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Effects of Clinician Theoretical Orientation and Patient Explanatory Bias on Initial Clinical Judgments

The effects of clinician theoretical orientation and patient explanatory bias (implicit orientation) were assessed in a 3 × 3 factorial design. Behavioral, cognitive, and psychodynamic clinical trainees viewed a videotaped intake interview with a female actress who explained her fear of going on elevators according to one of three explanatory biases: learned reactions, faulty thoughts, or underlying conflicts. After viewing the tape, clinicians made judgments about the patient's responsiveness to therapy. Across all three experimental conditions, psychodynamic clinicians expressed more "pessimistic" prognoses than both behavioral and cognitive clinicians who did not differ. However, among psychodynamic clinicians, those who viewed the patient whose explanatory bias was consistent with a psychodynamic orientation were less pessimistic than were their colleagues exposed to patient explanatory biases inconsistent with a psychodynamic orientation. The implications of the experiment for client–therapist matching, clinical training, and rapproachment between orientations are discussed.

The observation that clinicians make initial clinical judgments and form stable clinical impressions of clients as early as the first interview was noted by previous investigators of psychotherapy (Meehl, 1960; Strupp & Luborsky, 1962). Numerous therapy analogue investigations of bias in initial clinical judgments have examined the effects of therapist and client variables such as: gender and sex roles (Abramowitz & Dokecki, 1977; Whitley, 1979), political ideology (Abramowitz, Abramowitz, Jackson & Gomes, 1973; Braginsky & Braginsky, 1974; Mazer, 1979; Schwartz & Abramowitz, 1975), and attributional style (Batson, 1975; Snyder, 1977).

In a controversial analogue experiment, Langer and Abelson (1974) demonstrated that clinical judgment bias was a function of the interaction between clinician theoretical orientation (psychodynamic vs. behavioral) and the descriptive label (patient vs. job applicant) used to introduce the target person. This study of labeling effects showed that psychodynamic clinicians viewed the same person as more maladjusted when labeled "patient" than when labeled "job applicant."

Langer and Abelson's (1974) experiment pointed to the importance of investigating clinicians' theoretical orientations as influences on clinical judgments. Just as other scientists embrace particular paradigms and make tacit assumptions to understand the phenomena of their discipline (Hanson, 1958; Kuhn, 1970; Polanyi, 1958), so too, clinical psychologists utilize their theoretical orientations to make sense of clinical data. The continued existence of different theoretical orientations in clinical psychology is testimony to their functional utility. In addition to such utility, however, theoretical orientations can influence clinical perceptions. Indeed, because of such problems and limitations, clinical researchers interested in rapproachment have argued that clinical psychologists can be more effective by viewing clinical material from the complementary perspectives of several orientations (Garfield, 1982; Goldfried, 1982; Wachtel, 1982). One purpose of the present study was to assess the contribution of clinician theoretical orientation to clinical judgment.

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If a clinician's theoretical orientation can influence the ways that clinical information is processed and resulting impressions are formed, then it is reasonable to suppose that a client's "theoretical orientation" might also influence initial clinical judgments. Strictly speaking, patients rarely come to therapy with complete theoretical orientations, but as several clinical researchers have noted, persons who do come for therapy frequently state beliefs about what is causing their problems (Bandura, 1969; Mischel, 1977; Strupp & Luborsky, 1962). Such beliefs or *explanatory biases* may be either consistent or inconsistent with the more formal theoretical orientation of a clinician. Thus a second purpose of this study was to assess the influence of a patient's explanatory bias on initial clinical judgments when clinician orientation and patient bias were systematically matched and mismatched.

Clinicians from three theoretical orientations were included in this experiment: behavioral, cognitive, and psychodynamic. These three orientations were selected because they represented distinct views of the origins and treatment of clinical problems. To assess the effects on judgments associated with patient explanatory bias, patient material was constructed to contain the same presenting problem and symptoms but was systematically varied on how the patient explained the cause of the problem. Fear of going on elevators was chosen as the standardized presenting problem because each of the three theoretical orientations have proposed different conceptualizations of phobias (Arieti, 1979; Ellis, 1962; Marks, 1969).

Three hypotheses were tested: (a) following Langer and Abelson (1974), it was hypothesized that psychodynamic clinicians would be more "pessimistic" in their initial judgments than both behavioral clinicians and cognitive clinicians irrespective of the patient's explanatory bias; (b) based on the literature relating positive impressions and therapy outcomes to similarity of therapist and client beliefs (Berzins, 1977), it was predicted that a mismatch between clinician orientation and patient explanatory bias would result in less favorable prognostic judgments about the patient than when such beliefs were matched; (c) due to the above interaction between clinician orientation and patient explanatory bias, it was predicted that a patient whose beliefs were consistent with a psychodynamic orientation to phobias would be viewed more negatively than one who cast the problem within a cognitive framework. This third prediction was based on the assumption that both the behavioral and cognitive clinicians would respond more pessimistically to the psychodynamic patient, whereas the psychodynamic clinicians would view the cognitive patient more favorably, because this person was expressing some insight goals.

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Method

DESIGN

The experiment was conducted as a 3 × 3 factorial design with three levels of clinician orientation (behavioral, cognitive, and psychodynamic) and three levels of patient explanatory bias (problems caused by "learned reactions," by "faulty thoughts," and by "underlying conflicts"). Clinician subjects (N = 54) were randomly assigned to view one of three videotapes of the same patient presenting the problem from one of the three explanatory biases.

SUBJECTS

Twenty-nine female and 25 male trainees in clinical psychology from American Psychological Association (APA)-approved clinical training programs served as subjects. Subjects were recruited through posted announcements and letters to directors of clinical training at institutions noted for behavioral, cognitive, and psychodynamic orientations.[1] Subjects were paid $5.00 for participating. Eighteen subjects from each of three self-declared theoretical orientations (behavioral, cognitive, and psychodynamic) participated. The mean age for the three groups was as follows: behavioral = 27.89 years, cognitive = 25.78 years, and psychodynamic = 29.22 years. The mean number of years supervised clinical experience was as follows: behavioral = 2.44, cognitive = 1.86, and psychodynamic = 2.22. Both the behavioral and cognitive groups contained 11 women and 7 men, whereas the psychodynamic group contained 7 women and 11 men.

STIMULUS MATERIALS

Three scripts for an intake interview with a female patient were written to reflect the three explanatory biases about the presenting problem—the fear of going on elevators. The scripts were constructed around a core presentation by the patient, and the three explanatory biases were written in by changing certain key phrases. For example, after describing the history of her problem and the desire to overcome it, the patient said:

> Well, I just can't go on elevators. Whenever I walk past one . . .
> *Learned Reactions:* I get this funny feeling in my stomach. Then, if I walk by and don't really look at the elevator, the feeling goes away. But if I keep looking at it, or worse, walk up to it, my hands start to sweat and I get dizzy.
> *Faulty Thoughts:* I start thinking about what could happen if I got on it and got stuck. And I get this funny feeling in my stomach. Then, if I walk by and don't really think about what could happen, the feeling goes away. But if I keep thinking about what could happen, my hands start to sweat and I get dizzy.
> *Underlying Conflicts:* I get this funny feeling in my stomach. Then I start wondering what this really means. I mean maybe the elevator is just a symbol of something I don't really understand. When I try to figure it out my hands start to sweat and I get dizzy.

Videotape recordings were made from each script. The experienced actress, a middle-aged woman appropriately dressed as a secretary, delivered the patient lines and maintained the same level of affect across all three recordings. The videotapes showed the patient from the waist up as she responded to questions from a male interviewer who was off-camera.

A sample of 10 trainees comparable to the subjects who completed the study viewed all three videotapes as a pretest manipulation check. All 10 subjects correctly identified the explanatory bias of the patient in each tape, and ratings of the patient's level of affect were equivalent for all three tapes.

[1] The three institutions that provided subjects were the State University of New York at Stony Brook, Rutgers University, and Adelphi University.

PROCEDURE

Six subjects from each theoretical orientation were randomly assigned to view one of the three videotapes. Subjects signed consent forms and were instructed to view the patient clinically. They were told that they were viewing a segment of an intake interview and that they would be asked about their impressions and clinical judgments of the patient.

After observing the patient, subjects completed a questionnaire containing the dependent measures and additional information about their theoretical orientation. Although the instructions for viewing the videotape were deliberately vague about whether or not the interview was a simulation, postexperimental debriefings indicated that subjects uniformly reported viewing the tape as a simulation. No subject evidenced prior knowledge about the experimental manipulations or hypotheses, and debriefings also indicated that subjects correctly identified the particular explanatory bias presented in the tape they viewed.

DEPENDENT MEASURES

The major dependent variable was the sum response to 11 questions on the Clinical Judgment Scale (CJS), which asked subjects to make clinical judgments in the form of 5- and 7-point rating scales. Items were designed to sample first impression judgment domains that have been empirically correlated with therapy outcome (Brown, 1970; Garfield & Affleck, 1961; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; Mintz, 1972; Saltzman, Leutgert, Roth, Creaser, & Howard, 1976). The CJS items were rationally constructed to determine the subject's overall appraisal of the patient's responsiveness to therapy along a dimension of optimism–pessimism with a range from 11 to 73, the higher score indicating more pessimism. Individual judgments were made about (a) severity of the problem, (b) prognosis with treatment, (c) prognosis without treatment, (d) subjects' projected therapeutic effectiveness, (e) patient cooperation, (f) patient motivation, (g) likelihood that the patient would continue treatment with the subject to a mutually satisfactory conclusion, (h) subjects' comfort with the patient, (i) patient understanding of the problem, (j) subjects' liking for the patient, and (k) likelihood that the subject would continue treating the patient to a mutually satisfactory conclusion. It should be noted that the label "pessimism–optimism" was chosen to describe the global extent to which subjects' judgments were less or more hopeful about the success of the patient in therapy. It is, of course, assumed that such judgments are subjective, that clinicians of different orientations employ different subjective criteria, and that no "true/correct/objective" standard exists outside of the clinician making the judgments.

VALIDATION OF CLINICIAN ORIENTATION

In addition to providing a self-label of their theoretical orientation, subjects completed the Post-Judgment Follow-Up (PJF), a questionnaire designed to assess their strength of commitment to their self-declared orientation as well as their global ratings of effectiveness and thoroughness of the three approaches to therapy. Subjects also indicated which therapeutic approaches they themselves would use for a wide range of presenting problems.

Results

To establish comparability of the three groups except for theoretical orientation, separate one-way analyses of variance (ANOVAs) were conducted for age, years of supervised clinical experience, and reported number of treated cases like the one in the film. The results showed no significant differences among the three groups, $F(2, 51) = 2.43$, .97, and 2.47, respectively.

Table 1: Means and Standard Deviations of Total Scores on the Clinical Judgment Scale by Clinician Orientation and Patient Explanatory Bias

Patient explanatory bias	Clinician orientation		
	Behavioral	Cognitive	Psychodynamic
Learned reactions			
M	25.83	26.33	37.67
SD	3.55	5.79	9.09
Faulty thoughts			
M	26.33	29.33	41.00
SD	5.47	5.16	9.19
Underlying conflicts			
M	28.67	29.33	31.67
SD	1.51	3.39	5.57

Note. Maximum score = 73. A higher score indicates more pessimism about the patient's responsiveness to therapy.

VALIDATION OF DEPENDENT MEASURE

Responses for all 54 subjects on the CJS were submitted to a reliability and factor analysis to determine if the sum response on the 11 items approximated the criteria for a multifaceted but single construct, pessimism–optimism about the patient's responsiveness to therapy. The CJS proved to be internally consistent (Cronbach's $\alpha = .84$). The results of principle components factor analysis using a varimax rotation indicated that with the exception of rated severity of the problem and prognosis without treatment, items loaded on a single factor that accounted for 85% of the variance.

TEST OF MAJOR HYPOTHESES

Table 1 shows the mean scores on the CJS for each group and experimental condition. The results were submitted to a two-way ANOVA, and because the hypotheses were stated as specific directional predictions, each was evaluated by planned comparisons (Winer, 1971). The ANOVA yielded a highly significant main effect for clinician orientation, $F(2, 45) = 14.09, p < .001$.[2] Two orthogonal comparisons indicated that psychodynamic clinicians were significantly more pessimistic than were both behavioral and cognitive clinicians, $t(45) = 6.39, p < .001$, whereas cognitive and behavioral clinicians did not differ ($t < 1$).

The second hypothesis regarding mismatches between clinician orientation and patient explanatory bias was only partially supported. Psychodynamic clinicians responded with more pessimism to the learned reactions explanatory bias than they did to the underlying conflicts condition, $t(45)$, one tailed $= 1.76, p < .05$. Likewise, this group responded to the faulty thoughts condition with more pessimism than they did to the underlying conflicts one, $t(45) = 2.74, p < .05$.

The third hypothesis regarding main effects for patient explanatory bias was not supported, $F(2, 45) = .78$, *ns*. Indeed, the observed nonsignificant difference between

[2] Results were also submitted to a multivariate analysis of variance (MANOVA), which paralleled the results of the ANOVA with a main effect for clinician orientation, $F(22, 70) = 3.08, p < .001$, and no significant effects for either patient explanatory bias or the Orientation × Explanatory Bias interaction.

the faulty thoughts condition and the underlying conflicts condition, $t(45) = 1.47$, $p < .08$, tended in the direction opposite to that predicted, with the former eliciting more pessimistic judgments than the latter.

VALIDATION OF SELF-DECLARED CLINICIAN ORIENTATION

Clinicians from each group rated their strength of commitment to their orientation as well as the overall effectiveness and thoroughness of the three approaches to therapy. In each case, ratings were submitted to one-way ANOVAs followed by post hoc comparisons (Scheffé, 1959).

The analysis of strength of commitment to self-declared orientation resulted in significant differences among the three groups, $F(2, 51) = 4.61$, $p < .05$, and post hoc comparisons showed that psychodynamic clinicians were significantly more committed to their orientation than either of the other two groups were to theirs. No subject indicated less than moderate commitment to his or her theoretical orientation.

Analysis of rated effectiveness of therapy approaches yielded highly significant *Fs* for all three groups: behavioral, $F(2, 51) = 26.33$, $p < .001$; cognitive, $F(2, 51) = 21.48$, $p < .001$; psychodynamic, $F(2, 51) = 9.60$, $p < .001$. The post hoc analyses for behavioral and cognitive clinicians indicated that both rated behavioral and cognitive therapy as equally effective and significantly more effective than psychodynamic therapy. In contrast, psychodynamic clinicians rated the psychodynamic approach as more effective than either behavioral or cognitive approaches, which were seen as about equal in global effectiveness. This tendency for the subjects to favor their own orientation suggests that the procedure of asking the clinicians to self-label their orientations resulted in accurate self-descriptions.

Two of the three groups rated the thoroughness of the three approaches to therapy differently: behavioral, $F(2, 51) = 10.01$, $p < .001$; psychodynamic, $F(2, 51) = 71.93$, $p < .001$. The post hoc analysis for the behavioral group showed that they rated the behavioral and cognitive approaches as equally thorough and significantly more thorough than the psychodynamic approach. In contrast, the psychodynamic group rated the psychodynamic approach as more thorough than either the behavioral or cognitive approaches. This group also rated the cognitive approach as significantly more thorough than the behavioral.

All three groups provided information about what treatment approaches they would recommend across a range of problems including alcoholism, agoraphobia, depression, erectile failure, simple phobia, marital discord, obsessive rituals, orgasmic dysfunction, and schizophrenia. Table 2 shows the three groups' preferences for types of therapy across all nine problem areas. With the exception of the cognitive group, the three groups indicated treatment preferences consistent with their self-declared theoretical orientations. The cognitive group was not significantly different from the behavioral group except for their recommendations regarding the treatment of depression where they showed a significant preference for cognitive therapy, $\chi^2(3) = 9.00$, $p < .05$.

CROSS-GENDER ANALYSIS

Because the three groups contained different numbers of males and females, a two-way ANOVA (Gender × Theoretical Orientation) was carried out on the major dependent measure. The analysis showed no significant differences in clinical judgments due

Table 2: Frequency of Recommending Behavior Therapy, Cognitive Therapy, Psychodynamic Therapy, and Drug Therapy Across Problems According to Clinician Orientation

Clinical orientation	Type of therapy			
	Behavior	Cognitive	Psychodynamic	Drug
Behavioral	134(83%)	15(9%)	1(0.6%)	12(7.4%)
Cognitive	111(69%)	28(17%)	7(4%)	15(9.3%)
Psychodynamic	40(25%)	8(5%)	105(65%)	7(4%)

Note. Each clinician made a recommendation for each of nine problems. On one occasion a cognitive clinician made no response, and on two occasions a psychodynamic clinician made no response. For each group of clinicians, $N = 18$.

to the sex of therapist, $F(1, 48) = 2.20$, *ns*, nor any significant Gender × Orientation interaction, $F(2, 48) = 1.46$, *ns*. Instead, the cross-gender analysis of clinicians' judgments added further support to the finding that clinician orientation accounted for between-group differences in judgments about the patient, $F(2, 48) = 14.56, p < .001$.

Discussion

In drawing conclusions from this experiment it is important to note its limitations with respect to external validity. First, the participants were relatively inexperienced trainees, and it remains a question for further research whether similar results would obtain for seasoned clinicians. Second, the experimental conditions were contrived to ensure maximum internal validity, and though they paralleled the conditions under which clinicians typically form impressions of patients, future research in more naturalistic settings is not only warranted but needed. Within these limitations, the results show that clinicians' theoretical orientations can significantly affect their first impressions of a patient. The finding that psychodynamic clinicians were relatively more pessimistic is consistent with previous studies that have compared the judgments of behavioral and psychodynamic clinicians (Cohen & Oyster-Nelson, 1981; Langer & Abelson, 1974). Because this experiment did not presume a "true" judgment of the patient's responsiveness to therapy, the results could be interpreted in terms of the behavioral and cognitive-behavioral groups' optimism about the patient. The decision to focus on "pessimism" or negative expectancies was made because negative therapist expectancies have generally been associated with less positive therapy outcomes (Goldstein, 1962).

Although the present study did not empirically address the particular beliefs and values that may have accounted for the more pessimistic response of the psychodynamic clinicians, the results are nevertheless consistent with broad differences among the three approaches to therapy. In general, psychodynamic theorists view behavior change as more problematic and difficult than do either behavioral or cognitive theorists. For example, in the case of simple phobias, Arieti (1979), a traditional psychodynamic theorist, has pointed out that behavioral approaches such as guided exposure to the fear-provoking situation may be useful strategies for alleviating symptoms but are not sufficient to give the patient the necessary insight into interpersonal conflicts that are

symbolized by the situation or object in question. Similar reference to the characterological basis for phobias has been emphasized by Wachtel (1977), a psychodynamic theorist interested in rapproachment with behavior therapy. Such views stand in sharp contrast to behavioral and cognitive approaches, both of which share the view that "symptom relief" is the goal of therapy and can be achieved through manipulation of current determinants of behavior that are consciously available to the patient.

The finding that the behavioral group did not differ from the cognitive group suggests that these two groups were quite similar, and the cognitive group can best be described as a cognitive-behavioral group. Indeed, these two groups made virtually identical treatment recommendations for a range of problems and differed only on the treatment of depression. The failure to find significant judgment differences between these two groups is thus not surprising, and the fact that they differed on the treatment of depression suggests that a replication of this study with depression as the presenting problem may be fruitful.

In addition to the influence of a clinician's orientation, the results support the view that a patient's "orientation" may interact with a clinician's orientation to influence the direction of initial clinical judgments. Such interactions were apparent among the psychodynamic clinicians in the present study. This group was significantly less pessimistic about the patient whose explanatory bias was consistent with a psychodynamic orientation. Such a result is all the more interesting because the psychodynamic group reported stronger commitment to their orientation than did either of the other two groups.

The failure to find similar interactions for the behavioral and cognitive-behavioral groups is best understood in terms of a response set to the presenting problem. That is, faced with a presenting problem of simple phobia, both groups automatically considered behavior therapy as the treatment of choice. This inference can be tested in future research by including different presenting problems as manipulated variables in a similar research design.

When clinician orientation and patient explanatory bias so affect clinical perceptions, such factors need to be considered in the practice of psychotherapy, particularly in the assignment of patients to therapists. Research is needed to develop pretherapy assessment methods for determining the "theoretical orientation" of persons who come for therapy. Such assessment methods would make it possible to match patients and therapists so as to maximize positive therapist expectancies. When such optimum matching could not be achieved, pretherapy interventions similar to those previously reported (Orne & Wender, 1968; Strupp & Bloxom, 1973) could incorporate strategies for changing patient explanatory biases.

To avoid placing the burden of clinical judgment bias solely on the client, clinical training programs will need to recognize the influence of theoretical orientations in biasing clinical judgments. Though theoretical orientations provide the beginning clinician with a much needed framework for interpreting clinical data, the adoption of a particular orientation can lead to negative expectancies, especially when that orientation is different from a client's belief system. Precisely because inexperienced clinicians are more likely to endorse exclusive theoretical orientations (Cummings & Lucchese, 1978; Smith, 1982), there is a need for training programs to promote conceptual flexibility during the course of training. Whether such a goal can be accomplished without sacrificing conceptual and scientific rigor is a question that remains to be answered and may very well be the central challenge of the recent efforts to

promote rapproachment between differing theoretical orientations within the scientist–practitioner model of clinical training.

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