To the Graduate Council:

I am submitting herewith a dissertation written by James Thomas English entitled "The Effects of Client-Counselor Problem Similarity on Alcoholics' and Non-Alcoholics' Perceptions of Counselor Social Influence." I have examined the final copy of this disseration for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Education.

Mark A. Hector,
Major Professor

We have read this dissertation
and recommend its acceptance:

Accepted for the Council:

Vice Provost
and Dean of the Graduate
School

THE EFFECTS OF CLIENT-COUNSELOR PROBLEM SIMILARITY ON ALCOHOLICS' AND NON-ALCOHOLICS' PERCEPTIONS OF COUNSELOR SOCIAL INFLUENCE

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James Thomas English

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ABSTRACT

This study investigated the effects of client-counselor problem-similarity on alcoholics' and non-alcoholics' perceptions of counselor expertness, attractiveness, and trustworthiness. The alcoholic subjects were 34 white males currently engaged in inpatient treatment for alcohol dependency. The non-alcoholics were 31 white males who were either currently in, or had recently been in, outpatient counseling for a variety of personal problems. All subjects viewed the same video taped segment of a simulated counseling encounter that depicted treatment follow-up counseling with an alcoholic client. Subjects were randomly assigned to read one of three descriptions of the counselor which emphasized that the counselor had either (1) no history of a personal or alcohol problem, (2) previous history of counseling for a personal problem, or (3) previous history of counseling for an alcoholic problem. Subjects' perceptions of counselor social influence were assessed using the short version of the counselor Rating Form (Corrigan & Schmidt, 1983). Multivariate analyses of variance were performed to determine the effects of similarity and diagnosis on subjects' perceptions of counselor influence. Descriminant analysis was done as a follow up. Analysis of variance was used to assess the effect of similarity and diagnosis on expertness alone. The

results indicated that (a) problem-similarity had no significant effect on non-alcoholics' perceptions but was significant for alcoholics, (b) counselor expertness alone was not significantly affected by similarity for either diagnosis group, (c) a significant overall interaction occurred between similarity and diagnostic group, and (d) all three influence dimensions taken together best accounted for the interaction and for the similarity effect in the alcoholic group. These findings were discussed in relation to counselor social influence with alcoholics, the structure of the social influence model, and future field research in substance abuse counseling.

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CHAPTER I

INTRODUCTION

Statement of the Purpose

The purpose of this study was to investigate the effects of three different levels of client-counselor problem-similarity on alcoholics' and non-alcoholics' perceptions of counselor social influence. The effects of client-counselor similarity on various aspects of the counseling process have been widely studied (Atkinson, Brady, & Cases, 1980; Cheney, 1975; Giannandrea & Murphy, 1973; Murphy & Strong, 1972; Spiegel, 1976). This study, however, was believed to be the first to investigate the effect of different levels of client-counselor problem-similarity on counselor influence in the context of substance abuse counseling. It was also the first study to compare the perceptions of alcoholic clients and non-alcoholic clients regarding client-counselor problem-similarity. Furthermore, it was the first study to specifically investigate the relationship between client-counselor problem-similarity and client perceptions of counselor expertness in the context of professional substance abuse counseling. The results of the study may have implications for the debate in substance abuse counseling over the relative effectiveness of recovered

versus non-recovered counselors in the treatment of alcoholism.

Introduction to the Study

The degree of similarity that exists between a communicator and a receiver is considered to be an important variable mediating the amount of influence that the communicator has on the receiver's attitudes and opinions (Festinger, 1957; Mcguire, 1969, Simons, Berkowitz, & Moyer, 1970). Counseling is a special case of communication which involves an effort by the counselor to influence the client toward some desired behavioral or attitudinal change. The notion that similarity between the counselor and client might enhance counselor influence has received a great deal of research attention (Corrigan, Dell, Lewis, & Schmidt, 1987); Heppner & Dixon, 1981).

Similarity between counselor and client also has great intuitive appeal for its presumed effect on empathy in a helping relationship. When the counselor has suffered through the resolved problems similar to those presented by the client, he or she may be perceived as more credible and competent. This idea has served as the foundation for substance abuse treatment programs based on peer counseling, and self-help movements such as Alcoholics Anonymous. In these groups the counselor's status as a recovered addict, who has an extensive personal experience of sobriety, is

seen as an especially relevant factor for the newcomer in need of help.

As the field of substance abuse counseling becomes more professionalized, problem-similarity continues to be highly valued as a source of counselor expertise and influence in both professional and peer counseling situations. An ongoing debate has emerged within the field regarding the relative effectiveness of recovered versus non-recovered counselors in the treatment of alcohol and drug dependency (Aiken, Losciuto, & Ausetts, 1984; Argeriou & Manohar, 1978; Brown & Thompson, 1976; Krystal & Moore, 1963). In the context of this debate, problem-similarity is most often discussed in terms of its effect on counselor credibility and effectiveness. Research comparisons are often made between professional non-recovered counselors and paraprofessional recovered counselors. Increasingly, however, professional training and credentials are being acquired by recovered addicts who have made substance abuse counseling a career. This trend has added a new variable to the debate and to the considerations that must be taken into account when evaluating the credibility of counselors with problem backgrounds similar to those of their clients.

The social influence model of counseling has evolved to a point that it may provide a way to address more clearly the question of who is more credible in counseling substance abusers. Strong (1968) proposed a model that provides an

empirical basis for the discussion of client-counselor similarity and counselor influence. For Strong, the degree of counselor influence is determined by the interaction between client needs and the three counselor influence dimensions of attractiveness, expertness, and trustworthiness. Strong indicated that client perceptions of these three influence dimensions were based on an awareness of the counselor's background, the counselor's behavior in the session, and on other indicators that might be perceived during the counseling encounter. Strong viewed client-counselor similarity as a primary component of counselor attractiveness rather than counselor credibility. Subsequent research has shown that client-counselor similarity does have a positive effect on clients perceptions of counselor attractiveness (Daher & Banikiotes, 1976; Giannandrea & Murphy, 1973; Murphy & Strong, 1972; Schmidt & Strong, 1970). Other theorists and researchers have speculated that problem similarity, such as that found in peer counseling relationships, may affect perceptions of counselor credibility as well as attractiveness (Corrigan, Dell, Lewis, & Schmidt, 1970; Hovland, Janis, & Kelly, 1953). This reasoning supports the intuitive notion that client-counselor problem-similarity is an important basis for counselor credibility in substance abuse counseling.

Hovland and his associates speculated that the term expert should be "broadened to include persons who have

found adequate solutions to the problem an individual faces..." (Hovland, Janis, & Kelly, 1953, p.50). Corrigan et al. also found reason to speculate that, in the special case of problem-similarity, client-counselor similarity may serve to enhance perceptions of counselor expertness (Corrigan, Dell, Lewis & Schmidt, 1970, p.425). Corrigan and his associates suggested that, although the role of counselor carries with it an expectation of expertise in problem resolution, client-counselor problem-similarity may further enhance counselor credibility. When the client becomes aware that the counselor has suffered through and resolved a similar problem, depending on the nature and relevance of the problem to the client, he or she may attribute increased knowledge and experience in problem resolution to the counselor. The high value placed on problem-similarity in substance abuse counseling may arise, in part, from the belief that a counselor with a similar problem background is more expert in the resolution of that problem and can therefore offer more competent help with the problem.

Increasing professionalization in substance abuse counseling, with its emphasis on client-counselor problem-similarity, raises questions about the nature of problem-similarity and its relationship to counselor influence. Research is particularly lacking in professional substance abuse counseling. This study addressed the question of

whether or not perceptions of counselor expertness, trustworthiness and attractiveness are enhanced in substance abuse counseling when problem-similarity is part of the counselors' reputation. The study made use of Strong's social influence model to test the idea that client-counselor problem-similarity enhances perceptions of counselor credibility. Use of the social influence model may further clarify the question of the relative credibility of recovered versus non-recovered counselors in substance abuse treatment.

Review of Literature

The review that follows surveys the relevant similarity research in the areas of (a) general social influence theory, (b) counseling process relative to the three counselor social influence dimensions, and (c) alcohol and drug counseling. It brings together the findings of these areas of research to delineate the effect of similarity in the counseling process generally and in substance abuse counseling specifically. The review also points toward the need for further investigation into the effects of client-counselor problem-similarity in professional substance abuse counseling.

Similarity and social influence. Early studies in persuasion and opinion change established that communicator-receiver attitudinal and membership-group similarity

increased attraction to the communicator. This increase was seen as a function of the amount of positive reinforcement the similarity holds for the receiver (Byrne, 1961; Byrne, Clore, & Worchel, 1966; Byrne & Griffit, 1966; Byrne & London, 1966; Byrne & Nelson, 1965, Byrne & Ramey, 1965). Brock (1965) and Berscheid (1966) expanded on Byrne's work when they showed that the relevance of the similarity, as perceived by the receiver, tends to mediate the positive effect of the similarity on attraction to the communicator.

Simons, Berkowitz, and Moyer (1970) reviewed the extensive research on the effect of similarity on persuasion and opinion change. They found a more complex relationship between communicator-receiver similarity and communicator credibility and attraction than could be explained by Byrne's reinforcement model. Simons and his associates concluded that similarity between communicator and receiver can enhance perceptions of communicator credibility, as well as attraction to the communicator. They also noted that similarity may diminish attraction if it is irrelevant to the issue of the communication, if it is too psychologically close to the receiver, or if it somehow threatens the receiver's self esteem. Similarity based on membership-group has a less powerful effect on attraction and credibility than attitudinal similarity. However, the receiver may infer that the communicator holds a similar attitude about the issue if the membership-group similarity

is relevant to the issue. Membership-group similarity might then enhance attraction to a communicator or increase the credibility of the communicator. In general, for the similarity to have a measurable effect on attraction or credibility it must serve a reinforcing function for the receiver and the similarity must be relevant to the communication.

Although Simons, Berkowitz, and Moyer (1970) found support for Byrne's reinforcement theory, they also identified a number of variables that interact with the reinforcement process in communication. For Simons and his associates, the quality and amount of reinforcement that the receiver derives from the relationship is affected by the nature of the communication, the self-esteem of the receiver, and the relevance and psychological closeness of the similarity. Although the authors tended to equate similarity with attraction, they implied that the variables that interact to affect similarity and attraction may also interact to affect communicator credibility in much the same way. The propositions they put forward raised additional questions regarding the role of similarity in counseling relationships and spurred the efforts of counseling process researchers.

Similarity in counseling. Strong (1968) was the first counseling process researcher to conceptualize counseling as

a special case of interpersonal influence; one in which the need-state of the client and the perceived expertness, attractiveness, and trustworthiness of the counselor interact to determine counselor influence. In keeping with persuasion and opinion change theorists, Strong viewed similarity as primarily a component of counselor attractiveness. Later elaborations of Strong's original formulation continued to view counselor attractiveness as the influence dimension most affected by client-counselor similarity (Strong, 1978; Strong & Dixon, 1971; Strong & Matross, 1973). For Strong and his associates, counselor credibility was comprised of perceived expertness and trustworthiness. It was based on client perceptions of the counselor as one who possesses special knowledge and training as well as noble intentions and motives. The idea that perceptions of counselor expertness might be positively affected by client-counselor problem-similarity was not addressed in Strong's model.

In their review of social influence research in counseling Corrigan, Dell, Lewis, and Schmidt (1980) suggested that similarity may play a role in client perceptions of counselor expertness. However, little research has addressed the question of a similarity effect on perceptions of counselor expertness in the special case of client-counselor problem-similarity. Most of the studies reviewed by Corrigan and his associates continued to delimit

similarity in terms of its effect on counselor attractiveness. Also, most of the studies reviewed used client-counselor similarities that were not directly relevant to the presenting problem of the client.

Similarity and counselor attractiveness. Studies of the effects of client-counselor similarity on client perceptions of counselor attractiveness have used both direct reputational cues (Cheney, 1975; Goldstein, 1971; Greenberg, Goldstein, & Gable, 1971; Hogan, Hall, & Blank, 1972; Strohmer & Biggs, 1983) and in-session self-disclosure by the counselor (Atkinson, Brady, Casas, 1980; Daher & Banikiotes, 1976; Dowd & Boroto, 1982; Giannandrea & Murphy, 1973; Hoffman-Graff, 1977; Mann & Murphy, 1975; Schmidt & Strong, 1970) to establish client awareness of similarity with the counselor. Greenberg, Goldstein, and Gable (1971) crossed "warm" and "cold" counselor descriptions with pre-session information describing the counselor as having received or not received counseling during adolescence. Adolescent subjects from both control and treatment samples rated an audio-taped similar counselor more attractive across both warm and cold conditions. Goldstein (1971) interpreted the Greenberg et al. results in light of other research done with psychiatric patients in which direct reputational cues proved to have a powerful effect on attraction. Goldstein used pre-session information

regarding therapist-client personality similarity in a series of studies designed to investigate the effects of similarity on discrepant communications. Although the results provided by Goldstein did not show consistent attraction enhancing effects resulting from trait-structured similarity, they demonstrated that pre-session information can be used to manipulate perceptions of therapist-client similarity. Hogan, Hall and Blank (1972) used similarity on Holland's scale as pre-session information in a vocational counseling study. They found that college students were more attracted to other students with a similar interest profile. Trait-structure once again proved to be an effective way to manipulate perceptions of similarity.

Counseling research has not provided consistent support for the attraction-enhancing effect of client-counselor similarity. Studies by Cheney (1975) and Strohmer and Biggs (1983) stand in contrast to research showing high attraction to the counselor across different client-counselor similarity conditions. Cheney (1975) provided written information regarding therapist attitudes toward alcohol and alcoholism to structure subjects' perceptions of similarity or dissimilarity to the therapist. The subjects were males serving sentences for public intoxication. Control groups, who were given no information about counselor attitudes, were used to test the effects of crossing two levels of similarity (similar attitude versus

dissimilar attitude) and two levels of relevance (alcohol attitude versus general attitudes). Results indicated that subjects rated the therapist higher on attraction measures when problem-relevant (alcohol) attitude information was provided regardless of the degree of similarity expressed. Comparison with the control group, however, showed no significant difference from the experimental condition. This finding implies that a lack of relevance may decrease attraction more so than high relevance increases attraction. Cheney's results suggest that, in cases where persons with psychological problems are pre-exposed to the attitudes of a potential helper, the problem-relevance of the helper's attitude may increase the effect of similarity. It also implies that when the similarity is perceived as not relevant to the problem it may decrease attraction in a help-giving situation (Cheney, 1975, p. 4).

Strohmer and Biggs (1983) investigated the effects of membership-group similarity, as evidenced by disability status of the counselor, on disabled subjects' perceptions of both counselor attractiveness and expertness. Subjects were exposed to four video taped vignettes showing a disabled (wheelchair bound) counselor or a non-disabled counselor providing counseling on problems not associated with disability. Attractiveness cues, evidenced by attending or neutral counselor behavior, were crossed with four disability conditions. Reputational cues regarding the

counselors' training and experience were provided by a written information sheet. Results indicated that membership-group similarity and expertness cues did not increase disabled subjects' ratings of either attractiveness or expertness. Attending behavior, however, did produce a significant effect on ratings of both expertness and attractiveness. Strohmer and Biggs interpreted these results as not supporting the attraction-enhancing effect of membership-group similarity when it is based on disability status. These results suggest that perceptions of similarity may interact positively with behavioral cues which occur in the session. The Strohmer and Biggs results stand in contrast to studies of similarity based on racial and cultural membership. These studies indicate that counselors who come from similar racial or cultural groups to their clients tend to be perceived as more credible and attractive (Atkinson, Maruyama, & Matsui, 1978; Banks, Berenson, & Carkhuff, 1967).

Research using reputational or evidential cue manipulations to create perceptions of client-counselor similarity have shown inconsistent effects on counselor attractiveness. Studies making use of self-disclosure as a basis for establishing similarity have generally provided more consistent support for the attraction-enhancing effect of similarity. Schmidt and Strong (1970) developed attractive and unattractive counselor roles to study the

effects of counselor attractiveness in a quasi-counseling situation. Their "attractive" counselor used similarity self-disclosures as a central feature of the attractive role. Results of the studies employing these roles indicated that attractive counselors making use of similarity self-disclosures are consistently rated higher than unattractive counselors. Later, Murphy and Strong (1972) manipulated the number of similarity self-disclosures in a quasi-counseling study. Interviewers who self-disclosed similar background or life experiences were consistently rated more warm and friendly, i.e., more attractive, by college student subjects. Giannandrea and Murphy (1973) replicated the attractiveness-enhancing effect of a moderate number of similarity self-disclosures, while also showing that subjects of attractive interviewers would be more likely to return for a second interview. Both Murphy and Strong and Giannandrea and Murphy interpreted their results as supporting Byrne's (1961) "law of attraction".

The effects of an interviewer's positive and negative self-disclosures on measures of both counselor credibility and attractiveness have been investigated by a number of researchers. Hoffman-Graff (1977) viewed counselor disclosures of a similar problem-history as negative and used a negatively self-disclosing interviewer to test the effect of problem-similarity on client perceptions. Similar

(negatively disclosing) interviewers were rated significantly higher on empathy and warmth. Hoffman-Graff interpreted the results in terms of social exchange theory (Thibout & Kelly, 1959), and indicated that the similar interviewer may have been perceived as more reinforcing in terms of risks and costs for the interviewee. Daher and Banikiotes (1976) found college students more attracted and more likely to disclose to a hypotehtical, high-disclosing, high-similarity individual. The authors indicate that similarity in the content of disclosure was a primary variable affecting action, and that the effect follows the reinforcement model proposed by Byrne.

Atkinson, Brady, and Cases (1980) also found support for the similarity effect in an analogue study of counselors who disclosed similar attitudes or experiences regarding sexual preference to those held by a group of gay (male homosexual) subjects. Subjects rated the gay counselor more attractive than either the non-gay counselor or the counselor who disclosed no sexual preference information. Attraction to the gay counselor was further enhanced by the counselor's disclosure of a gay advocacy attitude similar to that of the rater. The authors noted that with gay subjects, both membership-group and attitudinal similarity had a significant positive effect on counselor attractiveness. Dowd and Boroto (1982) used a video-tape analogue design to show that both present and past

similarity self-disclosures positively affected attractiveness ratings. They also noted that expertness and trustworthiness were differentially affected by similarity. However, the college-student subjects indicated more willingness to be counseled in the future by a counselor who offered a dynamic interpretation of the presenting problem than by a counselor who offered either self-disclosing or self-involving statements. Consequently, Dowd and Boroto questioned the importance of attractiveness and, by definition, similarity in establishing a willingness to engaged in counseling.

In summary, studies of counselor attractiveness have manipulated client-counselor similarity by using reputational cues as well as self-disclosure. Such manipulations resulted in a range of effects on measures of counselor attractiveness, from highly significant to not significant. Counselor disclosure of having had either a similar problem or a similar attitude toward the problem appears to have provided the most consistent positive effect on attractiveness ratings. However, it remains unclear as to what factors account for the effect. The effect that client-counselor similarity has on perceptions of counselor attractiveness may be mediated by the importance the client places on the similarity. In the case of self-disclosed similarity, the counselor's timing and manner of disclosure may affect whether or not counselor attractiveness is

enhanced. Few counseling studies of the similarity effect on attractiveness have taken account of the relevance of the similarity, the notable exceptions being the studies by Atkinson, Brady, and Cases (1980), Cheney (1975), and Strohmer and Biggs (1983). Except for the Strohmer and Biggs study, these studies showed that the relevance of the similarity, whether based on attitude or membership-group, can have a powerful affect on attractiveness ratings.

Similarity and counselor expertness. Counselor expertness has traditionally been defined in terms of (a) its reputational aspects, such as training, status, seniority; (b) its evidential aspects, such as diplomas or certificates; and (c) its behavioral aspects, such as counselor use of psychological terminology, attentive posture, and empathic style. Due to this traditional definition and to the tendency of social influence theorists to define attraction in such a way as to make it synonymous with similarity (Byrne, 1961; Strong, 1968), the relationship between client-counselor similarity and counselor expertness has received little research attention. Although social exchange theorists such as Hovland, Janis, and Kelly (1953) and McGuire (1969) had speculated that communicator credibility might be increased by some types of similarity, Corrigan, Dell, Lewis, and Schmidt (1980) found little counseling process research that focused specifically

on the relationship between client-counselor similarity and and counselor expertness. However, like Hovland et al., Corrigan and his associates indicated that expertness might also be defined in terms of a history of successful problem-solving, particularly when the problem is similar to that presented by the client. Furthermore, the authors speculated that client perceptions of counselor expertness might be enhanced when the client believes that the counselor has suffered through and successfully resolved a similar problem (1980, p. 425). The effect that client-counselor similarity might have on client perceptions of counselor expertness was presumed to arise from a highly specific and relevant source such as problem-similarity.

Previous research on the counseling process has not manipulated client-counselor problem-similarity directly to affect client perceptions of counselor expertness. A few studies, however, have measured credibility and other indices which could be considered analogous to expertness when either membership-group similarity or attitudinal similarity was evident to the client. Atkinson, Brady, and Casas (1980) found that a counselor was rated more expert by gay male subjects when the counselor stated a sexual preference for men than when he stated a sexual preference for women. The effect was increased further when the counselor expressed a gay advocacy attitude similar to that of the subjects. Atkinson, Maruyama, and Matsui (1978)

studied the relationship between racial-group similarity and counselor credibility. They found that more highly politicized Asian-American college students rated a counselor more credible when the counselor's background was described as Asian-American. These findings are consistent with work by Banks, Berenson, and Carkhuff (1967) which showed positive effects on counselor credibility due to racially or culturally based client-counselor membership-group similarity.

Membership-group similarity has not proven to be a consistent basis for increased counselor credibility or expertness. However, Acosta and Sheehan (1976) found that when similarity based on Mexican-American heritage was crossed with professional or non-professional status introductions, Mexican-Americans rated the non-expert Mexican-American counselor as mostly likely to provide competent help. The Mexican-American expert counselor received the lowest overall ability ratings. Porche and Banikiotes (1982) demonstrated that a racially similar counselor produced no gain in expertness ratings by black adolescents. Brabham and Thorenson (1973) found that disabled counselors were rated as more credible than non-disabled counselors by disabled subjects, but no more so than by non-disabled raters. Disabled subjects did indicate, however, that they rated disabled counselors more credible because they perceived the disabled counselor as

more knowledgeable about disability. Non-disabled raters based their increased credibility rating on admiration for the counselor who has overcome adversity. Strohmer and Biggs (1983) also studied disability status as the basis for membership-group similarity. They found no significant effect on expertness ratings due to disability status. However, attending behavior did increase perceived expertness.

Similarity based on attitude has also shown inconsistent effects on client ratings of counselor credibility and expertness. Atkinson and Alpert (1981) found a positive correlation between female subjects holding an egalitarian attitude toward dating initiation and higher ratings for counselors with similar attitudes. The ratings were higher for expertness as well as attractiveness and trustworthiness. Studies by Good (1975) and Good and Good (1972) indicated that therapy patients rated psychotherpists who held similar attitudes more effective as well as more attractive. Bentler and his associates, however, found contradictory results in studies of both group psychotherapy and individual therapy (Bentler, Jobe, & Elkins, 1974; Bentler, Johnson, Neville, Elkins, & Jobe, 1975). Patients enrolled in group psychotherapy who indicated attitude similarity to their therapist rated their improvement higher, although ratings of attitude change were more related to initial attitude dissimilarity than to attitude

similarity. Ratings of the therapists' persuasive influence by patients in individual therapy showed an inverse relationship to initial patient-therapist attitude similarity. Therapists who were viewed as highly credible before therapy required less similarity than low credibility therapists to generate attitude change in psychiatric outpatients. Although the Good and the Bentler studies did not use expertness measures per se, they did address issues related to counselor credibility in the context of therapist-patient attitudinal similarity using a clinical population.

In a counseling analogue study with female college students, Lewis and Walsh (1980) found that counselors who explicitly communicated similar values regarding sexual behavior were rated higher on attractiveness and trustworthiness. A tendency toward significance was noted on ratings of counselor expertness. Spiegel (1976) investigated the effect of expertness cues in the context of membership group similarity based on age and student status. She found that expertness manipulations, using pre-exposure training information about the counselor, consistently increased counselor competence ratings regardless of the nature of the presenting problem. Background similarity manipulations proved ineffective in fostering perceptions of attitudinal similarity or increased counselor competence ratings regardless of the presenting problem. Spiegel's

results suggest that when similarity is based on age and student status, it has little power to increase perceptions of counselor competence, particularly when attributions of counselor expertness are based on role related cues. She concluded that similarity may be more important in a friendship relationship than a counseling relationship where expectations of counselor competence are presupposed by the client.

Although client perceptions of counselor expertness, credibility, and competence have been shown to be positively affected by some membership-group similarity manipulations and by some attitudinal similarity manipulations, the results are inconsistent and often contradictory. Few of the studies have made use of problem-relevant similarity with a clinical population. The results of studies have often proven difficult to interpret in terms of isolating the effect of similarity on counselor expertness due to the variations in definitions of expertness. It appears that similarity may have a positive effect on perceived expertness, and may act as a reputational cue for client perceptions of counselor expertness if the basis for client-counselor similarity is highly relevant and if other expertness cues are evident to the client.

Similarity and counselor trustworthiness. Corrigan, Dell, Lewis, and Schmidt (1980) gave indicated that little

research attention has been given to the trustworthiness dimension of counselor influence due to difficulty in manipulating trustworthiness cues in the context of a counseling relationship. Early social influence researchers tended to cluster trustworthiness with expertness under the broader heading of credibility. Consequently, they failed to isolate what might be identified as a trustworthiness effect.

A few counseling process studies have measured trustworthiness along with expertness and attractiveness in the context of client-counselor similarity. Atkinson, Brady, and Casas (1980) found that trustworthiness ratings increased along with expertness and attractiveness ratings when sexual preference similarity was stated between client and counselor. Increased trustworthiness ratings were also found by Atkinson and Alpert (1981) in their study of dating attitude similarity. However, the authors found only a small positive correlation between female subjects with egalitarian attitudes and high counselor social influence ratings. Their initial analysis did not find a main effect for similar attitudes across female-male counseling pairs or for counselors with traditional attitudes about dating initiation. Dowd and Boroto (1982), on the other hand, found that self-disclosure of a past similar problem by the counselor did not enhance perceptions of counselor expertness or trustworthiness. Since measures of

trustworthiness have often been linked to expertness, it is not surprising that high ratings of counselor trustworthiness have been related to high expertness ratings. However, client perceptions of counselor trustworthiness alone have not been consistently affected by client-counselor similarity manipulations.

Similarity in substance abuse counseling. The importance placed on client-counselor problem-similarity in substance abuse counseling arises from inferences that have traditionally been made about problem-similarity by self-help groups. If the counselor is a recovered alcoholic or drug addict, then it is generally supposed that the counselor possesses special expertise not available to the non-recovered counselor. This special form of membership-group similarity is thought to provide the basis for attitudinal similarity regarding the nature of drug or alcohol dependency, the importance of maintaining a program of abstinence from mood altering drugs, and the ongoing need for group support during recovery. It is also thought to give the counselor a special understanding of the emotionally painful effects of addiction and the struggle the addict must endure to achieve and maintain abstinence.

Although the importance of client-counselor problem-similarity continues to be debated in the field of alcohol and drug counseling (Argeriou & Manohar, 1978; Cook, 1985;

Covner, 1969; Krystal & Moore, 1963; Rosenberg, Gerrein, Manohar, & Liftik, 1976) well-controlled research on the issue is sparse and only one study has focused on how problem-similarity affects counselor influence. Cheney's (1975) study of alcohol attitude similarity between D.W.I. subjects and a counselor described as holding similar attitudes toward drinking found no effect on counselor attractiveness ratings due to similarity. However, he did find a significant effect for relevance of the similarity on willingness of subjects to see the counselor for actual counseling.

While Cheney's study is the only one using social influence theory to compare counselors in a substance abuse counseling context, other studies have attempted to compare counselor effectiveness based on problem-similarity. Argeriou and Manohar (1978) compared measures of the effectiveness of recovered alcoholic and non-alcoholic counselors following short-term counseling regimen. The authors found that positive changes in drinking behavior occurred significantly more often in young patients counseled by recovered alcoholic counselors than with young patients counseled by non-alcoholic counselors. Argeriou and Manohar failed, however, to control for counselor skill level and their counselor sample was relatively small. Brown and Thompson (1976) provided a more extensive comparison with clients of thirty recovered addicts versus

twenty-nine non-addict counselors in a methadone program. Using a variety of measures and treatment completion indices at one year following treatment, the authors found no significant differences in counselor effectiveness due to recovery background. Similar studies by Connett (1980) and Longwell, Miller, and Nichols (1978) comparing recovered addict counselors versus non-recovered counselors have also failed to find significant differences due to recovery status. Ottomanelli (1978), however, compared non-recovered professional and recovered addict paraprofessional counselors in terms of client changes in M.M.P.I. scores following a course of counseling. He found significant decreases in Depression (D) and Schizophrenia (Sc) scales from pre-session levels with clients of professionals while no analogous changes were noted in clients of recovered addict paraprofessionals.

Aiken, Losciuto, and Ausetts (1984) have provided the most extensive comparative study to date of recovered addict paraprofessional counselors and non-recovered professional counselors. Aiken and his associates went beyond previous comparative studies by controlling for race, sex, educational level, and geographic region of the eighty-two counselors used in their study. They also controlled for initial differences among the clients in order to highlight any significant differences in counselor effectiveness. Their study concluded that no differential effectiveness

existed between recovered and non-recovered counselors for patients of drug-free counseling and methadone maintenance programs. In a related follow-up study, Losciuto, Aiken, and Ausetts 91984) found that the same sample of clients saw their counselors as equally able to understand them regardless of recovery background, however, recovered addict counselors were seen as more knowledgeable about critical issues of drugs and the drug culture.

None of the studies to date have made a direct comparison of recovered versus non-recovered professional counselors using a social influence approach. Also, none of the studies have made this comparison while attempting to control for reputational, evidential, or behavioral cues other than client-counselor problem-similarity. In order to address more fully the issues central to this debate, further research is needed into the effect of problem-similarity on counselor social influence in substance abuse counseling.

Rationale for Current Research

Counseling has been conceptualized as a social influence process in which client-counselor similarity may play a major role. Membership-group similarities and attitudinal similarities between the client and counselor have been shown to produce positive, but inconsistent, effects on client perceptions of counselor social influence,

as well as on measures of counselor effectiveness. The field of substance abuse counseling has traditionally placed great importance on client-counselor problem-similarity, in part because of its supposed positive effect on client perceptions of counselor expertise in recovery from addiction. Research comparing recovered to non-recovered counselors has been focused on comparisons of paraprofessional recovered counselors and professional non-recovered counselors rather than a professional counseling context solely. Studies in substance abuse counselor effectiveness have not made use of the social influence model of counseling.

Hypotheses

The following hypotheses were tested using Strong's social influence model of counseling to compare the effect of client-counselor problem-similarity on alcoholics' and non-alcoholics' perceptions of counselor social influence.

1. Alcoholic and non-alcoholic subjects will rate the counselor higher on expertness, attractiveness, and trustworthiness if the counselor's background description includes counseling for and resolution of a life problem, compared with the counselor's background description that does not include counseling for and resolution of a life problem.

2. Alcoholic subjects will rate counselor expertness, attractiveness, and trustworthiness higher than non-alcoholic subjects when the counselor's background description includes counseling for and resolution of an alcohol abuse problem.

3. Alcoholic and non-alcoholic subjects will rate counselor expertness higher than attractiveness and trustworthiness when the counselor's background description includes counseling for and resolution of a life problem compared with the counselor's background description that does not include counseling for and resolution of a life problem.

4. Ratings of counselor expertness will be higher for alcoholic subjects in the alcohol problem-similarity condition than for either alcoholic or non-alcoholic subjects in all other conditions.

CHAPTER II

METHOD

Subjects

Thirty-four alcoholic subjects were chosen from volunteers who were identified from an available population of in-patients. All alcoholic subjects were individuals who had accepted the diagnosis of alcoholic dependency as part of their treatment. Thirty-one non-alcoholic subjects were chosen from volunteers who were identified from an available population of outpatient counseling or psychotherapy clients. Both subject groups consisted of males between the age of 20 and 55 who were able to read at the eighth grade level. Both alcoholic and non-alcoholic subjects had received at least four sessions of individual or group counseling within six months prior to their exposure to the conditions of this study in order to provide some reasonable matching between the subject groups in regard to experience in counseling. Alcoholic subjects were exposed to the conditions of the study within two weeks of beginning their treatment in order to minimize treatment influences which might have implied that a recovering alcoholic is best equipped to help another alcoholic.

Procedure

Stimulus materials. A fifteen minute video taped simulation of a white, male counselor counseling a white, male alcoholic client was developed to present the counseling session. The session was rated for basic counseling competency by three expert raters using the Counselor Rating Form-Short Version (Corrigan & schmidt, 1983). Two of the competency raters were advanced doctoral students in Counseling Psychology, and the other was a Ph.D. level counseling psychologist in counseling center practice. Average scores for the three competency raters were 5.1, 5.4, and 5.8 on the seven point scales. All of the competency raters rated the counselor at or above a summed score of 20 for the four seven point scales comprising the expertness dimension.

Since the counseling scenario was designed to represent a typical substance abuse follow-up session, a problem-solving oriented counseling approach was chosen. This type of approach tends to be used most often in substance abuse treatment follow-up counseling. It also provides a more active counselor role, thus providing more counselor behavior cues in a short segment.

The script for the session was developed from an audio tape of an actual counseling session with an alcoholic follow-up client accomplished by the author. The counselor and the client were asked to read the description of the

session and the script prior to making the video tape. Both were coached in the process until an adequate representation of the session was accomplished. The counselor on the tape holds an Ed.D. in Human Development Counseling, is a Certified Substance Abuse Counselor, and has eight years of counseling experience with substance abuse clients. The client on the tape is a recovered alcoholic paraprofessional with a BA degree who has had two years of counseling experience, and is in his seventh year of continuous sobriety. Neither the counselor nor the client were aware of the nature of the study at the time of the video taping.

Three written descriptions of the nature of the counseling session were developed. The three descriptions were identical in terms of information about the presenting problem, the history of the client, the experience level and credentials of the counselor, and the fact that the counselor was not involved in counseling with the client during the inpatient phase of his treatment. The three descriptions differred in that one indicated that the counselor had never had counseling for either a personal or an alcohol or drug problem. Another indicated that the counselor had received counseling for a personal problem which had resulted in resolution of that problem. A third description indicated that the counselor had received counseling for an alcohol abuse problem and had maintained an alcohol-abstinent lifestyle for the past seven years.

All of the descriptions indicated that the counselor had revealed his personal history to the client in a previous session. The client was described as having had treatment for alcohol dependency and marijuana abuse. The session was described as the second in a series of follow-up counseling sessions available to patients of that treatment program.

Information given to raters prior to their exposure to a stimulus condition has been shown to be an effective way to change the perceptions of raters and structure their responses to a taped therapist (Greenberg, Goldstein, and Perry, 1970; Greenberg, 1969). A number of counseling analogue studies have shown that the use of written pre-session information regarding counselor attributes and background has proven effective in generating differential perceptions in ratings of the counselor (Spiegel, 1976; Guttman & Haase, 1972; Strong & Schmidt, 1970).

Dependent measures. The short version of the Counselor Rating Form (CRF-S) was administered in the subjects immediately following their exposure to the video tape. The original thirty-six item CRF was an instrument designed by Barak and LaCrosse (1975) to measure client perceptions of counselor expertness, attractiveness, and trustworthiness. The CRF-S has been shown to be a valid instrument for use with clinical populations (LaCrosse, 1980). Corrigan and Schmidt (1983) developed a twelve item short form of the CRF

that also effectively measures the three influence dimensions. Replicating the validation techniques used by Barak and LaCrosse, Corrigan and Schmidt selected twelve items from the original thirty six by using factor analysis and reading level criteria. The structure of the items was also changed from the original CRF resulting in a seven point rating scale for the counselor dimensions from "not very" to "very" instead of ratings of bi-polar adjectives.

Reliability and validity results indicate that the CRF-S is comparable to the longer CRF, with inter-rater reliabilities of .91, .85, and .91 for attractiveness, expertness, and trustworthiness. These reliability estimates were obtained from a community mental health patients sample (Corrigan & Schmidt, 1983, p.69). Results also indicate that the CRF-S, like the CRF, is a valid instrument for distinguishing between the three source characteristics when used with a clinical population. The educational level required to complete the CRF-S is reported as equivalent to eighth grade. Scores on each item of the CRF-S can range from 1 for "not very" to 7 for "very". Scale scores for each of the three influence dimensions are computed by adding scores from the four items comprising each scale. Scale scores can range from 4 to 28, with a total score obtained by addition of the scale scores.

The rationale for using the CRF-S over the longer CRF was based upon several considerations. First, the CRF-S

requires less time to administer and a lower comprehension level to complete, thus making it more likely to be understood and accurately completed by client volunteers. Second, the CRF-S items are structured to "increase the variance in the ratings by decreasing the socially undesirable connotations of the negative adjectives in many CRF items" (Corrigan & Schmidt, 1983, p.65). The potential for increasing variance was thought to be of particular importance given the relatively small number of subjects used in this study. Finally, Corrigan and Schmidt used an extension sample of mental health center patients in their validation study and found the format of the CRF-S appropriate for use with clinical subjects similar to those used in this study.

Another questionnaire was developed to assess the importance that subjects placed on the counselors' personal background, personal appearance, counseling style, credentials, and counselor role. Subjects were asked to complete the importance questionnaire following their completion of the CRF-S. The questions were designed to investigate the relationship between these variables and influence dimension scores. A demographic questionnaire was also administered to collect data regarding age, educational level, marital status, financial status, problem for which subjects sought counseling, and extent of previous counseling and support group involvement. The questions

represented in the demographic questionnaire were chosen based on data that has shown them to be related to CRF-S scores (Corrigan & Schmidt, 1983, p.71).

Data collection. The video taped counseling session was presented to the subjects in small groups. Upon entering the study site each subject was given a packet which included a consent and release form as the face sheet, a description sheet, and the three questionnaires. The packets were randomly ordered and handed out in that order. Subjects were instructed not to converse with each other or ask questions of the experimenter until after they had viewed a video tape and completed some questionnaires. The consent and release form was read and signed by each subject prior to viewing the tape and filling out any of the forms. The CRF-S, the importance questionnaire, and the demographic questionnaire were completed after viewing the video tape. One group of alcoholic and non-alcoholic subjects received the same descriptive statement, thus creating randomly assigned groups of alcoholic and non-alcoholic subjects for each of the three conditions of this study.

CHAPTER III

RESULTS

A multivariate analysis of variance (MANOVA) was performed to determine if there was a significant difference between alcoholics and non-alcoholics on influence dimension scores as a result of being exposed to different client-counselor problem-similarity conditions. An alpha level of of .05 was used for all tests of statistical significance. Since cell sizes were unequal and the sample size (n= 65) was relatively small, the assumption of equal dispersion matrices was tested. A chi-square test for homogeneity of within group covariance matrices was used to test this assumption (Morrison, 1976). The chi-square for the diagnostic groups (alcoholic and non-alcoholics) was not significant (p= .49). This result indicated that covariance matrices were not significantly different, therefore, no data transformation was required and raw scores for expertness, attractiveness, and trustworthiness were used in all of the analyses. The Wilks' lambda criterion was used as a test of significant for multivariate main effects and interactions (Tatsuoka, 1971).

The Wilks' lambda was not significant for similarity or diagnosis, however, the interaction between similarity and diagnosis was significant (F= 2.99, df= 6/114, p= .01). The non-significant F for similarity resulted in failure to

support hypothesis one that alcoholics and non-alcoholics would rate the counselor higher on all three influence dimensions when the counselor's background description included counseling for and resolution of a life problem as compared with the counselor's background description that does not include counseling for and resolution of a life problem. Further analysis of the interaction between similarity and diagnosis will be discussed under additional results.

Hypothesis two predicted that alcoholic subjects would rate all three counselor influence dimensions higher than non-alcoholics when the counselor's background description included counseling for, and resolution of, an alcohol problem. A multivariate analysis for the alcohol problem-similarity and condition was performed to determine if a significant different existed between dimension scores for alcoholics and non-alcoholics. The F value for diagnosis was not significant at the .05 level, however, it approached significance ($F= 3.03$, $df= 3/18$, $p= .056$). Although the non-significant difference resulted in failure to support hypothesis two, the fact that the F value approached significance warranted further investigation. Examination of the cell means indicated that expertness and attractiveness scores were higher for alcoholics, while alcoholics' trustworthiness scores were lower than those of non-alcoholics (see Table I). In order to determine which

Table I

Mean Influence Dimension Scores[a] By Similarity Conditions

Group	Similarity Conditions					
	No-problem Similarity		Personal Problem Similarity		Alcohol Problem Similarity	
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
A	16.09	7.54	17.17	4.37	18.23	3.66
	19.64	5.82	19.08	4.40	19.73	4.90
	19.91	5.94	22.67	4.20	20.00	4.88
	(n=11)		(n=12)		(n=11)	
Non-A	15.30	5.89	17.60	5.04	16.27	5.25
	17.70	4.69	20.40	3.53	17.45	5.00
	18.70	6.17	20.40	2.95	21.18	4.38
	(n=10)		(n=10)		(n=11)	

[a] As measured by expertness, attractiveness and trustworthiness.

[b] = Alcoholics; Non = Alcoholics.

counselor influence dimension, or dominations of dimensions, best disciriminated between alcoholics and non-alcoholics a stepwise discriminant analysis was performed. The analysis revealed that significance was not approached until all three dimensions were entered into the analysis. This result suggests that all three counselor influence dimensions taken together best explains the difference between alcoholics' and non-alcoholics' perceptions of

counselor influence for the alcohol problem similarity condition.

Hypothesis three predicted that ratings of expertness would be higher than ratings of attractiveness or trustworthiness when the client-counselor similarity included counseling for, and resolution of, a life problem as compared to the no problem-similarity condition. Examination of the cell means indicated that expertness scores did not exceed attractiveness or trustworthiness scores in any similarity condition for either of the diagnostic groups. Hypothesis three, therefore was not supported.

Hypothesis number predicted that ratings of counselor expertness would be higher for the alcoholic subjects in the alcohol problem-similarity condition than for either alcoholic or non-alcoholic subjects in all other similarity conditions. Examination of the mean expertness score for the alcoholic subjects in the alcoholic problem-similarity condition relative to all other expertness means indicates that the highest average expertness score occured for alcoholic subjects in the alcohol problem-similarity condition. An analysis of variance was performed on expertness scores alone to determine if a significant main effect resulted due to similarity condition or diagnostic group. No significant main effect for similarity or diagnosis was found and the interaction did not achieve

significance. Although the highest mean score for expertness occurred in the alcohol problem-similarity condition for alcoholic subjects, the different between that mean and all other expertness means in the other conditions was not significant. Hypothesis four cannot, therefore, be supported.

Additional Findings

The finding of a significant multivariate interaction between diagnosis and similarity was further analyzed using separate multivariate procedures. First, a separate multivariate analysis of similarity conditions was performed on each diagnostic group. Second, multivariate analyses comparing the two diagnostic groups was done for each of the three similarity conditions. A significant main effect for similarity ($F= 2.79$, $df= 6/58$, $p= .02$) was found in the alcoholic group, while the similarity effect for non-alcoholics was not significant ($p= .32$). The main effect for diagnosis was not significant for the no problem-similarity condition ($p=.89$) but was significant for the personal problem-similarity condition ($F= 3.69$, $df= 3/18$, $p= .03$), and approached significance for the alcohol problem-similarity condition ($p= .056$). Pairwise comparisons were performed using a step-wise discriminant analysis to determine which similarity conditions in the alcoholic group differed significantly from each other. A

Bonferroni procedure was used to adjust for the nominal alpha. Results indicate that the personal problem-similarity condition was significantly different from the alcohol problem-similarity condition ($F= 5.63$, $df= 3/29$, $p= .004$), but not from the no problem-similarity condition ($p= .059$). Alcohol problem-similarity was also not significantly different from the no problem-similarity condition ($p= .49$). Examination of the cell means suggests that the interaction between diagnosis and similarity was most likely located in the alcoholic group who were exposed to the personal problem-similarity condition. Follow up analysis, utilizing a stepwise discriminant analysis for the alcoholic group by similarity condition and for the personal problem-similarity condition by diagnosis, revealed that significant levels were not achieved for the alcoholic group and for the personal problem-similarity condition until all three dimensions were entered in the analysis. Examination of the discriminant coefficients for the alcoholic group suggests that trustworthiness contributed more to the discrimination between similarity conditions (-2.45) than either expertness (1.46) or attractiveness (1.38), however, trustworthiness taken alone or in combination with either of the other two dimensions did not produce a significant discrimination. Discriminant coefficients for the personal problem-similarity condition comparison between diagnostic groups were .59 for expertness, 1.29 for attractiveness, and

-1.67 for trustworthiness. These findings suggest that all three influence dimensions taken together best explains the source of the interaction.

A Pearson correlation procedure was used to examine the relationship between counselor influence dimension scores and ratings of the importance subjects gave to (a) the description of the counselor's personal history, (b) the counselor's personal appearance, (c) the counselor's "nice guy" approach, (d) the description of the counselor's credentials and experience, and (e) the belief that counselors are supposed to be helpful experts. The scores for these questions were derived from a 0 to 4 scale ranging from no importance to "of prime importance" (see Appendix A). Correlations were made for each diagnostic group in order to afford some co comparison between alcoholics and non-alcoholics All correlations for both diagnostic groups proved to be surprisingly low (see Table II). There appears to be little correlation for these subject groups between influence dimension scores and the importance placed on the description of the counselor's personal background.

The counselor's personal appearance was the most highly correlated importance factor across all three dimensions for the non-alcoholics. The correlation between counselor personal appearance and trustworthiness for the non-alcoholic group was the highest among all of the correlations. None of the personal appearance correlations

Table II

Correlations Between Alcoholics' and Non-alcoholics' Dimension Scores and Importance Questionnaire Ratings

	Counselor Influence Dimensions					
Importance Ratings	Expertness		Attractiveness		Trustworthiness	
Counselor Personal History	A[a]	.04	A	.08	A	-.01
	Non[b]	-.12	Non	-.12	Non	-.04
Counselor Personal Appearance	A	.32	A	.26	A	.17 *
	Non	.44	Non	.47	Non	.56
Counselor "nice guy" Approach	A	.35	A	.26	A	.40
	Non	.35	Non	.38	Non	.44
Counselor Credentials	A	.10	A	.43	A	.42
	Non	.33	Non	.12	Non	.16
Counselor as Helpful Expert	A	.45 *	A	.16 *	A	.40 *
	Non	-.17	Non	-.43	Non	-.14

[a] A = alcoholics.

[b] Non = non alcoholics.

* $p < .05$

for the alcoholic group were above .50. Both the "nice guy" question and counselor credentials received low positive correlations for both diagnostic groups across all three influence dimensions. Correlations between dimension scores and subjects' belief that counselors are supposed to be

helpful experts showed the largest differential between alcoholics and non-alcoholics. Correlations were significantly different between alcoholics and non-alcoholics across all influence dimensions. Fisher's r' test (Howell, 1982) indicates that expertness was significant at p= .006, attractiveness at p= .009, and trustworthiness p= .015. Counselor personal appearance in relation to trustworthiness was the only other correlation that was significantly different (p= .027) between alcoholics and non-alcoholics. It was also the highest overall correlation, accounting for 31% of the variance in trustworthiness scores for the non-alcoholic group. No other importance variable accounted for more than 22% of the variance on any of the three dimensions.

A demographic questionnaire was also completed by every subject. Information was obtained regarding subjects' age, marital status, education level, average yearly income, type of problem, number of counseling sessions received, Alcoholics Anonymous/Narcotics Anonymous attendance, and length of AA/NA involvement. These variables were also correlated with the ratings of the three counselor influence dimensions. The response choices for age, income, education level, number of sessions, and length of AA/NA involvement (for the alcoholic group only) were assumed to represent an underlying continuous distribution in the population. These variables were correlated with the influence dimensions

using a Pearson correlation procedure. The categories of marital status were collapsed to create a dichotomous variable. This procedure necessitated the use of a point biserial correlation for examining the relationship between marital status and ratings of the counselor influence dimensions (see Table III). Educational level and income showed moderately positive correlations with expertness scores for the alcoholic group. For the non-alcoholic group, age showed a moderate negative correlation with trustworthiness scores. Number of sessions showed a moderate negative relationship with both attractiveness and trustworthiness scores. All other demographic variables were essentially uncorrelated with scores of the three influence dimensions. There was no significant different between the correlations of the alcoholic and non-alcoholic groups on any demographic variable.

Squared correlation cofficients indicated that only 17% of the variance in attractiveness scores was accounted for by number of sessions. No other correlation accounted for more than 13% of the variance for any dimension.

Table III

Correlations Between Alcoholics' and Non-Alcoholics' Dimension Scores and Demographic Variables

Demographic Variables	Counselor Influence Dimensions					
	Expertness		Attractiveness		Trustworthiness	
Age	A[a]	.07	A	-.10	A	-.04
	Non[b]	-.13	Non	-.03	Non	-.36
Education Level	A	.32	A	-.03	A	.10
	Non	.16	Non	-.07	Non	.14
Income Level	A	.33	A	.02	A	.14
	Non	.17	Non	.00	Non	.14
Number of Sessions	A	-.16	A	-.14	A	-.10
	Non	-.23	Non	-.41	Non	-.35
Length of AA/NA	A	-.17	A	-.26	A	-.06
	Non	.	Non	.	Non	.
Marital[c] Status	A	-.10	A	-.18	A	.11
	Non	.00	Non	-.17	Non	-.27

[a] A = alcoholics.

[b] Non = non-alcoholics.

[c] Marital status was correlated for married (1) and not married (2) using a point biserial correlation.

CHAPTER IV

DISCUSSION

General Limitations

There are several limitations that prevent this study from providing a definitive description of the effects of client-counselor problem similarity on alcoholics' and non-alcoholics' perceptions of counselor social influence. First, although this study used a counseling scenario based on an actual counseling encounter, the analogue design did not provide subjects an opportunity to interact with the counselor. Observing counseling probably does not generate the same perceptions as participating in counseling (Munley, 1974). Second, some researchers have noted that the validity of ratings may be diminished when the exposure to the stimulus is brief and the rating task is relatively complicated (Giannandrea & Murphy, 1973; Hoffman-Graff, 1977). Finally, generalizations cannot be made beyond the demographic characteristics of the subject groups who were involved in the study (see Appendix B).

Sampling and treatment issues may also have affected the validity and generalizability of the findings. All alcoholic subjects had completed detoxification and were assumed to be capable of competently performing the rating task, however, this assumption was not tested other than by experimenter observation. Also, alcoholic subjects were

within two weeks of beginning their treatment. Two weeks of treatment exposure may have allowed alcoholic subjects to be influenced by the notion that only a recovered alcoholic can understand and help another alcoholic. The non-alcoholic diagnostic group was drawn from populations that may have differed from each other in important ways. Nineteen of the non-alcoholics were outpatient counseling clients. The remaining twelve non-alcoholics were Vietnam veterans who were involved in counseling for post-traumatic stress concerns. The inpatient alcoholic group may have represented a more severely impaired population, as well as a more homogeneous diagnostic group.

An additional caution must be exercised when interpreting multivariate main effects and interactions. The MANOVA procedure is sensitive to the magnitude of differences among dependent variables as well as independent variables. The procedure also tends to find significance more often when differences in the magnitude of within group variances exists and when intercorrelations between dependent variables are high (Tatsuoka, 1971). Although counselor attractiveness and trustworthiness scores were generally higher than expertness scores, the magnitude of the differences was not great. Intercorrelations between trustworthiness and attractiveness and trustworthiness and expertness were moderately high at .66 and .73 respectively. However, only a moderate correlation (.45) existed between

expertness and attractiveness. It is possible that multivariate Fs may have been affected by differences in the magnitude of dimension scores within groups, as well as differences in the dimension score intercorrelations.

Implications

In spite of the limitations of this study a number of findings are noteworthy. The analysis of the interaction between problem-similarity and diagnosis suggests that alcoholics may perceive counselor expertness, attractiveness, and trustworthiness more favorably when the counselor has had experience in suffering through and resolving a personal problem. These results would tend to support the idea that problem-similarity is a variable capable of positively affecting perceptions of counselor influence in alcoholic clients.

Studies by Strohmer and Biggs (1983) and Cheney (1975) found little or no effect on perceptions of counselor influence dimensions due to problem similarity or alcohol use attitude similarity. Other research has shown perceptions of counselor influence to be positively effected by client-counselor attitude similarity (Atkinson, Brady & Casas, 1980; Dowd & Boroto, 1982). The finding that influence dimension scores were significantly affected by problem-similarity suggests that for alcoholic subjects attitude similarity may have been inferred from knowledge of

counselor problem-similarity. More importantly, it suggests that alcoholics' perceptions of counselor influence are positively affected by knowledge of counselor problem background. Counselor influence may be enhanced if alcoholic clients are made aware of the counselors' personal struggles with life problems.

The finding by Cheney (1975) that the effect of client-counselor attitude similarity was mediated by the relevance that the similarity holds for the client was not fully supported by this study. In the present study, the finding of no significance for the alcoholic problem-similarity condition suggests that knowledge of alcoholic problem-similarity may not enhance alcoholics' perceptions of counselor influence relative to knowledge of any personal problem resolution by the counselor. An alternative possibility noted by Cheney (1975), and supported by Simons, Berkowitz, and Moyer (1970), is that too much similarity in the early stages of a relationship may negatively affect perceptions of counselor attractiveness and credibility. The implication of this finding for substance abuse counseling is that client awareness of the counselor having recovered from alcoholism may not be more relevant than the awareness that the counselor has suffered through any personal problem.

The prediction that expertness would prove to be the influence dimension most affected by similarity between the

two diagnostic groups was not supported. Expertness scores proved to be consistently lower than those of either attractiveness or trustworthiness. It is possible that the description of the counselors' credentials as well as the subjects' brief exposure to counselor behavior in the session did not provide enough evidence of competence for the groups used in this study to justify higher expertness ratings relative to trustworthiness and attractiveness. Perceptions of counselor attractiveness may be more readily formed in a brief exposure than perceptions of expertness.

Although mean scores for expertness increased across similarity conditions for the alcoholic group and not for the non-alcoholic group, the magnitude of the differences was not statistically significant. An explanation for this is suggested by the failure to find any separate dimension, or sub-set of dimensions, that discriminated between groups; and by the relatively high intercorrelation between expertness and trustworthiness scores. Also, the CRF-S may lack the sensitivity to fully delineate an expertness effect with the type of design used in this study.

In the final analysis, for the alcoholic group used in this study, the perception of counselor influence was probably based on an overall nice guy effect, similar to that noted by Corrigan and Schmidt (1983), which served to overshadow the small expertness differential between groups. The implication for substance abuse counseling is that

client knowledge of counselor recovery from alcoholism may not significantly enhance perceptions of counselor expertness if other cues for counselor competence, attractiveness and trustworthiness are evident.

The finding that no single influence dimension or subset of influence dimensions discriminated between groups suggests that a three factor model, with all dimensions contributing, best accounts for differences in perceptions for the groups represented in this study. Strong's (1968) original counselor influence theory suggested a two dimensional structure with expertness and trustworthiness combining to form a credibility dimension and attractiveness as a separate and distinct dimension. Corrigan and Schmidt (1983) found that a three factor structure best explained the data observations of their CRF-S validation sample. In the three factor model all three dimensions are seen as distinct, but as providing the most discriminatory power when taken together. The results of this study lend support to the three factor model. However, stepwise discriminant analysis cannot differentiate whether the three factor model discriminates better than a one factor model with all items loaded on one factor.

The high intercorrelations between expertness and trustworthiness, and between attractiveness and trustworthiness suggest, as Corrigan and Schmidt had speculated, that a nice-guy factor may have been operating

to affect subjects' perceptions of the counselor influence dimensions. The highest overall positive correlations between dimension scores and the importance questions occurred for personal appearance, nice-guy approach, and counselor credentials. Also, dimension score correlations were significantly higher for alcoholic subjects than non-alcoholic subjects relative to the view of the counselor as a helpful expert. Taken together these findings suggest that alcoholic subjects' perceptions of counselor influence dimensions may have been overshadowed by a global perception of the counselor as a nice guy, with proper training, who was trying to help the client. The implication is that if the counselor is a reasonably competent practitioner who is perceived as personally attractive, attentive, and trustworthy, alcoholic clients may tend to operate with a more global perception of counselor influence.

Corrigan and Schmidt (1983) also explored demographic variables though to be related to perceptions of counselor influence. They found that client income accounted for more than half of the variance in dimension scores across all three dimensions relative to other variables such as marital satus, sex, race age, and education among others. In this study, no demographic variable accounted for more than 17% of the variance on any one dimension. That variable was number of sessions in relation to the attractiveness dimension. There was little relationship between the

demographics of the subjects of this study and influence dimension scores. Number of sessions showed low negative correlations for the alcoholic group and moderate negative correlations for the non-alcoholic group. This finding suggests that a decrement in perceptions of counselor attractiveness may have occurred for non-alcoholic subjects who had more experience with counseling.

Future Research

This study represents an initial attempt to compare the effect of client-counselor problem-similarity on alcoholics' and non-alcoholics perceptions of counselor social influence. As has been recommended by Gelso (1979) and Goldman (1976), this study should be followed by field studies measuring the same influence dimensions with similar subject groups involved in actual counseling. Surprisingly, field studies comparing recovered and non-recovered substance abuse counselors have not made use of social influence theory or related measures of counselor influence.

Lacrosse (1980) found the dimensions measured by the Counselor Rating Form to be applicable for use with substance abuse clients. Corrigan and Schmidt (1983) used a community mental health sample in their CRF-S validation study. It would appear that the social influence model of the counseling may be put to good use in comparing client

perceptions of counselor influence in the context of substance abuse counseling.

The results of this study also point to the need for further investigation into the effect of client-counselor problem-similarity wit different subject populations. Since this study was limited to white males, other studies should include female substance abusers and age limited groups such as adolescents and geriatric substance abusers.

Corrigan, Dell, Lewis, and Schmidt (1980) pointed up the need for well controlled field research on counselor social influence which would move beyond initial impressions to investigate the effect of different variables on counselor influence over time. Three related questions for field study arise out of the present study. First, what effect does problem-similarity, or lack of problem-similarity, have on alcoholics' perceptions of counselor influence over the course of treatment? Second, what effect does client-counselor problem-similarity have on perceptions of counselor influence and treatment outcome in a treatment context involving credentialled or licensed professional counseling? Third, does client-counselor problem-similarity have an equivalent effect on perceptions of counselor influence, and on treatment outcome, for other substance abusers?

The social influence theory of counseling provides an empirical model for the investigation of variables affecting

counselor influence and counselor effectiveness. The use of measures of counselor social influence should be encouraged in alcoholism and substance abuse research.

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APPENDIXES

APPENDIX A

QUESTIONNAIRE PACKET

Informed Consent

I would like to request your participation in a research study. The purpose of the study is to solicit your perception of a counselor after viewing a short video taped segment of a counseling session. After viewing the tape you will be asked to complete a counselor rating form which consists of 12 adjectives. You will also be asked to complete a short questionnaire concerned with the rationale you used for the ratings you give the counselor, as well as a few questions about you and your background. It will take about forty-five minutes to complete the entire task. Your name will not appear on any of the materials or questionnaires in this study. You will not be asked to identify yourself in any way. The confidentiality of your responses is assured.

Your therapy program will in no way be affected whether you choose to participate in this study or not. Your therapist(s) will not be aware of the nature of your participation in this study.

This study does not involve any known psychological or physical risks. Your participation in this study is unpaid. Personal satisfaction may be the only benefit you derive from participating in this research study.

Statement of Permission

I understand that this research is being conducted by Tom English, a doctoral student in the Department of Educational and Counseling Psychology, at the University of Tennessee, Knoxville. It is my understanding that he is being supervised by Dr. Mark Hector in the same department. After reading the above description, I understand that it is a truthful representation of this project. I consent to participation in the project with the understanding that my consent may be withdrawn at any time without penalty. If I have questions regarding my participation in this study, the researcher or his supervisor can be contacted at the addresses listed below.

Date_____ Signature_____

Tom English
Charter Northridge Hospital
400 Newton Rd. [P.O.B. 17927]
Raleigh, N.C. 27619
(919) 847-0008

Dr. Mark Hector
103 Claxton Hall
University of Tennessee
Knoxville, Tn. 37996
(615) 974-5146

Please Read Carefully

You will be viewing a short segment of a counseling session with an alcoholic patient who is involved in a follow-up program. The patient has recently completed a one month long inpatient treatment program for persons with chemical dependency problems. Prior to completing his inpatient treatment the patient had a four year history of alcohol dependency and marijuana abuse. The session you will be seeing is part of the second session in a follow-up counseling program that is available to those who have completed the inpatient program. The counselor in this session is not the same counselor that the patient worked with in his inpatient program.

The counselor that you are about to see has a degree in counseling psychology. He has five years of experience working with alcoholic patients and their families.

NOTE: This counselor has never had counseling for either alcoholic dependency or a personal problem. He has no history of alcoholism or psychological problems. The counselor on the tape has already discussed his personal background with the patient.

Please Read Carefully

You will be viewing a short segment of a counseling session with an alcoholic patient who is involved in a follow-up program. The patient has recently completed a one month long inpatient treatment program for persons with chemical dependency problems. Prior to completing his inpatient treatment the patient had a four year history of alcohol dependency and marijuana abuse. The session you will be seeing is part of the second session in a follow-up counseling program that is available to those who have completed the inpatient program. The counselor in this session is not the same counselor that the patient worked with in his inpatient program.

The counselor that you are about to see has a degree in counseling psychology. He has five years of experience working with alcoholic patients and their families.

NOTE: This counselor has never had counseling for either alcohol dependency or a personal problem. He has no history of alcoholism or psychological problems. The counselor on the tape has already discussed his personal background with the patient.

Please Read Carefully

You will be viewing a short segment of a counseling session with an alcoholic patient who is involved in a follow-up program. The patient had recently completed a one month long inpatient treatment program for persons with chemical dependency problems. Prior to completing his inpatient treatment the patient had a four year history of alcohol dependency and marijuana abuse. The session you will be seeing is part of the second session in a follow-up counseling program that is available to those who have completed the inpatient program. The counselor in this session is not the same counselor that the patient worked with in his inpatient program.

The counselor that you are about to see has a degree in counseling psychology. He has five years of experience working with alcoholic patients and their families.

NOTE: This counselor has had counseling for personal problems which he was able to resolve. He has no history of alcoholism. The counselor on the tape has already discussed his personal background with the patient.

Please Read Carefully

You will be viewing a short segment of a counseling session with an alcoholic patient who is involved in a follow-up program. The patient has recently completed a one month long inpatient treatment program for persons with chemical dependency problems. Prior to completing his inpatient treatment the patient had a four year history of alcohol dependency and marijuana abuse. The session you will be seeing is part of the second session in a follow-up counseling program that is available to those who have completed the inpatient program. The counselor in this session is not the same counselor that the patient worked with in his inpatient program.

The counselor that you are about to see his a degree in counseling psychology. He has five years of experience working with alcoholic patients and their families.

NOTE: This counselor has had counseling for an alcohol dependency problem. He has maintained a sober lifestyle for the past seven years. The counselor on the tape has already discussed his personal background with the patient.

INSTRUCTIONS

The counselor you have just observed on the tape has had counseling for an alcohol dependency problem. He has maintained a sober lifestyle for the past seven years. He has discussed this with the patient in earlier sessions.

Now I would like for you to rate several characteristics of the counselor you have just seen. For each characteristic on the following page, there is a seven-point scale that ranges from "not very" to "very." Please mark an "X" at the point on the scale that best represents how you view the counselor. For example:

Funny

not very __ : X : __ : __ : __ : __ : __ very

Well Dressed

not very __ : __ : __ : __ : __ : X : __ very

These ratings might show that the counselor does not joke around much, but dresses wisely.

Though all of the following characteristics are desirable, counselors differ in their strengths. We are interested in knowing how you view these differences. Remember, your responses are totally anonymous. There is no way to associate you or the counselor you have just seen with the ratings you make.

After you have completed the ratings, please complete the two other short questionnaires that are attached.

FRIENDLY
not very___:___:___:___:___:___:___very

EXPERIENCED
not very___:___:___:___:___:___:___very

HONEST
not very___:___:___:___:___:___:___very

LIKEABLE
not very___:___:___:___:___:___:___very

EXPERT
not very___:___:___:___:___:___:___very

RELIABLE
not very___:___:___:___:___:___:___very

SOCIABLE
not very___:___:___:___:___:___:___very

PREPARED
not very___:___:___:___:___:___:___very

SINCERE
not very___:___:___:___:___:___:___very

WARM
not very___:___:___:___:___:___:___very

SKILLFUL
not very___:___:___:___:___:___:___very

TRUSTWORTHY
not very___:___:___:___:___:___:___very

Please circle the number under each of the following statements that corresponds to how much you took that fact or belief into account in your rating of the counselor you observed on the tape.

1) The description of the counselors' personal history.

not at all	slightly important	moderately important	very important	of prime importance
0	1	2	3	4

2) The counselors' personal appearance.

not at all	slightly important	moderately important	very important	of prime importance
0	1	2	3	4

3) The counselors' nice guy approach.

not at all	slightly important	moderately important	very important	of prime importance
0	1	2	3	4

4) The description of the counselors' credentials and experience.

not at all	slightly important	moderately important	very important	of prime importance
0	1	2	3	4

5) Counselor's are supposed to be helpful experts.

not at all	slightly important	moderately important	very important	of prime importance
0	1	2	3	4

Please list any other aspects of the counselor that stood out as important for you. Rate each from 0 to 4 as in the above questions.

Please circle the number under each question corresponding to your answer:

1) Your age.
   1. 18-25
   2. 26-35
   3. over 35

2) Your marital status.
   1. single
   2. married
   3. divorced/separated
   4. widowed

3) Your education level.
   1. 10th grade or below
   2. high school or GED
   3. vocational or tech. training
   4. attended college
   5. college graduate

4) Average yearly income of your household.
   1. below $10,000
   2. $10,000 to $15,000
   3. $15,000 to $25,000
   4. $25,000 or over

5) Type of problem for which you received counseling.
   1. personal problem (other than alcohol/drug)
   2. alcohol/drug problem

6) Estimate the number of individual or group counseling sessions you have had in the past six months (not AA or NA meetings).
   1. 1 - 5
   2. 6 - 10
   3. 10 or more

7) If you had counseling for an alcohol/drug problem have you ever been involved in Alcoholics Anonymous or Narcotics Anonymous?
   1. yes
   2. no

8) If you have been involved with AA or NA, for how long have you been <u>actively</u> involved with these groups?
   1. 3 months or less
   2. 3 months to a year
   3. 1 year or more

APPENDIX B

DEMOGRAPHIC DATA

APPENDIX B

DEMOGRAPHIC DATA

		Alcoholics	Non-Alcoholics	Total
Age	18-25	8	8	16
	26-35	13	10	23
	35+	13	13	16
Marital Status	single	6	12	18
	married	19	15	34
	divorced/ separated	9	4	13
	widowed	0	0	0
Education	10th or less	8	0	8
	high school	8	3	11
	voc. school	4	0	4
	attended college	8	15	23
	college graduate	6	13	19
Income	below $10,000	2	3	5
	$10,000 to $15,000	3	7	10
	$15,000 to $25,000	11	9	20
	$25,000 +	18	12	30
Type of problem counseled	personal	0	31	31
	alcohol/drug	34	0	34
Number of sessions	4	11	13	24
	6 to 10	9	12	21
	10 +	14	6	20
AA attendance	yes	23	0	23
	no	11	31	42
How long in AA	3 months	23	0	23
	3 months to one year	0	0	0
	one year +			

APPENDIX C

RAW DATA

APPENDIX C

RAW DATA

Obs	Diag	Sim	Exp	Exper	Prep	Skil	Friend	Like	Soc	Warm
1	1	1	2	1	1	1	6	6	6	4
2	1	1	2	2	3	3	4	6	6	4
3	1	1	1	1	6	1	1	1	1	1
4	1	1	4	3	4	4	4	4	5	5
5	1	1	5	5	5	5	5	6	4	4
6	1	1	7	5	7	7	5	6	6	6
7	1	1	6	5	6	5	4	6	4	4
8	1	1	2	2	1	2	5	6	6	6
9	1	1	6	6	6	6	7	6	7	6
10	1	1	6	6	6	6	5	7	7	5
11	1	1	3	4	4	4	5	6	4	4
12	1	2	3	2	4	3	5	4	3	3
13	1	2	5	4	4	3	3	3	3	2
14	1	2	4	4	5	4	6	6	5	5
15	1	2	3	6	5	6	6	7	5	6
16	1	2	5	5	6	5	4	5	4	3
17	1	2	5	4	7	6	6	6	6	6
18	1	2	3	3	4	2	4	2	6	3
19	1	2	3	4	3	3	6	5	5	5
20	1	2	4	3	4	4	6	6	3	3
21	1	2	5	6	7	7	5	5	3	4
22	1	2	4	4	6	6	5	7	7	6
23	1	2	3	4	3	3	6	5	5	5
24	1	3	3	5	5	4	4	5	6	4
25	1	3	4	4	5	6	6	6	5	4
26	1	3	5	5	6	6	5	6	5	6
27	1	3	5	4	5	5	6	5	4	5
28	1	3	5	2	3	3	4	5	6	6
29	1	3	4	5	4	6	5	6	6	5
30	1	3	6	6	6	6	5	5	5	5
31	1	3	5	3	5	4	3	2	2	1
32	1	3	6	5	5	6	7	6	5	7
33	1	3	4	4	5	4	6	7	6	6
34	1	3	1	2	6	3	5	2	5	2

Obs = subject number
Diag = diagnosis
Sim = similarity condition
Exp = experienced
Exper= expert
Prep = prepared
Skil = skillful
Friend = friendly
Like = likable
Soc = sociable
Warm = warm

APPENDIX C (Continued)

RAW DATA

Obs	Diag	Sim	Exp	Exper	Prep	Skil	Friend	Like	Soc	Warm
35	2	1	4	3	6	5	5	5	5	6
36	2	1	5	5	6	5	4	3	4	4
37	2	1	2	3	2	4	4	4	5	4
38	2	1	2	2	3	5	4	5	6	6
39	2	1	5	5	7	7	6	7	7	7
40	2	1	3	2	3	1	3	3	4	2
41	2	1	2	1	2	2	4	1	4	4
42	2	1	4	3	2	3	4	4	2	3
43	2	1	6	5	6	5	6	5	5	2
44	2	1	4	4	5	4	5	5	5	5
45	2	2	3	4	7	5	6	5	7	5
46	2	2	5	5	6	5	6	5	6	5
47	2	2	3	4	4	4	4	6	6	5
48	2	2	5	4	5	5	5	5	5	4
49	2	2	5	5	4	4	6	6	6	6
50	2	2	3	3	3	3	6	6	5	6
51	2	2	4	5	4	4	5	5	5	5
52	2	2	1	1	4	2	3	1	7	2
53	2	2	5	4	6	6	6	5	6	6
54	2	2	6	6	7	7	4	4	4	4
55	2	3	5	3	4	3	4	3	2	3
56	2	3	5	3	4	4	7	6	5	5
57	2	3	3	4	2	5	4	4	4	3
58	2	3	4	4	4	4	4	5	2	4
59	2	3	3	3	5	4	4	5	6	5
60	2	3	7	5	4	5	5	4	4	5
61	2	3	1	1	2	4	4	1	1	3
62	2	3	7	6	7	7	5	6	6	5
63	2	3	7	7	3	4	6	6	7	7
64	2	3	2	2	4	2	3	3	5	4
65	2	3	4	4	4	4	5	4	5	3

Obs = subject number
Diag = diagnosis
Sim = similarity condition
Exp = experienced
Exper= expert
Prep = prepared
Skil = skillful
Friend = friendly
Like = likable
Soc = sociable
Warm = warm

APPENDIX C (Continued)

RAW DATA

Obs	Honest	Reli	Sinc	Trust	Pershx	Persap	Niceg	Creden
1	2	2	4	6	3	2	1	3
2	6	4	6	4	3	1	1	3
3	6	1	1	1	1	2	2	1
4	4	4	5	5	1	3	2	2
5	6	6	6	6	3	1	2	3
6	7	6	7	6	0	3	4	2
7	6	6	6	6	3	3	4	3
8	4	3	3	3	1	2	3	3
9	6	7	6	6	2	3	3	2
10	7	7	7	6	3	3	4	3
11	4	5	5	5	3	3	1	3
12	5	4	4	3	4	3	3	3
13	4	4	4	4	0	2	3	1
14	6	5	5	5	2	2	1	4
15	7	6	7	7	3	2	2	3
16	6	6	6	6	3	1	3	2
17	7	6	7	6	0	3	2	3
18	6	4	3	4	3	2	4	3
19	7	6	7	6	1	2	2	4
20	6	4	6	6	0	2	3	3
21	6	5	7	7	2	3	2	4
22	7	6	7	6	3	3	4	3
23	7	6	7	6	1	2	2	4
24	6	4	3	4	3	2	2	3
25	6	4	5	6	3	2	2	4
26	7	5	7	5	3	2	3	3
27	5	4	5	6	3	2	1	3
28	4	5	4	4	2	3	2	2
29	5	6	6	6	1	3	2	4
30	6	6	6	6	3	3	3	3
31	6	3	1	2	2	2	0	3
32	7	6	6	6	3	3	2	3
33	6	6	7	6	2	3	4	3
34	3	4	2	3	3	3	1	2

Obs = subject number
Honest = honest
Reli = reliable
Sinc = sincere
Trust = trustworthy

Pershx = counselor personal history
Persap = counselor personal appearance
Niceg = counselor nice guy approach
Creden = counselor credentials

APPENDIX C (Continued)

RAW DATA

Obs	Honest	Reli	Sinc	Trust	Pershx	Persap	Niceg	Creden
35	6	4	5	5	3	1	3	2
36	7	6	4	6	1	2	2	1
37	6	3	5	4	0	1	2	1
38	5	4	6	6	3	2	2	3
39	7	6	7	7	1	3	4	2
40	5	5	3	2	3	3	2	1
41	2	1	1	1	3	0	1	4
42	5	2	4	3	4	2	4	3
43	6	4	7	6	4	1	2	4
44	5	5	6	5	3	2	1	3
45	6	6	6	6	4	2	3	3
46	5	6	5	7	3	2	2	3
47	4	4	4	5	1	1	2	1
48	5	5	5	5	1	2	3	1
49	5	5	5	4	0	2	2	3
50	6	5	6	6	2	2	3	2
51	5	5	5	4	0	2	2	0
52	4	3	4	4	2	2	4	2
53	5	5	7	6	3	2	3	4
54	6	5	5	5	1	2	3	2
55	6	5	4	2	1	0	2	0
56	5	4	5	5	2	3	3	3
57	6	6	5	5	3	2	3	3
58	7	6	7	6	1	3	3	3
59	6	6	7	6	3	1	3	2
60	6	5	6	6	3	2	3	3
61	5	3	2	4	4	0	0	2
62	7	6	7	7	3	3	3	3
63	7	5	6	7	3	3	4	4
64	3	4	4	6	3	1	2	2
65	4	5	4	5	2	2	3	2

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Persap = counselor personal appearance
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Creden = counselor credentials

APPENDIX C (Continued)

Obs	Supp	Age	Marr	Educ	Inc	Prob	Nses	Aa	Naa
1	3	2	3	1	0	2	3	2	1
2	3	1	1	2	1	2	1	1	1
3	1	3	2	1	3	2	3	1	3
4	3	2	1	4	4	2	1	2	1
5	4	3	2	5	3	2	3	1	3
6	4	2	2	1	4	2	3	1	1
7	4	1	1	4	4	2	2	1	1
8	3	2	2	3	3	2	1	2	1
9	3	1	2	3	4	2	1	2	1
10	3	2	2	2	2	2	2	1	1
11	3	2	2	2	4	2	3	1	1
12	3	1	3	2	3	2	3	1	1
13	4	2	2	5	4	2	2	2	1
14	2	3	3	4	3	2	3	1	1
15	3	2	1	1	3	2	1	1	1
16	4	1	1	1	4	2	2	1	1
17	3	3	3	4	3	2	2	2	1
18	4	1	2	1	2	2	1	2	1
19	3	3	3	2	4	2	3	1	3
20	4	1	1	4	3	2	1	1	1
21	4	3	3	4	4	2	2	1	2
22	4	1	2	1	2	2	1	1	1
23	3	3	3	2	4	2	3	1	3
24	4	2	2	3	4	2	3	1	1
25	3	2	2	5	4	2	1	2	1
26	4	2	2	3	4	2	2	1	1
27	3	3	2	2	4	2	2	1	1
28	2	2	2	1	4	2	3	2	1
29	4	3	2	5	4	2	3	1	1
30	4	3	2	5	4	2	3	1	1
31	3	3	3	5	3	2	1	2	2
32	3	3	3	4	4	2	1	1	1
33	3	2	2	4	3	2	2	1	1
34	3	3	2	2	3	2	3	2	1

Obs = subject number
Supp = counselor as helpful expert
Age = subject age
Marr = subject marital status
Educ = subject educational level
Inc = subject income
Prob = problem counseled
Nses = number sessions
Aa = AA attendance
Naa = number AA meetings attended

APPENDIX C (Continued)

Obs	Supp	Age	Marr	Educ	Inc	Prob	Nses	Aa	Naa
35	3	2	3	4	2	1	2	.	.
36	3	1	1	5	3	1	2	.	.
37	2	3	2	5	4	1	1	.	.
38	3	3	2	4	4	1	2	.	.
39	3	2	2	4	4	1	2	.	.
40	4	3	2	4	3	1	3	.	.
41	4	3	2	2	2	1	3	.	.
42	4	3	3	4	1	3	3	.	.
43	4	3	2	2	4	1	3	.	.
44	2	2	2	5	4	1	1	.	.
45	2	1	1	4	2	1	1	.	.
46	2	3	2	5	4	1	1	.	.
47	1	3	1	4	2	1	2	.	.
48	3	2	2	5	4	1	1	.	.
49	3	3	2	5	4	1	1	.	.
50	2	1	1	4	2	1	2	.	.
51	2	3	2	5	4	1	2	.	.
52	3	2	1	5	3	1	3	.	.
53	4	2	2	4	3	1	1	.	.
54	3	2	1	5	3	1	1	.	.
55	4	1	1	5	4	1	2	.	.
56	3	1	1	4	1	1	1	.	.
57	4	2	1	3	2	1	1	.	.
58	4	1	1	4	3	1	2	.	.
59	4	1	1	4	3	1	1	.	.
60	3	1	1	5	4	1	2	.	.
61	4	3	2	4	3	1	2	.	.
62	3	3	3	5	3	1	3	.	.
63	4	3	3	2	1	1	1	.	.
64	4	2	2	4	2	1	1	.	.
65	3	2	2	5	4	1	2	.	.

Obs = subject number
Supp = counselor as helpful expert
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Aa = AA attendance
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APPENDIX D

VIDEO TAPE SCRIPT

Client - My wife is beginning to complain a lot and not much is changing at home. The plant manager seems to be watching me all the time now and I don't quite get that. Plus, I've got some real financial problems right now. In a couple of weeks I've got that DWI coming up and I don't have the money for a lawyer even. All of the sudden it just seems like too much .... just too much all at once.

Counselor - O.K. so you've been out of treatment two weeks now, wife problems, trouble with the boss, money pressure, and a DWI looking you in the face.

Client - Yea, and one more thing too. I've got a lot of old running buddies that seem to insist on hanging around the house. I've tried to run them off but I keep running into 'em. What am I supposed to do about that?

Counselor - You've been out two weeks and you thought your problems would be solved, but things keep getting to you.

Client - It is worse than I thought it would be.

Counselor - O.K., I remember when you were just getting out Gardner. You really felt confident and said don't worry, things were real smooth. Everything will fall into place. We talked about getting out. That's when the rubber hits the road. That's when you really start being challenged.

Client - Yea sure, but all at once?

Counselor - There is one thing I haven't heard you mention?

Client - What's that?

Counselor - I haven't heard you say what you're doing and what your plan is now to stay sober each day.

Client - Well I went to a couple of meetings but nothing happened. I just heard the same old song and dance about how everybody was staying sober. Part of it I can relate to, but I'm having trouble there too. I just don't know if it fits for me.

Counselor - O.K. so you've been out two weeks and you've been to two meetings.

Client - I have been to two; both this week. I haven't been coming to aftercare group but I went to two meetings.

Counselor - Gardner, let me encourage you to think about one thing. If you don't stay sober, none of these other things

will get any better at all and they may get much worse. So, let's look for a minute at your recovery plan; we'll get to these other issues you've been hit with soon enough. What are you doing now or what can you do to keep your focus on that number one thing?

Client - Well, my wife doesn't seem too happy about me going to the meetings anyway. It's taking time away from home and from her. Look, I know the meetings are good I guess, but I just thought I'd get more out of them.

Counselor - You've been to two and you haven't gotten what you thought you would.

Client - Not yet.

Counselor - I know people often have the experience when they first go, and they say well hell I've been to a couple of meetings, when do I get this peace of mind they talk about. I think what you have to look at is that in the first month or few months or even a year its a challenging time. You'll have a lot of things getting on you to blow away your peace of mind and change your priorities. All of these problems you haven't had to deal with in the last few years. It isn't the first time you have had trouble with your wife, boss, money or buddies but it may be the first time you have had to deal with them without using.

Client - Yea, I know, but I worry about whether it fits. They all seem so together at those meetings.

Counselor - Well, I know what seems to be helpful is if you can really get established in a support group. Just start going to the meetings and don't sit there on the back row. It sounds like you might be having some trouble making a real commitment to it.

Client - Well, I guess I have been sitting on the back row and haven't been saying much. I don't really know what to say. But I could say a lot I guess.

Counselor - I'm just suggesting that you might try to get in there and get involved in some way. Get off the back row. Just give it a try. What your going through now is a period of strangeness, not knowing many people in the groups, not having friends there. That is always a little uncomfortable at first. The more you get involved and the more you can open up and listen to them and they can listen to you, you start feeling more at home. You may even feel more peaceful inside about all the outside problems when you get that kind of group support.

Client - Well how long do you think this might take. Its getting pretty tight. I've got money problems big time. I can't can't even hire a lawyer.

Counselor - And I'm sure there's answers for those problems too. All I'm saying right now though is take care of the number one thing first, and that's having support and understanding that you need to not get overwhelmed by all this crap that's surrounding you. I mean most folks get out of treatment and all of the sudden they are hit with family problems, job problems, confidence problems, anxiety, and moodiness. All of that stuff can blow you right out of your boots if you let it. What you've got to do is kinda sit back and say "wait a minute, I'm getting wrapped up in this tornado. I need to just step back and get my support group, get some sober friends, and don't let this stuff drag me down. I need to just do some of the reading and relaxation things they taught me in treatment, get my mind centered again and remember the concepts I learned. Just slow myself down a little". You may feel like it's the need of the world but it'll be here tomorrow to deal with just like today. (pause) So, the first thing is let's practice getting into recovery, and slow down a little bit and get the support you need.

Client - Well I suppose so, but let me ask you another question while we're talking about that. How can I get this thing with my wife worked out?

Counselor - Remember, slow down. I'm going to keep pulling you back to the number one problem first, Gardner, then we will get into the thing with your wife. What do you think you can do between now and when we get together again just to get your recovery program back on track?

Client - All right, maybe I can come back to the meeting this week here. There's also a meeting tonight and Jim will be there. I've talked to him a little bit about how to use the meetings. Maybe it will be the best thing. . . I should just go back and talk to him because he's going to hold the meeting tonight.

Counselor - If Jim is a good guy for you, with a good period of sobriety, and you know him and are comfortable with him, I think that would be a great idea to talk to him and get some of this off your chest. Ask him how he handled it because I guarantee you he went through some of the same kinds of stresses and strains and adjustments. So, yeah, that's a great idea.

Client - Well, okay, not to get off the track about my program, don't you think my wife should go to Alanon meetings?

Counselor - That's a good point, but first let's get your program set. So, you're going to go...

Client - Yeah, I'll go to this meeting tonight and there's an Aftercare group on Friday. I think there's a meeting next Tuesday night, too, that's open so I might take my wife to that one.

Counselor - That's pretty good planning.

Client - And maybe you're right. I should slow things down and get back to my recovery plan (pause). Maybe I can get back on track because I feel like everything has caught up with me. Like you said, maybe it's the first time I've had to look at it sober.

Counselor - Good thinking. As I recall you had a pretty good plan for recovery when you left treatment. Now the danger since you're out of treatment is forgetting it, you know what I mean? A nice piece of paper, too bad we never looked at it again.

Client - Yeah, I guess I got my priorities all out of line.

Counselor - Well, that's a good idea. When we get to the end of this session, we'll get your plan out and look at it. After all, that's what will make it or break it for this next year. You're in a tough go. People get confident in treatment and feel like it will be easy. And now you're saying...well this period of life stresses and things, and you start feeling like "Whoa!, this is more than I can handle." And you know what kind of thing happens when that kind of thinking sets in.

Client - It was easy as long as I was in the treatment center. But when I got out in the real world, it just seemed too much.

Counselor - And that's why you need to keep keep your program going. Your recovery only begins when you get out of treatment. You're now re-dedicating yourself to the effort it will take over the next days, weeks, and months. So you're starting to live it now, and that's the important thing.

Client - I've never seen it hurt anybody. Even if it does take a lot of time, it would be worth it if you could get some piece of mind and stay on track with your recovery.

Counselor - Well, I guess I did get off track. But all of a sudden, it hit me that all these things were happening and I wasn't sure how to handle it. Maybe I'll just go back to the plan I had, talk to my sponsor more, and go to more meetings.

Counselor - That's right. I'm saying that's a good plan. You know you can do a lot of different things. But certainly, this gets you back focused on your sobriety. I'm not saying its' the only thing in your life, but it has to be number one right now because if you don't do that, everything else is a washout.

Client - I guess I can see that. I did realize in treatment that I had to stay sober. But figuring out how to stay sober is a real trip sometimes.

Counselor - And you're doing the right thing, being here for this session, going to the meeting tonight, having a sponsor like Jim, making a plan. Those are the right things to do to stay sober right now. See, you're starting to do what it takes. Sometimes people forget, you know? They get all the things lined out and forget all about doing them. So, now you're starting to pick up your tools and use them again.

Client - I guess so. It's got to be better than what I'm doing now.

Counselor - Well, now that we got that one sort of nailed down, let's look at these other things that have been bugging you--your wife, your drinking buddies, your job, the DWI. Which of these do they want to look at first? You sounded pretty worried about your marriage.

Client - Well, I've got to live with my wife, that's all there is to it. Maybe what I started to say a while ago was that if I could get her going to Alanon meetings, it might help her not to be so "up tight". She doesn't seem to understand all this.

Counselor - Well, you've got to remember your wife has been carrying the ball for the last ten years. And now you're sobered up and looking good. You seem better than you have in years. So, she feels like, "Okay, get in here and do these dishes now. What do you need to go to those meetings for?" She may not understand the kind of recovery that you have to work on. You're right. Alanon would help her

understand this better (pause). If she refuses Alanon, and if she seems not to understand or seems to be having a lot of trouble, give me a call next week and we can set a time when she can come in with you because it's probably not obvious to her what you're going to have to do.

Client - That sounds good to me. I've tried doing the dishes, and that didn't work.

Counselor - Just let me know, and if it continues to be a problem, let's just sit down together and see what we can work out.

Client - Well, let me tell you about my plant manager now. You know, like we've talked about before? He knew where I was, and the problem I've got. But, I still have a feeling that maybe he's watching me pretty close. I feel kind of uptight about it, and I get nervous when I think he's looking over my shoulder. You think I'm being paranoid about it?

Counselor - Well, fortunately now, if he is watching you, you'll be doing some good, sober work. If he was watching you before, he saw you drunk. What's he going to see now?

Client - You're right. I am at work now, and I get there on time, and I do good work. Maybe he was watching me before and I just didn't realize it. Ha! I think I'll ask him about it when I go back in tomorrow.

Counselor - That sounds pretty assertive to me...

Client - Well, he was pretty supportive when I came out of treatment. And I'm sure we could talk about it because maybe it's just my problem and not his.

Counselor - I know. It's so easy when you first get out of t treatment. Then, as you get more sober, you watch yourself and then you imagine that everybody else is watching you, too, because you're more tuned in to what people think. People who come out of treatment are more tuned in to themselves and they imagine that everybody else is waiting for the slip (pause). Sure, he wants to know how you're going to do. But, see if you can't put that on the back burner and just go ahead and do your job well. You know if he watches you then, he is only seeing what will get you a promotion later on.

Client - Let's hope so.

Counselor - I'm not sure I would even talk to him tomorrow about it. I might wait about a week or so and then sit down and ask him casually...What's his name?

Client - Jerry.

Counselor - Just ask Jerry, "Hey, I've been out of treatment here for a while, and you've helped me get back to work, and I really appreciate it. How do you think I'm doing now?" Just talk to him about it. I think you'll be surprised (pause). If you want to, next week we can practice.

Client - That might be a good idea because he makes me nervous (pause). I've still got a wife and I've still got a job, but I owe this treatment center a lot of money that the insurance didn't pay and a DWI hearing and no lawyer. Do you think I could get by without one?

Counselor - I wouldn't recommend it. But it sounds like we need to look at the alternatives (pause). You're saying that you don't have any resources?

Client - Not right now. I'm really strapped.

Counselor - Do you know anyone you could ask what options might be available?

Client - No, but I mentioned this to Jim the other day at that meeting. And he said he might have a friend of his that could help me. What does that sound like to you?

Counselor - If you trust him it sounds fine.

Client - Well, I guess I should trust him. I've asked him to be my sponsor.

Counselor - That would be good to go with a friend that he may have that could at least guide you. I know the Bar Association has a list of lawyers who do some sliding sale work sometimes. And then, there's Legal Aid for people with no resources. They may be able to help you, as well. That's three possibilities.

Client - I'll try Jim first because he's going to recommend...

VITA

James Thomas English was born in Springfield, Tennessee on August 1, 1945. He graduated from Springfield High School in June, 1963 and attended the University of Tennessee at Knoxville and Martin, Tennessee for two years prior to enlisting in the United States Navy from 1966 until 1970. In January 1970 he re-entered the University of Tennessee at Knoxville and received a Bachelor of Science Degree in Education in March 1972 and a Master of Science Degree in Rehabilitation Counseling in March 1974. After four and one half years of professional work with mental health services in Tennessee and North Carolina, he returned to the University of Tennessee at Knoxville to pursue a doctorate in Counseling Psychology. This degree was awarded in August 1986.

The author is currently the Director of Clinical Services at Charter Northridge Hospital in Raleigh, North Carolina and is engaged in private practice with families of substance abusers. He is a member of the American Psychological Association, the North Carolina Psychological Association, and Alcohol and Drug Professionals of North Carolina.