

## INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

**The quality of this reproduction is dependent upon the quality of the copy submitted.** Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

# UMI

A Bell & Howell Information Company  
300 North Zeeb Road, Ann Arbor MI 48106-1346 USA  
313/761-4700 800/521-0600



**Running head: THERAPY PREFERENCES AND EXPECTATIONS**

**Battered and Nonbattered Women's Preferences For and Expectations About  
Liberal Feminist, Radical Feminist, and Cognitive Therapy**

**Lize R. Jalbert**

**Lakehead University, Thunder Bay, Ontario**

**Thesis submitted in partial fulfilment of degree of Master of Arts, Clinical Psychology**

**© Lize Rachelle Jalbert, 1997**



National Library  
of Canada

Acquisitions and  
Bibliographic Services

395 Wellington Street  
Ottawa ON K1A 0N4  
Canada

Bibliothèque nationale  
du Canada

Acquisitions et  
services bibliographiques

395, rue Wellington  
Ottawa ON K1A 0N4  
Canada

*Your file Votre référence*

*Our file Notre référence*

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-33393-0

**Canada**

### Acknowledgments

My sincere thanks to Dr. Josephine Tan for her guidance in the completion of this work. I would also like to thank my parents for their support and encouragement during the last two years. Most of all, I would like to thank the women who participated in this project for their time and commitment, and the mental health agencies who helped to establish a link between the university and the community. Their contributions will help to ensure that women's opinions are considered in the development of new therapies.

Table of Contents

List of Tables	iv
List of Figures	v
List of Appendices	vi
Abstract	vii
Chapter I: Introduction	1
Types of Violence	2
Physical abuse	3
Sexual abuse	4
Psychological abuse	5
Prevalence of intimate violence in Canada	5
The Process of Violence Towards a Female Intimate	7
Walker's Cycle Theory of Violence	7
Effects of Violence on the Victim	9
Physical consequences	9
Psychological effects and coping responses	10
Explanations of Domestic Violence (Male to Female) and Implications for Therapy	11
Research on the Batterer	11
Psychoanalytic Theory	12
Family Systems Theory	15
Cognitive Theory	18
Feminist Theory	20
Women's Perceptions of Feminist Therapy	23
The Present Study: Purpose and Hypotheses	27

## Therapy Preferences and Expectations

<b>Chapter 2: Methodology</b>	<b>32</b>
<b>Participants</b>	<b>32</b>
<b>Design</b>	<b>33</b>
<b>Experimental Manipulation Check</b>	<b>33</b>
<b>Materials</b>	<b>34</b>
<b>Measures</b>	<b>37</b>
<b>Procedure</b>	<b>41</b>
<b>Chapter 3: Results</b>	<b>43</b>
<b>Experimental Manipulation Check</b>	<b>43</b>
<b>Sample Description</b>	<b>44</b>
<b>Correlations Between Scales</b>	<b>46</b>
<b>Overview of the Analyses</b>	<b>47</b>
<b>Pre-Analysis Issues</b>	<b>50</b>
<b>Main Analyses</b>	<b>54</b>
<b>Secondary Analyses</b>	<b>58</b>
<b>Chapter 4: Discussion</b>	<b>61</b>
<b>Main Hypotheses</b>	<b>61</b>
<b>Research and Clinical Implications</b>	<b>69</b>
<b>Limitations and Contributions of the Study and Suggestions     for Future Research</b>	<b>74</b>
<b>References</b>	<b>79</b>
<b>Tables and Figures</b>	<b>91</b>
<b>Appendices</b>	<b>110</b>

### List of Tables

1. Mean Ratings for Each Therapy Style	91
2. Number of Participants Within Each Age Range in Sample	92
3. Number of Participants Within Each Education Level in Sample	93
4. Differences Between the Abuse Experiences of Self-Identified Battered and Nonbattered Women	94
5. Correlation Matrix for Scales	95
6. Internal Consistency for Levels of Scale and Subscale Scores for Expectations	96
7. Summary Repeated-Measures MANOVA Table as a Function of Battering Status and Therapy Style on E-CAB and E-CC	97
8. Standardized Discriminant Function Coefficient, Structure Loading, and Results of Stepdown F-tests on Scales E-CAB and E-CC for Significant Therapy Style Effect	98
9. Post-hoc MANOVA Pairwise Comparison (Tukey's HSD) for Significant Main Effect of Therapy Style on E-CAB and E-CC	99
10. Summary Repeated-Measures ANOVA Table as a Function of Battering Status and Therapy Style on E-CPO	100
11. Post-hoc Pairwise Comparison (Tukey's HSD) for Significant Main Effect of Therapy Style on E-CPO	101
12. Internal Consistency for Levels of Scale and Subscale Scores for Preference	102
13. Summary Table for Paired Sample t-tests on Expectations and Preference Scales of CAB, CC, and CPO for CT, LFT, and RFT	103

## Therapy Preferences and Expectations

### List of Figures

1. Mean scores for the CT, LFT, and RFT on Scale E-CAB	104
2. Mean scores for the CT, LFT, and RFT on Scale E-CC	106
3. Mean scores for the CT, LFT, and RFT on Scale E-CPO	108

## Therapy Preferences and Expectations

### List of Appendices

A. List of Agencies Contacted for Recruitment of Participants	110
B. Demographic Questionnaire	111
C. Description of Counseling Concern	113
D. Cognitive Therapy Script	114
E. Liberal Feminist Therapy Script	119
F. Radical Feminist Therapy Script	124
G. Experimental Manipulation Check Rating Scale	129
H. Letter to Agencies	130
I. Participant Recruitment Letter	131
J. Informed Consent Form	132
K. Debriefing	133
L. Attitudes Towards Feminism and the Women's Movement Scale	134
M. Expectations Questionnaire	136
N. Item Numbers for the EAC-B Scales and Subscales	143
O. Preference Questionnaire	144
P. Perceived Helpfulness and Willingness to See Questionnaire	151

## Therapy Preferences and Expectations

### Abstract

Prior research has suggested that feminist therapy is an effective form of counseling for battered women (BW). To date however, virtually no studies have considered the importance of the client's expectations of, or preferences for feminist therapy over other types of therapy. In the present study, 20 battered and 20 nonbattered women (NBW) each read transcripts of three different types of therapy: nonsexist cognitive (CT), liberal feminist (LFT), and radical feminist (RFT). The order of presentation was counterbalanced. The women were measured on general therapy preferences for: Counselor Attitudes and Behaviors (P-CAB), Counselor Characteristics (P-CC), Counseling Process and Outcome (P-CPO). In addition, their expectations about each of the three therapists were measured on the following scales: Counselor Attitudes and Behaviors (E-CAB), Counselor Characteristics (E-CC), and Counseling Process and Outcome (E-CPO), Perceived Helpfulness (PH) of the therapist, and Willingness to See (WS) the therapist. Results indicated that BW and NBW did not differ significantly on any of these scales. However, both BW and NBW expected the RFT to show significantly more of the counselor attitudes and behaviors (i.e., acceptance, confrontation, directiveness, empathy, genuineness, nurturance, and self-disclosure) presented than the CT. In contrast, they expected the CT to possess more of the counselor characteristics (i.e., attractiveness, expertise, tolerance, and trustworthiness) than the RFT. Finally, they expected a more positive counseling process and outcome (i.e., concreteness, immediacy, and outcome) with the CT than with the RFT. Expectations about the LFT did not differ significantly from either expectations about the CT or the RFT on these scales. All three therapists were perceived as equally helpful, and the women were equally willing to see each of them. However, the majority (66%) of both BW and NBW chose the CT as their favorite therapist. The research and clinical implications of the findings are discussed.

CHAPTER 1

Introduction

Crucial to any study of violence against women is the knowledge of what constitutes abuse. However, the complex nature of abuse precludes the use of a single definition. Violence against women occurs on many different levels (i.e., in the private and public sphere), and in many different forms (i.e., physical, psychological/emotional, financial and spiritual) with varying degrees of severity. In 1993, a proposed United Nations Declaration (Final Report of The Canadian Panel on Violence Against Women, 1993) defined violence against women very generally, as:

...any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private life [and] ...a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and which have prevented women's full advancement." (p. 5).

This type of definition encompasses not only those direct acts of violence that might occur in the home but also the other more subtle kinds of violence such as sexual harassment in the workplace (Wigmore, 1995), bans against the ordination of women in

the Church (Wilson, 1991), and the exclusion of women from positions of power in the military (Enloe, 1988, 1993).

Other definitions of abuse are more specific, referring to those types of abuse seen primarily in a relationship between two familiar individuals. There is some controversy regarding the terminology used to describe the violence that occurs in an intimate relationship. Some critics object to the use of terms such as domestic violence, family violence, and spouse abuse, preferring the term male violence against women because they feel that the former terms obscure the gendered nature of the violence, thereby leading to biased case conceptualizations and treatment (McHugh, 1993). As the focus of this paper is women's perceptions of feminist therapy, only male to female violence in intimate relationships is described. In order to address the multilayered concept of battering, the present study attempts to use a balanced, inclusive definition of battering, focusing on physical violence, sexual violence, and psychological violence.

### Types of Violence

The different types of violence which occur in intimate relationships can generally be categorized into physical abuse, sexual abuse, and psychological abuse. A battering relationship may see one or more of these various forms of abuse. Though additional types of violence appear in the literature (e.g., spiritual abuse, and financial abuse), the present study limits itself to the three aforementioned categories.

### Physical Abuse

Physical abuse is the most obvious form of violence and can range from slapping, pushing and shoving to punching, kicking, severe beating, torture, and even murder.

(Canadian Panel on Violence Against Women, 1993). In 1979, Lenore Walker interviewed more than 120 battered women in an attempt to more clearly understand their experiences. Walker describes both minor and major physical assaults in her work.

Minor assaults included, "a slap in the face, a smack on the rear end, a pinch on the cheek or arm, a playful punch, and hair pulling" (p. 79). Only if these behaviors occurred regularly, and without respect for the woman's well-being were they classified as battering behavior. Major physical assaults included, according to Walker:

slaps and punches to the face and head; kicking, stomping, and punching all over the body; choking to the point of consciousness loss; pushing and severe shaking; arms twisted or broken; burns from irons, cigarettes and scalding liquids; injuries from thrown objects; forced shaving of pubic hair; forced violent sexual acts; stabbing and mutilation with a variety of objects, including knives and hatchets; and gunshot wounds. (p. 79)

Physical violence, even within a marital relationship, can be considered a criminal offence when it meets the criteria for assault as defined in the Canadian Criminal Code (1997). A person is said to have committed an assault when:

(a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly; (b) he attempts or threatens, by an act or a gesture, to apply force to another person, if he has, or causes that other person to believe upon reasonable grounds that he has, present ability to effect his purpose, or (c) while openly wearing or carrying a weapon or an imitation thereof, he accosts or impedes another person or begs. (p. 476)

### Sexual Abuse

The issue of sexual assault in an abusive relationship is somewhat more complex than that of physical assault for a number of reasons. Because sexual violence often occurs within socially sanctioned relationships such as marriage or common-law arrangements where sexual relations are common, it can sometimes be difficult to distinguish between consensual and nonconsensual sexual activity. Sexual assault has been defined as "unconsented use or attempted use of a woman's body (kissing, fondling, or sexual intercourse) due to her being forced, emotionally or physically threatened, drugged, unconscious, or in some way made physically helpless" (Russell, 1984, p. 67; cited in Thorne-Finch, 1992, p. 19). Like physical abuse, sexual abuse is also considered a criminal offence according to the Canadian Criminal Code (1997) which defines sexual assault as "...an assault, within any one of the definitions of that concept...which is committed in circumstances of a sexual nature such that the sexual integrity of the victim is violated." (p. 487).

### Psychological Abuse

Psychological or emotional abuse can be defined as "behavior sufficiently threatening to the woman so that she believes that her capacity to work, to interact in the family or society or to enjoy good physical or mental health, has been or might be threatened" (Hoffman, 1984, p. 37). Johnson and Sacco (1995) suggest, based on other researchers' findings (Dobash & Dobash, 1984; Hart, 1988; Walker, 1979), that psychological violence often manifests itself in the form of possessive, jealous and controlling behaviors on the part of the abusive man towards his partner. Therefore, in this study, psychological violence is indicated by the presence of these behaviors, as defined by the Conflict Tactics Scale (Strauss, 1979).

### Prevalence of Intimate Assault in Canada

In 1993, Statistics Canada conducted a national survey on Violence Against Women. Twelve thousand and three hundred women, who were of 18 years of age or older and living in Canada, were interviewed. Questions addressing physical and sexual assaults were formulated based upon definitions contained in the Canadian Criminal Code. An additional 10 questions based on a modified version of the Conflict Tactics Scale was used to assess marital violence. According to this survey, 45% of women experienced violence in their lifetime at the hands of a spouse or ex-spouse, date or boyfriend, family member, acquaintance or other known man (Johnson & Sacco, 1995).

With respect to women who were currently or had ever been married, or who were living in a common-law arrangement, 29% had been assaulted by a spouse or live-in partner. Forty-eight percent of violent acts occurred in past relationships as compared to 15% in current marriages or common-law relations. In fact, 19% of the women stated that violence was present at the time of separation, and one-third of these women reported that the violence became more severe at that time.

The most common forms of violence committed by marital or common-law partners, as reported by these women were pushing, grabbing and shoving (25%), threats of hitting (19%), slapping (15%), throwing something at her (11%), kicking, biting, and hitting with fists (11%). The percentage of women who had been beaten, choked, sexually assaulted, or had a gun or knife used against them were all less than 10%. However, the survey indicated that in each of these categories (where occurrence was below 10%), between 40,000 and 800,000 women reported having experienced assault. Another point of interest in this survey is that these women experienced repeated victimization. For example, 63% of women who had been assaulted by a spouse reported more than one episode and 32% reported more than ten. Furthermore, in previous marital or common-law unions, 41% involved 10 or more episodes, compared to 10% in the case of current relations.

The Process of Domestic Violence Towards a Female Intimate

Walker's Cycle Theory of Violence

The most prominent theory concerning the process of violence in a battering relationship is Walker's Cycle Theory of Violence. Walker first introduced this theory in her book "The Battered Woman" (1979), based on her indepth interviews with 120 battered women (and fragments from over 300 more stories). Walker hypothesized that a battering relationship goes through three predictable phases. The first of these is the tension-building phase, characterized by the presence of "minor" battering incidents (e.g., verbal assaults and/or being slapped). The second phase named "the acute battering incident", is characterized by extreme violence, a discharge of the tension built up in phase one. Finally, the third phase, "loving respite", is characterized by either apologetic behavior on the part of the batterer or simply an absence of violence.

According to Walker (1984), the length of each phase varies. Usually, the tension-building phase lasts the longest followed in length of time by the loving and contrition phase and the acute battering incident. The length of the phases differs both between couples and within a couple. For instance, Walker (1979) reports that in one battering relationship she studied, the tension-building phase would last longer and longer as the children grew older (up to ten years once the children were out of the home). In addition, situational events usually control the timing of the acute battering incident.

There is some research supporting Walker's cycle theory of violence. Walker (1984) interviewed 400 battered women about their experiences. The women were asked for detailed descriptions of the first, second, worst, and last battering incident before the interview. They found that in 65% of all cases, there was evidence for a tension-building phase, and in 58% of all cases, there was evidence for a loving and contrition phase. Evidence also suggested that as time went by in a relationship, the percentage of tension-building increased, while the percentage of loving and contrition decreased. For example, regarding the first violent incident reported by the women, 56% showed evidence of a tension-building phase, and 69% showed evidence of contrition. By the last incident however, the proportion of battering incidents which showed evidence of tension-building rose to 71% while that showing evidence of loving contrition fell to 42%. The escalation-of-violence phenomenon has been supported by other researchers in subsequent studies (Browne, 1987; Gelles & Straus, 1988). Others disagree with the cycle of violence interpretation. Schuller and Vidmar (1992) for instance, point out that the cycle of violence is not present in all battering situations. Dutton and Painter (1993) suggested that it is the intermittency of abuse rather than the predictability of a cycle of violence that is the main contributor to the battered woman syndrome outlined by Walker (1984).

### The Effects of Violence on the Victim

The effects of abuse on the victim can be experienced on a physical and a psychological level. They are discussed below.

#### Physical Consequences

The physical repercussions of a single beating can be staggering. The most common injuries reported are to the head, face, back and rib areas. Black eyes, broken noses, lost teeth, and concussions are all common head and face injuries. Broken arms, raised to ward off danger to the face and head, are also common, as are broken necks and backs in the more severe cases. Surgery is required in a large number of cases (Campbell & Humphreys, 1993; Thorne-Finch, 1992; Walker, 1979, 1984). Physical violence during pregnancy has been reported to occur in 7-17% of all pregnancies, and among approximately half of all battered women (Campbell & Humphreys, 1993). Over time, repeated beatings can lead to very serious health problems. The list is long and includes: hypertension, respiratory problems, eczema and other skin rashes, gastro-intestinal irritability, genito-urinary disturbances, sexually transmitted diseases, skeletal muscle tension, and sleep disorders. Additionally, eating disorders and increased drug and alcohol use are often diagnosed in battered women (Campbell & Humphreys, 1993; Thorne-Finch, 1992; Walker, 1979, 1984).

### Psychological Effects and Coping Responses

Many researchers have put forth hypotheses about what effect battering has on the victim, what meaning it has for her, and how she responds to it. The prevailing view for the last decade has been that battered women's emotional experiences parallel those of severe trauma victims. Some of the symptoms associated with both trauma victims and victims of physical abuse are: initial denial and disbelief, followed by rationalization, feelings of listlessness, depression, and helplessness, feelings of futility of escape, self-blame, and suicidal gestures (Campbell & Humphreys, 1993; Dutton, 1988; Follingstad, Neckerman, & Vorbrock, 1988; Symonds, 1975; Thorne-Finche, 1992; Walker, 1979, 1984, 1990). After repeated beatings, women come to experience severe psychological stress in anticipation of a beating. They report feeling anxious and depressed, and suffering from lack of sleep, a loss of appetite, or conversely overeating, oversleeping, and extreme fatigue (Walker, 1979). Walker (1984) proposed a syndrome to describe battered women's reactions in cases of repeated physical abuse. The proposed "Battered Woman Syndrome" is used to describe the psychological sequelae of repeated physical attacks. Walker posits that after repeated exposure to physical abuse, some women, who due to a number of factors are more susceptible than others to the learned helplessness construct, develop a pattern of coping that allows them to survive in the battering relationship, but which also leads to psychological entrapment (e.g., not actively seeking to end the relationship, defending the batterer to friends and relatives, etc.). More

recently, research has focused on the link between battered women and post-traumatic stress disorder (Astin, Lawrence & Foy, 1993; Astin, Ogland-Hand, Coleman, and Foy, 1995; Dutton & Goodman, 1994; Foy, 1992; Grant, 1995; Houskamp & Foy, 1991; Kaser-Boyd, 1993; Kemp, Green, Hovanitz, and Rawlings, 1995; Kemp, Rawlings, & Green, 1991; Levit, 1991; Saunders, 1994; Walker, 1991b; Woods & Campbell, 1993).

### Explanations for Domestic Violence (Male-to-Female) and Implications for Treatment

There is a variety of theories which attempt to explain abusive behavior. Some involve either the man or the woman primarily while others implicate both. An outline of these theories is presented here as well as the implications for treatment.

### Research on the Batterer

With respect to the physiology of abusive behavior, batterers have been studied from a genetic perspective (Buss, 1994), a brain damage or neurological deficit model (Elliot, 1977; Rosenbaum & Hoge, 1989; Rosenbaum, Hoge, Adelman, Warnken, Fletcher, & Kane, 1994), and a hormonal model (Kreuz & Rose, 1972; Persky, Smith, & Basu, 1971). The behavior of male batterers has also been extensively linked to psychological characteristics (Carden, 1994; Dutton, 1995; Hershorn & Rosenbaum, 1991; Maiuro, Cahn, Vitaliano, Wagner, & Zegree, 1988; Murphy, Meyer, & O'Leary, 1994; Prince & Arias, 1994), certain personality traits and mental disorders (Beasley, & Stoltenberg, 1992; Else, Wonderlich, Beatty, Christie, & Staton, 1993; Felthous,

Wingerter, & Barratt, 1991; Gondolf, 1988; Greene, Coles, & Johnson, 1994; Saunders, 1992), and the witnessing of interparental violence or the direct experience of childhood abuse (Hershorn & Rosenbaum, 1991; Hotaling & Sugarman, 1986; Kalmuss, 1984, & Kroll, Stock, & James, 1985). Finally, sociological and feminist models attribute male violence against women to such social forces as the peer group, media (i.e., depiction of women as objects in pornography and mainstream media), various institutions such as religion or the military (Thorne-Finch, 1992), and a patriarchal value system that rewards the use of aggression in males (Adams, 1988; Appleford, 1989; Dobash & Dobash, 1979; Thorne-Finch, 1992; Yllo & Bograd, 1988).

### Psychoanalytic Theory

In attempting to explain the etiology of abuse, classical psychoanalytic theory has often focused on the construct of female masochism. Freud (1971) postulated that female masochism is rooted in childhood development. According to Freud, during the phallic stage of development, the female child realizes that she has no penis. Traumatized at this revelation of her supposed inferiority, the girl becomes jealous of her brother, angry at her mother who is "castrated" like herself, and sexually attracted to her father. Deutsch (1945), expanding on Freud's theory, suggested that the desire for a penis is transferred from the "inadequate" clitoris to the "passive" vagina. According to Deutsch, in order to feel sexual excitement from the vagina, the female must be sexually overpowered by a male (i.e., in the missionary position with the man on top or dominant, and the woman on

the bottom, or submissive). The desire for a penis is replaced by the act of giving birth to his preferably male child.

Horney (1935), rejected the notion that discovery of the penis (or lack of it) caused girls to become masochistic, indicating that there were no data to support this hypothesis. Horney also cited economic dependence on men, the restriction of women to roles built upon emotional bonds, and the view of women as inferior as causative factors in masochism. Although Horney did not adhere to the traditional theory of etiology concerning what was called masochism, she did believe that masochism existed, and that women might seek it through menstruation, masturbation, intercourse and childbirth (1935).

Classical psychoanalytic theory has been strongly criticized with respect to its treatment of women in general and battered women in particular. A major criticism, as outlined by Harway (1993) is that the psychoanalytic interpretation "...describe[s] battered women as having a basic need to provoke violence, as displaying passive hostility that contributes to the violence, and as having a masochistic motivation that promotes continued violence" (p. 30). Caplan (1985) has also criticized the concept of female masochism, stating that society teaches women to behave in a passive manner and then labels that behavior as masochistic.

According to critics of psychoanalysis, the construct of female masochism continues to influence current diagnostic practices and is especially apparent in the

American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-Versions III-R, and IV. For example, the criteria for both the DSM-IV diagnosis of Dependent Personality Disorder (DPD) and the DSM III-R, proposed (and now rejected) Self-Defeating Personality Disorder closely resemble the "masochistic attitudes" of emotional dependence, and use of feelings of inferiority to obtain special advantages from others, as outlined by Horney. In fact, Self-Defeating Personality Disorder has also been called Masochistic Personality Disorder (DSM-III-R). Despite the fact that a review of over 400 studies found no support for an increased occurrence of such personality traits as passivity, low self-esteem and masochism in battered women (Hotaling & Sugarman, 1986), battered women continue to be frequently diagnosed with several "mental disorders" including: Dependent Personality Disorder, Post-traumatic Stress Disorder, and Borderline Personality Disorder (Hansen & Harway, 1993).

What implications does psychoanalytic theory have for women who have been victims of domestic violence? One very salient implication of such a theory is that when battered women reach out for help, they themselves may be seen as the cause of the battering, and as such may be directly or indirectly blamed for the batterer's behavior. For example, Snell, Rosenwald, and Robey (1964), studied 12 out of 37 families where the husbands had been charged with assault and referred to a psychiatric clinic. These researchers concluded that the wives of these men were masochistic, and that the husbands' behavior may have unconsciously filled the wives' needs. Similar biases have

been seen in the research of Schultz (1960). A further implication of the use of therapies derived from psychoanalytic theory is that, if battered women are labelled as masochistic, and are seen to be the source of the problem, they themselves will be the object of treatment. The label of masochism may therefore misplace the focus of treatment on the symptoms of the battered woman rather than on the abusive behavior. For instance, in Dobash and Dobash's study of battered women, 40% of the 87 women who went to a doctor spontaneously mentioned that they had been prescribed drugs.

### Family Systems Theory

The family systems approach was developed in the mid-1970s, in response to, among other things, the limitations presented by such reductionistic approaches as psychoanalysis. The main tenet of systems theory is that of circular causality. According to this theory, an individual's behavior is the result of family interactions rather than individual personality characteristics (Worden, 1994). The rationale for this approach was that, by concentrating on the actions/thoughts/feelings of the whole family as a unit, less emphasis would be placed on individual pathology. If an individual's problematic family context was addressed rather than the individual him/herself, gains made in therapy would be maintained outside of the therapeutic setting. Thus, family systems therapy appears to have potential for victims of domestic violence. For example, a battered woman may present for therapy for the symptoms of abuse, such as depression or anxiety, rather than to address the issue of abuse. Treating the context of the problem,

including confronting the husband/partner about his abusive behavior in therapy, would resolve the problem more effectively than treating the victim for her resulting depression and anxiety.

There are, however, several aspects of family therapy that are problematic with regard to a battering situation. The way in which family systems theory conceptualizes the treatment issue can obscure the violence in battering couples. For example, violence can be overcontextualized, meaning that if the therapist does not miss it altogether, it may be listed as one of many items needing work, rather than the primary goal of treatment (Bograd, 1984). Alternatively, violence in a couple might be decontextualized by family therapists (Bograd, 1984). Family systems theory treats the family as if it were a closed system, a separate entity without considering the outside factors which affect the system. Although most family therapists will acknowledge that outside factors do exist, they are rarely addressed as part of the treatment strategy. Finally, in family systems therapy, the issue of battering may be seen as a symptom of a more basic dysfunction within the family/couple, or it may be seen as a mechanism which maintains the equilibrium or homeostasis of the system (Weitzman & Dreen, 1982).

What are the effects of these systemic formulations of violence? The way in which battering is conceptualized will determine the structure and course of therapy. If both individuals are seen as contributors to the problem, it is likely that both will be seen in therapy together. There are several negative implications of conjoint therapy for

battering couples. First, simply the fact that both the man and the woman are brought into therapy may imply that the female victim is to some degree responsible either for the occurrence of or the cessation of the violence (Hansen, 1992). A second aspect of family systems therapy that warrants discussion is its use of systems language. Systems language is considered by family therapists to be neutral, and value-free. The advantage of using this type of language is that the system rather than the individuals within the family/couple is blamed. However, systems language may be detrimental when applied to a battering situation. For instance, the use of terms such as "domestic violence", and "violent couples" or phrases such as "violence acts homeostatically to reestablish complementarity" (Weitzman & Dreen, 1982) may place blame inappropriately on the recipient of the abuse. Neutral descriptions ignore the power imbalance that may exist between a couple in a battering situation.

A third negative implication of conjoint therapy is that the therapist is unlikely to get a clear idea of how intense or severe the battering is because the victim may not feel safe to speak her mind in the presence of the batterer for fear of retaliation (Bograd, 1984). According to some researchers (Coleman, 1980; Dutton, 1995), batterers may attend therapy not out of a desire to end the violence, but rather to regulate the information discussed with the therapist or because the wife/partner has threatened to leave. Furthermore, since women often blame themselves for the violence (Walker, 1979), they may be seen as more amenable to treatment and become the focus of

treatment. Family therapists may teach battered women assertiveness skills rather than addressing the power imbalance in the relationship. They may also be labelled as "overadequate" and as presenting a threat to their "underadequate" partners (Hoffman, 1981). They may be advised to somehow change their behavior, perhaps to be less demanding, in order to present less of a threat to their husband (Bograd, 1984). In placing the focus of therapy on the woman, therapists may be contributing to the continuation of the violence.

A final negative implication of conjoint therapy is that often, the primary goal of systems therapists is not to end the violence, but to preserve the relationship (Bograd, 1984). Research shows however, that batterers are most motivated to change their behavior when their partner threatens to leave (Walker, 1979). Additionally, women in a battering relationship may be in a state of psychological terror (Walker, 1984) and therefore unable to perceive a solution other than to remain in the relationship with the batterer. In this case, the preservation of the relationship (which if attained, would be considered a success by the therapist) could be very detrimental to the victim.

### Cognitive Theory

Cognitive theory sees human behavior as the result of an interaction between environmental consequences and those internal cognitive processes (e.g., thoughts, emotions, expectations) which mediate the interpretation of those consequences. Psychopathology, according to this view, can be defined as a poorness of fit between the

demands of an individual's environment and that individual's capacity to adapt to those demands (Kantrowitz & Ballou, 1992). Douglas and Strom (1988) have suggested that cognitive therapy can successfully help battered women overcome learned helplessness, a concept introduced by Seligman (1975), and a cardinal feature of the Battered Woman Syndrome, as defined by Walker (1984). Walker theorized that severely battered women lose the ability to predict the outcomes of their behavior, and as such often do not leave, even when it is possible to do so. According to Walker, learned helplessness, when applied to the battered woman, does not mean that she learns how to be helpless. Rather, it means that she learns that she is unable to predict what effect her behaviors will have on the battering behavior. These feelings of helplessness eventually generalize to other situations, and the battered woman comes to feel that her behavior is ineffective in all areas of her life. The resulting sense of futility and depression prevents the woman from leaving the battering relationship.

The use of cognitive therapy in the treatment of battered women represents an improvement over the psychoanalytic and the family systems approach, in that it includes an examination of the individual's environment in its conceptualization of the problem. Another strength of cognitive therapy is its commitment to continually examining, researching, and revising the basic tenets of their theory (Kantrowitz & Ballou, 1992). Finally, the theories behind cognitive therapy are more fluid, and leave more room for the incorporation of personal experience than either the psychodynamic or the family systems

theories. However, there are some drawbacks to its use with battered women. For example, cognitive therapists have been criticized for being too reductionistic and failing to recognize the richness and complexity of human behavior (Dutton-Douglas & Walker, 1988; Jackson, 1987; Kantrowitz & Ballou, 1992). Another criticism that has been made of cognitive therapy is that it presents as value-free, a standard of mental health that is based primarily on the dominant social standards in North America. The danger of adopting an ideal of mental health that was developed and promoted primarily by one gender, race and culture, is that it is not likely to be particularly responsive to the needs of those outside of that gender, race, and culture.

A final criticism of cognitive therapy is that, like those previously discussed, it may fail to challenge those outside influences which shape human, especially female behavior (Lerman, 1992). In practice, cognitive therapy often attempts to treat an individual's behavior so that he/she can better adapt to their environment (Kantrowitz & Ballou, 1992). To some extent, treating the behavior of an individual is desirable. However, in relation to battering, treating an individual in terms of their behavior, for remaining in a violent relationship, without challenging the environmental forces which may shape the behavior can be detrimental.

### Feminist Theory

Feminist theory maintains that wife battering occurs because men are socialized from birth to adopt the existing patriarchal value system in which males have more power

than females, and in which the use of aggression is an acceptable, even rewarded, means to maintain that power. According to this theory, males abuse their intimate partners because "cultural norms support his belief that...he is entitled to dominate and expected to control his wife" (Adams, 1988). In addition, violent acts towards one's partner are seen not as involuntary acts of men with emotional problems, but rather as instrumental aggression "consciously directed at a particular victim and directed at achieving a particular result" (Appleford, 1989, p. 19). As such, feminists believe that researchers looking for psychopathology in the abuser are misguided.

Several lines of research have supported feminist theory. For instance, Yllo (1984) found that in states where women's status is relatively high, women in couples dominated by the male were at an especially high risk for violence. Additionally, in states where women's status is relatively low, couples in which the woman dominated were especially at risk for violence. Straus, Gelles and Steinmetz (1980) reported that wife abuse was much more likely to occur among couples with husband-dominated versus egalitarian decision-making styles. Similar results were reported by Coleman and Straus (1986) who found in a national sample that egalitarian couples had the lowest rates of conflict and violence, while male-dominant couples had the highest rates of violence with female-dominant couples in between. Kantor and Straus (1987) further found that approval of violence toward a female intimate partner was a more reliable predictor of wife abuse than occupational status or level of alcohol use/abuse. Finally, Stith and

Farley (1993) reported data which suggested that wife abuse was related to: 1) nonegalitarian sex-role attitudes, and 2) approval of marital violence. Thus, these studies provide support for the feminist hypothesis that violence is used by the most powerful family member (usually male) as a means of legitimizing his or her dominant position.

Feminist theory has not been without criticism however. Sommers (1994) criticizes feminist theory regarding abuse stating that:

The gender feminist believes that the average man is a potential batterer because that is how men are “socialized” in the patriarchy. But ideology aside, there are indications that those who batter are not average. Talk of a generalized misogyny may be preventing us from seeing and facing the particular effect on women and men of the large criminal element in our society. (p. 199)

Sommers goes on to criticize feminist researchers for defining the term “abuse” too broadly, ignoring lesbian battering, and failing to implement a rigorous system of review for their research.

Despite criticism, feminist research continues to expand. One area on which feminist therapists have focused during the last decade is the application of feminist therapeutic interventions to specific problems including incest, sexual assault, eating disorders and battering (Enns, 1993). Therapy for battered women in particular has received much attention from feminist therapists and researchers (Dutton, 1992; Hartman, 1987; Herman, 1992; Lewis, 1983; Pressman, 1989a, 1989b; Register, 1993; Rosewater,

1985; Walker, 1985; Worell & Remer, 1992). For example, Pressman (1989a) suggests that, with respect to battered women, feminist therapists attempt to: (a) eliminate authoritarian behavior in therapy, (b) empower women by raising awareness about their choices and the amount of control they have over their lives, and (c) help women to see their unique strengths and worth. Although there are a variety of feminist therapies available to battered women, most share several common goals. These goals are: (1) assuring the woman's safety, (2) finding personal meaning in, and healing from the traumatic experience(s), and (3) exploration of available options and formation of new and supportive interpersonal relationships. These goals may be implemented as specific phases of therapy, and do not necessarily follow a specific order (although safety is usually a first priority when working with abused women). Furthermore, these goals may be achieved either in group or individual therapy, or both.

### Women's Perceptions of Feminist Therapy

Despite a proliferation of models of feminist therapy for battered women, and suggestions by some that it may be more appropriate than other forms of therapy for battered women (Pressman, 1989a), there is virtually no research on battered women's expectations about or preferences for any kind of therapy. A study on battered women's experiences with shelters indicated that battered women may experience feelings of inferiority and insecurity, and may fear criticism or a lack of acceptance by others

(Cannon & Sparks, 1989). In contrast, a study on battered women's experiences with a support groups (whose goals were compatible with those of feminist therapy) showed that attendance at women's support groups resulted in improvements in self-esteem, feelings of belongingness, locus of control, less traditional attitudes towards marriage and the family, perceived stress, and marital functioning. (Tutty, Bidgood, & Rothery, 1993). This preliminary research suggests that battered women should perceive feminist therapy positively because of its emphasis on external influences and the commonality of women's experiences.

There is a body of research which directly or indirectly examined individuals' (presumably nonbattered) perceptions of feminist therapy (Chambless & Wenk, 1982; Enns & Hackett, 1990, 1993; Epperson & Lewis, 1987; Glidden & Tracey, 1989; Hackett, Zetzer, & Enns, 1992; Lewis, Foley, & Epperson, 1989; Lewis, Lesmeister, & Davis, 1983; Mimick-Chalmers, 1986; Schneider, 1985; Wanigaratne & Barker, 1995). These research studies yielded conflicting results and were interpreted in different ways. For example, early studies looking at the importance of pretherapy information in a client's choice of therapist showed that the more information therapists who espouse controversial values (i.e., feminist or religious) reveal about those values, the more negatively they are viewed by potential clients (Epperson & Lewis, 1987; Lewis, Foley, & Epperson, 1989; Lewis, Lesmeister, & Davis, 1983; Schneider, 1985).

A later set of studies by Enns and Hackett (1990, 1992, 1993) pointed out that there were several methodological flaws in the previous studies which could account for the negative findings. Chief among these was the fact that only one type of feminist therapist was presented, that the description depicted the most radical form of feminism, and that the scales used to assess egalitarian values (The Attitudes Towards Women Scale--AWS, and the Attitudes Towards Feminism Scale) were outdated, reflecting values that, although once considered to be outside of the general mainstream, may now be taken to be part of general human rights.

Enns and Hackett (1990) compared women's reactions to three types of therapists: a radical feminist (based on the description of "feminist therapist" used in previous studies with a strong emphasis on social analysis and political activity), a liberal feminist (focusing on the analysis of the socialization process and individual change strategies, but little emphasis on social and political activity), and a nonsexist-humanist therapist (with an emphasis on personal growth, and no mention of societal or gender influences). They found that both liberal and radical feminist counselors were perceived as more trustworthy, expert, and helpful than the nonsexist-humanist counselor. As well, the women showed a stronger desire to see the feminist counselors than the nonsexist counselor for career and sexual harassment concerns and had an equally strong desire to see all of the counselors for personal and interpersonal concerns. Qualitative data revealed that all three of the counselors were perceived to be emphasizing different goals.

These findings were partially replicated by Hackett, Enns, and Zetzer (1992), where the liberal feminist counselor was perceived as more expert than the nonsexist or radical feminist counselor, and the women expressed the strongest desire to see a liberal feminist counselor for personal/interpersonal concerns. Enns and Hackett (1993) failed to replicate these findings a third time, but instead found that all counselors, including the liberal and radical feminist counselors were endorsed positively by women in terms of attractiveness, expertness, and trustworthiness, or preference.

One of the factors thought to influence an individual's reaction to feminist therapists is his/her attitude towards women and/or feminism. This question has been widely researched (Enns & Hackett, 1990, 1993; Epperson & Lewis, 1987; Hackett, Zetzer, & Enns, 1992; Lewis, Foley, & Epperson, 1989; Lewis, Lesmeister, & Davis, 1983; Mimick-Chalmers, 1986; Schneider, 1985). Results generally show that although attitudes towards feminism may influence willingness to seek therapy (Enns & Hackett, 1990; Hackett, Enns, & Zetzer, 1992) it does not have an influence on what kind of therapy one will seek (Enns & Hackett, 1993; Hackett, Enns, & Zetzer, 1992). However, the samples in most of these studies were composed of undergraduate university students, not battered women. Battered women, contrary to popular belief, have been shown to have attitudes toward women that are either as liberal or more liberal than nonbattered women as measured by the AWS (Walker, 1984; Frisch & MacKenzie, 1991), though

they were shown to be more feminine than nonbattered women as measured by the Bem Sex-Role Inventory (Warren & Lanning, 1992).

Tinsley, Bowman, and Ray (1988) have emphasized the importance of clearly distinguishing between expectations, perceptions, and preferences for therapy, noting that these terms have often been used interchangeably in previous research. Tinsley et al. define perceptions as "...knowledge gained about an event through direct observation", expectations as "...probability statements regarding the likelihood that an event will occur (e.g., the counselor will understand my problem) or a condition will exist (e.g., the counselor will seem trustworthy)", and preferences as "...desires regarding the occurrence of an event or the existence of a condition" (p. 100). Research with undergraduate students has shown that 1) students generally want more out of counseling (preference) than they think they will get (expectations), and 2) the greatest discrepancy between expectation and preference occurs with respect to outcome (i.e., students wanted counselors to help them, but were somewhat doubtful about that they would) (Tinsley & Benton, 1978; Galassi, Crace, Martin, James, & Wallace, 1992).

### The Present Study: Purpose and Hypotheses

Researchers have theorized that in addition to the effectiveness of therapy, clients' expectations may influence their decision to seek and stay in therapy (Apelbaum, 1958;

Frank, 1959; Robinson, 1950). As mentioned before, many different models of feminist therapy for battered women have been designed. However, missing in the academic literature is a consideration of battered women's expectations about or desire for feminist therapy as opposed to other forms of therapy. It is important not to further blame victims of battering by implementing various forms of therapy deemed to be effective without first considering the victims' responses to those forms of therapy.

Therefore, the purpose of the present study was to examine differences between battered and nonbattered women's expectations about, and preferences for different types of therapy. The three types of therapy which were examined in the present study were liberal feminist therapy (LFT), radical feminist therapy (RFT), and cognitive therapy (CT). The feminist therapies were the focus of the study in that a specific purpose of the study was to find out whether or not battered women prefer feminist therapies over a more mainstream type of therapy. Both liberal and radical feminist therapy were used because research has shown that feminist therapy is not a single entity and that studies examining both liberal and radical feminist therapy find differences between the two in terms of preference (Enns & Hackett, 1990). CT was chosen as a representative example of a mainstream therapy to be compared against the two feminist therapies. The major reason for choosing CT over other mainstream therapies is because, like feminist therapy, CT is directive. Thus its use would ensure that subjects are not simply responding to the directive components of the therapy but to those aspects which are unique to feminist

counseling, such as an emphasis on social analysis, and a focus on women's unique strengths and worth.

Preference for Counselor Attitudes and Behaviors (P-CAB), Counselor Characteristics (P-CC), and Counseling Process and Outcome (P-CPO) in general were assessed before any of the therapy styles were presented to the women in the study.

Following assessment of preferences, expectations about each type of therapy were assessed for each of the three following scales: (1) Counselor Attitudes and Behaviors (E-CAB), (2) Counselor Characteristics (E-CC), and (3) Counseling Process and Outcome (E-CPO). As originally developed by Tinsley (1982), each of these scales is comprised of various descriptive subscales in the following order: (1) CAB- acceptance, confrontation, directiveness, empathy, genuineness, nurturance, and self-disclosure, (2) CC - attractiveness, expertise, tolerance, and trustworthiness, and (3) CPO - concreteness, immediacy, and outcome. In addition, Perceived Helpfulness (PH) of therapist, and Willingness to See (WS) the therapist as a function of Battering Status and Therapy Style were assessed. Finally, this study assessed which of the three therapists was the women's favorite.

As battered women have been shown in some cases to have more liberal attitudes towards women than the general female population (Walker, 1984), Attitudes Towards Feminism was used as a covariate in the current study.

There are several reasons why battered women were expected to respond positively to feminist therapy. These include: (1) one of the initial aims of feminist therapy was to empower women to take control of their own lives and bodies (Enns, 1993), (2) the therapist-client relationship is egalitarian (Enns, 1993), (3) feminist therapy focuses on the unique strengths and worth of women (Pressman, 1989a), and (4) women in support groups consistent with feminist values have experienced improvements in self-esteem and locus of control (Tutty, Bidgood, and Rothery, 1993). Based on these reasons, the main hypotheses in this study were:

- (1) Battered women (BW) would have different therapy preferences (P-CAB, P-CC, P-CPO) than nonbattered women (NBW).
- (2) With respect to E-CAB, E-CC, and E-CPO, BW would rate the liberal feminist therapist (LFT) highest, and NBW would rate the cognitive therapist (CT) highest.
- (3) With respect to Perceived Helpfulness (PH), BW would rate the LFT highest, and NBW would rate the CT highest.
- (4) With respect to Willingness to See (WS), BW would rate the LFT highest, and NBW would rate the CT highest.

A secondary purpose of this study was to investigate whether or not there were differences between preferences for therapy and expectations about therapy as a function of Battering Status and Therapy Style. To that end, two additional hypotheses were:

- (5) For BW, general therapy preferences (P-CAB, P-CC, P-CPO) would be most closely matched by expectations (E-CAB, E-CC, E-CPO) for the LFT while for NBW, general therapy preferences would be most closely matched by expectations for the CT.

## CHAPTER 2

### Methodology

#### Participants

The participants for the present study consisted of two groups. The first group was composed of 20 women who described themselves as battered. They were recruited from the local women's shelter, various mental health agencies, and the Lakehead University and Confederation College student population (see Appendix A). The nonbattered group consisted of 20 women recruited from the Lakehead University and Confederation College student population and various mental health centers in the Thunder Bay area.

Women identified themselves to the experimenter as battered or nonbattered. The nature of the abuse (i.e., physical, psychological, and sexual) was investigated by means of responses to items on the Conflict Tactics Scale (see Appendix B, q.3), and one separate item on sexual abuse (see Appendix B, p. 4).

Women who were married, living in common-law relationships, and women who were in a relationship with their partner, but were not living with him, were included in the study. Initially, an attempt was made to include only women who had experienced violence in the last two years in order to keep the sample as homogenous as possible. However, as the majority of women were located through support groups at shelters or mental health agencies, most were dealing with abuses from past relationships. Therefore,

the time frame was extended to incorporate women who have experienced violence at the hands of their partners at any time in the past. The two groups of women (battered and nonbattered) were matched for age and education level.

### Design

The study used a 3 (within-subjects factor) Therapy Style (nonsexist-cognitive/liberal feminist/radical feminist) x 2 (between-subjects factor) Battering Status (battered/nonbattered) design. The presenting issue (see Appendix C) as well as the three therapy styles were depicted by written transcripts of therapy sessions (see Appendices D, E, and F), based on the previous work of Enns and Hackett (1990). The transcripts attended to the distinctions between nonsexist-cognitive, liberal feminist, and radical feminist philosophies. Client statements and the outcome of each interview were held constant to the extent possible, but counselor responses differed depending on the approach.

### Experimental Manipulation Check

Each of the three counseling scripts underwent a manipulation check for theoretical orientation by two independent expert raters. The cognitive script was evaluated by two clinical psychologists with expertise in the area of cognitive therapy, while the liberal and radical feminist scripts were each evaluated by two clinical

psychologists with expertise in the area of feminist therapy. Each script was evaluated on a 5-point Likert scale with respect to a) directiveness, b) self-disclosure, c) focus on internal/external factors, d) emphasis on social activism, and e) general representativeness of orientation. Raters also had the opportunity to make suggestions in an open-ended fashion on how to improve the script. The cognitive script was revised and resubmitted for evaluation (see Appendix G).

### Materials

#### Appendix C: Presenting Issue

As mentioned above, the presenting issue as well as the three therapy scripts (cognitive therapist, liberal feminist therapist and radical feminist therapist) were depicted by written transcripts of therapy sessions, based on the previous work of Enns and Hackett (1990). The presenting issue was somewhat modified from that used in previous studies (Enns & Hackett, 1990, 1993; Enns, Hackett, & Zetzer, 1992) to more accurately reflect an issue that might face the battered women. The presenting issue in the Enns and Hackett studies was that of a young woman who was trying to decide between going to college out of town to pursue her career goals, and staying home with her boyfriend. It is possible that participants' reactions to this issue could be influenced by their sex-role beliefs. Therefore, in order to avoid measuring sex-role beliefs and tap into differences in therapy expectations and preferences between battered and nonbattered

women, the presenting issue in the current study revolved around a woman who is trying to decide whether or not to end her current relationship (of 3 years) because she and her partner do not have much in common and have drifted apart (see Appendix C).

**Appendix D: Cognitive Therapy Script**

The cognitive condition in this study is based on Beck's theory of cognition (1972), and focused on the principles of collaborative empiricism, and looked at such cognitive distortions as dichotomous thinking. There was an acknowledgement of external influences, but the therapist emphasized internal processes (i.e., cognitive distortions). There was no self-disclosure. The script itself contained no overtly sex-biased responses but was not feminist (see Appendix D).

**Appendix E: Liberal Feminist Therapy Script**

The liberal feminist script was modelled after Rawlings and Carter's (1977) guidelines for nonsexist therapy (see Appendix E). In this therapy script, the counselor emphasized how external factors (i.e., socialization process) were implicated in the problem, but focused on individual change strategies. In addition, the therapist emphasized the commonality of women's experiences. There was no self-disclosure.

**Appendix F: Radical Feminist Therapy Script**

The radical feminist script was modelled after Rawlings and Carter's (1977) version of feminist therapy (see Appendix F). The therapist in this script strongly emphasized the external causes of the problem (i.e., women's lack of power in society),

emphasized women's commonalities, and encouraged social activism in the client. This therapist used self-disclosure as a therapeutic technique.

Letter of Introduction to Agencies (Appendix H).

The introductory letter addressed to the agency from which participants were recruited summarized the purpose of the study, outlined the requirements of participation, and emphasized the voluntary and confidential nature of participation in the study.

Recruiting Letter (Appendix I).

The recruiting letter described to the participants the purpose of the study, emphasized the voluntary nature of their participation, the anonymity and confidentiality of their responses, the time commitment required by participation, and the opportunity to obtain a summary of the results of the study.

Consent Form (Appendix J).

The consent form stated the topic of the research study, outlined the requirements for participation, assured the participant that no risk was involved, that participation was voluntary, anonymous and confidential, and provided the opportunity to receive a summary of the results of the study. This form was signed before participation in the study began.

Debriefing (Appendix K).

The debriefing reiterated that the main purpose of the study was to examine differences between battered and nonbattered women's expectations of and preferences

for liberal feminist, radical feminist, and cognitive therapy, explained the rationale for the study and discussed the major hypotheses of the study.

### Measures

#### Demographic Questionnaire (Appendix B)

This questionnaire assessed the age and education level of the participants, as well as whether or not they had previously gone to therapy. Additionally, the questionnaire assessed the nature of abuse. Physical and psychological abuse (see question 3, Appendix B) were assessed by means of the Conflict Tactics Scale (Straus, 1979). The CTS is a self-administered 15-item questionnaire designed to measure use of reasoning, verbal aggression, and violence in the family. Inter-item correlations for these three factors range from .44 to .91. Items 1 to 6 assess psychological violence, while items 7 to 15 assess physical aggression. This measure has also been shown to have construct validity in that high rates of verbal and physical aggression on the CTS are consistent with high rates of violence found in interview studies (Gelles, 1974). The presence of sexual abuse (see question 4, Appendix B) was assessed by asking the participant to respond “yes” or “no” to the following question based on the Canadian Criminal Code’s definition of sexual assault: “Has your current or former husband/partner ever forced you or attempted to force you into any sexual activity by threatening you, holding you down or hurting you

in some way?" Finally the demographic questionnaire inquired about which therapist depicted in the scripts the participant most wanted to see (i.e., "Favorite Therapist").

Questionnaire A (Appendix L)

Questionnaire A which is the Attitudes Toward Feminism and the Women's Movement Scale (FWM; Fassinger, 1994) assesses a person's subjective reactions to feminist ideology and the women's movement. It is a 10-item Thurstone attitudinal scale. For all 10 items participants were asked to respond on a 5-point scale from "strongly disagree" (1) to "strongly agree" (5). Five of the ten FWM items (2, 5, 7, and 9) were reverse-scored. Enns and Hackett reported a 2-week test-retest reliability of .81 for the FWM, while Fassinger (1994), in testing the internal consistency of the FWM, reported full-scale reliabilities of .90 for men, and .87 for women, with most individual item-total correlations above .60.

Expectations Questionnaire (Appendix M)

The Expectations Questionnaire is based on the Expectations About Counseling Scale - Brief (Expectations Version; EAC-B) by Tinsley (1982), and measures participants' expectations about counseling. It has 66 items to be answered on a 7-point Likert scale with response options that range from "not true" (1) to "definitely true" (5). The EAC-B consists of 18 subscales measuring expectations in four areas: (a) Client Attitudes and Behaviors; (b) Counselor Attitudes and Behaviors; (c) Counselor Characteristics; and (d) Counseling Process and Outcome.

For the purposes of this study, the scales of Counselor Attitudes and Behaviors, Counselor Characteristics and Counseling Process and Outcome and their associated subscales were used (see Appendix N for associated item numbers). Client Attitudes and Behaviors were not relevant to this study. Subscale scores were calculated by summing the responses to the items assigned to each subscale and dividing by the number of items. Scale scores were calculated by summing the subscale scores and dividing by the number of subscales. For instance, the subscale score for Attractiveness was obtained by summing the responses to items 1, 4, and 7 and dividing by 3.

Of the scales being used in this study, internal reliabilities range from .69 to .82 with a median of .76 (Tinsley, 1982). Two-month test-retest reliabilities for those scales used in this study range from .60 to .87 with a median of .72 (Tinsley, 1982). The correlation between scales on the EAC-B and the EAC-Full Form usually exceeds .85 (Tinsley, 1982). Construct validity for this instrument is provided by Tinsley and Westcot (1990) who gave the EAC-B to students and subsequently analyzed their cognitions to determine whether the instrument measured expectations about counseling or other related constructs (i.e., perception, preference, information). Each item elicited statements about expectations from 70% of the participants completing the EAC-B, whereas statements about other constructs occurred at a chance level.

Preferences Questionnaire (Appendix O)

The Preference Questionnaire is a modified version of the EAC-B to assess preferences, instead of expectations, for counseling (Tinsley & Benton, 1978). This was accomplished by changing the question stems from "I expect to..." to "I would like to...", and "I expect the counselor to..." to "I would like the counselor to..." The scales and subscales of interest in this study were identical to the EAC-B (Expectations version) above. Likewise, each subscale score were computed by averaging the item scores for that particular subscale.

Perceived Helpfulness (Appendix P)

The counselor's perceived helpfulness was measured in the Therapist Quality Questionnaire by the following item: "How helpful do you think this particular counselor would be in resolving your problems?" Participants recorded their responses on a Likert scale from "not at all helpful" (1), to "very helpful" (7).

Willingness to See (Appendix P)

Willingness to see the therapist was also measured in the Therapist Quality Questionnaire by the following item: "How willing would you be to see this particular counselor for your problems?" Participants recorded their responses on a Likert scale from "definitely not" (1) to "very willing" (7).

## Procedure

### Recruitment Phase

Participants were recruited from three sources: (1) the local women's shelter, (2) local mental health centers, and (3) the Lakehead University and Confederation College student population. During the first phase of recruitment, an introductory phone call was made to all agencies to establish an initial contact. They were informed of the purpose of the study (i.e., to examine therapy preferences and expectations of battered and nonbattered women), and asked if they were interested in receiving an information package containing further description of the study, and various forms. Agencies that indicated an interest received a package consisting of an introductory letter and a letter to the participants (see Appendices H & I, respectively), and in some cases, a copy of the study proposal. The ethics approval letter from the university was also forwarded to the agencies upon request.

The second phase of recruitment varied depending on the agency. If the agency was a shelter, the project was explained to the women during support group meetings (with an introduction by the group facilitator). If the agency did not serve battered women primarily, a letter explaining the project and requesting participation was left with a contact person to be disseminated to interested individuals. For participant recruitment at Lakehead University and Confederation College, the experimenter introduced the

purpose of the study verbally in several classes, and requested that interested students sign up for individual sessions.

### Experimental Phase

All experimental sessions were conducted on an individual basis at the various agencies, at Lakehead University, or at Confederation College. The experimenter greeted each participant and explained the purpose of the study as examining women's reactions to various types of counseling based on a limited amount of pretherapy information. Participants then filled out the informed consent form, followed by Questionnaire A: FWM. Following that, participants read a description of the counseling issue (see Appendix C) and then completed the Preference Questionnaire (see Appendix O) to assess therapy preferences regardless of therapy orientation. Participants then read one of the three counseling scripts (see Appendices D, E, or F), and completed the Expectations Questionnaire (see Appendix M), and Therapist Quality Questionnaire: Perceived Helpfulness and Willingness to See (see Appendix P). Subsequently, they read a second counseling script, filled out the measures (Expectations Questionnaire and Therapist Quality Questionnaire) a second time, followed by the third counseling script, and the measures a third time. The presentation of scripts was counterbalanced to avoid a bias due to the order of presentation. Participants were debriefed at the end of the experimental session (see Appendix K).

## CHAPTER 3

### Results

#### Experimental Manipulation Check

As mentioned earlier, each of the three counseling scripts underwent a manipulation check for theoretical orientation by two independent expert raters. Each script was evaluated on a 5-point Likert scale with respect to the following attributes: a) directiveness, b) self-disclosure, c) focus on internal/external factors, d) emphasis on social activism, and e) general representativeness of orientation. Table 1 shows the mean rating on all attributes for the cognitive, liberal feminist, and radical feminist therapist. As expected, the cognitive therapist scored high on directiveness, low on self-disclosure and emphasis on social activism, and acknowledged external factors but focused mainly on internal factors.

The liberal feminist therapist was rated as neither directive nor nondirective by one expert rater, and as mostly nondirective by the other expert rater, low on self-disclosure, focused on both internal and external factors, with a slight emphasis on internal factors, and low on emphasis on social activism.

Finally, the radical feminist therapist scored high on directiveness, moderately on self-disclosure, moderate to high on social activism, and acknowledged internal factors but focused mainly on external factors.

All three therapists were rated as being mostly representative of that type of therapy, and after suggested modifications had been made to the cognitive therapy script, it was rated as completely representative of that type of therapy by one of the expert raters (see Table 1).

### Sample Description

#### Sample Size

A total of 43 women participated in the study of which 23 were battered and 20 were nonbattered. Three of the participants from the battered group were excluded from the data analyses because no match on age and education from the group could be found. Thus, a total of 40 participants (20 battered and 20 nonbattered) were retained for analysis.

#### Age

Battered and nonbattered women were matched for age group. Five-year age groupings were used (see Table 2). The youngest participant fell within the 18-25 years age group while the oldest was within the 56-60 years age group. A majority of the women (30%) were between 31-35 years of age. The next largest group (20%) was between 46-50 years of age. A breakdown of age ranges and their frequencies is presented in Table 2.

### Education

Participants in the battered and nonbattered groups were also matched for level of education. As with age, categories of education were used in order to facilitate matching. Educational categories ranged from “Gr. 8 or less” to “College or university graduate”. The majority of the sample (85%) had at least some college or university education. A breakdown of the various categories of education and their frequencies is presented in Table 3.

### Abuse Experiences

Women identified themselves as battered or nonbattered. The nature of the abuse (physical, psychological, and sexual) was investigated by means of responses to items on the Conflict Tactics Scale (see Appendix B, q.3), and one separate item on sexual abuse (see Appendix B, p. 4). Table 4 presents a summary of the abuse experiences for women who identified themselves as battered and for those who identified themselves as nonbattered. The chi-square ( $\chi^2$ ) statistic was used to examine significant associations between abuse experiences and self-identification status (battered/nonbattered).

As can be seen in Table 3, all psychological abuse items (1 through 6) on the CTS differentiated battered from nonbattered women at an  $\alpha$  level of at least .001. At least 85% of battered women responded “yes” to each of these items with significantly lower percentages occurring in the nonbattered group (5-50%). Of particular interest are items 1 (“Insulted or swore at you”), and 4 (“Did or said something to spite you”) which

were experienced by 50% of the nonbattered women. When questioned as to whether they considered these behaviors to be abusive, most women in both the battered and nonbattered group indicated that such behaviors were not habitual, and thus considered to be part of the normal frustrations inherent in intimate relationships.

All of the physical abuse items (items 7 through 15), clearly discriminated between the women who identified themselves as battered or nonbattered. For the majority of these items, the difference between battered and nonbattered women was highly significant at an  $\alpha$  level of at least .001 (with the exception of the last item for which the  $\alpha$  was .05-see Table 4). In fact, for all of the physical abuse items except the second (item #8 of the CTS-see Appendix B), nonbattered women reported no occurrence at all. In addition, the separate question regarding sexual abuse clearly separated battered from nonbattered women, with 80% of the battered group and 0% of the nonbattered group responding “yes” to this item.

Together, these responses indicate that psychological, physical and sexual abuse were reported by significantly more women who identified themselves as battered than those who considered themselves nonbattered.

### Correlations between Scales

Table 5 presents the correlation matrix for all the scales examined in the current study. Correlations of .90 or higher pose the problem of multicollinearity, resulting in

possibly unstable multivariate solutions (Tabachnick & Fidell, 1996, p. 86). As shown in Table 5, the following pairs of variables were highly correlated: E-CPO-LF and E-CC-LF ( $r=.92$ ), E-CPO-RF and E-CC-RF ( $r=.96$ ), PH-RF and E-CC-RF ( $r=.90$ ), WS-LF and PH-LF ( $r=.92$ ), WS-RF and PH-RF ( $r=.93$ ). Tabachnick and Fidell suggested two strategies for dealing with multicollinearity: running highly correlated dependent variables in separate analyses, or using a composite score of the redundant variables (p. 86).

Therefore, a composite score named “Therapist Quality” was created by summing the scores for Willingness to See (WS) and Perceived Helpfulness (PH) within each of the three therapy conditions. Hence, there were three composite scores, “Therapist Quality”, for the cognitive, liberal feminist, and radical feminist within-subject condition. As for the remaining highly correlated pairs involving E-CPO and E-CC, these two scales were looked at in separate analyses because of conceptual differences between the scales. That is, although Counselor Characteristics (CC) and Counseling Process and Outcome (CPO) were highly related, they were assumed to be examining different features of therapy.

### Overview of the Analyses

#### Main Analyses

The design of the study was a 3 (within-subjects factor: Therapy Style) x 2 (between-subjects factor: Battering Status) with Attitudes Towards Feminism as a covariate. The following analyses were performed on the various scales:

1. A 3 (within) x 2 (between) MANCOVA on two scales: Expectations of Counselor Attitudes and Behaviors (E-CAB) and Expectations of Counselor Characteristics (E-CC).
2. A 3 (within) x 2 (between) repeated measures ANCOVA on Expectations for Counseling Process and Outcome (E-CPO).
3. A between subjects MANCOVA was performed on three scales: Preference for Counselor Attitudes and Behaviors (P-CAB), Preference for Counselor Characteristics (P-CC), and Preference for Counseling Process and Outcome (P-CPO). No within-subjects analysis was performed on these scales as preferences for therapy was assessed only once, prior to presentation of the therapy scripts.
4. A 3 (within) x 2 (between) ANCOVA on Therapist Quality.
5. Two chi-square analyses on Favorite Therapist

#### Post-hoc Analyses

For multivariate analyses, Pillai's criterion was used to see if significant differences existed between Battering Status or Therapy Style. Pillai's criterion was used as it is considered more robust than other criteria to violation of the homogeneity of the variance-covariance matrices assumption (Tabachnick & Fidell, 1996, p. 401).

Significant multivariate effects were followed up with discriminant function analysis and Roy-Bargman's stepdown analysis in order to determine which of the scales contributed

to the significant effects. Discriminant function analysis was used rather than univariate analysis of variance because of its ability to show the underlying dimensionality of the data (Borgen & Seling, 1978) and its ability to consider dependent variables which are intercorrelated (Haase & Ellis, 1987). Post-hoc Tukey's Honestly Significant Difference (HSD) tests were used to determine which therapy style differed from which one on the scales. The Tukey HSD test was chosen because it was designed primarily for use with equal sample sizes and it is generally regarded as the best procedure for controlling family-wise error rate (the probability that a group of conclusions will contain at least one Type I error) when all pairwise comparisons are being made among group means (Howell, 1992, p. 364).

For univariate analyses,  $F$ -tests were used to look for Battering Status or Therapy Style differences. Tukey's HSD tests were used as follow-up in order to determine where the differences occurred.

### Secondary Analyses

In order to look at differences between therapy preferences and expectations on CAB, CC, and CPO as a function of Battering Status and Therapy Style, nine separate paired sample  $t$ -tests were performed on the following pairs of variables: (P-CAB, E-CAB-C), (P-CAB, E-CAB-LF), (P-CAB, E-CAB-RF), (P-CC, E-CC-C), (P-CC, E-CC-LF), (P-CC, E-CC-RF), (P-CPO, E-CPO-C), (P-CPO, E-CPO-LF), and (P-CPO, E-CPO-RF).

### Pre-analysis Issues

#### Missing Data

Missing values on any questionnaire item were handled by substituting the group mean value for that item (Tabachnick & Fidell, 1996, p. 63). Group mean values were generated by the DESCRIPTIVES procedure of the Statistical Package for the Social Sciences (SPSS).

#### Univariate Outliers

Univariate outliers were detected through SPSS DESCRIPTIVES by requesting standardized scores for all dependent variables in each group. Standard score values greater than  $\pm 3.29$  were considered to be outliers (Tabachnick & Fidell, 1996, p. 67). No univariate outliers were detected. This was followed by an investigation for multivariate outliers.

#### Multivariate Outliers

Multivariate outliers within each group were examined using SPSS REGRESSION with participant number as a dependent variable (Tabachnick & Fidell, 1996, p. 68). (The participant number is independent of Battering Status). Two indices, Mahalanobis' distance and Cook's D, were used to identify influential outliers, defined as those scores with a Mahalanobis' distance greater than a critical cutoff value and a

Cook's D greater than one (Stevens, 1986, p. 94-95). No multivariate outliers were detected.

#### Assumptions for Univariate Analyses

Repeated measures ANCOVA assumes: i) that scores are normally distributed, ii) that within group variability is the same for each of the groups, iii) that scores are independent among groups (Girden, 1992), iv) homogeneity of regression, and v) independence of group and covariate.

The first assumption was not tested as the  $F$ -test is robust to violations of the normality assumption given a minimum of 20 degrees of freedom for the error term (Tabachnick & Fidell, 1996, p. 71). The ANOVAs on the E-CPO and the Therapist Quality variable met this requirement with 37 and 38 degrees of freedom respectively, for the term.

The second assumption, that of homogeneity of variance, was also not tested as the  $F$ -test has been shown to be robust to violations of this assumption as long as sample sizes are equal and the ratio between largest and smallest variance is smaller than 10:1 (Tabachnick & Fidell, 1996, p. 328). An examination of the within-group variance for the E-CPO variable showed this ratio to be approximately 2:1 while for the Quality of Therapist variable, this ratio was approximately 2:1.5.

As for the third assumption, random assignment to groups was not possible.

However, the presentation of the within-subjects variable (Therapy Style) was counterbalanced so as to ensure the assumption of independence of errors.

The fourth assumption, that of homogeneity of regression, was tested to ensure that there was no interaction between the independent variable (IV) and the covariate. This was accomplished by creating a product term from the IV (Battering Status) and the covariate (Attitudes Towards Feminism), and entering this variable as the last step in the SPSS REGRESSION-SEQUENTIAL procedure. Significance of this variable would indicate heterogeneity of regression (Tachnick & Fidell, 1996, p. 342). No significance emerged for either the E-CPO or the Quality of Therapist variable. The within-subjects factor was not tested as it was not a grouped variable.

The last assumption that was tested was that of independence of group (Battering Status) and covariate (Attitudes Towards Feminism). This was accomplished by means of a one-way ANOVA performed through the SPSS COMPARE MEANS procedure, with Attitudes Towards Feminism used as the dependent variable. No significant effect emerged. The within-subjects variable was not tested as it was not a grouped variable.

#### Assumptions for Multivariate Analyses

MANCOVA assumes: (i) multivariate normality, (ii) linearity, (iii) homogeneity of variance-covariance matrices, (iv) homogeneity of regression, and (v) independence of group and covariate.

The assumption of multivariate normality was examined using normal and detrended expected probability plots generated by SPSS MANOVA- REPEATED MEASURES for each dependent variable (Tabachnick & Fidell, 1996, p. 73). The assumption of linearity was examined through within-cell bivariate scatterplots generated by SPSS PLOT (Tabachnick & Fidell, 1996, p. 80). The assumption of homogeneity of variance-covariance matrices was tested through Box's M (Tabachnick & Fidell, 1996, p. 413) and found to be nonsignificant for all analyses. The assumptions of homogeneity of regression and independence of group and covariate were tested in the same manner as for the univariate analyses and found to be nonsignificant.

Repeated-measures MANCOVA makes the same assumptions as MANCOVA, with the exception that multisample sphericity is required rather than homogeneity of variance-covariance matrices. The assumption of multisample sphericity is a combination of two other assumptions, namely that 1) the population variance-covariance matrices for levels of the between-subjects factor (Battering Status) are equal, and 2) that their pooled matrix has a sphericity pattern (Girden 1992). Sphericity for the between-subjects factor (1) was tested by Box's M and found to be nonsignificant. Sphericity for the within-subjects factor (2) was not tested because robustness of multivariate tests to violation of this assumption is ensured if sample sizes are equal (Maxwell & Delaney, 1990, p. 675).

### Main Analyses

#### 1. Repeated Measures MANCOVA on E-CAB and E-CC

Given that the internal consistency (Cronbach's alpha) for three of the 33 subscales was below .70 (see Table 6), scale scores were used. Items on the Expectations About Counselor Attitudes and Behaviors (E-CAB) and Expectations About Counselor Characteristics (E-CC) scales were first checked for missing values as discussed above, followed by a check for univariate and multivariate outliers on the same scales. There were no missing values, nor were there any univariate or multivariate outliers on any of the dependent variables. Internal consistency (Cronbach's alpha) for the scales ranged from .76 for (E-CAB-RF) to .92 for (E-CC-LF-see Table 6).

A repeated measures MANCOVA as a function of Battering Status and Therapy Style was performed on the E-CAB and E-CC scales. The covariate (i.e., Attitudes Towards Feminism) had no significant effect. Thus, a repeated measures MANOVA was performed on the same scales, excluding the covariate. The results of the MANOVA are summarized in Table 7. A significant main effect of Therapy Style was found:  $F(4,35) = 9.70, p < .001$ . No other effects were significant. A discriminant function analysis yielded a canonical correlation coefficient of .73 for the discriminant function, indicating a moderate degree of association between the linear combination of E-CAB and E-CC, and Therapy Style. Structure loadings and stepdown  $F$ -tests showed that both E-CAB and E-CC made significant contributions to Therapy Style discrimination (see Table 8).

Post-hoc Tukey's Honestly Significant Difference (HSD) tests were performed on the scales to determine where the Therapy Style difference lay (see Table 9). They indicated that the mean for the radical feminist therapist was significantly higher ( $\underline{M} = 5.22$ ) than the mean for the cognitive therapist ( $\underline{M} = 4.83$ ), on the factor of E-CAB. The mean for the liberal feminist therapist fell in between ( $\underline{M} = 5.02$ ), but was not significantly different from either of the other two means (see Figure 1). With respect to E-CC, the opposite pattern emerged, with the mean for the cognitive therapist being significantly higher ( $\underline{M} = 5.40$ ) than the mean for the radical feminist therapist ( $\underline{M} = 4.75$ ). Once again, the mean for the liberal feminist therapist fell in between ( $\underline{M} = 5.28$ ), but was not significantly different from either of the other two means (see Figure 2).

## 2. Repeated Measures ANCOVA on E-CPO

Items on the Expectations About Counseling Process and Outcome (E-CPO) scales were first checked for missing values and then the scale itself was checked for outliers as discussed above. No missing values or univariate or multivariate outliers were found. Internal consistencies for this scale within each Therapy Style were as follows: cognitive ( $\alpha = .93$ ), liberal feminist ( $\alpha = .97$ ), and radical feminist ( $\alpha = .96$ ) (see Table 6).

A repeated measures ANCOVA as a function of Battering Status and Therapy Style was performed on E-CPO. Here again, there was no significant effect of the covariate. Therefore, the ANOVA was repeated without the covariate, yielding a main effect of Therapy Style:  $\underline{F}(2, 37) = 4.25, p < .05$ , (see Table 10). No other effects were

significant. The canonical correlation coefficient was .43, indicating a small relationship between E-CPO and Therapy Style. A post-hoc Tukey's HSD test (see Table 11) demonstrated that for E-CC, the mean for the cognitive therapist ( $M = 5.69$ ) was significantly higher than that for the radical feminist therapist ( $M = 4.71$ ). The mean for the liberal feminist therapist ( $M = 5.15$ ) fell between the other two means but was not significantly different from either of them (see Figure 3).

### 3. MANCOVA on P-CAB, P-CC, and P-CPO

Given that the internal consistency (Cronbach's alpha) for seven of the 14 subscales was below .70 (see Table 12), scale scores were used. Items on each of the three scales, Preference for Counselor Attitudes and Behaviors (P-CAB), Preference for Counselor Characteristics (P-CC), and Preference for Counseling Process and Outcome (P-CPO), were first checked for missing values. Then the scales themselves were checked for outliers as discussed above. There were no missing values, nor were there any univariate or multivariate outliers on any of the scales. Internal consistency (Cronbach's alpha) for the scales was as follows: .36 for P-CPO, .63 for P-CC, and .77 for P-CAB (see Table 12).

A multivariate analysis of covariance (MANCOVA) as a function of Battering Status was performed on all three scales: P-CAB, P-CC, and P-CPO. The covariate (i.e., Attitudes Towards Feminism) had no significant effect. Thus, a MANOVA was performed, excluding the covariate. This analysis produced no significant effects,

indicating that there was no significant difference between battered and nonbattered women with respect to preferences concerning Counselor Attitudes and Behaviors, Counselor Characteristics, or Counseling Process and Outcome.

#### 4. Repeated Measures ANCOVA on Therapist Quality

The items on the Therapist Quality scale were first checked for missing values and then the scale itself was examined for outliers. Missing values were detected for three cases and replaced with the group mean for that item. There were no univariate or multivariate outliers. A repeated measures ANCOVA as a function of Battering Status and Therapy Style was performed on the dependent variable of Therapist Quality, with Attitudes Towards Feminism as the covariate. The covariate again had no significant effect. Thus, a repeated measures ANOVA was performed, excluding the covariate. This analysis produced no significant effects. Therefore, neither Battering Status nor Therapy Style, nor the interaction between these two variables produced significant differences in women's ratings of Therapist Quality.

#### 5. Chi-square Analysis of Favorite Therapist

A chi-square analysis as a function of Battering Status was performed on the dependent variable of Favorite Therapist. There were no significant effect. Hence, a second chi-square analysis (pooled across Battering Status) was performed as a function of Therapy Style on the dependent variable of Favorite Therapist. A highly significant effect emerged:  $\chi^2(2, N = 40) = 18.05, p < .001$ . The cognitive therapist was favored by

66% ( $N = 25$ ) of the women, while the radical feminist therapist was favored by 18% ( $N = 7$ ), and the liberal feminist therapist was favored by 16% ( $N = 6$ ).

### Secondary Analyses

#### Paired t-tests for Differences Between Preferences and Expectations for Therapy Style on CAB, CC, and CPO

Individual preferences for and expectations of therapy among the women in the sample were compared in order to determine whether or not there was a significant difference between what women wanted and what they expected to get from the three different therapies. Because previous analyses (i.e., repeated measures ANOVA for Expectations and MANOVA for Preferences) showed no main effect of Battering Status, the scores of battered and nonbattered participants were pooled and examined together. Differences between preferences and expectations on CAB, CC, and CPO were investigated for each of the three therapists. Hence, nine separate  $t$ -tests for paired samples at an adjusted alpha level of .005 ( $\alpha = .05/9$ ) were performed on the following paired scales:

- 1) Preference for Counselor Attitudes and Behavior (P-CAB) and Expectations of Counselor Attitudes and Behavior for the cognitive therapist (E-CAB-C)

- 2) **P-CAB and Expectations of Counselor Attitudes and Behavior for the liberal feminist therapist (E-CAB-LF)**
- 3) **P-CAB and Expectations of Counselor Attitudes and Behavior for the radical feminist therapist (E-CAB-RF)**
- 4) **Preference for Counselor Characteristics (P-CC) and Expectations of Counselor Characteristics for cognitive therapist (E-CC-C)**
- 5) **P-CC and Expectations of Counselor Characteristics for liberal feminist therapist (E-CC-LF)**
- 6) **P-CC and Expectations of Counselor Characteristics for radical feminist therapist (E-CC-RF)**
- 7) **Preference for Counselor Process and Outcome (P-CPO) and Expectations of Counseling Process and Outcome for cognitive therapist (E-CPO-C)**
- 8) **P-CPO and Expectations of Counseling Process and Outcome for the liberal feminist therapist (E-CPO-LF)**
- 9) **P-CPO and Expectations of Counseling Process and Outcome for the radical feminist therapist (E-CPO-RF).**

The results of these comparisons are summarized in Table 13. As can be seen in Table 13, there were no significant differences between what women wanted in the way of Counselor Attitudes and Behaviors (P-CAB) and what they expected to get from any of

the three therapists (E-CAB-C, E-CAB-LF, and E-CAB-RF). However, significant differences did emerge across therapists with regard to both Counselor Characteristics (CC) and Counseling Process and Outcome (CPO). More specifically, for CC, women wanted more (P-CC) than they expected to get from either the liberal feminist (E-CC-LF) or radical feminist (E-CC-RF) therapists. No difference was found (at the adjusted alpha level of .005) for the cognitive therapist (E-CC-C). For CPO, women wanted more (P-CPO) than they expected to get from all three therapists (E-CPO-C, E-CPO-LF, E-CPO-RF). This difference was most pronounced for the radical feminist therapist and least pronounced for the cognitive therapist, with the liberal feminist therapist falling in between on both variables (see Table 13).

## CHAPTER 4

### Discussion

The main purpose of the present study was to examine battered and nonbattered women's expectations about three different kinds of therapy: cognitive, liberal feminist, and radical feminist. A second purpose was to examine the relationship between women's preferences for and expectations about therapy to see if women wanted more from therapy than they expected to get from the three therapists presented. In general, the results of this study do not support the notion that battered and nonbattered women differ in their expectations about or preferences for therapy. However, there is evidence that women (regardless of battering status) show a small but significant preference for the cognitive therapist over the radical feminist therapist. In this section, the findings of the study will be discussed in more detail, followed by a discussion of the research and clinical implications of the findings. Finally, limitations and contributions of the study will be outlined and new directions for future research in this area will be explored.

### Main Hypotheses

Five hypotheses were advanced in order to examine battered and nonbattered women's preferences for and expectations about therapy. Battered women were expected to differ from nonbattered women with respect to general therapy preferences (hypothesis 1). In addition, when presented with examples of three different kinds of therapy,

battered women were hypothesized to differ from nonbattered women in the following ways: expectations about the counselor attitudes and behaviors, counselor characteristics, counseling process and outcome would be highest for the liberal feminist therapist with battered women and highest for the cognitive therapist with nonbattered women (hypothesis 2). Furthermore quality of the therapist (i.e., perceived helpfulness and willingness to see) would be highest for the liberal feminist therapist with battered women and highest for the cognitive therapist with nonbattered women (hypotheses 3 and 4, respectively). Finally, it was predicted that for battered women, general therapy preferences would most closely match their expectations for the liberal feminist therapist, while for nonbattered women, general therapy preferences would most closely match their expectations of the cognitive therapist (hypothesis 5).

As the results of this study indicated, the battered women did not differ significantly from the nonbattered women on any of these dimensions. Given the preponderance of literature looking at the differences in personality and coping styles between battered and nonbattered women (Forte, Franks, Forte, & Rigsby, 1996; Nurius, Furrey, & Berliner, 1992; Rhodes, 1992; Schwartz & Mattley, 1993; Wilson, et al., 1992), and the wide variety of therapies that have been specifically developed/modified for use with female victims of domestic violence (Douglas & Strom, 1988; Hartman, 1987; Pressman, 1989b; Register, 1993; Walker, 1984, 1985; Worell & Remer, 1992), it was most surprising to find that battered women did not significantly differ from nonbattered

women in their preferences for and/or expectations about certain qualities in a therapist. There are several possible explanations for these findings.

One possible explanation is that battered and nonbattered women simply do not differ with respect to therapy preferences and/or expectations. Although the circumstances which lead them to seek therapy or the issues that they may have to deal with in therapy may indeed be very different, both groups may be looking for the same general qualities in a therapist. Frank (1982) posits that people seek psychotherapy not for symptoms alone, but also for their state of demoralization, coupled with cognitive unclarity. He suggests that there is a shared distress felt by clients that is responsive to certain common elements of psychotherapy. These are: 1) a confiding relationship with a helping person, 2) a healing setting, 3) a plausible explanation for the client's symptoms, and 4) a ritual, practiced by both the client and therapist, that is believed by both to help the client. Perhaps it is these common elements which both battered and nonbattered women seek from psychotherapy, in addition to relief from their specific situation.

An alternative explanation of the findings has to do with previous exposure to therapy. The majority (85%) of participants, regardless of battering status, were previously or currently in therapy. In addition, the sampling region (i.e., Thunder Bay) is fairly small, and likely offers a smaller variety of therapy types, when compared to some of the more metropolitan areas in which other therapy studies were conducted. Therefore,

a possible conclusion is that, because most of the participants (both battered and nonbattered) were currently in therapy or had been at some time in the past, and were probably being exposed to limited forms of therapy that were similar to one another, battered and nonbattered women may therefore have had similar ideas about what was preferable or expected in therapy, based on their own experiences.

A final explanation for the findings concerns the materials used in the study. In order to be applicable to both battered and nonbattered women, neither the counseling vignettes nor the scales used to measure preferences and expectations in this study directly addressed the issue of battering. In the counseling vignettes, the related but more general issue of deciding whether or not to leave an unhappy relationship was used. In an attempt to obtain responses as they applied specifically to battered and nonbattered women, participants were asked to pretend that they were going to see the counselor for their own issues when responding to the preference and expectations questionnaires. However, the scales measuring preferences and expectations used very general items such as, "I would like/expect the counselor to help me solve my problems," and "I would like/expect to gain some experience in new ways of solving problems within the counseling process". Thus, it would have been possible for both battered and nonbattered women to rate these items highly, with different problems in mind. Replication of this study in a larger city, using measures which assess more specific aspects of therapy (e.g., separately measuring each of the subscales on the CAB scale: acceptance, confrontation,

directiveness, empathy, genuineness, nurturance, and self-disclosure) would help to determine which of the preceding explanations is most plausible.

In addition to the findings concerning battered versus nonbattered women, the study also revealed some interesting findings regarding all of the women's expectations about the three types of therapy: cognitive, liberal feminist, and radical feminist. More specifically, the cognitive therapist was rated significantly higher than the radical feminist therapist on expectations about counselor characteristics and counseling process and outcome while the radical feminist therapist was rated significantly higher than the cognitive therapist on expectations about counselor attitudes and behaviors. The ratings for the liberal feminist therapist fell in between, but were not significantly different from those of the other two therapists on any of these scales. All three therapists were rated equally in terms of quality (i.e., perceived helpfulness and willingness to see), although the cognitive therapist was rated as the favorite therapist overall by both battered and nonbattered women. Finally, the discrepancy between what women wanted to get from therapy (i.e., preference) and what they expected to get from a given therapist was smallest for the cognitive therapist, and largest for the radical feminist therapist.

With respect to expectations about counselor characteristics (comprised of items assessing therapist attractiveness, expertise, tolerance, and trustworthiness) and counseling process and outcome (comprised of items assessing concreteness, immediacy, and outcome), the cognitive therapist was rated more highly than the radical feminist

therapist. In other words, all women in this study expected that the counselor characteristics and the counseling process and outcome items presented, most accurately described the cognitive therapist, and least accurately described the radical feminist therapist, with the liberal feminist therapist falling in between. This finding stands in contrast to the findings of Enns and Hackett (1990) who found that both the liberal feminist and radical feminist therapists were rated higher in terms of expertness and trustworthiness when compared to a nonsexist-humanist therapist.

A possible reason for the disparity in findings is that Enns and Hackett (1990) used a different measure, specifically designed to measure only counselor attractiveness, expertness, and trustworthiness, while the current study used a more general measure of counselor characteristics which included expertness and trustworthiness. Another possible explanation of the findings is that feminist therapists were rated as more attractive, expert, and trustworthy when compared to a humanistic therapist (the therapy style used for comparison in the Enns & Hackett study), but not when compared to a cognitive therapist (the therapy style used for comparison in the current study).

More in line with Enns and Hackett's findings are the results on expectations about counselor attitudes and behaviors, for which the radical feminist therapist was rated higher than the cognitive therapist, with the liberal feminist therapist falling in between. In other words, women expected that the counselor attitudes and behaviors factor (comprised of items measuring acceptance, confrontation, directiveness, empathy,

genuineness, nurturance, and self-disclosure) most accurately described the radical feminist therapist, and least accurately described the cognitive therapist, with the liberal feminist therapist falling in between.

It is curious that women's ratings of the three therapists on counselor attitudes and behaviors differed in direction from women's ratings of the therapists for all other aspects of therapy examined in this study. Since this variable contained subscales measuring self-disclosure, confrontation, and directiveness, it is possible that the radical feminist therapist (the only therapist to self-disclose) was perceived as more confrontational and directive than the cognitive therapist and therefore received higher ratings on this scale.

In contrast to findings on expectations about therapy, there were no significant differences in women's ratings of therapist quality (i.e., a combination of perceived helpfulness and willingness to see the therapist), meaning that women perceived the three therapists as equally helpful and were equally willing to see each of them. Thus, it seems that although women expected different things from each of the three therapists, they felt that they were equal in terms of quality. It should be noted however, that when asked which therapist was their favorite, the majority of the women (66%) chose the cognitive therapist.

The fact that all of the women in the sample preferred the same kinds of qualities in a therapist or therapy, in conjunction with the fact that they expected different things from the three therapists, suggests that there is some value in investigating how closely

the women's expectations of a therapist/therapy matched their preferences. For example, if a woman rated her expectations about the cognitive therapist more highly than her expectations about the radical feminist therapist, one might predict that her expectations about the cognitive therapist would more closely resemble her preferences for therapy in general than would those about the radical feminist therapist. That is, to some extent, what the results indicated.

Differences between preference for and expectations about therapy were examined for the total sample. With respect to counselor characteristics (which looked at therapist attractiveness, expertise, tolerance, and trustworthiness), women expected the cognitive therapist to possess more of these characteristics than the radical feminist therapist, with the liberal feminist therapist falling in between. This result is not surprising when preference for these characteristics is taken into consideration. Women's preferences for counselor characteristics were most closely matched to their expectations of the cognitive therapist, followed by the liberal feminist therapist, and least closely matched to their expectations of the radical feminist therapist. Thus, it would seem plausible that women had more positive expectations about the cognitive therapist because she more closely approximated what they preferred in a therapist, and less positive expectations about the radical feminist therapist because she least closely approximated their preferences.

Findings were in the same direction for counseling process and outcome (which looked at concreteness, immediacy, and outcome), except that women expected less than

they wanted to get from all three therapists. It is not surprising that women expected a less positive counseling process and outcome, given that previous research with students has shown that they generally want more than they expect to get, especially with respect to outcome (Tinsley & Benton, 1978).

### Research and Clinical Implications

Before beginning a discussion of the implications of the findings, it is important to discuss the difference between statistical significance and clinical meaningfulness. A finding may be statistically significant but have a small effect size and therefore may have limited clinical meaningfulness. In the current study, the finding that women have different expectations about the counselor attitudes and behaviors and counselor characteristics of the three therapists, accounted for a fairly large portion of the variance in participants' responses (52.6%), while the finding that women have different expectations about counseling process and outcome with the three therapists, accounted for a smaller portion of the variance in participants' responses (18.7%).

In addition to these moderate effect sizes, the findings were very consistent for most variables. That is to say, regardless of whether or not the findings were statistically significant, they were almost always in the same direction: the cognitive therapist was almost always rated more highly with respect to expectations than the liberal feminist therapist, and the liberal feminist therapist was almost always rated more highly than the

radical feminist therapist. Likewise, the discrepancies between preference and expectation were almost always smallest for the cognitive therapist, and greatest for the radical feminist therapist, with the liberal feminist therapist falling in between. Therefore, there is at least a possibility that the differences between women's expectations of the three therapists are clinically meaningful, and therefore a discussion of the clinical implications of the findings is warranted. However, it should be remembered that differences between expectations, and the discrepancy between preference and expectations, though significant for some scales, was fairly small for all therapists and should therefore be interpreted as relative differences.

It is intuitively appealing to think that battered women might bring their own unique set of desires and expectations to therapy, given their experiences. But such was not the case, at least for this sample of battered women. Since little research has been done in the area of women's preferences for and/or expectations about different kinds of therapy, the first clinical implication of these findings is that more effort has to be put into researching what battered women's preferences and needs for therapy are before new, potentially irrelevant models of treatment are developed.

Assuming that further research produces a similar pattern of results, therapies aimed at helping abused women need to go beyond analyzing the experience of abuse. Of course, it is certainly not recommended that those aspects of psychotherapy unique to a battered client (i.e., development of a safety plan) be discarded or given a low priority.

But rather than focusing solely on the fact that the woman is a victim/survivor of a battering relationship, therapists may need to place more emphasis on the common experiences of psychotherapy clients.

With respect to the findings about feminist therapy, several clinical implications are also evident. There are many general models of feminist therapy (Brody, 1987; Rosen & Stith, 1993; Rosewater & Walker, 1985) and also many models of feminist therapy specifically aimed at or modified for the treatment of battered women (Cameron & Rothery, 1989; Harway & Hansen, 1993; Pressman, 1989b; Worell and Remer, 1992). Yet, several of the principles of feminist therapy seem at odds with the preferences of both the battered and nonbattered women in this study. For example, Pressman (1989a) asserts that feminist therapists must have an “awareness of the necessity of bringing a feminist analysis to each woman’s current situation....Willingness ...to spell out his or her own values to women seeking their guidance [and] Willingness of the therapist to make use of self-disclosure as it relates to shared experiences” (p. 43). Perhaps however, a feminist analysis of their problem or the use of self-disclosure on the part of the therapist are out of sync with the preferences and expectations of both battered and nonbattered women. If further research were to confirm these observations, the principles of feminist therapy should then modified in some way to more effectively serve the populations they were developed for. However, it must be realized that the feminist therapies presented in this particular study are certainly not representative of all forms of feminist therapy. Not

all feminist therapies focus on self-disclosure. For instance, Rosen and Stith (1993) present a model of treatment which approximates the liberal feminist in this study in that, although hierarchical social structures and the socialization process are recognized and highlighted, the change strategy is individual with a three-tiered focus on safety of the client, development of new perspectives, and the strengthening of social supports.

The generally positive findings concerning the cognitive therapist are encouraging, given the mounting empirical evidence for the effectiveness of short-term cognitive therapy in a variety of areas (Cooper, Sober, & Fleming, 1996; Matheny, Brack, McCarthy, & Renick, 1996; Nelson-Gray, et al., 1996; Otto, Gould, & McLean, 1996). Douglas and Strom (1988) present a model of cognitive therapy for battered women which focuses on identifying and replacing those dysfunctional cognitions which function as vulnerability factors. The major clinical implication of women's preference for cognitive therapy is one of practicality. Short-term, solution-focused cognitive therapy is increasingly becoming the treatment of choice in a wide variety of institutions offering mental health services. In Canada, the implementation of employee assistance programs (which include short-term therapy that is paid by the employees) is growing at an impressive rate (MacDonald & Dooley, 1990, 1991; MacDonald & Wells, 1994). Although not a sufficient reason to choose one therapy over another, financial constraints are a consideration for many battered women, who do not always have access to family finances. Nevertheless, much like the feminist therapies presented in this study, the

cognitive therapy script is not necessarily representative of the wide array of cognitive therapies in use. For instance, rational-emotive therapy may be much more directive, even confrontational than the form of cognitive therapy presented here. Thus, caution in interpretation is warranted.

To summarize, the differences found in this study are of moderate size and consistent. Battered women in this study did not differ from nonbattered women with respect to therapy preferences or expectations. Important clinical implications of this finding are two-fold: 1) more research on women's preferences for therapy needs to be conducted prior to the development of new therapies, and 2) current therapies for battered women need to incorporate a heavier emphasis on the common distress felt by all psychotherapy clients. The radical feminist therapist was rated the least positively by all women and the discrepancies between preference and expectation were greatest with respect to her. It is difficult to make definitive conclusions about the liberal feminist therapist as she was not rated as significantly different from either the cognitive or the radical feminist therapist. These findings suggest that feminist therapists need to modify or further research the desire for some of their principles. Findings concerning the cognitive therapist are encouraging and have both theoretical and practical significance.

**Limitations and Contributions of the Study and Suggestions for Future Research**

As with all new areas of research, the results of this study must be interpreted with caution for a number of reasons. While every attempt was made to answer participants' questions and to ensure an adequate understanding of the questionnaire items, there is always some question as to the reliability and validity of self-report measures, which are open to a variety of biases, such as a social desirability response set or interviewer bias (Cozby, 1985). In addition, while practical, the use of a within-subjects design carries the risk of practice, carryover, and fatigue effects, and has been questioned with respect to its use in psychotherapy research specifically (Maxwell & Delaney, 1990). However, presentation of therapy scripts was counterbalanced in order to minimize these possible negative effects.

There are several additional aspects of this study which may limit its generalizability. First, the majority of participants (85%) had completed at least some college or university. Education at the postsecondary level may include exposure to information concerning both battering and therapy, which might differentiate the responses of battered women in college or university from those of battered women with a secondary school education or less. Also, due to the fact that many participants were recruited in shelters or at support groups, most of the battered women in this study had already left the battering relationship. Thus, these responses might reflect the opinions of a subset of battered women, (i.e., those who seek help from shelters or other mental

health agencies), and may not be representative of women who choose to remain in an abusive relationship. The final methodological issue that might affect the generalizeability of the findings is the possible lack of representativeness of the therapists. Although all therapists were rated as representative of their orientation by at least two experts in the field, both cognitive and feminist therapy include a broad range of theoretical principles and techniques. It is not practical, or even possible to present every combination of techniques used in these therapies. Therefore, the results with respect to preferences and expectations, must not be taken as the final word on the subject.

A final caveat in interpreting the results: preferences for or expectations about therapy are not the same as therapy outcome and should not be interpreted as such. What a person likes about or expects to get out of therapy may not be related to how beneficial the therapy is for that person. The process of psychotherapy is often a difficult one, and may at times be unpleasant. For battered women in particular, who may or may not be in a state of psychological entrapment or denial, preferences and expectations for therapy may be very different from the reality of therapy itself. Consequently, the results of this study must not be interpreted as reflecting the effectiveness of cognitive, liberal feminist, or radical feminist therapy. Rather, they should be interpreted as the opinions of potential clients when exposed to a limited amount of information about certain forms of therapy, not unlike what one might encounter when initially seeking therapy.

Despite the limitations, this study made two important contributions to the literature on battered women and therapy. First, it represents one of the first attempts to look at specific forms of therapy that have been proposed for use with battered women through their eyes. To date, researchers have rarely sought the opinion of battered women in the development of therapies designed for them. As mentioned earlier, in the development or modification of therapies for battered women, it is essential that psychotherapists avoid imposing various forms of therapy deemed “effective” without first considering the victims’ responses to those forms of therapy. Although therapy preferences and expectations cannot be the only factors employed when determining the usefulness of a particular therapy, they certainly are an important consideration.

A second contribution of this study is a clarification of the terminology used to study women’s opinions about therapy. While previous studies have used terms such as preferences, perceptions, and expectations interchangeably, the current study carefully defined each and looked at the discrepancy between preference (what one wants from therapy), and expectation (what one expects or thinks he/she will get out of therapy). As the results indicate, there are often significant differences between what both battered and nonbattered women want out of therapy and what they expect to get from currently available therapies. If such subtleties are not attended to, researchers run the risk of misinterpreting the needs of all women in therapy. Thus, this study succeeds in revealing not only what women expect to get from currently available therapies, but what they

would like to see in therapy. This may serve as a useful guide in the development and implementation of new, perhaps more appropriate therapies for battered women.

There are several avenues of inquiry that should be pursued in order to build upon existing literature concerning battered women and therapy. As mentioned earlier, a replication of the current study in a metropolitan center, using measures which assess the subtler aspects of therapy would determine whether the similarity of responses between battered and nonbattered women represents a valid similarity or a spurious effect of methodological limitations. Furthermore, additional research should be conducted on the preferences and expectations of battered women for alternative types of therapy. For example, the therapies addressed in this study were all directive forms of therapy. However, women (and battered women especially) may respond more positively towards nondirective forms of therapy such as Rogerian client-centered therapy (Rogers, 1951). As well, a more naturalistic method of studying reactions to therapists/therapy that more realistically simulates the therapist/client interaction might provide more reliable information than that offered by the use of written therapy scripts.

A final avenue for future research is that of psychotherapy outcome studies for battered women. Building on what is known about the therapy preferences and expectations of battered women, the next logical step would be to look at their therapy outcome with respect to cognitive and feminist therapy. These studies could be conducted separately, with several forms of cognitive therapy in one study and several

forms of feminist therapy in another study. Another alternative would be a comparative study of therapy outcome with one form of cognitive therapy and one form of feminist therapy. Research on therapy outcome in addition to continued research on the therapy preferences/expectations of battered women could go a long way towards bridging the gap between the theoretical focus of the therapist/academic and the practical needs of the client.

References

Adams, D. C. (1988). Treatment models of men who batter: A profeminist analysis. In K. Yllo & M. Bograd (Eds.), Feminist perspectives on wife abuse (pp. 176-199). Beverly Hills, CA: Sage Publications.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Apfelbaum, D. (1958). Dimensions of transference in psychotherapy. Berkeley, CA: University of California Press.

Appleford, B. (1989). Family violence review: Prevention and treatment of abusive behavior. (Report no. R-03). Ottawa, ON.

Astin, M. C., Lawrence, K.J., & Foy, D. W. (1993). Posttraumatic stress disorder among battered women: Risk and resiliency factors. Violence and Victims, 8, 17-28.

Astin, M. C., Ogland-Hand, S. M., Coleman, E. M., & Foy, D. W. (1995). Posttraumatic stress disorder and childhood abuse in battered women: Comparisons with maritally distressed women. Journal of Consulting and Clinical Psychology, 63, 308-312.

Beasley, R., & Stoltenberg, C. D. (1992). Personality characteristics of male spouse abusers. Professional Psychology: Research and Practice, 23, 310-317.

Beck, A. T. (1972). Depression: Causes and treatment. Philadelphia, PA: University of Pennsylvania Press.

Bograd, M. (1984). Family systems approaches to wife battering: A feminist critique. American Journal of Orthopsychiatry, 54, 558-568.

Borgen, F. H., & Seling, M. J. (1978). Uses of discriminant analysis following MANOVA: Multivariate statistics for multivariate purposes. Journal of Applied Psychology, 63, 689-697.

Brown, A. (1987). When battered women kill. New York: Free Press.

Buss, D. (1994). The evolution of desire: Strategies of human mating. New York, NY: Basic Books.

Campbell, J., & Humphreys, J. (1993). Nursing care of survivors of family violence. St. Louis, Missouri: Mosby-Year Book, Inc.

Canadian Panel on Violence Against Women. (1993). Changing the landscape: Ending violence, achieving equality (Catalogue No. SW45-1/1993E). Ottawa, ON: Minister of Supply and Services Canada.

Cannon, J. B., & Sparks, J. S. (1989). Shelters - An alternative to violence: A psychosocial case study. Journal of Community Psychology, 17, 203-213.

Caplan, P. (1985). The myth of women's masochism. New York: NAL-Dutton.

Carden, A. D. (1994). Wife abuse and the wife abuser: Review and recommendations. The Counseling Psychologist, 22, 539-582.

Chambless, D. L., & Wenk, N. M. (1982). Feminist vs. nonfeminist therapy: The client's perspective. Women & Therapy, 1(2), 57-65.

Coleman, D. H., & Straus, M. A. (1986). Marital power, conflict, and violence. Violence and Victims, 1, 141-157.

Coleman, K. (1980). Conjugal violence: what 33 men report. Journal of Marital and Family Therapy, 6, 207-213.

Cooper, P. J., Sober, S., Fleming, C. (1996). An evaluation of the efficacy of supervised cognitive-behavioral self-help for bulimia nervosa. Journal of Psychosomatic Research, 40, 281-287.

Cozby, P. C. (1985). Methods in behavioral research. Palo Alto, CA: Mayfield Publishing Company.

Deutsch, H. (1945). The psychology of women. (Vols. 1-2). New York: Grune & Stratton.

Dobash, R. E., & Dobash, R. (1979). Violence against wives. New York, NY: The Free Press.

Douglas, M. A., & Strom, J. (1988). Cognitive therapy with battered women. Journal of Rational-Emotive and Cognitive-Behavior Therapy, 6(1/2), 33-49.

Dutton, D. G. (1988). The domestic assault of women. Vancouver: University of British Columbia Press.

Dutton, D. G. (1995). The batterer. New York, NY: BasicBooks.

Dutton, D. G., & Painter, S. (1993). The battered woman syndrome: Effects of severity and intermittency of abuse. American Journal of Orthopsychiatry, 63, 614-622.

Dutton, M. A. (1992). Empowering and healing the battered woman: A model for assessment & intervention. New York, NY: Springer Publishing Company.

Dutton, M. A. & Goodman, L. A. (1994). Posttraumatic stress disorder among battered women: Analysis of legal implications. Behavioral Sciences and the Law, 12, 215-234.

Dutton-Douglas, M. A., & Walker, L. E. A. (1988). Introduction to feminist therapies. In M. A. Dutton-Douglas & L. E. A. Walker (Eds.), Feminist psychotherapies: Integration of therapeutic and feminist systems (pp. 3-11). Norwood NJ: Ablex.

Elliot, F. (1977). The neurology of explosive rage: The episodic dyscontrol syndrome. In M. Roy (ed.), Battered women: A psychosociological study of domestic violence (pp. 97-109). New York, NY: Van Nostrand.

Else, L., Wonderlich, S. A., Beatty, W. W., Christie, D. W., & Staton, R. D. (1993). Personality characteristics of men who physically abuse women. Hospital and Community Psychiatry, 44, 54-58.

Enloe, E. (1988). Does khaki become you? The militarization of women's lives. CITY: Pandora Publishers.

Enloe, E. (1993). The right to fight: A feminist catch-22. Ms., 4, 84-87.

Enns, C. Z. (1993). Twenty years of feminist counseling and therapy: From naming biases to implementing multifaceted practice. The Counseling Psychologist, 21, 3-87.

Enns, C. Z., & Hackett, G. (1990). Comparison of feminist and nonfeminist women's reactions to variants of nonsexist and feminist counseling. Journal of Counseling Psychology, 37, 33-40.

Enns, C. Z., & Hackett, G. (1993). A comparison of feminist and nonfeminist women's and men's reactions to nonsexist and feminist counseling: A replication and extension. Journal of Counseling & Development, 71, 499-509.

Epperson, D. L., & Lewis, K. N. (1987). Issues of informed entry into counseling: Perceptions and preferences resulting from different types and amounts of pretherapy information. Journal of Counseling Psychology, 34, 266-275.

Fassinger, R. (1994). Development and testing of the attitudes toward feminism and the women's movement (FWM) scale. Psychology of Women Quarterly, 18, 389-402.

Felthous, A. R., & Bryant, S. (1991). The diagnosis of intermittent explosive disorder in violent men. Bulletin of the American Academy of Psychiatry and Law, 19, 71-79.

Follingstad, D. R., Neckerman, A. P., & Vormbrock, J. (1988). Reactions to victimization and coping strategies of battered women: The ties that bind. Clinical Psychology Review, 8, 373-390.

Forte, J. A., Franks, D. D., Forte, J. A., & Rigsby, D. (1996). Asymmetric role-taking: Comparing battered and nonbattered women. Social Work, 41, 59-73.

Foy, D. W. (1992). Treating PTSD: Cognitive-behavioral strategies. New York, NY: Guilford Press.

Frank, J. D. (1959). The dynamics of the psychotherapeutic relationship. Psychiatry, 22, 17-39.

Frank, J. D. (1982). Therapeutic components shared by all psychotherapies. In J. H. Harvey & M. M. Parks (Eds.) The master lecture series, volume 1. Psychotherapy research and behavior change. Washington, DC: American Psychological Association.

Freud, S. (1971) A child is being beaten. In J. Strachey (Ed.), The complete works of Sigmund Freud (Vol XVII, pp. 179-204). London: The Hogarth Press and The Institute of Psycho-analysis.

Galassi, J. P., Crace, R. K., Martin, G. A., James, R. M., & Wallace, R. L. (1992). Client preferences and anticipations in career counseling: A preliminary investigation. Journal of Counseling Psychology, 39, 46-55.

Gelles, R. J. (1974). The Violent Home: A Study of Physical Aggression Between Husbands and Wives. Beverly Hills, CA: Sage Publications, Inc.

Gelles, R. J., & Straus, M. A. (1988). Intimate violence. New York: Simon & Schuster.

Girden, E. R. (1992). ANOVA: Repeated Measures. (Sage University Paper Series on Quantitative Applications in the Social Sciences, series no. 07-084). Newbury Park, CA: Sage Publications, Inc.

Glidden, C. E., & Tracey, T. J. (1989). Women's perceptions of personal versus sociocultural counseling interventions. Journal of Counseling Psychology, 36, 54-62.

Gondolf, E. W. (1988). Who are those Guys? Toward a behavioral typology of batterers. Violence and Victims, 3, 187-203.

Grant, C. A. (1995). Women who kill: The impact of abuse. Issues in Mental Health Nursing, 16, 315-326.

Greene, A. F., Coles, C. J., & Johnson, E. H. (1994). Psychopathology and anger in interpersonal violence offenders. Journal of Clinical Psychology, 50, 906-912.

Haase, R. F., & Ellis, M. V. (1987). Multivariate analysis of variance. Journal of Counseling Psychology, 34, 404-413.

Hackett, G., Zetzer, H. A., & Enns, C. Z. (1992). Reactions of women to nonsexist and feminist counseling: Effects of counselor orientation and mode of information delivery. Journal of Counseling Psychology, 39, 321-330.

Hansen, M. (1992). Feminism and family therapy: A review of feminist critiques of approaches to family violence. In M. Hansen & M. Harway (Eds.), Battering and family therapy: A feminist perspective (pp. 69-81). Newbury Park, CA: Sage Publications.

Hansen, M., & Harway, M. (1992). Battering and family therapy: A feminist perspective. Newbury Park, CA: Sage Publications.

Hartman, S. (1987). Therapeutic self-help group: A process of empowerment for women in abusive relationships. In V. Franks (Series Ed.) & C. Brody (Vol. Ed.), Focus on women: Vol. 10. Women's therapy groups: Paradigms of feminist treatment (pp. 67-81). New York, NY: Springer Publishing Company.

Harway, M. (1993). Battered women: Characteristics and causes. In M. Hansen, & M. Harway (Eds.), Battering and family therapy: A feminist perspective (pp. 29-41). Newbury Park, CA: Sage Publications.

Herman, J. L. (1992). Trauma and recovery. New York, NY: Basic Books.

Hershorn, M., & Rosenbaum, A. (1991). Over- vs. undercontrolled hostility: Application of the construct to the classification of maritally violent men. Violence & Victims, 6, 151-158.

Hoffman, L. (1981). Foundations of family therapy. New York, NY: BasicBooks.

Hoffman, P. (1984). Psychological abuse of women by spouses and live-in lovers. Women and Therapy, 3, 37-47.

Horney, K. (1935). The problem of feminine masochism. In J. B. Miller (Ed.), Psychoanalysis and women (pp. 21-38). Baltimore, MA: Penguin Books.

Hotaling, G. T., & Sugarman, D. B. (1986). An analysis of risk markers in husband to wife violence: The current state of knowledge. Violence and Victims, 1, 101-124.

Housecamp, B. M. & Foy, D. W. (1991). The assessment of posttraumatic stress disorder in battered women. Journal of Interpersonal Violence, 6, 367-375.

Howell, D. C. (1992). Statistical methods for psychology (3rd ed.). Boston, MA: PWS-Kent Publishing Company.

Jackson, G. G. (1987). Cross-cultural counseling with Afro-Americans. In P. Pedersen (Ed.), Handbook of cross-cultural counseling and therapy (pp. 231-237). New York, NY: Praeger.

Johnson, H., & Sacco, V. F. (1995). Researching violence against women: Statistics Canada's national survey. Canadian Journal of Criminology, 37, 281-304.

Kalmuss, D. S. (1984). The intergenerational transmission of marital aggression. Journal of Marriage and the Family, 46, 11-19.

Kantor, G. K., & Straus, M. A. (1987). The "drunken bum" theory of wife beating. Social Problems, 34, 213-230.

Kantrowitz, R. E., & Ballou, M. (1992). A feminist critique of cognitive-behavioral therapy. In L. S. Brown, & M. Ballou (Eds.), Personality and psychopathology: Feminist reappraisals (pp. 70-87). New York, NY: Guilford Press.

Kaser-Boyd, N. (1993). Rorschachs of women who commit homicide. Journal of Personality Assessment, 60, 458-470.

Kemp, A., Green, B. L., Hovanitz, C., & Rawlings, E. I. (1995). Incidence and correlates of posttraumatic stress disorder in battered women: Shelter and community samples. Journal of Interpersonal Violence, 10, 43-55.

Kemp, A., Rawlings, E. I., & Green, B. L. (1991). Post-traumatic stress disorder (PTSD) in battered women: A shelter sample. Journal of Traumatic Stress, 4, 137-148.

Kreuz, L. E., & Rose, R. M. (1972). Assessment of aggressive behavior and plasma testosterone in a young criminal population. Psychosomatic Medicine, 34, 321-332.

Kroll, P. D., Stock, D. F., & James, M. E. (1985). The behavior of adult alcoholic men abused as children. The Journal of Nervous and Mental Disease, 173, 689-693.

Lerman, H. (1992). The limits of phenomenology: A feminist critique of the humanistic personality theories. In L. S. Brown, & M. Ballou (Eds.), Personality and psychopathology: Feminist reappraisals (pp. 8-19). New York, NY: Guilford Press.

Levit, H. I. (1991). Battered women: Syndrome versus self-defense. American Journal of Forensic Psychology, 9, 29-35.

Lewis, E. (1983). The group treatment of battered women. Women & Therapy, 2, 51-58.

Lewis, K. N., Foley, J., & Epperson, D. L. (1989). Informed entry into counseling: Client's perceptions and preferences resulting from different types and amounts of pretherapy information. Journal of Counseling Psychology, 36, 279-285.

Lewis, K. N., Lesmeister, R., & Davis, C. S. (1983). Pretherapy information: An investigation of client responses. Journal of Counseling Psychology, 30, 108-112.

Macdonald, S., & Dooley, S. (1990). Employee Assistance Programs: Emerging trends. Canadian Journal of Community Mental Health, 9, 97-105.

MacDonald, S., & Dooley, S. (1991). The nature and extent of employee assistance programs and drug screening programs in Canadian transportation companies. Employee Assistance Quarterly, 6(4), 23-40.

MacDonald, S., & Wells, S. (1994). The prevalence and characteristics of employee assistance, health promotion and drug testing programs in Ontario. Employee Assistance Quarterly, 10, 25-60.

Maiuro, R. D., Cahn, T. S., Vitaliano, P. P., Wagner, B. C., & Zegree, J. B. (1988). Anger, hostility, and depression in domestically violent versus generally

assaultive men and nonviolent control subjects. Journal of Consulting and Clinical Psychology, 56, 17-23.

Martin, J. C. (1996). Martin's Annual Criminal Code (1997). Toronto, ON: Canada Law Book.

Matheny, K. B., Brack, G. L., McCarthy, C. J., Renick, J. M. (1996). The effectiveness of cognitively-based approaches in treating stress-related symptoms. Psychotherapy, 33, 305-320.

Maxwell, S. E., & Delaney, H. D. (1990). Designing experiments and analyzing data: A model comparison perspective. Belmont, CA: Wadsworth Publishing Company.

McHugh, M. C. (1993). Studying battered women and batterers: Feminist perspectives on methodology. In M. Hansen & M. Harway (Eds.), Battering and family therapy: A feminist perspective (pp. 54-68). Newbury Park, CA: Sage Publications.

Mimick-Chalmers, C. (1986). A study of college women: Androgyny and perceptions of a feminist therapist. Sex Roles, 14, 281-286.

Murphy, C. M., Meyer, S. L., & O' Leary, K. D. (1994). Dependency characteristics of partner assaultive men. Journal of Abnormal Psychology, 103, 729-735.

Nelson-Gray, R. O., Johnson, D., Foyle, L. W., Daniel, S. S., et al. (1996). The effectiveness of cognitive therapy tailored to depressives with personality disorders. Journal of Personality Disorders, 10, 132-152.

Nurius, P. S., Furrey, J., & Berliner, L. (1992). Coping capacity among women with abusive partners. Violence and Victims, 7, 229-243.

Otto, M. W., Gould, R. A., McLean, R. Y. S. (1996). The effectiveness of cognitive-behavioral therapy for panic disorder without concurrent medication treatment: A reply to Power and Sharp. Journal of Psychopharmacology, 10, 254-256.

Persky, H., Smith, K. D., & Basu, G. P. (1971). Relation of psychologic measures of aggression and hostility to testosterone production in man. Psychosomatic Medicine, 33, 265-277.

Pressman, B. (1989a). Treatment of wife abuse: The case for feminist therapy. In B. Pressman, G. Cameron, & M. Rothery (Eds.), Intervening with assaulted women:

Current theory, research, and practice (pp. 21-45). Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers.

Pressman, B. (1989b). Wife-abused couples: The need for comprehensive theoretical perspectives and integrated treatment models. Journal of Feminist Family Therapy, 1, 23-43.

Prince, J. E., & Arias, I. (1994). The role of perceived control and the desirability of control among abusive and nonabusive husbands. The American Journal of Family Therapy, 33, 126-134.

Rawlings, E. I., & Carter, D. K. (1977). Feminist and nonsexist psychotherapy. In E. I. Rawlings & D. K. Carter (Eds.), Psychotherapy for women: Treatment towards equality (pp. 14-23). Springfield, IL: Charles C. Thomas.

Register, E. (1993). Feminism and recovering from battering: Working with the individual woman. In M. Hansen & M. Harway (Eds.), Battering and family therapy: A feminist perspective (pp. 93-104). New York, NY: Sage Publications.

Rhodes, N. R. (1992). Comparison of MMPI Psychopathic Deviation scores of battered and nonbattered women. Journal of Family Violence, 7, 297-307.

Robinson, F. P. (1950). Principles and procedures in student counseling. New York, NY: Harper & Row.

Rogers, C. R. (1951). Client-centered therapy: Its current practice, implications, and theory. Boston, MA: Houghton Mifflin.

Rosen, K. H., & Stith, S. M. (1993). Intervention strategies for treating women in violent dating relationships. Family Relations, 42, 427-433.

Rosenbaum, A., & Hoge, S. K. (1989). Head injury and marital aggression. American Journal of Psychiatry, 146, 1048-1051.

Rosenbaum, A., Hoge, S. K., Adelman, S. A., Warnken, W. J., Fletcher, K. E., & Kane, R. L. (1994). Head injury in partner-abusive men. Journal of Consulting and Clinical Psychology, 62, 1187-1193.

Rosewater, L. B. (1985). Schizophrenic, borderline, or battered? In L. B. Rosewater, & L. E. A. Walker (Eds.), Handbook of feminist therapy: Women's issues in psychotherapy (pp. 215-225). New York, NY: Springer Publishing Company.

Saunders, D. G. (1992). A typology of men who batter: Three types derived from cluster analysis. American Journal of Orthopsychiatry, 62, 264-275.

Saunders, D. G. (1994). Posttraumatic stress symptom profiles of battered women: A comparison of survivors in two settings. Violence and Victims, 9, 31-44.

Schneider, L. J. (1985). Feminist values in announcements of professional services. Journal of Counseling Psychology, 32, 637-640.

Schuller, R. A., & Vidmar, N. (1992). Battered woman syndrome evidence in the courtroom: A review of the literature. Special Issue: Expert Evidence, Law and Human Behavior, 16, 273-291.

Schultz, L. G. (1960). The wife assaulter. Journal of Social Therapy, 6, 103-112.

Schwartz, M. D., & Mattley, C. L. (1993). The Battered Woman Scale and gender identities. Journal of Family Violence, 8, 277-287.

Seligman, M. E. P. (1975). Helplessness: On depression, development and death. San Francisco: Freeman.

Snell, J. E., Rosenwald, R., and Robey, A. (1964). The wifebeater's wife: A study of family interaction. Archives of General Psychiatry, 11, 107-112.

Sommers, C. H. (1994). Who stole feminism? New York, NY: Simon & Schuster.

Stevens, J. (1986). Applied Multivariate Statistics for the Social Sciences. Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers.

Stith, S. M., & Farley, S. C. (1993). A predictive model of male spousal violence. Journal of Family Violence, 8, 183-201.

Straus, M. A. (1979). Measuring intra family conflict and violence: The Conflict Tactics (CT) Scales. Journal of Marriage and the Family, 41, 75-88.

Straus, M. A., Gelles, R. J., & Steinmetz, S. K. (1980). Behind closed doors: Violence in the American family. Garden City, NY: Anchor/Doubleday.

Symonds, M. (1975). Victims of violence: Psychological effects and after effects. American Journal of Psychoanalysis, 35, 19-26.

Tabachnick, B. G., & Fidell, L. S. (1996). Using multivariate statistics (3rd ed.). Northridge, CA: Harper Collins College Publishers.

Thorne-Finch, R. (1992). Ending the silence: The origins and treatment of male violence against women. Toronto: University of Toronto Press.

Tinsley, H. E. A. (1982). Expectations about counseling. Unpublished test manual, Southern Illinois University, Department of Psychology, Carbondale.

Tinsley, H. E. A., & Benton, B. L. (1978). Expectations and preferences in counseling. Journal of College Student Personnel, 19, 537-543.

Tinsley, H. E. A., Bowman, S. L., & Ray, S. B. (1988). Manipulation of expectancies about counseling and psychotherapy: Review and analysis of expectancy manipulation strategies and results. Journal of Counseling Psychology, 35, 99-108.

Tinsley, H. E. A., & Westcot, A. M. (1990). Analysis of the cognitions stimulated by the items on the Expectations About Counseling--Brief Form: An analysis of construct validity. Journal of Counseling Psychology, 37, 223-226.

Tutty, L. M., Bidgood, B. A., & Rothery, M. A. (1993). Support groups for battered women: Research on their efficacy. Journal of Family Violence, 8, 325-343.

Walker, L. (1979). The battered woman. New York, NY: HarperPerennial.

Walker, L. E. A. (1984). The battered woman syndrome. New York, NY: Springer.

Walker, L. E. A. (1985). Feminist therapy with victim/survivors of interpersonal violence. In L. B. Rosewater & L. E. A. Walker (Eds.), Handbook of feminist therapy: Women's issues in psychotherapy (pp. 203-214). New York, NY: Springer Publishing Company.

Walker, L. E. A. (1990). Terrifying love: Why battered women kill and how society responds. New York, NY: HarperPerennial.

Walker, L. E. A. (1991b). Post-traumatic stress disorder in women: Diagnosis and treatment of battered woman syndrome. Psychotherapy, 28, 21-29.

Wanigaratne, S., & Barker, C. (1995). Clients' preferences for styles of therapy. British Journal of Clinical Psychology, 34, 215-222.

Warren, J., & Lanning, W. (1992). Sex role beliefs, control, and social isolation of battered women. Journal of Family Violence, 7, 1-8.

Weitzman, J., & Dreen, K. (1982). Wife beating: A view of the marital dyad. Social Casework, 63, 259-265.

Wigmore, D. (1995). Violence in the workplace: It doesn't have to go with the job. Herizons, 8(4), 26-30, 42.

Wilson, K., Vercella, R., Brems, C., Benning, D., et al. (1992). Levels of learned helplessness in abused women. Women and Therapy, 13(4), 53-67.

Wilson, L. (1991). Strategies for change in Christian churches. Canadian Woman Studies, 12, 109.

Woods, S. J. & Campbell, J. C. (1993). Posttraumatic stress in battered women: Does the diagnosis fit? Issues in Mental Health Nursing, 14, 173-186.

Worden, M. (1994). Family therapy basics. Pacific Grove, CA: Brooks/Cole Publishing Company.

Worell, J., & Remer, P. (1992). Feminist perspectives in therapy: An empowerment model for women. New York, NY: John Wiley & Sons.

Yllo, K. (1984). The status of women, marital equality and violence against wives. A contextual analysis. Journal of Family Issues, 5, 307-320.

Yllo, K., & Bograd, M. (1988). Feminist perspectives on wife abuse. Newbury Park, CA: Sage Publications.

Table 1

Mean Ratings for Each Therapy Style by Expert Raters

Attribute	Therapy Style		
	Cognitive	Liberal Feminist	Radical Feminist
Directiveness	4.5	2.5	4
Self-Disclosure	1.5	1	3
Internal/External Focus	1.8	2.5	4
Emphasis on Social Activism	1	1	3.5
General Representativeness	5	4	4

Note. Higher scores on each attribute indicate greater endorsement of that attribute. Higher scores on the Internal/External Focus item denote greater external focus.

Table 2

Number of Participants Within Each Age Range in Sample

Age Range (years)	Frequency	Percent (%)
18-25	2	5
26-30	4	10
31-35	12	30
36-40	4	10
41-45	6	15
46-50	8	20
51-55	2	5
56-60	2	5
61-65	0	0
66 years and over	0	0

Note.  $N = 40$ .

Table 3

**Number of Participants Within Each Education Level in Sample**

Education Level	Frequency	Percent (%)
Gr. 8 or less	0	0
Some high school	4	10
High school graduate	2	5
Some college or university	18	45
College or university graduate	16	40

Note.  $N = 40$ .

Table 4

Differences ( $\chi^2$ ) Between the Abuse Experiences of Self-Identified Battered and Nonbattered Women

CTS Item	% of Battered Women Responding "Yes"	% of Nonbattered Women Responding "Yes"	$\chi^2$ and $\alpha$ level
1. Insulted or swore at you	95	50	10.16, $p < .001$
2. Put you down in front of friends or family	95	15	25.86, $p < .0001$
3. Accused you of having affairs with other people	85	5	25.86, $p < .0001$
4. Did or said something to spite you	100	50	13.33, $p < .001$
5. Threatened to hit or throw something at you	85	5	28.98, $p < .0001$
6. Threw, smashed or kicked something	90	10	22.56, $p < .0001$
7. Threw something at you	80	0	26.67, $p < .0001$
8. Pushed, grabbed or shoved you	90	15	22.56, $p < .0001$
9. Slapped you	80	0	26.67, $p < .0001$
10. Kicked, bit, or hit you with fist	65	0	19.26, $p < .0001$
11. Hit or tried to hit you with something	80	0	26.67, $p < .0001$
12. Beat you up	60	0	17.14, $p < .0001$
13. Choked you	70	0	24.00, $p < .0001$
14. Threatened you with a knife or gun	45	0	11.61, $p < .001$
15. Used a knife or gun on you	20	0	4.44, $p < .05$

Note. N = 40.

Table 5

Correlation Matrix for Scales

	E-CAB-C	E-CC-C	E-CPO-C	E-CAB-LF	E-CC-LF	E-CPO-LF	E-CAB-RF	E-CC-RF	E-CPO-RF	P-CAB	P-CC	P-CPO	PH-C	PH-LF	PH-RF	WS-C	WS-LF	WS-RF	
E-CAB-C	1.00																		
E-CC-C	.70	1.00																	
E-CPO-C	.56	.87	1.00																
E-CAB-LF	.39	.10	-.04	1.00															
E-CC-LF	.18	.21	-.00	.76	1.00														
E-CPO-LF	.23	.24	.09	.72	.92	1.00													
E-CAB-RF	-.05	.03	-.11	.39	.36	.33	1.00												
E-CC-RF	-.14	-.23	-.36	.35	.29	.21	.76	1.00											
E-CPO-RF	-.13	-.15	-.27	.35	.37	.31	.77	.96	1.00										
P-CAB	.23	-.02	-.19	.48	.37	.26	.42	.54	.45	1.00									
P-CC	.23	.24	-.03	.35	.41	.29	.43	.42	.39	.77	1.00								
P-CPO	-.08	-.01	-.00	.14	.12	.01	.33	.30	.25	.32	.39	1.00							
PH-C	.42	.69	.78	-.05	-.01	.09	-.15	-.28	-.18	-.39	-.24	-.11	1.00						
PH-LF	.18	.17	.00	.72	.88	.86	.26	.11	.21	.18	.24	.03	.04	1.00					
PH-RF	-.20	-.30	-.40	.28	.28	.23	.63	.90	.87	.39	.20	.15	-.27	.20	1.00				
WS-C	.48	.61	.69	-.02	-.00	.09	-.29	-.37	-.28	-.36	-.30	-.10	.89	.11	-.36	1.00			
WS-LF	.12	.12	-.04	.64	.85	.85	.22	.04	.17	.17	.22	-.04	-.04	.92	.13	.04	1.00		
WS-RF	-.23	-.33	-.42	.23	.19	.14	.59	.88	.81	.32	.18	.21	-.31	.12	.93	-.40	.04	1.00	

Table 6

Internal Consistency ( $\alpha$ ) for Levels of Scale and Subscale Scores for Expectations

Scale/Subscale name	Internal Consistency ( $\alpha$ ) for Each Therapist		
	Cognitive	Liberal Feminist	Radical Feminist
<u>Scales</u>			
E-CAB	.80	.80	.76
E-CC	.90	.92	.88
E-CPO	.93	.97	.96
<u>Subscales</u>			
Acceptance	.74	.83	.82
Confrontation	.79	.86	.81
Directiveness	.80	.72	.50
Empathy	.88	.85	.92
Genuineness	.79	.84	.73
Nurturance	.76	.80	.87
Self-Disclosure	.82	.78	.90
Attractiveness	.94	.97	.97
Expertise	.71	.59	.65
Tolerance	.94	.81	.91
Trustworthiness	.90	.92	.92
Concreteness	.86	.94	.95
Immediacy	.89	.94	.95
Outcome	.94	.95	.96

Note.  $N=40$ . Scale Abbreviations:

- E-CAB = Expectations About Counselor Attitudes and Behaviors
- E-CC = Expectations About Counselor Characteristics
- E-CPO = Expectations About Counseling Process and Outcome

Table 7

Summary Repeated-Measures MANOVA Table as a Function of Battering Status and Therapy Style on Expectations about Counselor Attitudes and Behaviors (E-CAB) and Expectations about Counselor Characteristics (E-CC)

Source	<u>df</u>	<u>F</u>
Between Subjects (A) (Battering Status)	2	.07
Within Subjects (B) (Therapy Style)	4	9.70*
A X B	4	1.58

Note. N = 40. All F's were based on Pillai's criterion.

\* Significant at  $p \leq .001$

Table 8

**Standardized Discriminant Function Coefficient, Structure Loading and Results of Stepdown F-tests on Scales E-CAB and E-CC for Significant Therapy Style Effect**

Scale	S.D.F.C.	S.L.	Stepdown F-tests	
			df	F
E-CAB	1.52	.35	1	5.26*
E-CC	-1.61	-.33	1	28.86**

**Note.** N=40. Scale Abbreviations:

- E-CAB = Expectations About Counselor Attitudes and Behaviors
- E-CC = Expectations About Counselor Characteristics

\* Significant at  $p \leq .05$

\*\* Significant at  $p \leq .001$

Table 9

**Post-hoc MANOVA Pairwise Comparison (Tukey's HSD) for Significant Main Effect of Therapy Style on Expectations about Counselor Attitudes and Behaviors (E-CAB) and Expectations about Counselor Characteristics (E-CC)**

Pairwise comparison	Critical Difference	Mean Difference	p
E-CAB-C vs. E-CAB-LF	.32	.19	ns
E-CAB-LF vs. E-CAB-RF	.32	.20	ns
E-CAB-C vs. E-CAB-RF	.38	.39	.05
E-CC-C vs. E-CC-LF	.55	.13	ns
E-CC-LF vs. E-CC-RF	.55	.53	ns
E-CC-C vs. E-CC-RF	.66	.66	.05

**Note.** N=40. Scale Abbreviations:

-E-CAB-C = Expectations About Counselor Attitudes and Behaviors-Cognitive Therapist

-E-CAB-LF = Expectations About Counselor Attitudes and Behaviors-Liberal Feminist Therapist

-E-CAB-RF = Expectations About Counselor Attitudes and Behaviors-Radical Feminist Therapist

-E-CC-C = Expectations About Counselor Characteristics-Cognitive Therapist

-E-CC-LF = Expectations About Counselor Characteristics-Liberal Feminist Therapist

-E-CC-RF = Expectations About Counselor Characteristics-Radical Feminist Therapist

Table 10

**Summary Repeated-Measures ANOVA Table as a Function of Battering Status and Therapy Style on Expectations about Counseling Process and Outcome (E-CPO)**

Source	<u>df</u>	<u>F</u>	<u>p</u>
Between Subjects (A) (Battering Status)	1	.81	.38
Within Subjects (B) (Therapy Style)	2	4.25	.02
A X B	2	.14	.87
Within cells	76	(1.77)	

**Note.** N=40. All F's are based on Pillai's criterion. Value enclosed in parentheses represents mean square error.

Table 11

Post-hoc ANOVA Pairwise Comparison (Tukey's HSD) for Significant Main Effect of Therapy Style on Expectations about Counseling Process and Outcome (E-CPO)

Pairwise comparison	Critical Difference	Mean Difference	p
E-CPO-C vs. E-CPO-LF	.61	.54	ns
E-CPO-LF vs. E-CPO-RF	.61	.44	ns
E-CPO-C vs. E-CPO-RF	.93	.98	.01

Note. N=40. Scale Abbreviations:

- E-CPO-C = Expectations About Counseling Process and Outcome-Cognitive Therapist
- E-CPO-LF = Expectations About Counseling Process and Outcome-Liberal Feminist Therapist
- E-CPO-RF = Expectations About Counseling Process and Outcome-Radical Feminist Therapist

Table 12

Internal Consistency ( $\alpha$ ) for Levels of Scale and Subscale Scores for Preference

Scale/Subscale Name	Internal Consistency ( $\alpha$ )
<u>Scale</u>	
P-CAB	.77
P-CC	.63
P-CPO	.36
<u>Subscale</u>	
Acceptance	.84
Confrontation	.84
Directiveness	.82
Empathy	.76
Genuineness	.03
Nurturance	.57
Self-Disclosure	.82
Attractiveness	.72
Expertise	.52
Tolerance	.68
Trustworthiness	.66
Concreteness	.77
Immediacy	.57
Outcome	.54

Note. N=40. Scale Abbreviations:

-P-CAB = Preference for Counselor Attitudes and Behaviors

-P-CC = Preference for Counselor Characteristics

-P-CPO = Preference for Counseling Process and Outcome

Table 13

Summary Table for Paired Sample t-tests on Expectations and Preference Scales of CAB, CC, and CPO for Cognitive, Liberal Feminist, and Radical Feminist Therapists

Source Pair	Mean	df	t
P-CAB E-CAB-C	5.02 4.83	39	-1.24
P-CAB E-CAB-LF	5.02 5.02	39	-.05
P-CAB E-CAB-RF	5.02 5.22	39	-1.45
P-CC E-CC-C	5.84 5.41	39	-2.64*
P-CC E-CC-LF	5.84 5.28	39	-3.07**
P-CC E-CC-RF	5.84 4.75	39	5.37***
P-CPO E-CPO-C	6.48 5.69	39	-4.74***
P-CPO E-CPO-LF	6.48 5.15	39	-5.62***
P-CPO E-CPO-RF	6.48 4.71	39	6.97***

Note. N=40. Each t-test was evaluated at adjusted  $\alpha=(.05/9)=.005$ . See Tables 8, 10, and 11 for Scale abbreviations.

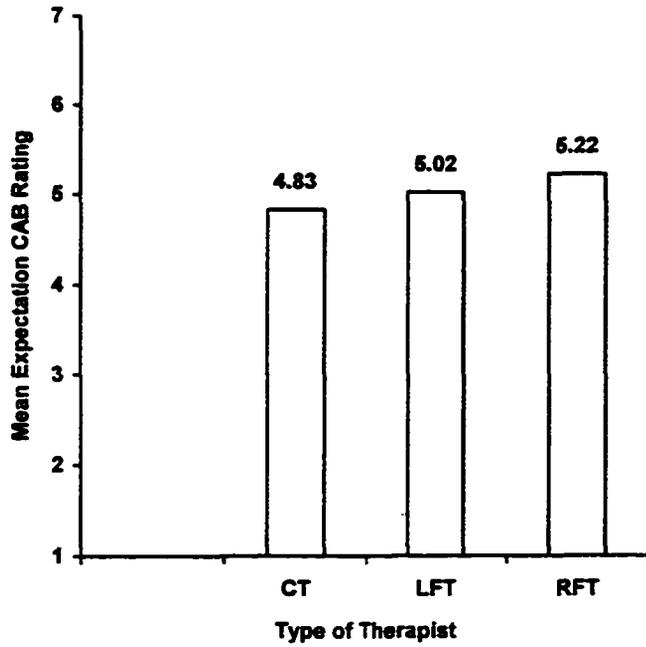
\* Significant at  $p \leq .05$ .

\*\* Significant at  $p \leq .01$ .

\*\*\* Significant at  $p \leq .001$

Figure Caption

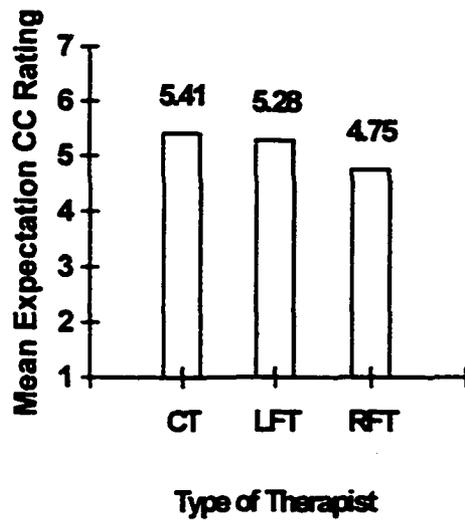
**Figure 1. Mean scores for the cognitive therapist, liberal feminist therapist, and radical feminist therapist on the Scale of Expectations about Counselor Attitudes and Behaviors (E-CAB) from the Expectations Questionnaire.**



Note. Means for the radical feminist therapist ( $M=5.22$ ) and the cognitive therapist ( $M=4.83$ ) are significantly different ( $p<.05$ ).

**Figure Caption**

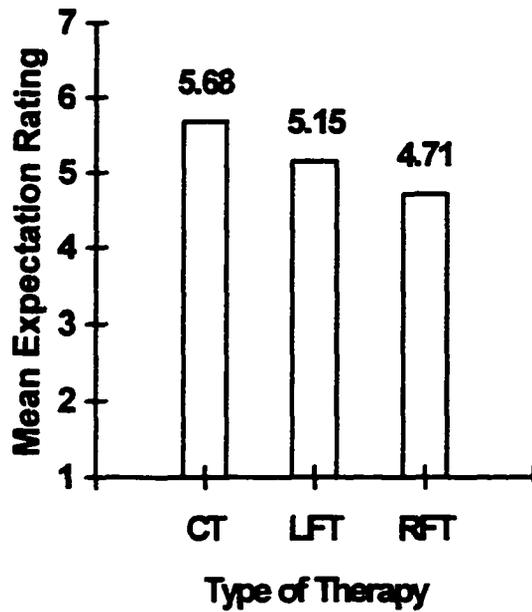
**Figure 2.** Mean scores for the cognitive therapist, liberal feminist therapist, and radical feminist therapist on the Scale of Expectations About Counselor Characteristics (E-CC) from the Expectations Questionnaire.



Note. Means for the cognitive therapist ( $M=5.41$ ) and the radical feminist therapist ( $M=4.75$ ) are significantly different ( $p<.05$ ).

Figure Caption

**Figure 3.** Mean scores for the cognitive therapist, liberal feminist therapist, and radical feminist therapist on the Scale of Expectations about Counseling Process and Outcome (E-CPO) from the Expectations Questionnaire.



Note. Means for the cognitive therapist ( $M=5.68$ ) and the radical feminist therapist ( $M=4.71$ ) are significantly different ( $p<.01$ ).

**Appendix A: List of Agencies Contacted for Recruitment of Participants**

1. Faye Peterson Transition House
2. Community Residence
3. Catholic Family Development Centre
4. Family Services Thunder Bay
5. Northern Women's Centre
6. Lakehead University
7. Confederation College

**Appendix B: Demographic Questionnaire**

Please answer the following questions. They will help to ensure that we accurately identify a representative group of women who have and have not experienced violence in their relationships.

1. Into which category does your age range fall?

- (a) 18-25 yrs.
- (b) 26-30 yrs.
- (c) 31-35 yrs.
- (d) 36-40 yrs.
- (e) 41-45 yrs.
- (f) 46-50 yrs.
- (g) 51-55 yrs.
- (h) 56-60 yrs.
- (i) 61-65 yrs.
- (j) 65 yrs. and older

2. What is the highest level of education you have attained?

- (a) Gr. 8 or less
- (b) Some high school
- (c) Graduated from high school
- (d) Some college or university
- (e) College or university graduate
- (f) Postgraduate studies

3. Please indicate whether or not your current or previous partner has used the following strategies with you (Please answer both sections [A] and [B]).

	[A]	[B]
	<u>Yes/No (Please circle)</u>	<u>Current or Previous Partner (Please circle)</u>
a) Insulted or swore at you	Yes or No	Current or Previous
b) Put you down in front of friends or family	Yes or No	Current or Previous
c) Accused you of having affairs with other people	Yes or No	Current or Previous
d) Did or said something to spite you	Yes or No	Current or Previous
e) Threatened to hit or throw something at you	Yes or No	Current or Previous

- |    |  |           |                     |
|----|--|-----------|---------------------|
| f) | Threw, smashed or kicked something     | Yes or No | Current or Previous |
| g) | Threw something at you                 | Yes or No | Current or Previous |
| h) | Pushed, grabbed or shoved you          | Yes or No | Current or Previous |
| i) | Slapped you                            | Yes or No | Current or Previous |
| j) | Kicked, bit or hit you with fist       | Yes or No | Current or Previous |
| k) | Hit or tried to hit you with something | Yes or No | Current or Previous |
| l) | Beat you up                            | Yes or No | Current or Previous |
| m) | Choked you                             | Yes or No | Current or Previous |
| n) | Threatened you with a knife or gun     | Yes or No | Current or Previous |
| o) | Used a knife or gun on you             | Yes or No | Current or Previous |

4. Has your current or former husband/partner ever forced you or attempted to force you into any sexual activity by threatening you, holding you down or hurting you in some way?

- (a)      1      Yes  
           2      No

- (b)      1      Current partner  
           2      Former partner      →      (Specify how many years you have been out of this relationship \_\_\_\_\_ )

5. Have you ever been to counseling before?

- 1      No  
 2      Yes

6. Which of the three therapists you read about today would you most want to see?

- 1      Therapist A  
 2      Therapist B  
 3      Therapist C

### Appendix C: Description of Counseling Concern

Kathleen, the client, is a 28 year old sales manager. In her early 20s, she attended university majoring in business, but she dropped out at the beginning of her third year to pursue a full-time job. Recently, Kathleen has returned part-time to university to complete her degree in business, and hopes to open her own business when she graduates.

Kathleen is currently seeing Richard, a 35 yr. old teacher she has been intimately involved with for the last three years. They have been living together for about a year. Although Kathleen feels that she and Richard get along and that she enjoys spending time with him she is not certain that he is the kind of person that she wants to spend the rest of her life with. They often have difficulty making plans for the future or even deciding how to spend their time together because their interests and goals are so different. For instance, Richard who is very practical and methodical with respect to financial matters, thinks that it would be foolish and risky for Kathleen to risk leaving her full-time job which pays moderately well, to open a business that could fail. Kathleen, on the other hand, feels that if she doesn't take the risk now, it will be too late to do so later on.

Lately, it seems as though she and Richard have been drifting further apart with each passing day, and Kathleen has been thinking that she would like to end her relationship with Richard and perhaps have the chance to meet someone with interests and goals more similar to her own. However, she is undecided about her feelings towards him. On the one hand, she knows she loves him, but on the other, she feels like something is missing. And she feels guilty about leaving him because she knows how much he loves her, and that he would one day like to marry her. If she stays, she is assured a secure life with a man that loves her. If she leaves, she will perhaps have the opportunity to lead a more fulfilling life, but it will hurt both of them.

During the last few weeks, Kathleen has been feeling down a lot of the time. She is often tired, but has difficulty getting to sleep at night. She has missed several classes because she can't seem to concentrate on anything, and her grades have begun to slip. Sometimes she wishes she could just stay in bed all day long. Kathleen has experienced strong feelings of worthlessness related to her inability to make a decision. She visited her doctor who prescribed some antidepressants and suggested she seek counseling.

During the first interview, Kathleen expressed a good deal of confusion about her situation. The counselor spent most of the hour listening and gathering information about Kathleen's current situation and concerns. At the conclusion of that session, Kathleen and the counselor agreed to meet in one week in order to explore the issues in more depth.

Appendix D: Cognitive Therapist Script

You will now read how therapist 'A' approaches Kathleen's problem.

THERAPIST 'A' DESCRIBES HER COUNSELING APPROACH

**Couns.:** Before we get started, I'd like to make a few comments about how I approach counseling. Essentially, I believe that people experience problems when they think negatively about themselves and others, and about the world around them. These negative thoughts cloud their judgement and keep them from understanding their relationships with others accurately.

**Client:** That's a unique way of looking at things.

**Couns.:** How individuals feel about themselves and about how the world operates is determined in large part by their fundamental beliefs, values and attitudes which are usually developed in early childhood, and influenced by later experience. Are you with me so far?

**Client:** Yeah, this is interesting.

**Couns.:** Therapists who use this approach believe that individuals can change negative beliefs and attitudes into positive ones, which can then lead to a change in behavior. I think that when someone starts thinking and acting more positively, others begin to treat them more positively, encouraging that person to continue their positive thoughts and actions.

**Client:** That certainly seems to make sense.

**Couns.:** So, during our counseling sessions, I'll be encouraging you to examine your negative beliefs about yourself and the world against reality. Together we'll work to find out which of your beliefs is creating problems for you and explore how we can replace them with more realistic beliefs. How does that sound?

**Client:** It's really helpful to hear you talk about how you think about counseling. I think I'll be able to use our sessions better now that I know a little bit about how you work.

You will now read transcripts of parts of Kathleen's therapy sessions with Counselor 'A'.

ONE OF THE FIRST SESSIONS

**Couns.:** Last week when we talked, it was really clear that this is an unsettling time for you. How are you feeling today?

**Client:** To tell you the truth, I don't know what to think..or feel. I'm just really confused. It seems like I just can't decide what to do.

**Couns.:** Your feelings are all mixed up inside. And it's really difficult to think clearly about what you need for yourself.

**Client:** Yeah, I feel like I really love Richard and would like to see things work out between us, but I also really want to start this business and I just don't see how I can have both. It's sort of like I'm being pushed up against a wall. I don't think he realizes what it means to me to open this business. I'm angry at him for not seeing things my way. But I feel guilty and selfish when I'm angry with him. I don't think I should be angry at someone who cares so much about me..and I don't think I should be doubting his concern for me. It feels like no matter what I do, I can't win. And not being able to make this decision really makes me feel weak and worthless.

**Couns.:** Often, when we have difficulty making tough decisions, we tend to think and feel negatively about ourselves. It sounds like you're feeling angry towards Richard, but don't think you have the right to be angry with him, leaving you feeling guilty and frustrated at the same time. Let's look at the assumption you're making. What is it about following your own interests that you think makes you a selfish person?

**Client:** Well, if I just leave Richard to do what I want, even if it might not work out, I think that makes me a selfish person.

**Couns.:** What would make you an unselfish person?

**Client:** Just staying with Richard and not making waves.

**Couns.:** So if I've got this right, you're equating taking a risk, both to start a business and to leave Richard, with being selfish, and keeping things as they are with being unselfish.

**Client:** Yeah, that's how I feel about it.

**Couns.:** Sometimes, people make things difficult for themselves by thinking in black and white terms. By this I mean that just because you want to put yourself first doesn't make you a bad or selfish person. Earlier you mentioned that if you didn't start your business now, you wouldn't ever be able to. I think that's another example of dichotomous or black and white thinking. There is no set rule that says that you must start a business now or be doomed to failure. When we think only in terms of black and white, we miss a lot of the options available to us. It's important to check the conclusions we make about ourselves to make sure they are realistic. What do you think?

**Client:** I never thought about it that way. You're saying that it's unrealistic for me to think that putting my needs first makes me a selfish person, and that I might be limiting my options because of the way I tend to categorize things into right and wrong. I see what you mean about how important it is to check out the assumptions I make about myself.

**Couns.:** It's surprising what a profound effect negative thoughts can have on both our physical and emotional well-being. That's why it's so important for you to look at your thoughts objectively to make sure that they are not irrational or unrealistic. An important first step in the counseling process is to recognize the negative assumptions we make about ourselves. I'm going to give you a homework assignment. It's important for you to know that the bulk of your therapy will occur outside of your sessions with me. How does that sound?

**Client:** It sounds as though this will be hard work, but interesting.

**Couns.:** Between now and our next session, I would like for you to keep a daily journal. Pay close attention to the negative assumptions you may be making about yourself each day and record them in the journal. We will discuss them at our next session.

### ONE OF THE MIDDLE SESSIONS

**Couns.:** Today, I'd like to begin by discussing what has happened since last week. Then I'd like to go over our homework assignment, and finally, I'd like for us to set some goals for you to work towards until our next session. How do you feel about that?

**Client:** That sounds great. Basically, I spent this week really paying attention to the negative thoughts I have about myself when I think about how to solve this problem with Richard.

**Couns.:** How have things been going with Richard this week?

**Client:** Better, but I am still having a hard time making this decision.

**Couns.:** Let's talk about some of the negative assumptions you recorded in your journal this week. Tell me about them.

**Client:** Well, one of the main things that keeps coming up is that it's wrong to put my needs ahead of Richard's. I just can't seem to get past this, so it must be true.

**Couns.:** Just because a negative assumption might be persistent doesn't mean it's true. What is it about putting your needs first that's wrong, in your opinion?

**Client:** I guess it's just easier not to rock the boat than to have to deal with the consequences?

**Couns.:** That might be true for now, but what about in the future?

**Client:** I might be giving up an important opportunity for me to prove to myself that I can successfully start my own business.

**Couns.:** Maybe it only seems easier now to do what Richard wants, but it may actually be more difficult in the long run?

**Client:** Yeah, I think that's probably true.

**Couns.:** What we've just done is replace a faulty negative assumption (that it's easier not to rock the boat than to deal with the consequences) with a more realistic belief (that it may be easier now, but more difficult in the long-term). I would like you to continue not only to monitor your negative thoughts in your journal, but also to examine them, decide if they are accurate, and if not, replace them with more accurate and realistic beliefs in your journal. We will continue to discuss them at our sessions. What do you think about that?

**Client:** I think I can do that.

ONE OF THE LAST SESSIONS

**Client:** When Richard and I talked this week, I suggested that we should take a break from each other. I told him that I loved him very much, but that I had to think about what my motivations were for staying in the relationship and about what possibilities were open to me.

**Couns.:** I think it's good that you're starting to look at some of those shades of grey rather than thinking solely in terms of black and white.

**Client:** There's still a part of me that is scared to leave Richard. I feel responsible for him and guilty for hurting him.

**Couns.:** Again, I think it's important for you to test your assumption that you're responsible for Richard's happiness, rather than automatically accepting it as fact and feeling guilty about it.

**Client:** Yeah, that's something I'll have to remember.

**Couns.:** It can be a bit scary, but I think it's important to deal with your fear rationally and decide what you want, not what others want.

**Client:** I just hope I can work things out! I need some more time, I guess.

**Couns.:** Kathleen, before we end today, I'd like to say that I think you have the ability to carefully think about what's best for you. It seems to me that if you treat your thoughts as assumptions rather than facts, and test them on a regular basis, you'll always act in your best interest, and feel more positively towards yourself because of it.

Appendix E: Liberal-Feminist Therapy Script

You will now read how therapist 'B' approaches Kathleen's problem.

THERAPIST 'B' DESCRIBES HER COUNSELING APPROACH

Couns.: Before we get started, I'd like to make a few comments about how I approach counseling. I think that it's important for women to realize how social and family issues influence their behavior and decisions.

Client: That does sound important.

Couns.: Many women live by a lot of "shoulds" that they learn from childhood on. Women need to get in touch with these issues. It's also important for women to have equal opportunities to reach their potential—both in their personal relationships and their work experiences. Are you with me so far?

Client: Yeah, this is interesting.

Couns.: Basically, I believe that a wide variety of behaviors are appropriate for both men and women. For example, women should feel free to be autonomous and assertive,...(pause) and men should be able to be expressive and nurturing.

Client: That's a unique way of looking at things.

Couns.: Anyway, during our counseling, I'll encourage you to discover your strengths and skills. (pause) And I hope you'll make decisions on the basis of what will work for you, and not on the basis of what is expected by others. How does that sound?

Client: It's really helpful to hear you talk about how you think about counseling. I think I'll be able to use our sessions better now that I know a little bit about how you work.

You will now read transcripts of parts of Kathleen's therapy sessions with Counselor 'B'.

ONE OF THE FIRST SESSIONS

**Couns.:** Last week when we talked, it was really clear that this is an unsettling time for you. How are you feeling today?

**Client:** To tell you the truth, I don't know what to think..or feel. I'm just really confused. It seems like I just can't decide what to do.

**Couns.:** Your feelings are all mixed up inside. And it's really difficult to think clearly about what you need for yourself.

**Client:** Yeah, I feel like I really love Richard and would like to see things work out between us, but I also really want to start this business and I just don't see how I can have both.

**Couns.:** So both your relationship with Richard and starting your own business are important to you, but you don't feel like you can have both. And the pressure has been frustrating to deal with.

**Client:** Yeah, it's sort of like I'm pushed up against a wall. I love Richard and I want to be happy with him, but it's so difficult because we're so different. Sometimes I just don't think we belong together..

**Couns.:** You seem pretty confused....and angry about Richard's responses. Your own needs and wants are getting pushed aside.

**Client:** Yeah, I feel like I'm being pulled in two directions. I really am angry. But I feel guilty when I'm angry with him. I don't think I should be angry at someone who cares so much about me..and I don't think I should be doubting his concern for me. It feels like no matter what I do, I can't win. And not being able to make this decision really makes me feel weak and worthless.

**Couns.:** I noticed you used the word "should" several times. I want you to know that women often struggle with "shoulds" because caring and nurturing are valued so highly in our experiences. I think you've picked up cues that it's not okay to be angry.

**Client:** I never thought about that. I think that's true. But maybe I am being selfish--or unfair--and just thinking about myself. I feel like I'm being self-centered and ungrateful.

**Couns.:** So you're directing a lot of your negative feelings inward, blaming yourself for Richard's reactions.

**Client:** Yeah, I've been so tense, and I've had this incredible knot in my stomach. I can't sleep. I can't study. I feel like I'm going to fail. I just want to stick my head in the sand, and let someone else make the decision. I don't know why I can't trust my own judgement. It's so frustrating.

**Couns.:** It sounds like your anger is affecting you more than you thought. ...and you do want to look at what it's all about and how you can use it constructively.

### ONE OF THE MIDDLE SESSIONS

**Client:** As we're talking, I still have this nagging feeling that if I end this relationship, it will make me a selfish person for hurting Richard. But if I don't try to start this business soon, I'll never be able to do it. Then I will have sacrificed my relationship with Richard for nothing.

**Couns.:** I think you're caught between a set of competing demands that many women face. You want a career and you want to have a relationship with someone who's quite different than yourself. And you're scared that there's no way to have both, or to reach some sort of compromise.

**Client:** I feel caught in a double bind. It seems I can't make myself happy without making him unhappy. It doesn't seem fair!

**Couns.:** It is pretty confusing. (pause)...Maybe we can start by looking at the messages you've picked up about what it means to be a woman. What kinds of things did you learn from your parents?

**Client:** You mean like from when I was growing up?

**Couns.:** Um Hmm.

**Client:** I can remember a lot of subtle messages about being a woman. Although I don't think it was intentional, my mother always assumed that I would leave school to get married, so that I could start a family. Dad was a businessman,... and I think he would have liked to see me make it in the field...but he's never really

encouraged me like my brothers. My mother and father were always proud of my accomplishments in school... but that never seemed as important to them as knowing when I was going to get married and start a family. It was a lot different for my two older brothers.

Couns.: I guess you were told through subtle ways that putting others needs before your own is more important than focusing on what you want for yourself. It's hard not getting the support you want.

Client: Richard's attitude really bugs me too. Although he tells me it's great that I'm getting my degree, he thinks it's silly to risk my job for the chance of having something better. He would rather we spend the next twenty years saving our pennies instead of taking a chance and possibly gaining a lot more. That's what I mean when I say we have nothing in common.

Couns.: Um Hmm. That's hard. It sounds like Richard wants you to be successful, but not to take any risks. Am I right?

Client: Exactly.

Couns.: How has this situation affected the power in your relationship?

Client: I'm feeling as though there's some kind of a power struggle between us--but I don't like using those words. They sound so negative. Maybe it's because he loves me so much and doesn't want to see me get hurt if things don't work out. Maybe he'll come around to my way of seeing things.

Couns.: I'm asking because many women find that once a certain kind of power structure is set up, it can be difficult to change. I think it's important for you to look at the issues we've raised--and then decide what's going to be best for you.

### ONE OF THE LAST SESSIONS

Client: When Richard and I talked this week, I suggested that we should take a break from each other. I told him that I loved him very much, but that I had to think about what my motivations were for staying in the relationship and about what possibilities were open to me.

Couns.: I think it's good that you're starting to think about some of the things that might make you happy.

**Client:** There's a part of me that feels that leaving Richard to start this business is not realistic for me.

**Couns.:** I think it's important to check out the job market. You might start by checking to see if there are any women's business organizations in the area, and if there are affirmative action programs in place.

**Client:** Yeah, that's something I'll have to consider.

**Couns.:** You know what Richard wants. But what do you want?

**Client:** I want to start this business, but it's really scary to think about leaving something that's so familiar and safe to me.

**Couns.:** It is a bit scary, but I think it's important to deal with your fear and decide what you want, not what others want. You're a creative and intelligent woman, and I believe you can make it in the field of business...if that's what you want.

**Client:** I just hope I can work things out! I need some more time, I guess.

**Couns.:** Well, Kathleen, I'm glad you came in today. Before you leave, I'd like to let you know about some special talks that are being sponsored by the women's centre. Several women will be talking about personal issues and barriers they faced in their professions. They might help you sort out what parts of your situation are internal issues...and what pressures are coming from outside. (pause) When you do come to the point of needing to decide how you'll face these issues, your actual choices may not be as crucial as the fact that you've explored all the options open to you.

Appendix F: Radical-Feminist Therapy Script

You will now read how therapist 'C' approaches Kathleen's problem.

THERAPIST 'C' DESCRIBES HER COUNSELING APPROACH

Couns.: Before we get started, I'd like to make a few comments about how I approach counseling. Basically, I believe that most of women's problems are due to external barriers and not personal conflicts.

Client: Hm. That's a different way of looking at problems.

Couns.: Well, women experience a lot of built-in stress because of the way our culture is designed....and that stress is the source of our problems. Understanding these stresses and barriers is necessary for women to actively work toward changing the situations they're involved in. Are you with me so far?

Client: Yeah, this is interesting.

Couns.: I believe that friendships and love relationships should be based on equality of personal and financial power. Our counseling relationship should also be one of equality (pause)..So I'll be honest and up-front with you and we'll work together in developing goals for our sessions.

Client: I think I'll like that.

Couns.: Good! In addition to helping you work through your personal circumstances, I'm committed to getting involved in social action to change women's situations. And I'll probably encourage you to get involved in a consciousness-raising group. How does that sound?

Client: It's helpful to hear you talk about how you think about counseling. I think I'll be able to use our sessions better now that I know something about how you work.

You will now read transcripts of parts of Kathleen's therapy sessions with Counselor 'C'.

ONE OF THE FIRST SESSIONS

**Couns.:** Last week when we talked, it was really clear that this is an unsettling time for you. How are you feeling today?

**Client:** To tell you the truth, I don't know what to think..or feel. I'm just really confused. It seems like I just can't decide what to do.

**Couns.:** Your feelings are all mixed up inside. And it's really difficult to think clearly about what you need for yourself.

**Client:** Yeah, I feel like I really love Richard and would like to see things work out between us, but I also really want to start this business and I just don't see how I can have both.

**Couns.:** So both your relationship with Richard and starting your own business are important to you, but you don't feel like you can have both. And the pressure has been frustrating to deal with.

**Client:** Yeah, it's sort of like I'm pushed up against a wall. I love Richard and I want to be happy with him, but it's so difficult because we're so different. Sometimes, I just don't think we belong together.

**Couns.:** I sense that you're pretty angry...and confused about his response to your situation. Your own needs and wants are getting pushed aside.

**Client:** Yeah, I feel like I'm being pulled in all directions. I really am angry. But I feel guilty when I'm angry with him. I don't think I should be angry at someone who cares so much about me..and I don't think I should be doubting his concern for me. It feels like no matter what I do, I can't win. And not being able to make this decision really makes me feel weak and worthless.

**Couns.:** I noticed you used the word "should" several times just now. I think you're experiencing something that many women feel. As women, we're encouraged to be responsive to the needs of others. And we learn that it's not okay to be angry.

**Client:** I never thought about that. I think that's true. But maybe I am being selfish--or unfair--and just thinking about myself. I feel like I'm being self-centered and ungrateful.

**Couns.:** So you're directing your anger at yourself. My own experience as a woman tells me that anger is the most difficult, but most important emotion for women to get in touch with.

**Client:** I've been so tense and I've had this incredible knot in my stomach. I can't sleep. I can't study. I feel like I'm going to fail. I just want to stick my head in the sand, and let someone else make the decision. I don't know why I can't trust my own judgement. It's so frustrating.

**Couns.:** When I was in a similar situation, I also felt guilty for being angry at people who were placing limits on me—but it was an incredibly freeing experience to get in touch with and then let go of my anger. I was much more capable of making good, sound choices, instead of just reacting in frustration.

### ONE OF THE MIDDLE SESSIONS

**Client:** As we're talking, I still have this nagging feeling that if I end this relationship, it will make me a selfish person for hurting Richard. But if I don't try to start this business soon, I'll never be able to do it. Then I will have sacrificed my relationship with Richard for nothing.

**Couns.:** It sounds like you're caught in a double bind that many women face. If you decide to emphasize the caring side of you, you might have to give up your goals for a business career. If you emphasize the assertive, goal-oriented part of you, you'll have to seriously evaluate how you think about what role you play in this relationship.

**Client:** I do feel caught in a double bind. It seems that I can't make myself happy without making others unhappy. It doesn't seem fair!

**Couns.:** I can understand. It is really difficult to find ways to be both caring and independent—particularly with the way our culture is structured. Maybe we can start by looking at some of the messages you've picked up about what it means to be a woman.

**Client:** You mean like from when I was growing up?

**Couns.:** Um Hmm.

**Client:** I can remember a lot of subtle messages about being a woman. Although I don't think it was intentional, my mother always assumed that I would leave school to

get married, so that I could start a family. Dad was a businessman,...and I think he would have liked to see me make it in the field...but he's never really encouraged me like my brothers. My mother and father were always proud of my accomplishments in school...but that never seemed as important to them as knowing when I was going to get married and start a family. It was a lot different for my two older brothers.

**Couns.:** It's difficult for you to feel certain and strong about your own choices when you've never received any active support for them.

**Client:** Richard's attitude really bugs me too. Although he tells me it's great that I'm getting my degree, he thinks it's silly to risk my job for the chance of having something better. He would rather we spend the next twenty years saving our pennies rather than take a chance and possibly gain a lot more. That's what I mean when I say we have nothing in common.

**Couns.:** Um Hmm. That's hard. Richard wants you to be successful, but not to take any risks.

**Client:** Exactly.

**Couns.:** He figures that by his having a career while you have a job, he'll have more power in your relationship. From my own experience, I think it's really important that relationships start out with full equality--both financially and personally.

**Client:** I'm feeling as though there's some kind of a power struggle between us--but I don't like using those words. They sound so negative. Maybe it's because he loves me so much and doesn't want to see me get hurt if things don't work out. Maybe he'll come around to my way of seeing things.

**Couns.:** I think it's important to know that once a certain power dynamic is set up, it can be very difficult to change. If you want an equal relationship, both you and Richard need to be committed to being nurturing and caring, as well as autonomous and independent.

### ONE OF THE LAST SESSIONS

**Client:** When Richard and I talked this week, I suggested that we should take a break

from each other. I told him that I loved him very much, but that I had to think about what my motivations were for staying in the relationship and about what possibilities were open to me.

**Couns.:** It's wonderful to see you start to think about yourself rather than about what Richard wants.

**Client:** There's a part of me that feels that leaving Richard to start this business is not realistic for me.

**Couns.:** I think it's important to remember that, in general, women still make less for every dollar that men make. They also work harder to advance in companies. Until we're able to change the way our culture treats women and men, it's a reality we'll have to deal with. So it may be even more important for you to finish your degree.

**Client:** That sounds so negative. But I'll think about it.

**Couns.:** You know what Richard wants. But what do you want?

**Client:** I want to start this business, but it's really scary to think about leaving something that's so familiar and safe to me.

**Couns.:** Professional women are more likely to postpone entering intimate relationships....and yet they're often happier than women who follow a more traditional path. You're lucky in that you'll have the opportunity to experience both! I think the satisfaction will come from the fact that you are choosing, not just reacting.

**Client:** I just hope I can work things out! I need some time, I guess.

**Couns.:** Before we end, I'd like to say that women need support from each other. I'd like you to begin thinking about getting involved in a consciousness raising group. At some point, I'd also like you to consider joining a community committee on the status of women. It would be a great way for you to express your concerns and positively influence the lives of other women. Kathleen, I've also been faced by situations in which I had to make difficult decisions. When I've sought out the support of other women and emphasized the importance of equality in my relationships, I've been the most satisfied.



Appendix H: Letter to Agencies

Dear Sir/Madam

This is to follow up on our telephone conversation dated \_\_\_\_\_. To reiterate, I am a graduate student in Clinical Psychology at Lakehead University. I am currently completing a research thesis as part of my Master's degree. As a thesis topic, I have chosen to study women's perceptions of therapy. I am interested in recruiting female participants from a variety of sources, including (a) the university student population, (b) various health centers in Thunder Bay, and (c) the Thunder Bay general population. I hope to be able to post a request for participation in your office.

Participants in this study will not undergo therapy directly. Rather, they will be asked to read a transcript of a simulated therapy session between a counselor and a client. Then they will be asked to rate several aspects of the therapist's behavior. I am interested in how participants perceive and evaluate different types of therapists. Involvement in this research project will take no more than 1 hour of the participant's time. There are no foreseeable risks for participants, and each person will be fully debriefed following her participation.

Participation is completely voluntary and each individual will be free to withdraw from the study at any time. All information will be numerically coded and kept strictly confidential. Identity will not be revealed at any time. All data obtained in this research project will be stored with the principal researcher, Lize Jalbert, and a copy of the data will be kept by the project supervisor, Dr. Josephine Tan at her Psychology research lab for a period of 7 years. The study will commence after approval from the Ethics Committee at Lakehead University. I will be calling some time in the next week to obtain official permission to post a request for participation from your agency.

If you have any questions, please feel free to contact either myself or my thesis advisor:

Lize Jalbert, B. A.  
Psychology Department  
Lakehead University  
Phone: 343-8110 (w)  
344-4831 (h)

Dr. Josephine Tan,  
Psychology Department  
Lakehead University  
Phone: 346-7751

Thank you very much for your consideration in this matter.

Sincerely

Lize Jalbert

Appendix I: Participant Recruitment Letter

Dear Prospective Participant,

I am a graduate student in clinical psychology at Lakehead University. I am currently doing research in the area of counseling. I would like to find out what women think about different kinds of counseling and what they like or dislike about them. I am looking for women who have experienced either physical sexual, or psychological violence from their partners (married, common-law, or relationship), as well as women who have never experienced violence from their partners to participate in this research project.

Participants will not be asked to go to therapy. Instead, they will be presented with examples of different kinds of therapy and asked for their opinions about that particular counselor. All responses will be anonymous and confidential, and participants are free to withdraw at any time. There are no foreseeable risks or benefits to participation in this study. The data obtained in this research will be kept with the principal researcher, Lize Jalbert, and a copy of the data will be kept by the project supervisor, Dr. Josephine Tan at her Psychology research lab for a period of 7 years. No one other than the previously named individuals will have at any time have access to the research data. Participation in this project would take approximately 1 hour. A summary of the results of this study will be distributed to any participant who requests a copy of the results.

If you are interested in participating in this research project, please call me. My home phone number is 344-4831, and my work number is 343-8476. I will be completing this research upon receiving ethical approval from the university.

Sincerely

Lize Jalbert

**Appendix J: Informed Consent Form**

**INFORMED CONSENT FORM**

1. The title of this research is Therapy Preferences.
2. I, \_\_\_\_\_ consent to take part in a study which will examine my reactions to a written description of a counseling problem and examples of three different kinds of therapy. The purpose of this study is to learn about what abused and nonabused women's preferences and expectations for therapy are.
3. I will be asked to give my opinion about the three kinds of therapy presented.
4. I understand that my responses will be anonymous and confidential.
5. I understand that only the researcher, Ms. Lize Jalbert, and the project supervisor, Dr. Josephine Tan, will have access to my responses. There will be no way to trace anything back to me.
6. I understand that the data obtained in this research will be kept with Lize Jalbert, and a copy of the data will be kept by Dr. Josephine Tan in her Psychology research lab for a period of 7 years.
7. I understand that no one other than the previously named individuals will have at any time have access to the research data.
8. I understand that there are no foreseeable risks or benefits to participation in this study.
9. I understand that I am free to discontinue my participation in this study at any time and for any reason, without explanation or penalty.

I have read the above description of the study and wish to participate in it. I understand that I am free to withdraw at any time without penalty or explanation, even after signing this form.

\_\_\_\_\_  
(signed)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(witness)

## Appendix K: Debriefing

### Debriefing Information

The purpose of this research project was to discover what women want and expect to get in therapy. Many different types of therapy have been suggested for use with various groups of women. However, research has not yet looked at whether one type of therapy is preferred over another by women, particularly women in violent relationships. It is essential that women's views be taken into account if effective counseling interventions are to be developed. This project looked at three different kinds of therapy: cognitive, liberal feminist, and radical feminist. These types of therapy have all been suggested for use in counseling abuse survivors. Cognitive therapy focuses on the different types of thoughts people have and how these thoughts affect their feelings and behavior. Liberal feminist therapy focuses on showing women how they have been taught from birth to be feminine, and how this role prevents women from achieving their full potential. Radical feminist therapists emphasize that many of women's problems are caused by external factors such as a lack of power in society, and focuses on women's commonality by sharing her their own experiences. This type of therapist is also likely to encourage women to get involved socially and politically in helping other women.

My research examined what women want in a therapist, as well as what they expected to get from the three counselors presented. In addition, this study looked at how helpful women think these counselors would be in a variety of different areas and their willingness to see them for different concerns. Some of the major questions posed by my study are: 1) Do women in violent relationships prefer feminist therapy over other mainstream therapies such as cognitive therapy, 2) Do they prefer liberal feminist therapy over radical feminist therapy? 3) What do they prefer and expect in therapy compared to nonbattered women? It is my hope that the results of this research will be used to develop counseling interventions that more effectively meet the needs of abuse survivors.

**Appendix L: Attitudes Towards Feminism and the Women's Movement Scale**

**Questionnaire A**

**DIRECTIONS:** Please circle the number that most accurately reflects how strongly you agree or disagree with each statement.

1.	The leaders of the women's movement may be extreme but they have the right idea.	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
2.	There are better ways for women to fight for equality than through the women's movement.	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
3.	More people would favor the women's movement if they knew more about it.	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
4.	The women's movement has positively influenced relationships between men and women.	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree

Therapy Preferences and Expectations 135

		1	2	3	4	5
		Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
5.	The women's movement is too radical and extreme in its views.	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
6.	The women's movement has made important gains in equal rights and political power for women.	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
7.	Feminists are too visionary for a practical world.	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
8.	Feminist principles should be adopted everywhere.	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
9.	Feminists are a menace to this nation and the world.	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
10.	I am overjoyed that women's liberation is finally happening in this country.	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree

Appendix M: Expectations Questionnaire

Questionnaire C

**DIRECTIONS:** Pretend that you are the person in the counseling session you just read. We would like to know just what you expect (think) counseling would be like with this particular therapist. On the following pages are statements about counseling. In each instance please indicate what you expect (think) counseling would be like, by circling the number which most accurately reflects your expectations.

I EXPECT TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
1. Like the counselor							

I EXPECT TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
2. Gain some experience in new ways of solving problems within the counseling process.							

I EXPECT TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
3. Get practice in relating openly and honestly to another person within the counseling relationship.							

I EXPECT TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
4. Enjoy my interviews with the counselor.							

**I EXPECT TO ...**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
5.	Practice some of the things I need to learn in the counseling relationship.							

**I EXPECT TO ...**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
6.	Get a better understanding of myself and others.							

**I EXPECT TO ...**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
7.	Enjoy being with the counselor.							

**I EXPECT TO ...**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
8.	Find that the counseling relationship will help the counselor and me identify problems on which I need to work.							

**I EXPECT TO ...**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
9.	Become better able to help myself in the future.							

**I EXPECT TO ...**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
10.	Improve my relationships with others.							

**I EXPECT THE COUNSELOR TO:**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
11.	Explain what's wrong.							

**Therapy Preferences and Expectations 138**

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>12.</b>	<b>Help me identify and label my feelings so I can better understand them.</b>						

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>13.</b>	<b>Tell me what to do.</b>						

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>14.</b>	<b>Know how I feel even when I cannot say what I mean.</b>						

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>15.</b>	<b>Know how to help me.</b>						

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>16.</b>	<b>Help me identify particular situations where I have problems.</b>						

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>17.</b>	<b>Give encouragement and reassurance.</b>						

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>18.</b>	<b>Help me to know how I am feeling by putting my feelings into words for me.</b>						

**I EXPECT THE COUNSELOR TO:**

		1	2	3	4	5	6	7
19.	Be a "real" person, not just a person doing a job.	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

**I EXPECT THE COUNSELOR TO:**

		1	2	3	4	5	6	7
20.	Help me discover what particular aspects of my behavior are relevant to my problems.	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

**I EXPECT THE COUNSELOR TO:**

		1	2	3	4	5	6	7
21.	Inspire confidence and trust.	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

**I EXPECT THE COUNSELOR TO:**

		1	2	3	4	5	6	7
22.	Frequently offer me advice.	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

**I EXPECT THE COUNSELOR TO:**

		1	2	3	4	5	6	7
23.	Be honest with me.	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

**I EXPECT THE COUNSELOR TO:**

		1	2	3	4	5	6	7
24.	Be someone who can be counted on.	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

**I EXPECT THE COUNSELOR TO:**

		1	2	3	4	5	6	7
25.	Be friendly and warm towards me.	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

**Therapy Preferences and Expectations 140**

**I EXPECT THE COUNSELOR TO:**

	1	2	3	4	5	6	7
	Not	Slightly	Somewhat	Fairly	Quite	Very	Definitely
	True	True	True	True	True	True	True
26. Help me solve my problems.							

**I EXPECT THE COUNSELOR TO:**

	1	2	3	4	5	6	7
	Not	Slightly	Somewhat	Fairly	Quite	Very	Definitely
	True	True	True	True	True	True	True
27. Discuss his or her own attitudes and relate them to my problem.							

**I EXPECT THE COUNSELOR TO:**

	1	2	3	4	5	6	7
	Not	Slightly	Somewhat	Fairly	Quite	Very	Definitely
	True	True	True	True	True	True	True
28. Give me support.							

**I EXPECT THE COUNSELOR TO:**

	1	2	3	4	5	6	7
	Not	Slightly	Somewhat	Fairly	Quite	Very	Definitely
	True	True	True	True	True	True	True
29. Decide what treatment plan is best.							

**I EXPECT THE COUNSELOR TO:**

	1	2	3	4	5	6	7
	Not	Slightly	Somewhat	Fairly	Quite	Very	Definitely
	True	True	True	True	True	True	True
30. Know how I feel, at times, without my having to speak.							

**I EXPECT THE COUNSELOR TO:**

	1	2	3	4	5	6	7
	Not	Slightly	Somewhat	Fairly	Quite	Very	Definitely
	True	True	True	True	True	True	True
31. Respect me as a person.							

**I EXPECT THE COUNSELOR TO:**

	1	2	3	4	5	6	7
	Not	Slightly	Somewhat	Fairly	Quite	Very	Definitely
	True	True	True	True	True	True	True
32. Discuss his or her experiences and relate them to my problem.							

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>33. Praise me when I show improvement.</b>							

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>34. Make me face up to the differences between what I say and how I behave.</b>							

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>35. Talk freely about himself or herself.</b>							

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>36. Have no trouble getting along with people.</b>							

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>37. Like me.</b>							

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>38. Be someone that I can really trust.</b>							

**I EXPECT THE COUNSELOR TO:**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>39. Like me in spite of the bad things that he or she knows about me.</b>							

**Therapy Preferences and Expectations 142**

**I EXPECT THE COUNSELOR TO:**

		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>40.</b>	<b>Make me face up to the differences between what I am and how I am seen by others.</b>	<b>Not True</b>	<b>Slightly True</b>	<b>Somewhat True</b>	<b>Fairly True</b>	<b>Quite True</b>	<b>Very True</b>	<b>Definitely True</b>

**I EXPECT THE COUNSELOR TO:**

		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>41.</b>	<b>Be someone who is calm and easygoing.</b>	<b>Not True</b>	<b>Slightly True</b>	<b>Somewhat True</b>	<b>Fairly True</b>	<b>Quite True</b>	<b>Very True</b>	<b>Definitely True</b>

**I EXPECT THE COUNSELOR TO:**

		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>42.</b>	<b>Point out to me the differences between what I am and what I want to be.</b>	<b>Not True</b>	<b>Slightly True</b>	<b>Somewhat True</b>	<b>Fairly True</b>	<b>Quite True</b>	<b>Very True</b>	<b>Definitely True</b>

**I EXPECT THE COUNSELOR TO:**

		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>43.</b>	<b>Get along well in the world.</b>	<b>Not True</b>	<b>Slightly True</b>	<b>Somewhat True</b>	<b>Fairly True</b>	<b>Quite True</b>	<b>Very True</b>	<b>Definitely True</b>

Appendix N: Item Numbers for the EAC-B Scales and Subscales

<b>Factor</b>	<b>Scales</b>	<b>Item Numbers</b>
Counselor attitudes and behaviors	Acceptance	25, 37, 49
	Confrontation	34, 40, 42
	Genuineness	19, 23, 31
	Directiveness	11, 13, 22
	Empathy	14, 18, 30
	Self-disclosure	27, 32, 35
	Nurturance	17, 28, 33
Counselor characteristics	Attractiveness	1, 4, 7
	Expertise	15, 26, 29
	Trustworthiness	21, 24, 38
	Tolerance	36, 41, 43
Counseling process and outcome	Concreteness	12, 16, 20
	Immediacy	2, 3, 5, 8
	Outcome	6, 9, 10

Appendix O: Preference Questionnaire

Questionnaire B

**DIRECTIONS:** Pretend that you are the person in the description you just read, and that you are about to see a counseling psychologist for your first interview. We would like to know just what you would like counseling to be like. On the following pages are statements about counseling. In each instance please indicate what you would like counseling to be like, by circling the number which most accurately reflects your preference.

**I WOULD LIKE TO ...**

		1	2	3	4	5	6	7
1.	Like the counselor.	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

**I WOULD LIKE TO ...**

		1	2	3	4	5	6	7
2.	Gain some experience in new ways of solving problems within the counseling process.	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

**I WOULD LIKE TO ...**

		1	2	3	4	5	6	7
3.	Get practice in relating openly and honestly to another person within the counseling relationship.	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

**I WOULD LIKE TO ...**

		1	2	3	4	5	6	7
4.	Enjoy my interviews with the counselor.	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

## Therapy Preferences and Expectations 145

**I WOULD LIKE TO ...**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
5.	Practice some of the things I need to learn in the counseling relationship.							

**I WOULD LIKE TO ...**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
6.	Get a better understanding of myself and others.							

**I WOULD LIKE TO ...**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
7.	Enjoy being with the counselor							

**I WOULD LIKE TO ...**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
8.	Find that the counseling relationship will help the counselor and me identify problems on which I need to work.							

**I WOULD LIKE TO ...**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
9.	Become better able to help myself in the future.							

**I WOULD LIKE TO ...**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
10.	Improve my relationships with others.							

**I WOULD LIKE THE COUNSELOR TO ...**

		1	2	3	4	5	6	7
		Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
11.	Explain what's wrong.							

**Therapy Preferences and Expectations 146**

**I WOULD LIKE THE COUNSELOR TO ...**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>12.</b>							
	<b>Help me identify and label my feelings so I can better understand them.</b>						

**I WOULD LIKE THE COUNSELOR TO ...**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>13.</b>							
	<b>Tell me what to do.</b>						

**I WOULD LIKE THE COUNSELOR TO ...**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>14.</b>							
	<b>Know how I feel even when I cannot say what I mean.</b>						

**I WOULD LIKE THE COUNSELOR TO ...**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>15.</b>							
	<b>Know how to help me.</b>						

**I WOULD LIKE THE COUNSELOR TO ...**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>16.</b>							
	<b>Help me identify particular situations where I have problems.</b>						

**I WOULD LIKE THE COUNSELOR TO ...**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>17.</b>							
	<b>Give encouragement and reassurance.</b>						

**I WOULD LIKE THE COUNSELOR TO ...**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	<b>Not</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Fairly</b>	<b>Quite</b>	<b>Very</b>	<b>Definitely</b>
	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>	<b>True</b>
<b>18.</b>							
	<b>Help me to know how I am feeling by putting my feelings into words for me.</b>						

Therapy Preferences and Expectations 147

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
19. Be a "real" person, not just a person doing a job.							

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
20. Help me discover what particular aspects of my behavior are relevant to my problems.							

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
21. Inspire confidence and trust.							

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
22. Frequently offer me advice.							

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
23. Be honest with me.							

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
24. Be someone who can be counted on.							

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
25. Be friendly and warm towards me.							

**Therapy Preferences and Expectations 148**

**I WOULD LIKE THE COUNSELOR TO ...**

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
26. Help me solve my problems.							

**I WOULD LIKE THE COUNSELOR TO ...**

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
27. Discuss his or her own attitudes and relate them to my problem.							

**I WOULD LIKE THE COUNSELOR TO ...**

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
28. Give me support.							

**I WOULD LIKE THE COUNSELOR TO ...**

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
29. Decide what treatment plan is best.							

**I WOULD LIKE THE COUNSELOR TO ...**

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
30. Know how I feel, at times, without my having to speak.							

**I WOULD LIKE THE COUNSELOR TO ...**

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
31. Respect me as a person.							

**I WOULD LIKE THE COUNSELOR TO ...**

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
32. Discuss his or her experiences and relate them to my problem.							

Therapy Preferences and Expectations 149

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
33. Praise me when I show improvement.							

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
34. Make me face up to the differences between what I say and how I behave.							

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
35. Talk freely about himself or herself.							

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
36. Have no trouble getting along with people.							

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
37. Like me.							

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
38. Be someone that I can really trust.							

I WOULD LIKE THE COUNSELOR TO ...

	1	2	3	4	5	6	7
	Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True
39. Like me in spite of the bad things that he or she knows about me.							

**Therapy Preferences and Expectations 150**

**I WOULD LIKE THE COUNSELOR TO ...**

		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>40.</b>	<b>Make me face up to the differences between what I am and how I am seen by others.</b>	<b>Not True</b>	<b>Slightly True</b>	<b>Somewhat True</b>	<b>Fairly True</b>	<b>Quite True</b>	<b>Very True</b>	<b>Definitely True</b>

**I WOULD LIKE THE COUNSELOR TO ...**

		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>41.</b>	<b>Be someone who is calm and easygoing.</b>	<b>Not True</b>	<b>Slightly True</b>	<b>Somewhat True</b>	<b>Fairly True</b>	<b>Quite True</b>	<b>Very True</b>	<b>Definitely True</b>

**I WOULD LIKE THE COUNSELOR TO ...**

		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>42.</b>	<b>Point out to me the differences between what I am and what I want to be.</b>	<b>Not True</b>	<b>Slightly True</b>	<b>Somewhat True</b>	<b>Fairly True</b>	<b>Quite True</b>	<b>Very True</b>	<b>Definitely True</b>

**I WOULD LIKE THE COUNSELOR TO ...**

		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>43.</b>	<b>Get along well in the world.</b>	<b>Not True</b>	<b>Slightly True</b>	<b>Somewhat True</b>	<b>Fairly True</b>	<b>Quite True</b>	<b>Very True</b>	<b>Definitely True</b>

Appendix P: Perceived Helpfulness and Willingness to See

Therapist Quality Questionnaire

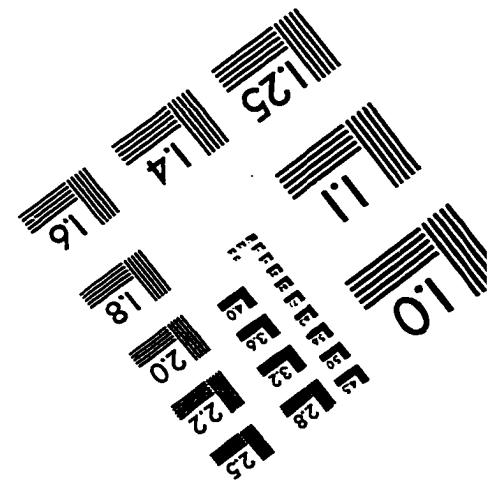
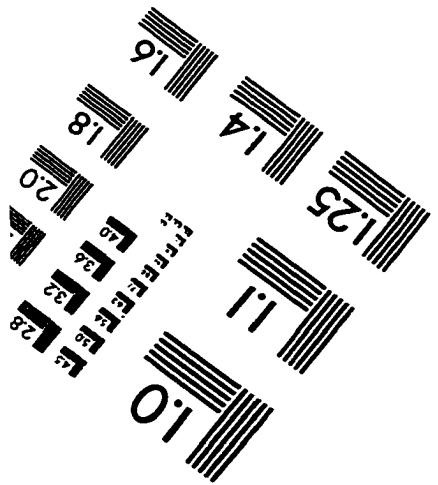
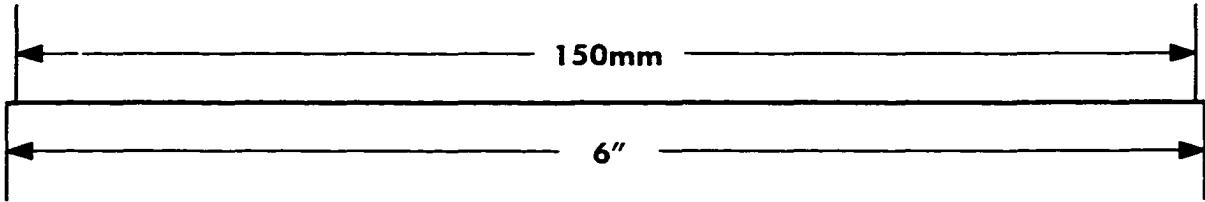
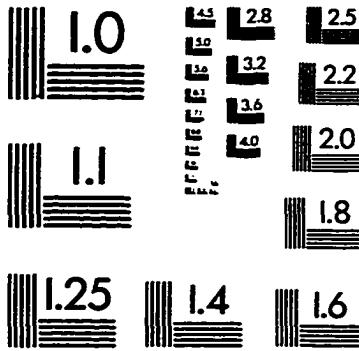
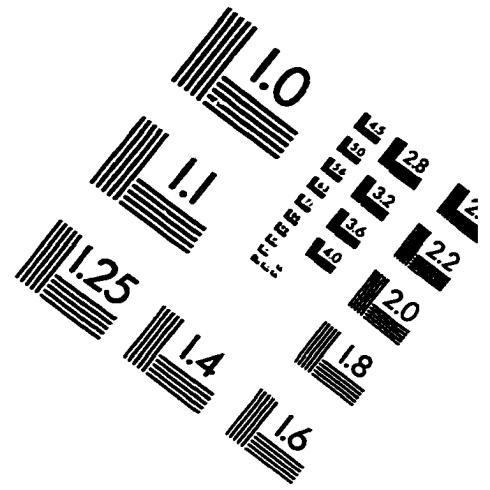
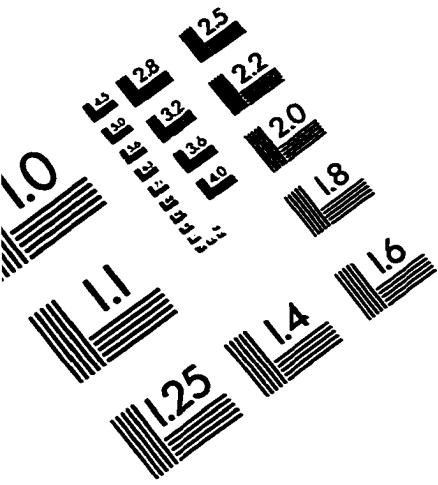
1. How helpful do you think this particular counselor would be you resolve your problems?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 7  
not at all very helpful  
helpful

2. How willing would you be to see this particular counselor for your problems?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 7  
definitely not very willing

# IMAGE EVALUATION TEST TARGET (QA-3)



APPLIED IMAGE, Inc  
1653 East Main Street  
Rochester, NY 14609 USA  
Phone: 716/482-0300  
Fax: 716/288-5989

© 1993, Applied Image, Inc., All Rights Reserved