that trained and untrained therapists achieve similar results and that this applied independent of presenting problem or treatment regimen. However, these authors discussed training for its relationship to outcome. The present study, which is confined only to the affective response of the therapist, suggests that professional training appropriate to the therapeutic context may temper the affect experienced by the therapist.

It was also noted in this interaction between professional role and level of Neuroticism that psychologists low and high in Neuroticism reported a steeper gradient of difference between their mean positive affect levels. Whereas low Neurotic psychologists,

medical practitioners and nurses showed relatively little difference in positive affect. psychologists high in Neuroticism responded with less positive affect than all other groups. This would tend to suggest that high Neurotic psychologists were less engaged by the clients than other groups. The reasons for this difference are unclear.

Neuroticism and Theoretical Orientation

The trend towards a relationship between level of Neuroticism and the theoretical orientation adopted by the therapist suggests that a theoretical orientation providing a framework not specific to the problems encountered in psychological therapy is less effective in enabling therapists to manage their negative feelings towards clients. The client-centred, psychodynamic and cognitive-behavioural therapists differed little from each other at either low or high levels of Neuroticism. Therapists with a human occupation theoretical approach did not differ from therapists of other orientations at low levels of Neuroticism, but at high levels of Neuroticism diverged strongly from other groups to report much higher levels of negative affect. This suggests that when Neurotic traits such as worry, self-doubt and anxiety are present and there is not theoretical orientation to appropriately guide practice with the client group, the therapist may be less able to contain the propensity to negative affect and therefore may respond more negatively to the client.

The caveat with all such considerations of the differences between theoretical orientations and professional groups is that affective response is not necessarily translated into behaviour. That is, although more neurotic therapists of different professional affiliation and theoretical orientation may report more negative or positive experiences than their more stable counterparts, the question of whether this is reflected in behaviour is

not answered. However, whether or not the therapist acts on his or her feelings there may well be negative consequences for the therapist, particularly in having to manage high levels of negativity in the therapeutic environment. For example, persisting high levels of negative affect may increase even the most dedicated therapist's sense of inadequacy, self-doubt and worry in psychological therapy, leading either to burnout and/or inappropriate behaviours. On the other hand too much positive affect may mean a tendency to identify too closely with the client's difficulties and to sympathise rather than empathise. This also may ultimately be manifested in a reduced objectivity and the possibility of inappropriate behaviours.

The conclusion from this study is that, in the context of higher levels of neuroticism, therapists' theoretical orientations and professional affiliations may buffer the therapist against increased levels of both positive and negative affect. In this study, the tendency to experience more negative affect in high Neurotic therapists was more evident when the theoretical approach to the client was not framed to address the issues raised in the context of psychological problems. Moreover, for high Neurotic therapists, the professional group to which the therapist belonged appeared to relate to the level of positive affect experienced in the therapy setting.

The Vanderbilt studies conducted by Hans Strupp and his colleagues (see Strupp, 1993, for a synopsis of this research) have extensively investigated client and therapist characteristics for their impact on psychotherapy process and outcome. The earlier studies in the Vanderbilt research appeared to indicate that differences in professional training (for example, dynamic versus experiential) did not necessarily produce significantly different outcomes. Even more controversially, it was suggested by some that untrained but empathic "therapists" were no less effective than trained therapists. The Vanderbilt II studies extended the research to investigate aspects of the therapeutic alliance and these studies provided evidence that professional training and level of experience did not necessarily buffer the therapist against responding with negative affect to certain client behaviours (Henry, Schacht, Strupp, Butler et al, 1993).

The present study compared trained psychological therapists with a group of therapists whose work required a close therapeutic relationship but whose training was not specific to psychological therapy. The results indicated that affect level differed between the groups trained in psychological therapy and the untrained group when level of Neuroticism was high. There is thus some evidence from this study that professional training may mediate the emotional response to the client. In some respects, therefore, the results of this research are in contrast with those obtained in the Vanderbilt research in which professional training did not appear to affect outcome, although affective differences were noted among therapists.

Chapter 11

GENERAL DISCUSSION

The aim of this thesis was to examine the relationship between therapist affective experience and those therapist factors, both extrinsic and intrinsic to the therapy environment, contributing to affective experience in the therapeutic relationship. The purpose of such an undertaking was to develop greater understanding of how therapist affect is generated and maintained, and how it may be better utilised in training and later practice.

Throughout its history psychological therapy has acknowledged that therapist affect is an inevitable accompaniment to the events of therapy. However, until relatively recent times, this acknowledgement has been in lip service to the notion, rather than in full recognition of its origins and implications. The myth of the unfeeling therapist, who acts as a mirror reflecting without distortion the patient's productions, an uninvolved teacher and facilitator, or a benign and tolerant parent, has persisted to haunt and daunt psychotherapy practitioners and trainees alike.

With comparatively few exceptions research has addressed the therapist's affective experience in an oblique manner, considering it as a by-product of other, more technical, factors in the therapeutic process, or as an impetus to negative behavioural outcomes that need to be redressed. In the gradual evolution of psychological therapy away from its roots in the psychoanalytic and behaviourist traditions, a more enlightened view of the therapist as an experiencing individual is beginning to emerge. Much of this more recent view

appears to have grown from the increasing recognition that the therapeutic relationship plays a key part in the therapy process.

In this thesis the aim was to conceptualise therapist affect as a nonspecific factor of the therapeutic relationship. Therapist affect is common to all approaches to psychological therapy, spanning all orientations to therapy and dispersing artificial boundaries of the unitary whole that is psychological therapy. Affect is a fundamental human function, serving to alert and inform self and other about the individual's external and internal world (Lazarus, 1991a). Translated into the practice of psychological therapy, affect therefore becomes a universal tool whose functions make it a resource of, rather than an encumbrance to, therapy.

The approach taken to the research reported in this thesis was to view affect as a global phenomenon that stands independent of partisan conceptualisations of therapy. The therapist factors selected for potential relationship to affective experience were also approached broadly, with the intention that findings from the research could be accessed by researchers of different theoretical persuasions. Two factors extrinsic to the therapist's professional role, and two factors intrinsic to professional role, were examined in relation to affective experience in an analogue of the therapy encounter.

Overview of Findings

In the first study, male and female undergraduate students of psychology first completed self-report measures of personality and trait affect, and then assumed the mental set of therapist to observe simulated interviews with four female clients presenting a variety of affect-inducing behavioural styles. At the conclusion of each interview participants reported what they felt about each client using an eleven item adjective

checklist. Responses were aggregated across the four client interviews and mean negative and positive affect scores were obtained.

Both the gender and personality of the participants were found to contribute to the variance in state affective response. Supporting previously reported male-female therapist differences in affective responding (e.g. Howard, Orlinsky & Hill, 1969), male participants responded with more state negative affect than did female participants, and female participants showed a trend to respond with more state positive affect. Moreover, when a measure of participants' trait affect was taken into consideration, the differences in affect remained apparent, and this was interpreted as meaning that affect differences extended beyond participants' habitual trait mood to the more immediate effects of the particular situation.

Of the five broad personality dimensions measured, only one dimension, Neuroticism, showed a relationship to state affective experience. Participants who were high in Neuroticism reported experiencing more negative affect than did participants who were low in Neuroticism. However, the effect did not persist when trait negative affect level was taken into account, suggesting that the affective response to the interviews was trait- rather than situationally-based. An unexpected result was the tendency for participants high in Neuroticism to report less positive affect than their low Neuroticism counterparts. This had not been predicted by the theorised relationship between personality and affect which posits Neuroticism and positive affect to be unrelated (Costa & McCrae, 1980; Watson & Clark, 1992; Watson & Tellegen, 1985), although other researchers have reported a similar inverse relationship (Izard, Libero, Putnam & Haynes, 1993).

The second study essentially replicated the first in its method, but here the participants were a large group of practising therapists from a range of professional backgrounds. The aim of this study was first, to test whether similar gender and personality effects on affective experience would be found when trained therapists, rather than untrained undergraduate students, observed the stimulus interviews.

The results obtained for this group of practising therapists were somewhat different from those obtained with untrained observers. The same gender effects were not apparent. Male and female therapists reported similar levels of both state negative and positive affect and this result was unchanged by the addition of trait affect as a covariate. The results for five personality dimensions were, however, quite similar to those obtained in the previous study. Once again, the only personality dimension to show a significant relationship to state affect was Neuroticism. Therapists high in Neuroticism reported experiencing more negative affect than therapists low in Neuroticism. One difference was notable, however. When trait negative affect score was included as a covariate, the significant difference between the low and high Neuroticism groups persisted. This suggested that, for practising therapists, at least some of the negative affect experienced by more neurotic therapists was a response to the specific context of the task and not purely a reflection of enduring trait levels of affect.

The final phase of this research was to consider the effects of factors intrinsic to the role of therapist for their association with affect experienced in psychological therapy; specifically, theoretical orientation, and the professional affiliation of the therapist. When these two variables, and the personality dimension Neuroticism (previously found to be associated with differential affective response), were analysed for their effects on global

affective experience, only personality was found to have an independent relationship to state negative affect. However, theoretical orientation interacted with level of Neuroticism, as did also professional affiliation.

Specifically, in each of the interactions of Neuroticism with theoretical orientation and professional group, it was the comparison group (occupational therapists) which showed differential affective response. In particular, occupational therapists who were identified as high in Neuroticism responded to the interviews with more positive affect than did members of the other professional groups who were high in Neuroticism. Moreover, occupational therapists were also differentiated for low Neuroticism in that these individuals the lowest levels of positive affect. In other words, occupational therapists showed an opposite positive affective response to other professional groups at both low and high levels of Neuroticism.

In the interaction between Neuroticism and theoretical orientation, it was again the comparison group (Human Occupation theory) whose affective response tended to be different from other groups. In this case, however, the difference occurred for negative affect and was only apparent for high levels of Neuroticism. Although the difference in affective experience was quite disparate for this group, the effect was not sufficiently strong to reach a statistical significance.

In sum, each of the variables examined in this research showed some relationship to affective experience. The effects were not however entirely clearcut, except for level of Neuroticism which consistently showed a relationship to negative affect across both participant populations. Gender was related to affect only for the undergraduate student sample. Personality variables that in other research have been shown to have a strong

association with affect at both a trait and state level, failed to show any relationship to affect in this task. Theoretical orientation and professional affiliation only showed a relationship to affect when personality characteristics were those showing a powerful relation to affect. Finally, for the high Neuroticism therapist population, negative affective response could not solely be accounted for by the trait propensity to experience more negative mood. At least some of the negative affect reported by these therapists appeared to be a state response to the particular situation represented in the vignettes.

Implications of the Research

This research has shown that, in an analogue of the therapeutic setting, therapists' affective experience may be shaped by personal factors of gender and personality, and to a lesser extent, by professional factors of theoretical orientation and professional affiliation. Employing a trait-state model of affect, affective experience was shown to vary with level of emotional instability (or neuroticism) such that those high in emotional instability were more likely to respond negatively to the events of therapy. Moreover, negative affective response remained apparent when trait level of negative affect had been taken into account, suggesting that beyond the personal, low level background of the therapist's trait mood, factors in the context of therapy may serve to generate negative feeling in the therapist. This conforms with the long espoused view that therapist attitudes and emotions are a significant contributor to the way therapy progresses (Strupp, 1993). This, indeed, is the basis of countertransference which, in its more recent conceptualisation, holds that the attitudes and emotions of the therapist may act to the benefit or detriment of therapy. It also conforms to Rogers' (1957) view that the therapist should achieve a non-judgemental, genuine and congruent position in relation to the client.

In terms of Lazarus' (1991a, 1991b) relational theory of emotion, when the therapist's personal beliefs, values and attitudes are allowed to enter his or her appraisal of the client, then affect will ensue. It is within the capacity of the therapist to recognise and re-appraise the meaning of that affect that psychological therapy stands to benefit. If the therapist comprehends the source and meaning of his or her own affect, not only for its information about the client, but for information about how personal values, evaluations or needs have been allowed to enter the therapist's judgements, then the therapist is free to re-evaluate the basis of those evaluations and to recognise how they were produced by the interaction with the client. There is nothing new about this view, except that it is couched in terms that do not borrow the language of a particular theoretical orientation.

The case of gender differences in affect is a case in point. In this research, gender differences were identified only in a sample of untrained undergraduate students who adopted the stance of therapist in observing the simulated interviews. However, other research has suggested that differences in affective experience do occur between male and female therapists. In recent years, under the impetus from social change, much has been made of the relative merits of gender matching in psychotherapy (Atkinson & Schein, 1986). Recent conceptualisations of gender differences in affective experience suggest that, rather than being based in the sex of the individual, such differences are better explained in socio-cultural terms (Brody & Hall, 1993). Specifically, it has been proposed that males and females are socialised to a gender-stereotypic view of how affect is experienced and this is applied not only to evaluation of the self, but to evaluation of others. Thus, in therapy, the therapist both evaluates his or her own feelings in relation to gender-stereotypes and also evaluates the client's expressed affect in the framework of his

or her (the therapist's) own conceptualisation of what is appropriate affective behaviour for the client.

The case for proposing that professional characteristics of theoretical orientation and professional background influence affective experience was less strong. Differences were only noted among the high Neurotic therapists, and principally between all other groups and the comparison group who were not trained in psychological therapy and did not use a theoretical orientation that was oriented to the treatment of psychological therapy. It had been proposed that, because a theoretical orientation represents the adoption of a system of values and beliefs that reflect the personal beliefs of the therapist, then those therapists sharing a theoretical orientation would be likely to use that theory to modify their affective response. Similarities between theoretical orientations in their affective response might then be evident. However, differences in theoretical orientation were only apparent as a trend toward an interaction with level of emotional instability and the major difference was in the therapists who embraced the "non-therapy" orientation.

When the results of this research are considered for their implications for the practice of psychological therapy, there is some evidence of differences in affective responding related to both extrinsic and intrinsic therapist characteristics. For many therapists, training has been shown to inadequately prepare them for the ways in which affect can infiltrate the therapeutic relationship. It is also the case that therapists working alone may have little opportunity for supervision, peer support or other forms of continuing education. Under such circumstances, where there are no external challenges to the therapist's personal belief system, it is increasingly likely that the therapist will gradually lose the necessary awareness of where realistic evaluation ends and personal

appraisal begins. If the results of this research accurately reflect the way in which personality, gender, professional orientation and role impact on affective experience then it is important for therapy training programmes to incorporate components in their programmes that educate trainee therapists to these potential effects.

Strengths and Limitations of the Current Research

Much of the research conducted in psychological therapy relies on trainee therapists to act as subjects. However, using therapists in the early stages of their training and without solid experience in the therapeutic setting considerably limits the generalisability of research findings. Moreover, in research that does employ practising therapists, sample sizes are very small, again effectively reducing the generalisability of the results. In the present research, a large group of practising therapists participated in one study. Furthermore, effort was made to obtain participants whose clinical backgrounds were diverse and who represented a broad cross-section of employment in clinical, counselling, in-patient and out-patient therapy environments.

The approach taken to the present research had the express intention of conceptualising therapy and affect in a manner that freed them from the constraints of assumptions limited to a specific theoretical approach. In psychotherapy research, it is most often the case that the researcher draws hypotheses from a particular theoretical position. The effect of this has been to limit the interest in research findings to a readership that also embraces that position. The result has been that valuable empirical evidence has been disseminated across a broad spectrum of theoretical positions, making comparison and integration of research findings difficult, if not impossible. The approach

of the present research to offer a broad-based approach to affect does not disbar itself from consideration by a variety of professional approaches.

One limitation of this study was in the use of vignettes to provide an analogue of the therapeutic setting. Since psychological therapy is an avowedly interpersonal relationship, the use of vignettes which impose on the observer a generally more passive role than in actuality occurs in therapy, can be criticised for inadequately representing the therapy situation. However, the tension between the decision to sacrifice relevance for rigor (Gelso, 1985; Stone, 1984) is not easily resolved. It was considered that, for this

In the present research, only female clients were portrayed in the videotaped simulated interviews. It is acknowledged that this also represents a limitation for the research, since there is evidence from therapy research that male and female participants may well have responded differentially to male and female clients. Indeed, as was discussed in Chapter 5, it is recommended by some researchers that gender matching of therapists with clients is advisable because of the differences in values, beliefs and attitudes of male and female therapists. This is borne out by research into different aspects of the therapeutic relationship, in particular the countertransference relationship, where male and female therapists have been to register different emotional responses to female clients. In future research it would therefore be desirable that interviews with both male and female clients be included as stimulus materials.

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A further limitation of this study was that the study that used practising therapists as participants was unable to obtain match numbers of participants across levels of factors. In particular, the failure to obtain sufficient numbers of practising therapists of each gender made it impossible to make comparisons of gender across all factors. In part, this reflects the inherent bias of some professions to attract more of one gender than another. However, a future study might seek to obtain more balanced numbers across groups.

Future Directions and Conclusions

Overall, this findings of this thesis add weight to the argument that aspects of personality and also gender are related to affective experience, and that these effects can be observed in therapy analogues. It was argued in this thesis that the gender differences obtained in the population of undergraduate students may have resulted from their inexperience in the therapeutic environment. One means of testing this hypothesis would

be to obtain the cooperation of, for example, young people of equivalent background who work voluntarily as counsellors for charity organisations and who receive basic training and experience in responding to actual client problems. A study comparing the affective responses of youth with and without training and experience in psychological counselling would prove an interesting further test of the validity of the explanations offered here for the obtained results.

The conviction driving the present research was that studies need to be designed for accessibility to practitioners of more than one theoretical allegiance. In particular, it has been argued that there is considerable advantage in creating ways to bring a convergence of minds to the already complex task of unravelling the many interacting variables in psychotherapy research, rather than creating further divisions. Moreover, in the developing current climate of intense interest in the psychology of emotion, there are opportunities to access the burgeoning body of knowledge accumulating from general emotions theory and to apply it in the somewhat parochial world of psychotherapy research. In particular, there are opportunities to extend our understandings beyond global measures of positive and negative affect, and to explore more explicitly the role of discrete emotions, such as anger, anxiety, in the therapeutic encounter. Here, theorists and researchers may benefit from a closer examination of the close relationship literature, where strides are being taken in understanding the role played by affect and emotion in the relational context. Clearly, there is ample opportunity for researchers in psychological therapy to develop and apply these understandings to the study of the therapeutic relationship.

In conclusion, for more than a century the role of therapist affect in psychological therapy has been tacitly acknowledged and explicitly ignored. The intention of the current

research, then, was to offer information about aspects of the therapist's response to therapy that has been too long been a topic of neglect or disapprobation. It is to be hoped that, in the coming century, recognition of the integral role of emotion in the process and practice of psychological therapy will inspire more research on this fascinating aspect of the therapeutic relationship.

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APPENDIX A

Photographic Stimuli described in Chapter 6

Please decide how attractive and how likable you consider this person to be. Use the criteria which are *personally relevant to you* (eg appearance, speech, manners) and which you might normally employ in making such judgements in everyday life.

Use the following scale to make your judgements.
1=not at all; 2=a little; 3=moderately; 4=a lot; 5=extremely

How attractive is this person?	1	2	3	4	5
How likable is this person?	1	2	3	4	5

Please decide how attractive and how likable you consider this person to be. Use the criteria which are *personally relevant to you* (eg appearance, speech, manners) and which you might normally employ in making such judgements in everyday life.

Use the following scale to make your judgements.
1=not at all; 2=a little; 3=moderately; 4=a lot; 5=extremely

How attractive is this person?	1	2	3	4	5
How likable is this person?	1	2	3	4	5

CATHY

Please decide how attractive and how likable you consider this person to be. Use the criteria which are *personally relevant to you* (eg appearance, speech, manners) and which you might normally employ in making such judgements in everyday life.

Use the following scale to make your judgements.
1=not at all; 2=a little; 3=moderately; 4=a lot; 5=extremely

How attractive is this person?	1	2	3	4	5
How likable is this person?	1	2	3	4	5

ANGELA

Please decide how attractive and how likable you consider this person to be. Use the criteria which are *personally relevant to you* (eg appearance, speech, manners) and which you might normally employ in making such judgements in everyday life.

Use the following scale to make your judgements.
1=not at all; 2=a little; 3=moderately; 4=a lot; 5=extremely

How attractive is this person?	1	2	3	4	5
How likable is this person?	1	2	3	4	5

APPENDIX B

Adjective Checklist

ANGELA

Angela is a 24 year old woman who completed a degree in nursing two years ago and now works full time as a theatre nurse in a major hospital. She sought counselling after her relationship of two years with Jack ended when Jack started a relationship with one of Angela's friends. Angela grew up in a family of two girls and now shares a house close to her work with two female friends.

Code FA_____

Thinking about the video you have just watched, read each word and then mark the appropriate answer in the space next to each of the words. Indicate **to what extent each word describes the way you felt while viewing the video clip about ANGELA.**

Use the following scale to record how you felt about Angela:

1	2	3	4	5
not at all	a little	moderately	quite a bit	extremely

When I watched the video about Angela I felt:

_____happy	_____scared	_____tired
_____self assured	_____guilty	_____attentive
_____shy	_____hostile	_____surprised
_____relaxed	_____drawn to	_____sad

CATHY

Cathy is a 21 year old university student in her third year of an Arts degree. She sought counselling after her relationship with Bob broke up two months ago at Bob's instigation. They had been seeing each other for about eight months. Cathy is the youngest in a family of three children. She shares a house in the city with three friends. She receives a student allowance and works part time as a shop assistant.

Code FC_____

Thinking about the video you have just watched, read each word and then mark the appropriate answer in the space next to each of the words. Indicate **to what extent each word describes the way you felt while viewing the video clip about CATHY.**

Use the following scale to record how you felt about Cathy:

1	2	3	4	5
not at all	a little	moderately	quite a bit	extremely

When I watched the video about Cathy I felt:

_____happy	_____scared	_____tired
_____self assured	_____guilty	_____attentive
_____shy	_____hostile	_____surprised
_____relaxed	_____drawn to	_____sad

DIANA

Diana is a 25 year old woman who shares a flat with her boyfriend, Josh, whom she met in their first year at university. She is the eldest of four children. After completing her university degree Diana commenced work with a multi-national company. Recently she has been offered a position which will take her away from home for relatively long periods. Josh would prefer she did not accept the position.

Code FD_____

Thinking about the video you have just watched, read each word and then mark the appropriate answer in the space next to each of the words. Indicate **to what extent each word describes the way you felt while viewing the video clip about DIANA.**

Use the following scale to record how you felt about Diana:

1	2	3	4	5
not at all	a little	moderately	quite a bit	extremely

When I watched the video about Diana I felt:

_____happy	_____scared	_____tired
_____self assured	_____guilty	_____attentive
_____shy	_____hostile	_____surprised
_____relaxed	_____drawn to	_____sad

LYNNETTE

Lynnette is a 22 year old fashion design student. She has recently deferred her final year of study and is working full time in a shop which hires fancy dress. Lynnette has broken off her relationship with Ben, with whom she had been living for eighteen months. She has now moved back home to live with her parents and her younger brother. She sought counselling at the suggestion of her parents.

Code FL_____

Thinking about the video you have just watched, read each word and then mark the appropriate answer in the space next to each of the words. Indicate **to what extent each word describes the way you felt while viewing the video clip about LYNNETTE.**

Use the following scale to record how you felt about Lynnette:

1	2	3	4	5
not at all	a little	moderately	quite a bit	extremely

When I watched the video about Lynnette I felt:

_____happy	_____scared	_____tired
_____self assured	_____guilty	_____attentive
_____shy	_____hostile	_____surprised
_____relaxed	_____drawn to	_____sad

APPENDIX C

Comment on Method of Statistical Analysis Employed in Studies 1 and 2.

In these studies Analyses of Variance and Covariance were employed in analysing the data. An alternative approach would have been to use multiple regression analysis. In these studies, however, a priori predictions were made on the basis of a theoretical position regarding the relationship between the various independent variables, and affect as the dependent variable. Thus, hypotheses were derived from theory and for this reason Analysis of Variance was deemed the most appropriate method of statistical analysis. Had the analysis of the data been exploratory, rather than theory-driven, an appropriate approach would have been to use a multiple regression analysis to identify what variables accounted for the most variance in a particular variable.