LOCUS OF CONTROL AND THE PREFERENCE FOR DIRECTIVE OR NONDIRECTIVE THERAPEUTIC TECHNIQUES IN A MILITARY PERSONNEL POPULATION

by

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Chapter 1

INTRODUCTION

Since the introduction of the locus of control construct into the psychological literature in the early 1960's, there has been an overwhelming abundance of research pertaining to locus of control. In recent years there has been a growing interest in the relationship between the locus of control of individuals, their preference for, and the effect of various therapeutic interventions. However, research in this area has been limited mainly to patients in an institutionalized setting and to students. Evidence has been found supporting the relationship between locus of control and the positive effect of different therapeutic techniques (Abramowitz, Abramowitz, Koback & Jackson, 1974; Dougherty & Horne, 1977; Helweg & Gaines, 1977; Kilmann & Howell, 1974; Morley & Watkins, 1978). Persons with an external locus of control have been found to rely upon individuals perceived as competent; that is, they obtain a higher level of status and authority for the external individual. Externals perceive consequences to be unrelated to personal behavior. These individuals have shown greater preference for highly directive therapy and a greater positive therapeutic change with this format (Baker, 1979; Kilmann & Howell, 1974). Internally controlled individuals, on the other hand, have been found to react against perceived high influence attempts and view reinforcement as being a consequence of their own actions. These individuals

have shown more preference for and greater positive therapeutic change with a highly nondirective treatment format.

Research of this kind, however, has not been conducted utilizing a nonstudent or noninstitutionalized population. With the steadily growing population of employee assistance programs which provide therapy for employees in work settings, the implications for this type of research on such a population are great. Army personnel make up a specific population which fulfills the latter description. The Army, each individual base throughout the United States, has its own mental health and psychiatric program available for the use and service of Army personnel. (See Chapter 3 for further information on the various programs the Army offers.) Military personnel represent a distinct employee population, not altogether separate from other employee populations such as industrial employee populations; but still disjoint in many different ways. The need exists to study a broad range of levels of populations, and an Army population offers a unique sample that has not yet been researched.

Several general implications can be made through the use of the Army as a sample population. The findings from the group of enlisted personnel in some ways can be generalized toward an industrial blue collar sample, for both enlisted Army personnel and blue collar employees typically partake in manual labor. Just as the latter assumption can be made from the Army toward the general population, the findings from the group of Army officers might be generalized toward an industrial white collar sample, for both Army officers and white

collar employees typically partake in higher level status positions requiring a higher level of authority.

Also, should the preference for a specific therapy format be found in Army personnel with a lower level of education (e.g. high school only), a lower salary (e.g. $10,000 and under), a more external locus of control, etc., then these findings can be used in a number of counseling or therapeutic settings (schools, hospitals, clinics, employee assistance programs), to predict which type of therapy each individual client would prefer. This idea is based on the assumption that certain demographic information about each client will be available to the persons lending their therapeutic or counseling services.

Purpose

The purpose of this study was to explore the relationship between locus of control and preference for directive or nondirective therapy and the variables of level of employment (military rank), education level, age, race, and sex. Locus of control was measured by the Internal-External Locus of Control Scale designed and constructed by Rotter (1966). Preference for directive or nondirective therapy was measured by the Psychotherapy Preference Questionnaire designed and constructed by Clum (1981). A demographic data questionnaire was included to obtain information concerning the variables of level of employment (military rank), level of education, age, sex, and race. Specifically, the study focuses on answering the following questions:

1) Does a relationship exist between the level of employment (rank) of an individual and his locus of control?
2) Does a relationship exist between the level of employment (rank) of an individual and his preference for therapy style?
3) Does a relationship exist between locus of control and psychotherapy preference?
4) Does a relationship exist between level of employment (rank), locus of control, and psychotherapy preference?
5) Does a relationship exist between psychotherapy preference and level of employment, level of education, age, sex, and race?

Definition of Terms

1) Locus of Control. The extent to which persons perceive contingency relationships between their actions and their outcomes (Rotter, 1966).
2) External Locus of Control. The belief that outcomes are directed by agents or factors extrinsic to themselves, e.g. fate, luck, powerful others (Rotter, 1966).
3) Internal Locus of Control. The belief that individuals have some control over their destiny; the belief that some control resides within the individual (Rotter, 1966).
4) Level of Employment. The point at which an employee is placed on the employment hierarchy. Lower positions on the

hierarchy (lower ranked military personnel) are characterized as blue-collar workers and higher positions on the hierarchy (higher ranked personnel) are characterized as white collar workers.

5) Blue-Collar Worker. A manual or industrial worker (Ehrlich, Flexner, Carruth & Hawkins, 1980); military personnel with a rank level of E1 to E9.

6) White-Collar Worker. A worker who is not engaged in manual labor, such as an office worker (Ehrlich, et al., 1980); military personnel with an officer ranking from WO1 - CW4 to O1 - O5.

7) Military Rank.

E1 - private
E2 - private
E3 - private first class
E4 - specialist 4th class
E5 - sergeant
E6 - staff sergeant
E7 - sergeant 1st class
E8 - master sergeant/1st class
E9 - sergeant major

WO1 - warrant officer
WO2 - warrant officer
CW3 - chief warrant officer
CW4 - chief warrant officer

O1 - 2nd lieutenant
O2 - 1st lieutenant
O3 - captain
O4 - major
O5 - lieutenant colonel

8) Lower Income Employees. Enlisted military personnel who fall within the ranking category E1 - E9.

9) Higher Income Employees. Military officers who fall within the ranking categories WO1 - CW4 and O1 - O5.

10) Employee Assistance Program. A program that provides therapy for employees, which is designed to relieve the psychological and physical stress many employees experience. An "in-house" employee assistance program is provided by the employer for the use of all employees, and is located within the employment setting. Mental health professionals such as family and marriage therapists, psychologists, and social workers are hired by companies to run the "in-house" employee assistance programs. An "out-house" employee assistance program consists of an outside mental health agency to which employers can refer employees for help.

11) The Rotter Internal-External Locus of Control Scale. This scale is a 23-item forced choice questionnaire which is defined as a social reaction inventory. The scale is scored in the external direction; the higher the score the more external is the individual. (For further information see Chapter 3.)

12) The Psychotherapy Preference Questionnaire. This scale is a 48-item forced choice questionnaire which assesses specific expectancies and preferences for psychotherapy. Higher scores on the scale indicate a stronger preference for directive therapy. (For further information see Chapter 3.)

Rationale and Hypotheses

While several research studies in the past have found that acquiring a greater amount of education and more prestigious positions in the job market have changed an external locus of control to an internal locus of control, further research is needed on a population different from those already tested (Harvey, 1973; Mink & Watts, 1973; Thomas & Carpenter, 1976; Vasquez, 1978).

Harvey (1973) found that governmental administrators who had been working within the governmental system for a longer amount of time, and who had been promoted from one class to another throughout their years of employment, scored in the more internal direction on the Rotter Internal-External Locus of Control Scale. High internal scores were attributed to the amount of responsibility an employee had.

Vasquez (1978) found that persons in a lower socioeconomic class tend to score as externals while persons in a higher socioeconomic class tend to score as internals. Individuals who live in a lower class lifestyle believe that external forces are largely responsible for what happens to them and have great difficulty in attributing causality to themselves. Persons intending to go to college were more internal than those individuals who had no such future plans. Persons who believe they control their own lives are in a position to work toward receiving the reinforcements they desire; they will make future plans. Those persons not intending to attend college, the more external individuals in Vasquez' study, see less relationship between their own actions and what happens in their lives. Therefore, they

tend to make fewer long range plans. Thomas and Carpenter (1976) found evidence that suggested that persons with an external locus of control are lower in mature career attitudes.

Evidence from Mink and Watts' (1973) research suggested that students' persistence in school is related to changes that occur in their internal-external locus of control. Students' persistence increased as their locus of control changed in the internal direction.

Based on the evidence cited, it is reasonable to hypothesize that:

H_1 = Blue-collar employees will score higher (more external) on the Rotter Internal-External Locus of Control Scale than will white-collar employees.

Based on the previous rationale and the research supporting the evidence that persons with a lower socioeconomic status will prefer a more directive therapeutic technique, assumptions concerning the relationship between employment level and psychotherapy preference are made. Helweg and Gaines (1977) presented subjects with individual films of the same patient being separately interviewed by therapists. They found evidence that persons preferring an Ellis presentation (a directive style of therapy), had a lower educational level than those persons who preferred the Rogerian presentation (a nondirective therapeutic style). Based on this evidence and the assumptions pulled from the rationale from hypothesis one, it is reasonable to hypothesize that:

H_2 = Blue-collar employees will score higher (greater preference for directive therapy) on the Psychotherapy Preference Questionnaire than will white-collar employees.

Several research studies have provided evidence for a relationship between locus of control and preference for psychotherapy approaches. Results indicate that individuals with an internally directed locus of control prefer nondirective therapy techniques, while externally oriented individuals prefer more directive therapy techniques (Abramowitz, et al., 1974; Baker, 1979; Friedman & Dies, 1974; Helweg & Gaines, 1971; Jacobson, 1970; Kilmann, Albert & Sotile, 1975; Kilmann & Howell, 1974; Kilmann & Sotile, 1976; Morley & Watkins, 1978; Stuehm, Cashen & Johnson, 1977; Winter, 1975).

Morley and Watkins, (1978) examined different therapeutic approaches and their results in facilitating the decrease of observable anxious behavior. Direct disputing of client beliefs was most effective among those clients who had an external locus of control and less directive therapeutic conditions were more effective for relieving anxiety behaviors in internally oriented persons. Morley and Watkins suggested that because internally controlled clients assume personal responsibility for control of their environment, they considered the directive disputing of the traditional Rational Emotive Therapy approach (Ellis' technique) as a threat to their self worth. Internally oriented participants, therefore, displayed the greatest therapeutic change under less directive therapeutic conditions than offered by conventional Rational Emotive Therapy. People with an externally controlled orientation tend to ascribe power for change to an authority or circumstance beyond their personal control. These persons tended to adopt the therapists' judgments with no sense of personal diminish-

ment; they preferred the conventional directive Rational Emotive Therapy approach.

Kilmann, Albert, and Sotile (1975) interpreted the results on the "Inner-Directedness" Scale of the Personal Orientation Inventory as suggesting that external clients may achieve the most significant therapeutic benefits from a structured therapist intervention program, while internal clients may require a therapist model of minimum control and structure to achieve maximum therapeutic gains. One year later Kilmann and Sotile (1976) achieved similar results.

Jacobson (1970), Helweg and Gaines (1971), and Stuehm, et al., (1975) all found similar results as Kilmann, et al., (1975 and 1976). Each of these researchers used different methods of obtaining their results. Jacobson had subjects choose their therapy preference on the basis of written descriptions of two different therapists' way of working with clients. One therapist focused in a directive style while the other focused on a nondirective style. Helweg and Gaines' results were determined by questionnaires with forced choice responses. Stuehm, et al., obtained their results through the use of videotapes, displaying initial counseling sessions illustrative of both directive and nondirective types of therapy. It is reasonable to hypothesize, based on the research cited that:

H_3 = A positive relationship will exist between scores on the Rotter Internal-External Locus of Control Scale and scores on the Psychotherapy Preference Questionnaire.

Many empirical investigations have reported relationships between internality and adaptive behaviors such as intellectual ability and achievement (Baker, 1979; Mink & Watts, 1973; Thomas & Carpenter, 1976; Vasquez, 1978).

Mink and Watts (1973) found that as internality increased, so did one's grade point average. Persistence in school (continuing with an education beyond a state's required level) was further correlated with an internal locus of control.

Thomas and Carpenter (1976) found evidence indicating that locus of control has a great effect on the development of mature career attitudes across a variety of age groups. A high level of career maturity was exhibited by internals and a low level of career maturity was exhibited by externals.

Vasquez' study (1978) gave strong support that internal locus of control is closely tied to high levels of aspiration, expectancies of success, achievement motivation, intensity of work, and socioeconomic status. Vasquez concluded that external students tend to lack many traits that are important to effective learning. The great majority of lower socioeconomic students, participating in Vasquez' research, achieve a lower-than-average level academically and the great majority of the lower socioeconomic students score as externals on the Rotter Internal-External Locus of Control Scale. Baker's (1979) research added support to that done by Vasquez. It is reasonable to assume in the following hypotheses that:

H_4 = There will be a negative relationship between level of education and scores on the Rotter Internal-External Locus of Control Scale (higher levels of education should correlate with an internal locus of control while lower levels of education should correlate with an external locus of control).

H_5 = There will be a negative relationship between level of education and scores on the Psychotherapy Preference Questionnaire (higher levels of education should correlate with a greater preference for nondirective therapy while lower levels of education should correlate with a greater preference for directive therapy).

H_6 = There will be a negative relationship between level of income and scores on the Rotter Internal-External Locus of Control Scale (higher levels of income should correlate with an internal locus of control while lower levels of income should correlate with an external locus of control).

H_7 = There will be a negative relationship between level of income and scores on the Psychotherapy Preference Questionnaire (higher levels of income should correlate with a greater preference for nondirective therapy while lower levels of income should correlate with a greater preference for directive therapy).

Evidence was not cited in the research that suggested any significant correlations between the variables of age, sex, and race and the difference of locus of control and the preference for therapy style. If any relationship did exist, the correlation was attributed to variables such as those used as preference data in this research: level of employment, locus of control, psychotherapy preference, education level, and income level. Age, sex, and race will be further examined in this study as they relate to the preference data within a military personnel population.

Methodological Assumptions

1. The employees who participate in this research are representative of the universe of employees working in a wide variety of settings.
2. Information obtained by means of questionnaires distributed to the stratified random sample of military personnel will be accurate enough to register significant correlations between the preference data.
3. Preference for a specific style of therapy is also representative of the style of therapy that would prove most successful with any given individual.

Chapter II

REVIEW OF LITERATURE

A vast amount of research pertaining to the locus of control construct, on individual's preference for a directive or nondirective style of therapy, and the outcome of therapeutic gain derived from a specific therapeutic technique exists in the literature. A majority of the literature supports the hypothesis that a positive relationship exists between the external locus of control and a preference for directive therapy and an internal locus of control and a preference for nondirective therapy. Externality, in the research, has been correlated with persons having a lower level of education and a lower level of income. The populations for these research studies, however, have been persons in clinical or institutional settings or college students. Little research has been focused outside of these settings when studying the relationship of locus of control to therapeutic format preference.

Little attention in the research has also been given to the identification of additional variables that could aid in identifying a specific person's psychotherapy preference. Locus of control as a predictive variable has been the focus of a majority of the research. Easily identified individual characteristics such as level of employment, education, income, age, and sex are just a few of the characteristics which would prove most helpful to therapists in identifying

or predicting a persons psychotherapy preference. These predictor variables would be especially helpful in an employment environment where this information would be easily obtainable.

Locus of Control and Preference for Directive versus Nondirective Therapy

Locus of control and its relationship to the preference for directive or nondirective therapy research became popular in the psychological literature in the 1960's. Since this time, an abundance of research studies have been introduced into this field, tapping numerous causes and results of internality and externality. College students and clinical or institutional patients made up the majority of the samples used for this research. The basic focuses for the following studies were to investigate relationships between an individual's locus of control and psychotherapy preference, to lay a groundwork for a new system of patient-therapist matching, and to identify personality variables with locus of control and psychotherapy preference. The studies hypothesized that differences in locus of control would exist between persons choosing a nondirective oriented therapeutic approach and persons choosing a directive therapeutic style. Subjects who would choose a directive therapy format, it was hypothesized, would be more dependent, more authoritarian, and more externally oriented; while subjects who would choose a nondirective therapy format would be more independent, more democratic and more internally oriented.

Helweg and Gaines' (1977) research investigating the relationship between personality variables and psychotherapy preference confirmed the hypotheses. Seventy-seven college undergraduates and 77 hospitalized psychiatric patients participated in the study. Measures for each subject were obtained on the Rotter Internal-External Scale the Rokeach Dogmatism Scale (Form E), the Taylor Manifest Anxiety Scale, and Gordon's Survey of Interpersonal Values. Each subject was then presented with sound-film recordings of initial therapeutic interviews. There were two films, one depicting Ellis' directive therapeutic approach, and the other portraying Rogers' nondirective therapeutic approach. After presentation of the film each subject was asked to complete the Barrett-Lennard Relationship Inventory to control for possible order effects, and then state a preference for one of the therapeutic approaches. Both students and patients who were more externally oriented and more dogmatic preferred a directive therapeutic approach; and, the more internally controlled and less dogmatic students and patients preferred a nondirective therapeutic approach. Patients who preferred a more directive approach were more anxious and had a lower level of education than patients who preferred a more nondirective approach, but those same results were not procured among the student sample. The education level between patients and college students is a possible confounding variable in this result. Both patients and students who preferred a nondirective therapeutic approach valued independence as a basis for relating to other persons, more so than those patients and students who preferred a directive

style of therapy. The findings of this research indicate that the addition of dogmatism and possibly anxiety may also be useful in terms of clasifying individual cases into the two therapeutic preference groups, directive or nondirective therapy.

Helweg and Gaines' study was one of the few studies in which a strong correlation between locus of control and psychotherapy preference was found. The significance of this study may be due to the fact that additional personality variables were added. This study indicated the need for further research on additional predictor variables for psychotherapy preference. Several studies found no correlation between locus of control and psychotherapy preference.

Jacobson (1970) conducted a study composed of 100 undergraduates (62 female, 38 male), none of whom were undergoing psychotherapy or were advanced students in psychology. Locus of control and other personality dimensions were measured by means of the Fordyce Dependency and Social Desirability Scale. Preference for therapeutic style was obtained by asking the subjects to imagine that they were experiencing personal problems in their lives and that, upon applying for therapy, they were to choose between two equally experienced and competent therapists; one of the therapists having a directive style of therapy and the other, a nondirective style. The goal of identifying a new system of patient-matching was not achieved. Apparently locus of control was not sufficient to adequately discriminate between preference for psychotherapy; no statistical significance was obtained.

Stuehm, Cashen, and Johnson's (1977) research of preference for an approach to counseling was an effort to isolate various factors related to successful counseling outcomes; specifically clients' preference for different theoretical approaches. Twenty-four graduate students, enrolled in an introductory psychology course at Illinois State University, participated in the research. Initially, all participants were given Rotter's Internal-External Locus of Control Scale. Following this test, each subject viewed videotapes of counseling sessions illustrative of Rogers' and May's humanistic therapy, Freud's psychoanalytic therapy, and Ellis' and Krumboltz's behavioral therapy. Each approach was represented by a 15-minute segment with the same therapist, same client, and same presenting concern. The subjects were told to "Please pay attention to these films as you will be asked to give some opinions of them after you have seen them." The subjects were then asked which therapy segment they preferred and why. Contrary to the hypotheses of the study, no significant differences between internals and externals in preference for counseling approach were found. Structure appeared to be the most important factor considered by the subjects when stating the preference for therapeutic approach. Structure was correlated with "getting something done;" accomplishment, closure, and a sense of resolving the presenting problem. The responsibility for the success of the therapy was seen as resting with the counselor by externals and with the client by internals.

Dougherty and Horne (1977) studied how institutionalized adolescent males perceived the helpfulness of three therapeutic models in regard to the adolescents' locus of control orientation. The three models were as follows: advice giving, Adlerian interpretation, and analytically derived interpretation. Twenty internal and 20 external male subjects were chosen from a state training center for delinquent boys. Internal locus of control was defined by a score in the lower 40% of the group on the Rotter Internal-External Scale and external locus of control was defined by a score in the upper 40% of the group. The videotape consisted of eight role-played therapy segments. A problem statement was presented by a role-playing male adolescent, and a role-playing counselor then gave three separate counseling responses, each one representing one of the three specific therapeutic methods. The subjects were tested in groups. The adolescents participating rated each response on a scale from one to three; the subject was to place a "1" in the box on the answer sheet next to the counseling statement he found most helpful, a "3" in the box next to the statement he found least helpful, and a "2" in the box next to the remaining statement. The Rotter Internal-External Scale was orally administered to the subjects. Both internal and external subjects ranked advice-giving as most helpful. Internals ranked analytically derived interpretation as more helpful than Adlerian interpretation, possibly indicating that internal institutionalized males may be more sensitive to the causes of their behavior than externals.

These latter research studies in which the hypotheses were not supported represent examples of research where only a limited number of variables were considered in the attempt to determine psychotherapy preference. Locus of control was the focus personality characteristic in these studies. Notice that when additional variables (e.g. dogmatism and anxiety) were looked at in Helweg and Gaines' research, greater support for the hypotheses was found. Also, once again, it can be seen that the populations tested were limited. More emphasis in future research should be put in expanding the type of population sampled. Dougherty and Horne introduced a very difficult procedure into their study; that of administering the Rotter Scale orally to a group. This scale was not designed to be conducted in this manner, therefore, this process of administration could have significantly swayed the results of the hypotheses in the negative direction. Jacobson's study, using undergraduates as a sample, may not have obtained significant results because the sample was not a diversified enough group for differences to come into play; the differences were not strong enough to get a prediction. Because the scores on the Rotter Scale, used in defining internal and external orientations, were not defined, there is doubt as to whether there was consistency in classifying internals and externals in each specific study.

Locus of Control and Outcome in Directive versus Nondirective Therapy

Several studies have been carried out to determine the implications of locus of control and its use in determining positive outcome in psychotherapy. Each study attempted to evaluate the effectiveness of a method of psychotherapy on persons either internally or externally controlled. The main hypothesis of each study was that those persons who were internally controlled would experience a more positive therapeutic gain with nondirective therapy while those individuals who were externally controlled would experience a more positive therapeutic gain with directive therapeutic techniques. Rotter (1966) expressed that psychotherapeutic transaction can be viewed as a process of interpersonal influence and an individual's position along the internal-external dimension might help explain his differential reaction to the various therapeutic formats. As cited from past studies, it has been found that internally controlled persons are not easily captivated by arguments presented by authorities; but attitude change is definitely more apparent in these internals when allowed more active participation. In contrast to internals, externals appear to be more responsive to more prestigious sources of influence. This response is validated by the externals' ready acceptance of suggestions and directives.

Abramowitz, Abramowitz, Roback, and Jacobson, (1974) conducted research with a sample of mildly distressed college student clients (14 male, 12 female), who were randomly assigned to a nondirective or to one of three directive groups, all led by the same therapist.

Subjects' locus of control was measured by Rotter's Internal-External Scale. As hypothesized, the individuals who were assigned to a therapy group more closely matched to their locus of control experienced greater therapeutic gains than did those students whose treatments had not been fit to their personality.

Friedman and Dies (1974) found that internally oriented subjects would show greater resistance and gain less from directive therapy than would externals. Test-anxious students were examined according to their locus of control, measured by Rotter's Internal-External Scale, and their responses to three forms of therapy: counseling, systematic desensitization, and automated desensitization. The sample consisted of 18 extreme external subjects and 18 extreme internal subjects. Three comparable treatment groups were formed from this sample. The treatment group received one of the three forms of therapy over a five-week period. At the end of this five-week period clients were questioned as to their satisfaction with certain aspects of the program. Externally controlled individuals who were given control of the therapy sessions felt like they were given "too much" of the therapeutic control. Internals significantly more often chose the "client controlled" therapeutic format. This evidence supports the prediction that internal subjects would show greater resistance to the control implied in the two directive-behavioral therapies than external subjects.

In Winter's (1975) study, locus of control was chosen as a predictor variable for obesity treatment strategy outcome. Parti-

cipants in the study volunteered by responding to a newspaper advertisement. Forty community women answered the ad which asked for obese females willing to participate in a therapeutic treatment strategy (the goal of the therapy being reduction of weight in the women.) A specific goal of the researcher was to obtain a sample differing from the typical "mildly overweight college females" studied in previous weight reduction research. Each of the four treatment programs differed in the amount of structure, type of reinforcement, peer influence, and function of the therapies. The groups met for one and one-half hour sessions each week for eight weeks. The Rotter Internal-External Scale was given initially. The internal treatment format stressed self-management techniques, whereas the external treatment format stressed environment planning techniques. The reinforcement of weight loss varied as to presence of therapist-peer reinforcement (public-weighings) or absence of therapist peer reinforcement (private-weighings). Results of this research exhibit weight loss as being affected by the locus of control variable and the treatment strategies. Subjects placed in parallel groups, either self control/internal or external control/external, displayed a significant amount of weight loss as compared to the subjects placed in cross-matched groups; either self control/external or external control/internal. Locus of control was detected as an effective predictor variable when used to assign specific treatment types to clients for successful outcome.

Kilmann and Sotile (1976) and Kinder and Kilmann (1976) conducted additional studies on the effects of direct and nondirect leader roles on internally and externally controlled group participants. The first study mentioned (Kilmann and Sotile) explored the relationship between locus of control, structure of leader role and outcome through a 16-hour marathon format; a therapeutic format claimed to have a more controlled impact than other treatment structures. An exact replication of the treatment used in Kilmann, et al.'s study in 1975 was used. Exact exercises and measures were also used; but in addition, as in Thomas and Kilmann's study in 1974, a measure of conflict-handling styles was utilized to identify the concommitants of internal and external subjects' responsivity to leader role. Also included was a measure of three negative affect traits: anxiety, depression and hostility. Rotter's Locus of Control Scale was used as a dependent and independent variable because prior research has found changes in clients' locus of control orientation following their therapeutic experience. Prior studies have associated externality with pathology and less adaptive coping mechanisms (e.g. Palmer, 1971 and Shybut, 1968). Further research has found internality to be associated with positive personal adjustment and freedom from pathology (e.g. Hersch & Scheibe, 1967 and Phares, Ritchie, & Davis, 1968). On the basis of this past research, it was assumed that a shift toward externality for internal and external subjects would be reflective of negative change. The subjects participating in this research were 23 male and female undergraduate university students from the University of

South Carolina. These students enrolled in a Psychology of Marriage course, all volunteered to participate in the 16-hour marathon group. Six females and six males were assigned to the structured marathon group; and six females and five males were assigned to the unstructured marathon group. The subjects were randomly assigned to one of the two groups on the basis of their pretreatment scores on the Rotter Scale. Subjects scoring below the median score of the group were identified as internals and subjects scoring above the median were identified as externals. The role taken by the leader in the structured marathon group was to control the order of member participation, while his role in the unstructured group was to create and maintain participant responsibility for the session. An identical sequence of exercises was utilized within both groups. The measures used were the following: The Personal Orientation Inventory, measuring personality characteristics associated with "positive mental health;" Management-of-Differences Exercises, measuring five interpersonal conflict-handling styles (competition, collaboration, sharing, avoiding, and accomodation); Rotter Internal-External Locus of Control Scale, measuring an individual's generalized expectation about personal control over the reinforcements that occur relative to the individual's behavior; The Multiple Affect Adjective Checklist, measuring three clinically relevant negative affects - anxiety, depression, and hostility; participant ratings of the leader, tapping participant perceptions of the group leader; and participant ratings of the group, assessing subjects perceptions of the usefulness, process, and effect

of the group. Results of the study revealed that external subjects within the structured group rated the group and the leader more positively than did the internals, and internal participants within the unstructured group rated the group and the leader more positively than did the externals; results that were predicted initially. Also, internals and externals reported differential changes in the predicted direction as a function of leader structure on general anxiety, general depression, and locus of control orientation. No significant differences were found between internals and externals as a function of treatment condition on the personal orientation inventory, but significant locus of control by treatment interactions were detected on the Multiple Affect Adjective Checklist, as well as on the Rotter Internal-External Locus of Control Scale. This study provides further support for the appropriateness of an unstructured leader role for internally controlled individuals and a structured leader role for externally controlled individuals.

Several studies obtained results that did not confirm the hypotheses supported in the previous research. Marathon group format was used in these studies. The groups were often lead by the same leader (both directive and nondirective marathon therapy groups). Experimenter bias is a possible factor for the insignificant results of the research.

Kinder and Kilmann investigated the hypothesis of Bednar, Malnick, and Kaul (1974) that assumes a high level of structure in the initial stages of therapy should be beneficial to all individuals

involved. Under these conditions of low client responsibility it was hypothesized that clients would then tend to engage more quickly and openly in high-risk behaviors, behaviors relevant to a positive treatment outcome. A 23-hour marathon group format was used to investigate the impact of high and low leader structure on self-actualization for internally and externally controlled participants. Five treatment groups existed in this study: the first was highly structured for the first half of the treatment process, changing to an unstructured format for the second half; the second group was highly unstructured during the first half, followed by a highly structured leader role; the third group, for the purpose of comparison with previous investigations, was highly structured throughout the entire treatment session; a fourth group remained entirely unstructured throughout the entire session; and lastly a no-treatment control group. Forty-seven male and female college students, ranging from 18 to 52 years (average age being 28.5 years), participated in the study. All of the subjects in the four treatment groups were exposed to identical, prearranged group exercises. In the structured group sequences the therapist defined his leadership role from the beginning and continued to overtly assert his leadership role. The therapist initiated topics of discussion, participant feedback and constantly attempted to engage all group members in active participation. In the unstructured group sequences the therapist did not define his role unless one of the subjects asked that he do so. The therapist defined his role, in these instances, as another active member of the group. When

describing the exercises, the therapist attempted to exert as little control as possible. Group members were supported by the therapist to take initiative for the treatment process and the leader requested no feedback or inputs from any specific group members. The measures used in this research were Rotter's Locus of Control Scale and Shostrom's Personal Orientation Inventory, a measure of self-actualization. In previous research, it has been indicated that these two scales yield the most meaningful measures of self-actualization or personal adjustment. Subjects scoring eight or below on Rotter's scale were identified as internals and those scoring nine or above on Rotter's scale were designated as externals. By this classification the subjects were assigned randomly to one of the five groups. Upon examination of the effect of varying structure within each group no significant differences were found in Groups I (unstructured-structured), II (unstructured throughout), or V (controls). In Group III, the structured-unstructured group, internals were significantly different from externals, and a lower level of significance was obtained in Group IV (structured throughout). The results of this study indicate that the hypothesis is tenable; the group with the structured format in the initial stages and the unstructured format in the following stages was more benficial to all individuals involved than the other groups. The difference in internals and externals may be explained by the ceiling effect which most probably occurred in the internals, in that they had high scores prior to

treatment. No interacton between locus of control and therapist structure was found in this study using the marathon format.

In 1978 Schmidt tested the hypothesis that tailoring the treatment strategy to control orientation enhances therapeutic change with an alcoholic population. Sixty male alcoholics from an Army Rehabilitation Center participated in the study. After completing five self-report tests, subjects were randomly assigned to two experimental and one control conditions. One of the experimental groups stressed self-direction and the second stressed and encouraged relying on group members. The results of the study did not support the hypothesis. Interally controlled subjects experienced greater therapeutic gains than did externally controlled subjects, regardless of the therapy format. Data from one of the self-report measures indicated that internals were signficiantly less anxious than externals. Several other studies have documented results of internals responding more favorably to treatment despite the specific technique used. Subjects benefitted most from internally directed treatment, regardless of their locus of control. It was suggested here that the sample's considerable lack of interpersonal trust interferred with the effectiveness of the externally-directed treatment. Even though the main hypothesis of this study was not supported, differences in response were detected on the basis of locus of control orientation. These findings suggest that failure to include relevant personality variables can mask treatment effects.

One year later, in 1979, Pickett conducted a similar study utilizing surgical patients for her sample. Evidence exists indicating that the surgical experience is a highly stressful and anxiety-producing event for most individuals. Evidence also exists that shows poor post surgical adjustment is related to high levels of presurgical anxiety. Three focuses existed in this study: 1) examine the effects of relaxation training information in aiding postoperative outcome; 2) examine the effects of relaxation information in aiding postoperative outcome; and 3) examine the effects of matching patients by locus of control with treatments designed to be congruent with their locus of control expectations. Anxiety and pain measures were taken to assess preoperative and postoperative outcome, as well as the number of days the patient spent in the hospital and the number of analgesics the patient received. Twenty-one male and 75 female patients about to undergo elective cholecystectomy surgery participated in the study. Subjects were divided into internal and external groups and assigned to one of four groups: relaxation training and the relaxation infor- pseudotherapy, and a no-treatment control. No significant interactions were found between the relaxation training and the relaxation information groups by locus of control; but trends in the data showed externals, who had received relaxation information, to have lower post-operative pain. Internals receiving pseudotherapy while externals receiving relaxation training had less pain than individuals who scored in the mid-range on locus of control who also receive relaxation training.

Further research in 1974 by Kilmann and Howell gave some additional information to the commonly asked questions: Does psychotherapy work? Whom does it make better, worse, why, and how? The outcome of external and internal scorers on Rotter's locus of control scale was compared with therapeutic change with direct and nondirect marathon group therapy. Eighty-four institutionalized female drug addicts were randomly assigned to one of five groups: two nondirect marathon groups, two direct marathon groups, and a no-treatment control group. The results of this research showed that internals (scores fell within 2-7 on the Rotter Internal-External Scale) evaluated themselves more favorably, evidenced greater efforts to be successful, became more involved in therapy, more reflective, more serious, and made more attempts to understand themselves regardless of a direct or nondirect therapist technique. The findings suggest that externals (scores fell within 12-19 on the Rotter Internal-External Scale) may require a more intensive or more prolonged therapeutic contact than internals to achieve similar goals. The inability to determine the predicted interaction between locus of control and type of therapy may have been a function of the complexity of marathon group therapy. Age or type of disorder are further suggested as possible variables affecting the results of the research.

Morley and Watkins (1974) assumed that the different tendencies typical of these individual personalities (internals and externals) might influence the degree of benefit a specific therapy approach will have with particular clients. Thirty students in a public speaking

course, previously identified with the Rotter Scale as being internally or externally controlled, were used to investigate the hypotheses of the study. Internals were identified as those subjects scoring between 0 and 8 points and externals were identified as those subjects scoring between 13 and 20. Two therapeutic group approaches were used: Rational Emotive Therapy, a directive therapeutic style, which includes an active disputing of a client's irrational beliefs and a modified Rationale Emotive Therapy group which excluded the open disputing of irrational beliefs. Participants were randomly assigned to one of the two treatment approaches. Subjects rated the severity of their speech anxiety on two separate self-report instruments both before and after treatment. A one-way analysis of variance reported no significant difference in the reduced rate of speech anxiety by internally or externally controlled subjects in either treatment condition. However, a similar statistical analysis of the scores on the speech anxiety scale produced different results. Externally controlled subjects treated with conventional Rationale Emotive Therapy and internally controlled subjects treated with modified Rational Emotive Therapy displayed the greatest therapeutic gains. Evidence of a significant reduction in frequency of overt anxious behaviors existed. These findings are questioned because of the opposite findings of significance with the two different statistical tests. It is suspected that probably the numbers were rearranged in order to find a significant difference in the data.

Hayden's (1970) research was designed to evaluate the effectiveness of a method of psychotherapy which emphasized client awareness of control expectancies and encouraged an internal locus of control orientation. Participants in the study were clients at a private mental health center who had been accepted for individual therapy. Each subject was assigned to one of two different treatment groups until the subjects appointed to each group had completed six treatment sessions. Clients in one group received "internalization or more nondirect therapy while clients in the other group received "non-internalization" or more direct therapy. Pretest-posttest measures included the Rotter Internal-External Scale, the Mooney Problem Checklist, the Minnesota Multiphasic Personality Inventory, and a previously untried Psychotherapy Questionnaire. No significant differences were found for a reduction in self-reported problems and "internalized" therapy. Several weaknesses in the study were cited, one of these being that groups were not initially divided according to locus of control construct, peronality characteristics, and/or a specific problem orientation.

These studies on locus of control and psychotherapy outcome also emphasize the need for the increased identification of other personality variables in order to be a significant finding. Experimenter bias is also prominent in studies where only one therapist is used in multiple test group situations. Also, marathon group format (the different amount of time involved) is a possible contributor to the insignificant findings. Further research with a "normal" population

was suggested. A majority of the past research was conducted with patient populations. These populations may not be a diverse enough group to show significant statistical results. Therapy also does not take place solely in institutions and hopsitals, but within communities, within employment environments, and within various other settings as well.

Locus of Control and Adaptive Behavior Variables

In a sample of 77 students from an advanced studies program (ASP) at Southeastern Community College in North Carolina, the relationship between grade point average and persistence in school was compared with locus of control (Mink & Watts, 1973). Prior to enrollment in ASP, Rotter's Locus of Control Scale was administered to the 77 freshman participating in the program. Students with scores of 10 or above were identified as externally oriented and students with scores below 10 were considered to be internally oriented. Results of this study showed that a higher percentage of internals persisted in the educational program, than did externals, but out of the total sample the rate of persistence was high in both internals and externals. Sixty-eight percent of the 28 externally oriented subjects remained in school for the entire year. A significant statistical correlation also existed between low grade point averages and an external locus of control and high grade point averages and an internal locus of control.

Thomas and Carpenter (1976) conducted a developmental study of the mediating effects of locus of control on career maturity. Career maturity was defined as a point on the continuum of vocational develop-

ment. Locus of control was hypothesized to be related to the growth or the acquisition of mature career attitudes; an internal locus of control related to more mature career goals and an external locus of control related to less mature career goals. A cross section of age groups was utilized for the sample. The objective of the study, determining the degree to which locus of control mediates the development of mature career attitudes, was measured with the following scales: Rotter's Locus of Control Scale, a Career Developmental Responsibility Scale designed by Thomas, and Crite's (1973) Career Maturity Inventory. Statistical analysis indicated that those individuals who were externally controlled had the least mature career attitudes while the most mature career attitudes were held by those individuals who were controlled internally. With the socioeconomic status held constant in this study, locus of control and race appeared to have a more significant effect on career maturity than did grade and sex.

Vasquez (1978) hypothesized that lower socio-economic status individuals would score as externals, while higher socio-economic status individuals would score as internals. Externality was believed to be a by-product of poverty and racial and cultural barriers. Vasquez found much evidence to support this hypothesis (Franklin, 1963; Battle & Rotter, 1961; Shaw & Uhe, 1971; Gruen & Ottinger, 1969; and Jessor, 1968).

The objective of Sherman and Hoffman's study in 1980 was to describe the relationship between locus of control and two measures of academic achievement, grade point average and standardized achieve-

ment scores. The effects of sex and socio-economic status on these relationships were also noted. One hundred and seventy-four eighth graders from a suburban district in the Midwest were chosen for this research. The sample consisted of approximately 23% blacks, 77% whites and 53% males and 47% females. Locus of control was measured by the Nowicki-Strickland scale and achievement was measured by the Stanford Achievement Test. Grade-point averages were determined from the student's Spring Quarter grades in the areas of mathematics, English, science, history, and reading. The Hollingshead Two-Factor Index of Social Position was utilized to determine socio-economic status. Significant correlations were found between locus of control and grade point average and achievement scores, though little significance was found between locus of control and socio-economic status and sex.

Vasquez (1978) reviewed an abundance of literature explaining locus of control and its effect on learning. Tseng's research (1970) found that internally controlled individuals from a sample of 140 vocational rehabilitation clients, scored higher in self-reliance than externally controlled individuals. In Franklin's research (1963) with high school students, internals had a higher level of aspiration than externals. Level of aspiration was measured by intention to go to college. Internally controlled high school students had a higher expectancy of success for their futures than did externals, according to Frieze and Weiner (1971). Immediate discouragement to failure on a given task was used to measure the correlation. Weiner, et al. (1969), Reimanis (1970), McClelland, et al. (1953), Atkinson (1958),

and Crandall (1963) all suggest that high achievement motivation is positively correlated with an internal locus of control. Locus of control also appears to affect the intensity with which one works (Weiner, 1972a) and an affective reaction to reinforcement (Weiner et al., 1972b). Individuals with an internal locus of control showed a greater intensity toward their work and a more affective reaction to reinforcement. Many studies have confirmed this observation (Lanzetta & Hanna, 1969; Leventhal & Michaels, 1971; Weiner & Kukla, 1970). Keller (1971) showed that those students preferring to work under conditions in which outcomes are determined by skill rather than chance, are internally oriented. These students also performed better under the same conditions. Externals preferred and performed better under chance conditions, since these conditions do not allow the individual to directly affect the environment. Gozali, et al. (1973), in a study with 63 university students, found a positive relationship between internality and time utilization.

All of these variables controlled for in the research discussed here were not controlled for in the previous research on locus of control and psychotherapy preference and outcome. These studies indicate that the variables of school persistence (education level), grade point average, career maturity, and socio-economic status could very well be confounding variables in the previous research.

Employee Assistance Programs

The literature on employee assistance programs serves to emphasize their importance and the need for such a service in today's society. The information revealed here supports the strong implications for this study, and its use for industries with existing or projected programs which offer therapy and counseling to their employees. The implications can also be applied to other populations which make use of therapy; therapy clinics in medical settings such as hospitals, mental health agencies, private practices, and many more.

Family and marital problems ranging from children doing poorly in school to divorcing a spouse, and mental ailments ranging from boredom to grief, affect an individual's performance on the job. Statistics show that 10% to 12% of all workers in industry have serious personal problems (Pesmen, 1980). These troubled employees need some help and support. A few companies have discovered the use of employee assistance programs. These programs provide counseling, assist employees to recognize the problems that affect their work, and help them and their families work out the problems they face. Employee assistance programs are conducted by professionals such as psychologists, family and marriage therapists and social workers. These professionals help employees uproot problems that adversely affect production, and help build a relationship of trust and openness within the work setting (Business Week, 1979; Cutting & Prosser, 1979; Grote, 1971). A survey by the American Management Association in New York of 2,281 upper and lower management personnel indicated that

90% thought that corporations should be concerned with the total person, not just daily output (Bloomquist, Gray, & Smith, 1979). Counseling the troubled employee would raise morale which could raise a department's productivity (Gould, 1970). "You need to take care of your employees' health and it's good business to do so" (Lavins, 1978).

It is possible that employee assistance programs can also save companies money. If a troubled person does not get help, he might have an accident on the job that could cost the company much more financially, than paying the salaries of professional therapists (Pesmen, 1980). Training new employees to replace old ones who have been fired because of their problems would also be more costly. Employees with problems are costly and unproductive and replacing them is expensive. However, current employees can be assisted with their troubles for less cost and with less disruption of production (Bloomquist, et al., 1979). In 1972 it was estimated that troubled employees operating at about 50% efficiency were costing industry three to 10 billion dollars per year.

Research reveals that up to 15% of the national work force struggles with personal problems that adversely affect work performance (Brasch, 1980). These struggles cover a wide range of problems: marital discord, anxiety with family life, financial demands, physical disorders, divorce, dealing with death, gambling, overeating, stress, and drinking. Everyone, from the president of the company down to the assembly line worker can be affected by personal problems.

In the past, programs in industry were set up for employees with alcohol problems only. Once the problems were identified they were treated on an individual or group basis. As these programs developed, it gradually became evident that alcohol was only one of the many problems affecting the lives and working ability of employees. Thus, services such as marital and family counseling and extensive services also became available (Bloomquist, et al., 1979). Outside help can often make the difference between ending the problem immediately and further problems developing because of the original one.

Tremendous amounts of money (up to $20 billion) are lost in production because of troubled workers (Brasch, 1980; McGaffey, 1978; Googins, 1975). Employee problems cost companies money because of loss of employee performance, accidents, errors in judgment, mistakes, absenteeism, health benefit payments, unnecessary high turnover, sub-standard production, and poor employee morale (Lamberson, 1978; Lavins, 1978; McGaffey, 1978; Noland, 1973; Slotkin, Levy & Wetmore, 1971; Roethlisberger, 1977). Employee problems may result from chronic job dissatisfaction because of job changes; failure to achieve the goals his intelligence, training and experience merit; and job tensions which lead to psychological disorders (Noland, 1973). Often, in the past, the value and dignity of employees as emotional human beings were ignored. Today the emotions of employees are regarded as factors playing an important part in job performance (Cutting & Prosser, 1979).

Employee assistance programs have a success rate of 70% to 75% or higher (Schneider, 1979; "Help for the Troubled Employee," 1975).

Listening skills must be utilized so that the subordinate will not feel uneasy discussing problems and bringing them into the open, before they take over his ability to perform on the job. Employing mental health workers within an industry to train upper management in relationships between employees and supervisors and to counsel employees suffering from personal problems is an advantage for the industry (McGaffey, 1978; Lavins, 1978). Solving the problems early can save the company money and the risk of losing a skilled and capable employee (Lavins, 1978). The key to the program is intervention and prevention.

An "In-house" employee assistance program is run within the company itself. Mental health professionals are paid a regular monthly salary (not depending on how many cases are handled), and their offices are located at the plant location. In-house programs make it possible for industrial leaders to retain control over the funds that subsidize the service. They also allow for earlier detection of emotional problems in employees. Western Electric, Prudential Life, Caterpillar Tractor, The Naval Under-Water Systems Center in Connecticut, Kennecott Copper, Polaroid, Mallinckrodt Chemical Works, Northwestern Bell, and Philip Morris, Inc. are all companies with in-house employee assistance programs (Staples, Kelsey, & Thomas, 1980; Bloomquist, et al., 1979; Cutting & Prosser, 1979; Noland, 1973; Gould, 1970).

The Hawthorne Plant of the Western Electric Company was the first nonpsychiatric industrial counseling program put into operation. The program was started in 1936. The counselors were all from higher management and had no formal training. The goal of this program was

to "bring about adjustments and changes" in the employees' attitudes through the interviewing method (Staples, et al., 1980).

In 1948 the Prudential Life Company esablished a counseling program in its Newark home office. The staff consisted of two professionally trained psychologists and a social worker, whose main goals were the improvement of employee morale and job satisfaction. Polaroid started their employee assistance program in 1958 with the idea of "maximizing human potential" (Staples, et al., 1980).

One specific employee assistance program, the Insight Program at Kennecott Copper Corporation's Salt Lake City, Utah plant, conducted a study to evaluate how important the program was in improving employee-company conflict. One sample of employees averaged 5.8 working days per month absence; weekly indemnity costs averaged $70.67 per person per month; and hopsital, medical, and surgical costs averaged $109.64 per person per month. After a 12 month involvement in the employee assistance program, the same sample displayed significant change. Absenteeism decreased to an average of 2.93 working days per month, and weekly indemnity costs averaged $25.33 per person per month. Those whom were not involved in the program showed an absenteeism increase of 2.9%; weekly indemnity 28.5%, and hospital, medical, and surgical costs, 7.7% (Skidmore, Balsam, & Jones, 1974).

Bell Telephone's statistics revealed a dire need for an employee assistance program. In 1975, 1,567 persons were seen in four districts. The number of counseling sessions held was 2,916. In 1976 1,764 persons were seen by the counselors; in 1977 1,874 individuals were counseled;

and in 1978 1,907 employees were seen by counselors (Staples, et al., 1980).

Most employees learned of programs within their companies through articles appearing in the organization's publication and from word-of-mouth contacts with people who had used the services (Cutting & Prosser, 1979). Evidence shows that people take advantage of services immediately visible and available to them. An in-house employee assistance program makes its services readily available to employees, and removes the stigma of using social services (Bloomquist, et al., 1979). The record shows that through such activity jobs are saved, marriages are saved, families are saved, and lives are saved. The rewards of employee assistance programs are numerous. Employees beset by personal problems are as much a headache to their employers as they are to themselves. Knowing the company supports the employee in every aspect will not only be comforting to the individual but to his family as well.

Individuals and their various skills are critical to the successful operation of the organization regardless of their personal problems. Most people suffer from "not relating well" and "not really" hearing other people. An important function of employee assistance programs is to teach employers listening and communication skills necessary for them to respond in an appropriate manner to employees in stressful situations. The ability of a manager or supervisor to explore various alternatives to guide employees in choosing a beneficial source of aid is also of importance to the basic overall mental state of subor-

dinants. If conflict within a specific department is viewed as a motivation for change, it will be seen as acceptable rather than a condition to hide and fear. The long range results of this type of stress intervention are far superior to ignoring or disregarding problems that exist (Merman, 1976; Slotkin, et al., 1971).

Chapter III

PROCEDURES

Sample

Letters requesting participating in the research, along with summary descriptions of the study (See Appendices A and B) were sent to companies and other employee populations with employee assistance programs across the United States. Mailgrams (See Appendix C) were sent to all employers who had not responded within a two week time period. An Army unit within the continental United States (the location of this unit must remain confidential), respondended positively to my request within three months of the initial participation request.

Approximately 600 officers are employed at the Army base participating in the research. Fifty officers were chosen randomly from this population to fill out the questionnaire. The Battalion Executive Officer was given the responsibility of choosing the random sample of officers within the batallion. It is assumed, because of educational level and position, that Army officers are equivalent to white-collar personnel.

The Company Commanders were given responsibility for randomly choosing ten enlisted personnel from each of the five companies. It is assumed, because of education level and position, that Army enlisted noncommissioned personnel are equivalent to blue-collar workers.

Mental health and psychiatric assistance is available in an abundance of services to Army personnel. Trained marriage and family therapists, Army chaplains, and social workers are available for Army personnel needing marital and/or family therapy. Company Commanders are responsible for any individual therapeutic needs. Enlisted noncommissioned personnel utilize the majority of these services. It is rare for officers to ask for help; probably because of their position and the prestige surrounding it.

The Army also has available to its employees an alcohol and drug abuse program with outpatient counseling by trained substance abuse counselors and inpatient services. A house with a capacity of 15 persons is available for patients requiring 24 hour care and rehabilitation. This program, both the inpatient and the outpatient, has proven to be very successful. The program is open to officers, but is mainly used by enlisted noncommissioned personnel.

A weight program is also available to Army personnel. Since the Army requires certain weight standards, this program is extremely important. A counselor and a dietician staff this particular program.

These particular services vary with each specific Army unit across the United States. The unit that participated in the research appears to have an adequate number of services, services designed to meet every possible need of the Army personnel.

Testing Instruments

The first portion of the questionnaire booklet is a demographic data sheet (See Appendix E). The variables participants were asked to

report are the following: sex, age, race or ethnic group, rank, and educaton.

The Rotter Internal-External Locus of Control Scale (Rotter I-E Scale) (See Appendix F) was designed and constructed by J. B. Rotter in 1966. This scale is a 23-item forced choice questionnaire with six filler items adapted from the 50-item James Scale. It is scored in the external direction, that is, the higher the score, the more external the individual. The test is defined as a Social Reaction Inventory. Each question is followed by two possible responses "a" and "b". The participant is to mark the statement he believes to be true. In some instances the person being tested may believe both statements to the same question, or neither one. In this case the person is asked to select the statement he more strongly believes to be the case (Lefcourt, 1976).

The Rotter Internal-External Locus of Control Scale is the most widely used test of internal-external locus of control. In the majority of the research studies previously discussed, Rotter's scale served as a chief mode of data collection. Norms for Rotter's I-E Scale exist for the following populations: male and female undergraduates, undergraduates in psychology or social science majors, male addict patients, first year female undergraduates, female student nurses, male soldiers, administrators, male VA psychiatric patients, hospitalized male veterans, students at a Southern Negro school, inmates at a correctional institution, negro college students, and male and female smokers (Lefcourt, 1976).

The Psychotherapy Preference Questionnaire (see Appendix G) was designed and constructed by G. Clum in 1981. The questionnaire was adapted in this study to meet the needs of the "laymen" asked to complete the questionnaire (see Appendix H). The original wording of the survey was professionally oriented, often difficult for persons unfamiliar with psychiatric jargon to understand. The question content and intended impact was not changed. This scale is a 48-item forced choice questionnaire. The scale assesses specific expectancies and preference for psychotherapy. Higher scores on the scale indicate stronger preference for a directive treatment. Subjects who score low on the scale prefer a nondirective therapy format. Each question is followed by two possible responses "a" and "b". The participant is to mark the statement with which he most agrees, or the statement with which he more strongly agrees (Clum & Schotte, 1981; Osborn, 1981).

Norms for the Psychotherapy Preference Questionnaire exist for male and female undergraduate students from the University of Georgia, male and female undergraduate psychology students from Virginia Polytechnic Institute and State University, and clients from the Psychological Services Center at Virginia Polytechnic Institute and State University. The scale bore a significant relationship to comfort and success of the therapy, and caring on the client's part, for the therapist (Osborn, 1981).

Testing Procedures

One hundred questionnaire booklets were sent to one specific Company Commander at the Army base participating in the research. This Company Commander randomly chose 50 officers, from five separate companies, to complete the questionnaire (ten officers from each company were chosen).

The Company Commander in charge of distributing the questionnaires also randomly chose five platoons. From each platoon the Commander randomly assigned ten enlisted noncommissioned personnel to complete the questionnaire.

The questionnaire booklets were returned to the Company Commander via the Army base mail. The booklets were then returned to the examiner by mail. All participants anonymity has been protected throughout the study.

Analysis of Data

The statistical analysis of the data was conducted using subprograms of SAS; the Statistical Analysis System (Blair, et al., 1979). A t-test was used for testing the first and second hypotheses; the hypotheses predicting that blue-collar personnel will score higher on the Rotter Internal-External Locus of Control Scale and on the Psychotherapy Preference Questionnaire (more external and more directive respectively) than will white-collar personnel. Locus of control and psychotherapy preference are the dependent variables, with blue and white-collar personnel serving as the testing groups.

The method of analysis used for testing the third, fourth, fifth, sixth and seventh hypotheses was the Pearson-r correlation. The third hypothesis focuses on the relationship between scores on the Rotter Internal-External Locus of Control Scale and scores on the Psychotherapy Preference Questionnaire. Hypotheses four through seven look at the level of education and income level of the Army personnel, and the expected negative relationship with the Rotter Locus of Control Scale and the Psychotherapy Preference Questionnaire.

A one-way analysis of variance was used to determine if the three rank categories of military personnel and the four race categories differed with respect to locus of control orientation and psychotherapy preference. A test for linear trend was also conducted on the rank categories in respect to their locus of control and psychotherapy preference.

A multiple regression method of analysis was used to examine the hypotheses that either locus of control or psychotherapy preference could be predicted by using the variables of age, rank, and education.

Chapter IV

RESULTS AND DISCUSSION

Seven hypotheses were tested in this study to determine the relationships between level of employment (military rank), locus of control, and preference for directive or nondirective therapy. Both the variables of locus of control and psychotherapy preference were also analyzed for their relationship with the education level, age, and race of the military personnel population. The individual characteristics of locus of control, education, rank, and race (the variables as defined in the research) were all statistically examined separately and as a group in an attempt to predict which people prefer which therapy. Jacobson (1970) was unable to identify specific individual characteristics, making this predictive ability possible. This research was still another attempt to obtain this predictive ability, yet using a nonclinical/nonstudent population. Eighty-three employees from an Army base in the continental United States participated in the research. These employees represent a sample, different from any other that has ever been tested before, in research of this kind.

Description of the Sample

Forty-one enlisted noncommissioned personnel and 42 officers from the Army branch of the military participated in the research. Thirty-

four noncommissioned and 41 officer personnel were males, while only seven of the enlisted noncommissioned personnel and one officer were female. This small representation of females in the sample precluded the use of sex as an independent variable, therefore statistical analysis of sex in relation to psychotherapy preference and locus of control was not conducted.

The average age category of military personnel represented in both the enlisted noncommissioned and the officer groups was the "20-30" range. Thirty enlisted personnel and 27 officers fell in this category, while only two persons from the total sample fell in the "less than 20" range. These individuals were noncomissioned personnel. Nine enlisted noncommissioned Army personnel and 15 officers were between the ages of 31 and 40. This was the highest age represented in this military sample.

The majority of the individuals were white (caucasian). The next most frequently represented racial group was black. Twenty-two of the enlisted personnel and 40 of the officers were caucasian. All ten of the black personnel were represented by enlisted noncommissioned personnel. Four enlisted persons were Hispanic and five categorized themselves as "other". Two of the officers were Hispanic. This sample may represent a somewhat "biased" sample, as it is primarily white, younger (20-40 age range) personnel. This factor was considered in the explanation of the research findings.

The average education level completed by the enlisted sample was technical or trade school. An associate degree was the average

level of schooling completed by the officer sample. This may seem low for the officer personnel, but a large part of the officer sample represented lower ranked officers (WO1 - CW4), and a four-year college degree is not a requirement for this rank status. (See Table 1 for a numerical representation and description of the sample.)

Testing and Discussion of Hypotheses

The first hypothesis concentrates on the difference between scores on the Rotter Internal-External Locus of Control Scale of enlisted military personnel (blue collar employees) and military officers (white collar employees). The prediction of a negative relationship in scores (enlisted men of low ranking were predicted to score high on the Rotter Locus of Control Scale, representing an external locus of control, and officers of high ranking were predicted to score low on the Rotter scale, representing an internal locus of control), was examined with a one-sided t-test. Several respondents omitted items on the Rotter Scale. Therefore, averages rather than totals were preferred in order to analyze the results of the one-sided t-test. No significant difference between the groups was found; the mean locus of control does not significantly differ between officers and enlisted personnel. Therefore, the null hypothesis of equal means was accepted, thus not supporting the expected difference between groups on the Rotter Scale.

Lefcourt (1976) reports that norms on the Rotter Internal-External Locus of Control Scale do not significantly discriminate between groups. Therefore, results on the analysis of scores between rank groups are

Table 1

Descriptive Characteristics of the Sample

Characteristic	Enlisted Noncommissioned Personnel	Officer Personnel
Numbers in sample:	41	42
Sex:		
Male	34	41
Female	7	1
Age:		
less than 20	2	-
20-30	30	27
31-40	9	15
41-50	-	-
51-60	-	-
over 60	-	-
Mean age category	20-30	20-30
Race:		
Caucasian (white)	22	40
Black	10	-
Hispanic	4	2
Other	5	-
Education:		
Average level completed	Technical or Trade School	Associate Degree

not unlike those found in many of the populations used to obtain norms on Rotter's Scale. Scores do not weigh heavily on either the external (extremely high scores) or internal (extremely low scores) side of the scale, but are often spread fairly evenly throughout the scale. The group means indicate that the trend toward discrimination of locus of control between enlisted noncommissioned personnel and officer personnel was in the right direction, but not strong enough to obtain statistical significance. The mean proportion of external responses on the Rotter Internal-External Locus of Control Scale for the two groups were: enlisted noncommissioned personnel was .403; officer personnel was .383.

Another point that must be considered here is the population sampled. Though the sample differed in regard to rank status; age, race, and sex were not equally represented. These are variables Rotter and other researchers (Harvey, 1973; Mink & Watts, 1973; Thomas & Carpenter, 1976; Vasquez, 1978) have concentrated on and for which "significant" differences regarding locus of control between groups have been found.

Several respondents omitted items on the Psychotherapy Preference Questionnaire. Because of this, averages are used in preference to totals for the statistical analysis of the data. For each research participant in the study, the number of responses indicating a greater preference for directive therapy was divided by the number of items answered (out of 48) to obtain a proportion between zero and one. A high value of this porportion indicates greater preference for

directive therapy, and a low value indicates greater preference for nondirective therapy.

The second hypothesis focuses on answering the question, do the enlisted military personnel of noncommissioned status and military personnel with officer status differ with respect to psychotherapy preference? From previous discussion it was expected that enlisted men would have higher psychotherapy preference scores than officers (i.e. enlisted men would score in the direction representing greater preference for directive therapy). (Recall, from the above explanation, that a high value of a proportion between zero and one indicates greater preference for directive therapy, and a low value indicates greater preference for nondirective therapy.) The method of analysis, a one-sided t-test, showed a significant difference between the two groups. The null hypothesis of equal mean psychotherapy preference scores was rejected in favor of the alternative that the enlisted men showed greater preference for directive therapy than did the officers. The result is significant at the .0006 level ($t = 3.3562$, $df = 81$). The average proportion of directive responses on the Psychotherapy Preference Questionnaire for the enlisted nonofficer personnel was .390. The average for officers was .318. (See Table 2).

It is not surprising, taking into consideration the positive results from the previously cited research (Helweg & Gaines, 1977), that the lowest ranked military personnel would prefer a more directive therapeutic style and those employees with an officer ranking would prefer a more nondirective therapeutic style. Previous research

Table 2

Differences Between Scores on the Psychotherapy Preference Questionnaire of Enlisted Noncommissioned Personnel and Officer Personnel

	Enlisted Noncommissioned Personnel		Officer Personnel
Mean	.390		.318
Standard Deviation	.113		.082
Degrees of Freedom		81.0	
t value		3.3562	
Probability Level		.0006	

supports the conclusions that persons who are at higher levels in an employment setting have exhibited tendencies for a nondirective therapy preference, while those persons who work at lower employment levels have exhibited tendencies for a directive therapy preference (Harvey, 1973). This finding specifically concerning the three rank categories (E1 - E9 = enlisted, WO1 - CW4 = officers, O1 - O5 = top ranked officers) will prove especially helpful to the Army. These results can be applied to the Army mental/psychiatric assistance programs, identifying, according to rank, which style of therapy would be most preferred by the specific individual utilizing the program.

The third hypothesis focuses on the relationship between scores on the Rotter Internal External Locus of Control Scale and scores on the Psychotherapy Preference Questionnaire for the enlisted military personnel and the military officers. It was expected that these scores would be positively related since the literature has shown that an external locus of control is positively related to a preference for directive therapeutic techniques, while an internal locus of control has been shown to be positively related to a preference for a nondirective therapeutic format. The method of analysis was the Pearson-r correlation; no significant correlation was determined. Therefore, the null hypothesis was accepted and no support for the expected correlation was obtained.

This finding supports Osborn's (1981) and Messer and Meinster's (1980) research criticizing many of the interaction hypothesis studies on locus of control and psychotherapy preference. However, the ambiguity of this specific hypothesis is confusing, for several studies (see Chapter II) have supported the positive relationship between locus of control and psychotherapy preference. This hypothesis should not be refuted without further study, for one or both of the measures used in this research may represent inferior measures of locus of of control and/or psychotherapy preference.

Rotter (1975) points out in a research article that his Internal-External Locus of Control Scale taps only generalized expectancies allowing for only a low degree of prediction of behavior across a wide range of situations. The scale does not tap specific expectancies with higher predictability to particular situations.

Secondly, the Psychotherapy Preference Questionnaire, being a fairly new scale, has been validated on a limited variety of persons; students have been used solely as a means of validating the Psychotherapy Preference Questionnaire. When, in this present research, the examiner attempted to widen population sampling (e.g. industries and various other employee facilities), it was stated that the questionnaire was "too professionally written; difficult for the lay person to comprehend." Therefore, the wording of the questionnaire was changed to meet the needs and comprehension of the military population sampled.

The fourth hypothesis predicts that there will be a negative relationship between level of education and scores on the Rotter Internal-External Locus of Control Scale. Again a Pearson-r correlation was used to determine the significance of the relationship between level of education and externality (higher scores on the Rotter Internal-External Locus of Control Scale). The null hypothesis of no correlation was accepted.

The expected negative relationship between level of education and preference for directive therapy, determined from scores on the Psychotherapy Preference Questionnaire was also found to be insignificant at the .05 level. This conclusion was determined also with the Pearson-r correlation.

In summary, results do not confirm either of the negative relationships between education level and scores on the Rotter Internal-External Locus of Control Scale and the Psychotherapy Preference Questionnaire.

Again, the special population (Military personnel) sampled may explain the insignificant findings for hypotheses four and five. Despite a person's education level, a great deal of skill and hard work can help a military person increase his rank status. Therefore, the variables for many of the individuals sampled may have been confounding. For example, an officer with a rank status of WO2 may have reached this position after many years from an E1

rank (the lowest military rank). This factor will definitely influence the results of the research, possibly explaining the different findings as compared with other research studies.

Hypotheses six and seven predict a negative relationship between the level of income and scores on the Rotter Internal-External Locus of Control Scale and also a negative relationship between the level of income and scores on the Psychotherapy Preference Questionnaire. (The higher the rank, the lower the scores and the lower the rank, the higher the scores on the locus of control and psychotherapy preference scales). Because of the specific sample who participated in this research, military rank was substituted for income. The lower an individual is ranked in the military the lower he is paid and consequently, the higher one ranks the more he is paid. The negative relationship between military rank and scores on Rotter's scale was not significant. Therefore, it is concluded that the locus of control and rank are not negatively correlated; the null of hypothesis six is accepted.

Again, locus of control orientation findings in this research are not in accordance with many other locus of control studies. Though the trend was in the right direction, the r value obtained ($r = -.063$) was not strong enough to meet the .05 level of significance. Further research on different populations (other than college students and clinical or institutional patients) must be conducted.

The negative relationship between income level (rank and status) and scores on the Psychotherapy Preference Questionnaire were significant at the significance level.003. The statistical method of analysis used in this procedure was the Pearson-r correlation. The enlisted personnel or those military persons of lower rank, scored more in the directive direction on the Psychotherapy Preference Questionnaire, than did the officers, or higher ranked personnel (r value = - 0.298).

This hypothesis was experimental in nature. Very little research has been conducted comparing psychotherapy preference with variables other than that of the individuals locus of control; therefore a minimum of literature is available supporting the hypothesis. The significance of the hypothesis, shown by the results, indicates a fruitful avenue for further research.

In addition to the latter hypotheses, several other relationships were examined. Age was not significantly related to either locus of control or psychotherapy preference. A large age range was not represented in the data. The mean age category of the sample was 20 - 30 years. Therefore, the lack of significance here is not surprising.

A one-way analysis of variance was used to determine if the three rank groupings of military personnel differed with respect to locus of control. No significance was found, therefore, it was concluded that the three ranks do not differ on locus of control.

Another question asked was, do the three ranks differ with respect to psychotherapy preference? The findings here show a strong significant difference in average psychotherapy preference values

between the groups. The method of analysis was a one-way analysis of variance. The result is significant at the .0052 level ($f = 5.62$, $df = 2,80$). A test for linear trend was significant at the .0223 level ($F = 5.43$, $df = 1,80$). The mean proportions of directive responses on the Psychotherapy Preference Qustionnaire for the three ranks were: E1 - E9 = .390; WO1 - CW4 = .313; O1 - O5 = .324. A perfect linear trend would have produced decreasing psychotherapy preference (for a directive therapeutic style) as rank increased. While the results were not in this exact order, it is clear that the lowest rank (enlisted noncommissioned personnel, E1 - E9) had a higher preference for directive psychotherapy than either officer group (WO1 - CW4, O1 - O5).

Race was grouped into four categories (caucasian, black, hispanic, and other) and was tested to determine if the different racial groups had different averages on locus of control. The one-way analysis of variance found that locus of control does not differ significantly among the four racial groups.

The four racial categories were found to differ with respect to psychotherapy preference. Again, using a one-way analysis of variance, race was significant at the .0154 level ($F = 3.68$, $df = 3,79$). The means for the psychotherapy preference for the four race categories were whites = .3336; blacks = .4324; hispanics = .3727; and other = .4179. The higher the mean value the higher the preference for directive therapy. In this military population blacks preferred a directive therapeutic format, followed by hispanics, with whites preferring directive therapy least. The "other" group, containing only

four observations, was not a significant enough representation to be worth examination (See Table 3).

The significant results of this test make sense when we consider the representation of race in comparison to rank status. Blacks were not represented at all among the officer category, only among the enlisted noncommissioned personnel. Because significance in the relationship between psychotherapy preference and rank was found, significance would also be expected among racial groups with blacks representing only the enlisted group, and with the majority of officers (40 out of 42) being caucasian. This finding again indicates the need for further study in terms of sex, age, and racial characteristics.

A multiple regression method of analysis was used to examine the hypotheses that either locus of control or psychotherapy preference could be predicted by using the variables of age, rank, and education. With the multiple regression, the variables could not predict locus of control. However, significant prediction of psychotherapy preference from these same variables (age, rank, and education) was observed. The multiple regression was significant at the .037 level ($F = 2.96$, $df = 3,78$). Rank continued to be identified as the strongest predictive variable. The significance levels for partial F-tests on these variables were age = .238, rank = .022, and education = .517. In fact, since rank and income level were the only predictor variables with a significance level less than .05, it is questionable whether age and education were of any benefit in predicting psychotherapy preference.

Table 3

Differences Between Scores on the Psychotherapy Preference Questionnaire Among Racial Categories

	Mean	Standard Deviation	F value	Probability Level
White	.333	.087		
Black	.432	.140		
			.015	3.68
Hispanic	.374	.168		
Other	.418	.058		

In conclusion, the findings in this research are unique in that a special population was used, a population different from those that have been sampled before in similar research. Other studies have not attempted to find "predictive variables" capable of identifying a person's psychotherapy preference by merely knowing a few of the individual's characteristics; characteristics which would be easily identified. In this case rank status and income level were the most significant variables found for predicting a person's psychotherapy preference. Rank status and income level were combined in this research because in the military a set income exists for each rank level. As a person's rank increases so does his income. This factor is controlled for in all military populations in the continental United States.

Locus of control findings remained insignificant throughout the entire study. The nondiscriminative characteristics of the Rotter Internal-External Locus of Control Scale as well as the particular samples utilized (and the unequal representation of each variable within the sample) were used to explain these findings.

Limitations

While a large sample size was used in this study, as well as a type of sample never tested before in this kind of research, certain limitations should be recognized. The Army military personnel population represented a very specific type of employee setting. Even though results are generalized to a wider variety of employee populations, it is necessary for actual testing to be conducted with these

other employee samples before definite conclusions can be made. This factor somewhat limits the generalizability of the findings.

The sample participating in this research represents a somewhat "biased" sample, as it is primarily white, younger (20-40 age range) military personnel. This factor also limits the generalizability of the findings to persons either much younger or much older than the persons sampled, as well as to persons who are not white.

The Psychotherapy Preference Questionnaire was a fairly new scale. Because of the limited norms available on the questionnaire, the information on its reliability is limited. Therefore the reliability of the scale remains questionable.

Chapter V

SUMMARY AND CONCLUSIONS

Summary

The purpose of this study was to explore the relationship between locus of control orientation and psychotherapy preference and the variables of employment level (rank status), education level, age, race, and sex on a population outside of college students and clinical or institutional patients. Additional intentions of this research were to identify predictive variables in order to maximize a therapist's ability to predict individual therapeutic preferences. This study was an extension of an abundance of previous research comparing locus of control orientation in relation to psychotherapy preference and outcome of specific styles of therapeutic format.

A random sample of 50 enlisted noncommissioned personnel, from a population of approximately 500 enlisted persons, was selected for the sample. Forty-one of these 50 enlisted personnel participated in the study. A random sample of 50 officers, from a population of approximately 600 officers, was chosen for the research. Forty-two of these fifty officers returned completed questionnaires via the military base mail system. The entire sample (all 83 military personnel who participated in the research by completing the questionnaire) was used in the statistical analysis.

Two measuring instruments were used: the Rotter Internal-External Locus of Control Scale (Rotter, 1966) which measures individuals' locus of control orientation; and the Psychotherapy Preference Questionnaire, which measures individuals' specific preference for either direct or nondirect therapeutic styles. Additional information was obtained through a demographic information questionnaire measuring sex, age, race, rank, and education level.

Several hypotheses were tested in the study. The first hypothesis which was statistically significant was the hypothesis addressing the difference of scores on the Psychotherapy Preference Questionnaire between enlisted noncommissioned personnel and officers in the Army. Enlisted personnel had significantly more preference for directive therapy while officers had significantly more preference for non-directive therapy. This military personnel characteristic, rank, is a distinctive trait among military personnel, and therefore a valuable predictive variable of psychotherapy preference for the military psychiatric/mental health service programs.

The second statistically significant hypothesis addressed the relationship between income level and scores on the Psychotherapy Preference Questionnaire. This hypothesis is similar to the latter because of the specific population mentioned (rank and income level have a positive relationship among military personnel).

Race was found to significantly relate to preference for psychotherapy. Blacks preferred directive therapy significantly more than did whites or hispanics. Race has not been examined in relation to

psychotherapy preference in the available literature. Therefore, the direction of this finding again indicates a good possibility for further research.

Several hypotheses were not significantly supported in the study. The first insignificant hypothesis addressed the difference between scores on the Rotter Internal-External Locus of Control Scale for enlisted noncommissioned military personnel and officers. The insignificant finding was unexpected and suggests the possibility that the Rotter Scale was not a discriminating enough measure to determine differences between the two groups. Also, a further explanation of the insignificant results may be due to the fact that the sample was not entirely representative of the population at large; particularly on the variables of age, race, and sex.

Another unexpected finding was the insignificance of the relationship between scores on the Rotter Internal-External Locus of Control Scale and scores on the Psychotherapy Preference Questionnaire. This finding suggested that each individual questionnaire may not serve as a predictor of the other (e.g. locus of control scores predicting psychotherapy preference scores) with this particular population; though in the type of populations already tested (patients and students) a positive relationship has been observed.

The hypothesis testing the relationship between level of education and locus of control orientation also resulted in an insignificant correlation. This finding suggests that education may be an extenu-

ating variable in relation to locus of control; other factors may override this characteristic.

The hypothesis testing the relationship between education level and psychotherapy preference was also insignificant suggesting once again the possibility that education is not a strong enough predictive characteristic for identifying a specific psychotherapy preference. Other characteristics related to education level, or ones' desire to pursue an education beyond that required by the state have been examined and significant results obtained (Baker, 1979; Mink & Watts, 1973; Thomas & Carpenter, 1976; Vasquez, 1978).

The hypothesized negative relationship between income level and locus of control orientation was also statistically insignificant. This finding suggests that level of income as a separate variable is not significant in detecting an individual's locus of control. Additional variables are necessary for detecting one's internal or external locus of control orientation.

Conclusions

This study has yielded some interesting and surprising results. First of all, some of the most unexpected findings are those in reference to the specific variables of psychotherapy preference, level of employment, education level, age, and race in relation to locus of control. These findings are not congruent with previous research. Helweg and Gaines, (1977), Mink and Watts (1973), Thomas and Carpenter (1976), Vasquez (1978), Sherman and Hoffman (1980),

Tseng (1970), Franklin (1963), Frieze and Wiener (1971), and several others all report significant relationships between one or more of the variables listed and locus of control orientation. The first explanation for not finding such relationships is the uniqueness of the population sampled, as compared to a clinical or student population; those populations sampled in the previous research. It is a possibility that the locus of control research findings cannot be generalized outside of clinical and student samples. The Army military sample represented the more general population. Further study with more populations of this kind must take place before specific conclusions can be made about the locus of control orientation and its relationship to age, sex, race, income, education, and employment level.

The second explanation for this finding is the possibility that locus of control is too ambiguous a characteristic to measure. Rotter (1975) points out himself that his locus of control scale taps only generalized expectancies allowing for a low degree of prediction of behavior across a wide range of situations.

Secondly, some useful findings of the study are those reporting that rank status and race significantly predict an individual's psychotherapy preference. The implications for further research and the possibility of achieving the ability to predict which individuals prefer which style of therapy are numerous. The curvilinear trend found with rank and psychotherapy preference poses the

potential for further identification of traits related to or removed from rank status relevant to an individual's preference for a direct or nondirect therapeutic format.

Implications

The implications for the military are great. A majority of the military positions are contracted positions, meaning military personnel have agreed to stay with the Army for a specific number of years. Because of this as well as an overall concern for the persons working for the United States Army, the military has set up quite an extensive program of psychiatric and mental health services for its employees. The significant findings of identifying rank status and race to psychotherapy preference can aid the counselors, therapists, and doctors toward tailoring a specific therapy style to meet the special needs and desires of the individual client.

These findings can be further generalized to other employee settings with employee assistance programs, assuming the Army is an example of an employee setting and is not necessarily distinct from these other employment environments. An employee's position in the employment hierarchy as well as his income level (a significant variable in this study) could be used to identify the employee's psychotherapy preference. Going one step further these findings can be generalized also to other settings where therapy or counseling takes place (e.g. schools, clinics, mental health centers, hospitals). This area

requires further research in an effort to identify other predictive traits of individuals.

Unfortunately not all people respond equally well to specific therapeutic techniques. The ability to predict an individual's therapy preference would help to alleviate wasted time, effort, and money; both the clients' as well as the therapists'.

Findings from this research were based on a nonpatient/non-student population. Overall this point in itself has significant implications. Many persons within an employment setting will be utilizing a counseling/therapy service. Not all of these people are students or patients; and therefore research on different populations is necessary.

Suggestions for Future Research

Further research in this area that would be a beneficial follow-up to this research would be an investigation of both another Army population or military population and another type of employee population (e.g. an industrial population). The analysis can be examined for similar or equal findings, thus supporting this present study. If subsequent findings do support the present findings, it would be safe to say that psychotherapy preference could be predicted through various characteristics. Should the follow-up research report different findings, then possibly the findings here are specific to the particular individuals tested.

Other suggestions for further research would be to emphasize greater control on the variables tested. For instance, if the examiner

was looking at the variables of age, sex, education level, employment level, and income level in relation to psychotherapy, it would be helpful to the examiner to obtain equal numbers for each variable within the sample. This would aid the examiner in the analysis of the data; each variable would be equally represented, and more accurate comparisons could be made.

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APPENDICES

APPENDIX A

Research Participation Request Letter

COLLEGE OF HOME ECONOMICS

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Blacksburg, Virginia 24061

DEPARTMENT OF MANAGEMENT, HOUSING AND FAMILY DEVELOPMENT (703) 961 6163

December 1, 1981

Attn: Director of Personnel

Dear Madam or Sir,

At Virginia Polytechnic Institute and State University a research project has been proposed, studying the locus of control and the preference for direct or nondirect therapeutic techniques in an employee population. The availability of an employee assistance program to the employee population is a significant factor, and is the reason we are contacting you for participation in this study.

I am a graduate student, working toward a degree in Marital and Family Therapy in the Department of Family and Child Development, and am responsible for conducting this research. Working directly with me are three professors, two from my department, and one from the statistics department at the university.

One hundred employees, fifty white-collar and fifty blue-collar employees, will be needed for the sample. A ramdom sample from the two levels of employment is necessary in order to obtain statistically worthwhile data. Each participant in the study will be asked to fill out three brief questionnaires; the Rotter Internal-External Locus of Control Scale, The Psychotherapy Preference Questionnaire, and a demographic information data sheet. Approximately fifteen to twenty minutes will be required to complete the questionnaires.

In an effort to make this study as beneficial for you and your employees as it will be for me, I will incorporate into the research any additional materials you may need for your own research or information. I would be happy to give you the results of the study.

Please contact me, either by telephone, (703) 961-7201, or mail and I can give you any additional information you may need to know.

Thank you for your time. I hope that we can get together in making this project a beneficial endeavor for both my purposes and any you may have in mind. I am more than willing to work within your guidelines, in a special effort to avoid becoming a nuisance to you and your employees.

Sincerely,

Susan E. Keck
Virginia Tech

APPENDIX B

Description/Summary of the Research

LOCUS OF CONTROL AND THE PREFERENCE FOR DIRECTIVE OR NON-DIRECTIVE THERAPEUTIC TECHNIQUES IN AN INDUSTRIAL EMPLOYEE POPULATION

(DESCRIPTION/SUMMARY OF THE RESEARCH)

In recent years there has been a growing interest in the relationship between the locus of control of individuals and their preference for therapeutic interventions. Research in this area has been limited mainly to patients in an institutionalized setting and to students. Never before has research of this kind been conducted utilizing the special population of employees in a work environment. With the steadily growing popularity of employee assistance programs, the implications for this type of research on such a population are great.

Evidence has been found, supporting the relationship between locus of control and the positive effect of different therapeutic techniques (Abramowitz, Abramowitz, Robach, & Jackson, 1974; Helweg & Gaines, 1977; Kilmann & Howell, 1974; Messer & Meinster, 1980; Morley & Watkins, 1978). Persons with an external locus of control have been found to rely upon individuals perceived as compentent; they perceive consequences to be unrelated to personal behavior. These individuals have shown greater preference for and greater positive therapeutic change with a directive therapy format. Internally controlled individuals, who have been found to react against perceived high influence attempts and view reinforcement as being a consequence of his own actions, have shown more preference for and greater positive therapeutic change with a highly non-directive format (Baker, 1979; Kilmann & Howell, 1974).

Locus of control and the preference for directive or nondirective therapy in relation to the level of employment (blue-collar or white-collar position) will be studied. Age, sex, race, and educational background will also be examined for their relationship to the preference data. It is the goal of this research to enable therapists to determine the most effective therapeutic styles to use with clients even before clients enter a counseling session. For instance, if blue-collar workers showed a positive correlation between their locus of control and their preference for either directive or nondirective therapy, the therapists could tailor their therapeutic style to this particular client population.

Locus of control will be measured by The Internal-External Locus of Control Scale designed and constructed by Rotter in 1966. Preference for directive or nondirective therapy will be measured by the Psychotherapy Preference Questionnaire designed and constructed by Clum in 1981.

APPENDIX C

Sample Mailgram

MAILGRAM SERVICE CENTER
MIDDLETOWN, VA. 22645

western union Mailgram® UNITED STATES POSTAL SERVICE U.S.MAIL

4-019218S335002 12/01/81 ICS IPMMTZZ CSP ROAB
1 7039615770 MGM TDMT BLACKSBURG VA 12-01 1211P EST

SUSAN E KECK
4 STONEGATE APTS BROCE DR
BLACKSBURG VA 24060

THIS MAILGRAM IS A CONFIRMATION COPY OF THE FOLLOWING MESSAGE:

7039615770 MGM TDMT BLACKSBURG VA 49 12-01 1211P EST
ZIP
PHILLIP MORRIS INC
ATTN DR REDMOND, SALES OFFICE
2307 PARHAM RD
RICHMOND VA 23229

REMINDER

REFERENCE LETTER OF NOVEMBER 11TH IT IS VITAL THAT I RECEIVE A RESPONSE FROM YOU AS SOON AS POSSIBLE. THANK YOU FOR YOUR IMMEDIATE ATTENTION TO MY@REQUEST.

SINCERELY
SUSAN E KECK
VIRGINIA TECH

1215 EST

MGMCOMP MGM

5241 (R1/78)

TO REPLY BY MAILGRAM, SEE REVERSE SIDE FOR WESTERN UNION'S TOLL - FREE PHONE NUMBERS

APPENDIX D

Questionnaire Title Page

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

DEPARTMENT OF MANAGEMENT, HOUSING, AND FAMILY DEVELOPMENT

Blacksburg, Virginia

Thank you for your participation in this study.
Your help in answering the following questions
is very important to the outcome of this research.

This survey consists of three parts.
Please respond to all of the questions.
All information will remain completely confidential.

APPENDIX E

Demographic Data Questionnaire

Please complete the following information.

1. Sex (please circle): Male or Female

2. Age Category (please circle):

   a. less than 20
   b. 20 - 30
   c. 31 - 40
   d. 41 - 50
   e. 51 - 60
   f. over 60

3. Race or Ethnic Group (please circle):

   a. Caucasian (White)
   b. Black
   c. Hispanic
   d. Other _____

4. Rank (please circle):

   a. E1 - E9
   b. WO1 - CW4
   c. O1 - O5

5. Grade or Level of Education Completed (please circle):

   Grade School/High School

   1 2 3 4 5 6 7

   8 9 10 11 12

   Technical or Trade School

   a. some training but no diploma
   b. successful completion

   College

   a. some college but no degree
   b. Associate Degree
   c. Bachelor's Degree

   Graduate Study

   a. some study but no degree
   b. Master's Degree
   c. Doctorate

6. If I had concerns with which I felt a counselor could help, I would take advantage of a counseling program provided by an organization for which I work. (Please circle the words which best represent your answer to this question.)

Definitely Would Use	Probably Would Use	Undecided	Probably Would Not Use	Definitely Would Not Use

APPENDIX F

Rotter Internal-External Locus of Control Scale

This is a questionnaire to find out the way in which certain events in our society affect different people. Each item consists of a pair of alternatives lettered a or b. Please select the one statement of each pair (and only one) which you more strongly believe to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true, rather than the one you think you should choose or the one you would like to be true. This is a measure of personal belief: obviously there are no right or wrong answers.

1. a. Children get into trouble because their parents punish them too much.
   b. The trouble with most children nowadays is that their parents are too easy with them.

2. a. Many of the unhappy things in people's lives are partly due to bad luck.
   b. People's misfortunes result from the mistakes they make.

3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.
   b. There will always be wars, no matter how hard people try to prevent them.

4. a. In the long run people get the respect they deserve in this world.
   b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. a. The idea that teachers are unfair to students is nonsense.
   b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. a. Without the right breaks one cannot be an effective leader.
   b. Capable people who fail to become leaders have not taken advantage of their opportunities.

7. a. No matter how hard you try, some people just don't like you.
   b. People who can't get others to like them don't understand how to get along with others.

8. a. Heredity plays the major role in determining one's personality.
   b. It is one's experiences in life which determine what they're like.

9. a. I have often found that what is going to happen will happen.
   b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. a. In the case of the well-prepared student there is rarely if ever such a thing as an unfair test.
    b. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
    b. Getting a good job depends mainly on being in the right place at the right time.

12. a. The average citizen can have an influence in government decisions.
    b. This world is run by the few people in power, and there is not much the little guy can do about it.

13. a. When I make plans, I am almost certain that I can make them work.
    b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyway.

14. a. There are certain people who are just no good.
    b. There is some good in everybody.

15. a. In my case getting what I want has little or nothing to do with luck.
    b. Many times we might just as well decide what to do by flipping a coin.

16. a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
    b. Getting people to the right thing depends upon ability; luck has little or nothing to do with it.

17. a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand nor control.
    b. By taking an active part in political and social affairs the people can control world events.

18. a. Most people don't realize the extent to which their lives are controlled by accidental happenings.
    b. There is really no such thing as "luck."

19. a. One should always be willing to admit mistakes.
    b. It is usually best to cover up one's mistakes.

20. a. It is hard to know whether or not a person really likes you.
    b. How many friends you have depends upon how nice a person you are.

21. a. In the long run the bad things that happen to us are balanced by the good ones.
    b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. a. With enough effort we can wipe out political corruption.
    b. It is difficult for people to have much control over the things politicians do in office.

23. a. Sometimes I can't understand how teachers arrive at the grades they give.
    b. There is a direct connection between how hard I study and the grades I get.

24. a. A good leader expects people to decide for themselves what they should do.
    b. A good leader makes it clear to everybody what their jobs are.

25. a. Many times I feel that I have little influence over the things that happen to me.
    b. It is impossible for me to believe that chance or luck plays an important role in my life.

26. a. People are lonely because they don't try to be friendly.
    b. There's not much use in trying too hard to please people, if they like you, they like you.

27. a. There is too little emphasis on atletics in high school.
    b. Team sports are an excellent way to build character.

28. a. What happens to me is my own doing.
    b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. a. Most of the time I can't understand why politicians behave the way they do.
    b. In the long run the people are responsible for bad government on a national as well as a local level.

Note: Score is the total of underlined items endorsed. High scores indicate a more external locus of control.

APPENDIX G

Psychotherapy Preference Questionnaire

Instructions: The following questions refer to expectations and preferences you may have if you were to begin or are beginning psychotherapy for an emotional problem. For each item there are two alternate statements. Select the one with which you most agree and circle the letter. Do not skip questions.

1. a. My therapist is more qualified than I to decide what the goals of therapy should be.
   b. I should set the goals of therapy rather than my therapist.

2. a. No matter how hard I try I will not improve without help from my therapist.
   b. I can improve with minimal help from a therapist.

3. a. We should worry less about psychology and therapy, and more about what we can do about our problems on our own.
   b. People cannot solve psychological problems without the help of an objective counselor.

4. a. Therapy will move along better if I do not try to plan or organize it.
   b. A well organized therapy plan is necessary for therapy to be successful.

5. a. A good therapist should almost always understand why I feel and act as I do even if I have trouble understanding it myself.
   b. I can only help my therapist to understand me after I first understand myself.

6. a. There is little that I can do which will affect my outcome in therapy.
   b. The success or failure of therapy rests on my shoulders.

7. a. Everyone is responsible for their own improvement in psychotherapy.
   b. My therapist is responsible for my improvement in psychotherapy.

8. a. My life is in the hands of my therapist who insures that things happen for my own good even if I don't understand them at the time.
   b. I will not improve unless I understand how what the therapist does is related to solving my problems.

9. a. I expect my therapist to plan our sessions before they start.
   b. I expect my therapist to adjust his/her treatment plan to the problem I bring in on each session.

10. a. The individual in therapy has more influence than the therapist on the outcome.
    b. Relatively speaking, the therapist has more influence on the outcome of therapy than the patient.

11. a. I would prefer my therapist to plan and organize our sessions.
    b. I prefer my therapist to leave our sessions unstructured.

12. a. It is difficult for a client to have much control over what occurs in therapy sessions.
    b. Clients are in control of what happens during therapy sessions.

13. a. What I say should shape how my therapist views my problems.
    b. The therapist's knowledge of problems similar to mine is the most important determination of how my therapist views my problems.

14. a. If I had enough time and the rights books to refer to I could solve my own difficulties.
    b. People cannot solve their own problems without some kind of professional help.

15. a. I would like the therapist to schedule our time together so that we can get the most important things done.
    b. I am responsible for deciding what I want to discuss in therapy.

16. a. I expect the advice, interpretations, and assignments given by my therapist to be the main cause of my improvement.
    b. I expect that I will improve more if I arrive at an understanding of my problems with minimal guidance from a therapist.

17. a. I can easily hide my feelings from a therapist.
    b. A good therapist will understand what is going on with you even when you are trying to hide your feelings.

18. a. I've seldom been stopped by any personal problem I have wanted to solve.
    b. I have found most personal problems too much to solve on my own.

19. a. Trying to change the things that happen to me is a waste of time; I might as well just learn to cope with them.
    b. One can learn to structure one's environment.

20. a. As a person in therapy I want to participate fully in making all decisions related to my treatment.
    b. I don't know enough to decide what is best for me in treatment -- experts are trained to do that.

21. a. I prefer to go along with the flow of therapy rather than direct it.
    b. I prefer to decide how therapy will go in advance.

22. a. People can stay psychologically healthy all the time if they just relax.
    b. People need to be taught how to relax -- it doesn't just come naturally.

23. a. When I have a personal problem to solve I usually seek out the advice of someone.
    b. I prefer to solve my problems on my own.

24. a. Anyone can break a bad habit if they want to.
    b. Habits can be broken with outside help.

25. a. I think I will do well in therapy if I try hard enough.
    b. Therapy will progress even if I just attend the sessions.

26. a. I think it best to list one's problems before seeking psychological help.
    b. People need to be more willing to seek psychological help.

27. a. Our personal problems can only be solved by a return to traditional religious principles.
    b. Personal problems are best solved by competent therapists.

28. a. If I really worked at it I could be a good therapist too.
    b. I'll leave solving personal problems to the experts.

29. a. Even if I get good advice on solving my problems I have trouble implementing it.
    b. With minimal advice I could solve most of my problems.

30. a. Psychotherapy would work better if the therapist gave weekly assignments for the client to carry out.
    b. If any assignments are to help they must come from the client.

31. a. I'd prefer a therapist who let me decide what topics to cover.
    b. I'd prefer a therapist who asked questions.

32. a. I'd prefer the therapist to do most of the talking in a psychotherapy session.
    b. I'd prefer to do most of the talking in therapy.

33. a. I frequently seek and follow the advice of others.
    b. I get angry when others try to tell me now to solve my problems.

34. a. Therapists should provide clients with solutions to problems rather than let the patient discover them for himself/herself.
    b. The best solutions are those generated by the client.

35. a. I'd get more out of therapy if the therapist provided me with a list of do's and don't's.
    b. I'd find a therapist who told me what to do annoying.

36. a. The patient should decide when enough change has taken place for therapy to end.
    b. The therapist should decide when the client should leave therapy.

37. a. I'd prefer it if the therapist provided me with a written explanation of how he/she was going to solve my problems.
    b. I expect the solutions to problems will unfold as I proceed through therapy.

38. a. One of the worst things a therapist can do is just sit there while I try to think of something to say.
    b. Silences are good since they give me time to get a better grasp of what is going on with me.

39. a. I'd prefer my therapist to remain anonymous rather than get to know him/her on a personal basis.
    b. I'd prefer a therapist who shared his/her solutions to problems similar to mine.

40. a. The therapist's personality should neither help nor hinder the process of therapy.
    b. The therapist's personality is an important part of getting better or worse.

41. a. A wise client would follow his/her therapists' advice even if it did not make sense at the time.
    b. A wise client would demand an explanation of anything they didn't understand.

42. a. A client should never challenge his/her therapist.
    b. A wise client would demand an explanation of anything they didn't understand.

43. a. I'd prefer a therapist who thought the way I do.
    b. I'd prefer a therapist with a different view of things than mine.

44. a. Therapy should start off with the patient explaining how he or she understands the problem at hand.
    b. Therapy should begin with the therapist's view of the problem.

45. a. A psychotherapist is like a physician, prescribing the best treatment for the problems presented to him/her.
    b. Unlike the physician the role of the therapist is to guide rather than direct the patient.

46. a. An understanding friend can do you just as much good as a trained therapist with a lot of techniques.
    b. Specific treatment techniques must be known to help difficult problems.

47. a. If I don't get better in psychotherapy the principal reason will be my own lack of effort.
    b. Lack of progress in therapy can usually be solved by finding a better therapist.

48. a. If I had my way in therapy, it'd be sure to fail.
    b. I know what is best for me in therapy.

Note: Score is the total of underlined items endorsed. High scores indicate a greater preference for directive therapy.

APPENDIX H

Adapted Psychotherapy Preference Questionnaire

The following questions refer to expectations and preferences you may have if you were to begin or are beginning counseling for personal problems. For each item there are two alternate statements. Select the one with which you most agree and circle the letter. Please do not skip questions.

1. a. My counselor is more qualified than I to decide what the goals of counseling should be.
   b. I should set the goals of counseling rather than my counselor.

2. a. No matter how hard I try I will not improve without help from my counselor.
   b. I can improve without much help from a counselor.

3. a. We should worry less about psychology and counseling, and more about what we can do about our problems on our own.
   b. People cannot solve personal problems without the help of a counselor.

4. a. Counseling will move along better if I do not try to plan or organize it.
   b. A well organized counseling plan is necessary for counseling to be successful.

5. a. A good counselor should almost always understand why I feel and act as I do even if I have trouble understanding it myself.
   b. I can help my counselor to understand me only after I first understand myself.

6. a. There is little that I can do which will affect the results of my counseling.
   b. The success or failure of the treatment rests on my shoulders.

7. a. Everyone is responsible for his own improvement in counseling.
   b. My counselor is responsible for my improvement.

8. a. My life is in the hands of my counselor who insures that things happen for my own good even if I don't understand them at the time.
   b. I will not improve unless I understand that what the counselor does is related to solving my problems.

9. a. I expect my counselor to plan our sessions before they start.
   b. I expect my counselor to adjust his treatment plan to the problem I bring in on each session.

10. a. I have more influence on the results of counseling than the counselor does.
    b. The counselor has more influence on the results of counseling than I do.

11. a. I would prefer my counselor to plan and organize our sessions.
    b. I prefer that my counselor have no specific plan for our sessions.

12. a. It is difficult for a person in counseling to have much control over what occurs in the counseling sessions.
    b. Persons in counseling are in control of what happens during counseling sessions.

13. a. What I say should shape how my counselor views my problems.
    b. The counselor's knowledge of problems similar to mine is the most important determination of how my counselor views my problems.

14. a. If I had enough time and the right books to refer to I could solve my own difficulties.
    b. People cannot solve their own problems without some kind of professional help.

15. a. I would like the counselor to schedule our time together so that we can get the most important things done.
    b. I am responsible for deciding what I want to discuss in counseling.

16. a. I expect the advice, interpretations, and assignments given by my counselor to be the main cause of improvement.
    b. I expect that I will improve more if I arrive at an understanding of my problems without very much guidance from a counselor.

17. a. I can easily hide my feelings from a counselor.
    b. A good counselor will understand what is going on with you even when you are trying to hide your feelings.

18. a. I have seldom been stopped by any personal problem I have wanted to solve.
    b. I have found most personal problems too much to solve on my own.

19. a. Trying to change the things that happen to me is a waste of time; I might as well just learn to cope with them.
    b. One can learn to organize one's environment.

20. a. As a person in counseling I want to participate fully in making all decisions related to my treatment.
    b. I don't know enough to decide what is best for me in treatment; experts are trained to do that.

21. a. I prefer just to go along with the counseling rather than to try to direct it.
    b. I prefer to decide in advance how counseling will go.

22. a. People can stay emotionally healthy all the time if they just relax.
    b. People need to be taught how to relax; it doesn't just come naturally.

23. a. When I have a personal problem to solve I usually ask somebody else about it.
    b. I prefer to solve my problems by myself.

24. a. Anyone can break a bad habit if he wants to.
    b. Habits can only be broken with outside help.

25. a. I think I will do well in counseling if I try hard enough.
    b. Counseling will be useful if I attend but don't try at all.

26. a. I think it is best for a person to list his problems before asking for counseling.
    b. People should be more willing to ask for counseling help.

27. a. Our personal problems can only be solved by a return to traditional religious principles.
    b. Personal problems are best solved by a good counselor.

28. a. If I really worked at it I could be a good counselor too.
    b. I will leave solving personal problems to the experts.

29. a. Even if I get good advice on solving my problems I have trouble following it.
    b. I could solve most of my problems with just a little advice.

30. a. Counseling would work better if the counselor gave weekly assignments to the person being counseled.
    b. If any assignments are to help they must come from the person being counseled.

31. a. I would prefer the counselor who let me decide what topics to cover.
    b. I would prefer a counselor who asked questions.

32. a. I would prefer the counselor to do most of the talking in a counseling session.
    b. I would prefer to do most of the talking in a counseling session.

33. a. I frequently ask for and follow the advice of others.
    b. I get angry when others try to tell me how to solve problems.

34. a. Counselors should provide patients with solutions to problems rather than let the patient discover them for himself.
    b. The best solutions are those which the patient thinks of himself.

35. a. I would get more out of counseling if the counselor provided me with a list of do's and don't's.
    b. I would be upset with a counselor who told me what to do.

36. a. The patient should decide when he has had enough counseling.
    b. The counselor should decide when the patient has had enough counseling.

37. a. I would like the counselor to show me a written plan of how he would solve my problems.
    b. I expect my problems to be solved during therapy.

38. a. One of the worst things a counselor can do is just sit there while I try to think of something to say.
    b. Silences are good since they give me a change to think about what is going on with me.

39. a. I would prefer my counselor to remain a stranger rather than get to know him on a personal basis.
    b. I would prefer a counselor who shared his solutions to problems similar to mine.

40. a. The counselor's personality should neither help nor hurt the counseling sessions.
    b. The counselor's personality has a lot to do with whether I get better or worse.

41. a. A wise patient would follow his counselor's advice even if it did not make sense at the time.
    b. A wise patient would demand an explanation of anything he didn't understand.

42. a. A patient should never question his counselor.
    b. Counselors should be questioned whenever it is appropriate.

43. a. I would prefer a counselor who thought the way I do.
    b. I would prefer a counselor with a different view of things than mine.

44. a. Counseling should start off with the patient explaining he understands the problem.
    b. Counseling should begin with the counselor's view of the problem.

45. a. A counselor is like a physician, prescribing the best treatment for the problems presented to him.
    b. Unlike the physician the role of the counselor is to guide rather than direct the patient.

46. a. An understanding friend can do you just as much good as a trained counselor with a lot of techniques.
    b. Specific treatment techniques must be used to help difficult problems.

47. a. If I don't get better in counseling the main reason will be my own lack of effort.
    b. Lack of progress in counseling can usually be solved by finding a better counselor.

48. a. If I had my way in counseling, it would be sure to fail.
    b. I know what is best for me in counseling.

Thank you for completing the questionnaire.
Your participation in this study is appreciated.

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The three page vita has been removed from the scanned document. Page 2 of 3

The three page vita has been removed from the scanned document. Page 3 of 3

LOCUS OF CONTROL AND THE PREFERENCE FOR DIRECTIVE OR NONDIRECTIVE THERAPEUTIC TECHNIQUES IN A MILITARY PERSONNEL POPULATION

by

Susan Elaine Keck

(ABSTRACT)

The purpose of this study was to explore the relationship between locus of control and psychotherapy preference and the variables of rank (employment and income levels), education level, age, race, and sex on a population outside of students and clinical or institutional patients. Also, the researcher sought to identify variables in order to maximize a therapist's ability to predict individual therapeutic preferences.

Eighty-three military personnel; 41 noncommissioned personnel and 42 officers, participated. The sample was chosen randomly from a population of approximately 500 enlisted personnel and 600 officers.

Two measuring instruments were used: Rotter's (1966) Internal-External Locus of Control Scale and Clum's (1981) Psychotherapy Preference Questionnaire.

Several hypotheses were tested. Significant results were obtained in the hypotheses addressing the difference of scores for

psychotherapy preference between rank categories (employment and income levels) and racial categories.

Insignificant results were obtained in the hypotheses addressing the difference in locus of control orientation between rank categories (employment and income levels) and education categories; the difference of scores for psychotherapy preference between education levels; and the relationship between scores on the locus of control and psychotherapy preference scales.