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GROWTH AND CHANGE IN PERSONALITY CHARACTERISTICS

OF

BEGINNING PSYCHOTHERAPISTS

by

GERALD PERLMAN

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

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Chapter I

Introduction

Personal and Theoretical Perspectives

A good deal of research has been aimed at delineating the changes in personality that result from an individual's having undergone psychotherapy (Rogers & Dymond, 1954; Strupp, Wallach & Wogan, 1964; Strupp & Bergin, 1969; Truax & Carkhuff, 1967). However, little experimental investigation of this nature has been addressed to the other member of the therapeutic dyad--namely, the therapist. Van der Veen (1967) noted that theory in psychotherapy has dealt with how the therapist influences the patient, but has given little systematic attention to how the therapist is influenced by the patient. He pointed out how this focus has obscured the reality of the truly interdependent nature of the therapy relationship. In a discussion of the therapist's contribution to psychotherapy, Lennard & Bernstein (1960) suggested that researchers consider that the therapist is influenced by the therapeutic process just as the patient. They went on to say that there has been very little careful scientific investigation of this process, though there is the suggestion based on impressionistic studies of doctor-patient relationships that the direction of influence is not all one-sided. Theodor Reik (1948) pointed out the affective and psychotherapeutic value of the analysis of another person to the analyst himself. He went on to say that any experienced

analyst knows that his analyses of others helps him master "old accumulations of emotion..." In fact, Reik dedicated his book to the proposition that "The organ of psychological observation, and therefore of psychological research and discovery, is to be found within oneself." Arbuckle (1966) has stated that the counselor finds it more difficult to examine his "self" than others.

Certain mental health professionals have queried about the changes they have felt in themselves at different stages of their professional development. S. C. Klagsbrun (1967) described the personal aspects of a psychiatric resident's experiences and his changing attitudes. Starting with an idealized image of what a psychiatrist should be, his mutual interchange with patients led him to give up his uncritical acceptance of dogma and enter into a phase of cynicism and disbelief; this, finally, yielded to a potentially creative attempt at integrating his objectified self-system with his image of a "proper" psychotherapist. At the other extreme, Kenneth Fisher (1957), an experienced analyst going through an "identity crisis," stated, "To be a therapist is to a degree an effort to escape being a person." He maintains that we wear a professional mask which cracks as our "own nature and circumstances reassert themselves, concurrent with the steady impact of patients; this forces us to take stock and eventually find new clarification and strength along the line of our (own) basic personality" (p. 289). Otto Will (1967)[1] also suggests, as do the above authors, that a therapist must come to terms with himself; he must meet and accept himself and learn to be comfortable

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[1] personal communication

in the therapeutic milieu. Carl Rogers (1961), "speaking personally" set down as a rule he has learned, "In my relationships with persons, I have found that it does not help...to act as though I were something I am not."

A social psychologist (Stein, 1967) taking a post-doctoral internship in a clinical setting spoke of feeling as though "the props had been taken out from under (him)." He was particularly uneasy with the similarities he found between the patients' problems and their childhood experiences and his own. Stein sensed a difficulty in erecting barriers that allowed him to differentiate himself from his patients and still remain open enough to listen to and understand the person with whom he was engaged in a therapeutic dialogue.

Reporting on his training at Bethel's Annual Summer Laboratory in Human Relations Training, Hugh Storrow (1964) quoted Spenser Klaw who expressed the feeling that best fit that experience: "Most people who have been to a laboratory return to the cultural mainland with a conviction that the expedition was worthwhile. But they are usually hard put to say how or why--or, indeed, to convey any but the vaguest notion of what they have actually experienced." That an experience of this nature results in a profound change in the individual can hardly be denied.

Erik Erikson (1956) believes that the major integration of identity occurs in adolescence, but emphasizes that identity-formation is a lifelong process. Out of the aggregate of all his previous significant relationships to other persons and groups, the individual derives a conception of what and who he himself is, an "identity."

And from this a sense of self-esteem derives.

Carl Rogers (1961) epitomized how the therapeutic impact has effected him by stating, "Experience is, for me, the highest authority."

Many of these personal remarks have a ring of conviction. But can scientific evidence adduce that the therapeutic experience changes the therapist, and if so, how? It is to the task of answering these questions that the present investigation is directed.

Research Perspective

Concern with the growth and development of psychiatric residents during and after training, was expressed by Modlin, Benjamin, Lacy, Hale, and Salten (1959). Interested primarily in the evaluation of their teaching program, they gave multiple-choice questions on facts, theory, and application of clinical material to groups of subjects which ranged from first week residents to certified diplomates in psychiatry. Although a growth trend was obvious, the only consistently increasing improvement in knowledge was in the area of psychodynamics. Even though these authors did not ask questions pertaining to therapist personality changes, their one consistent finding lends itself to the interpretation that a personality change of ever increasing importance was taking place as the young professional became more involved in the practice of psychotherapy.

Holt and Luborsky (1958) have carried out research which helps bridge the gap between the work of Modlin et al. (1959) and the current theme of this research. In attempting to assess the personality requisites for psychiatrists, they questioned a large number of highly re-

spected professionals. Henry Murray, for example, pointed out that the good psychiatrist should have "flexibility: the ability to absorb other points of view, to change, to develop mentally..." This is very similar to the quality Rogers (1954) noted in patients who had undergone psychotherapy. English (1968) noted that if a therapist is to be successful in helping patients to attempt change, he must be willing and able to do the same.

The Shakow committee (1947) listed the qualities of the "good clinical psychologist" which overlap almost completely with those compiled by Holt and Luborsky (1958) in regard to the "good psychiatrist." Furthermore, these characteristics bear a remarkable likeness to the variables of personality enumerated by Kelly and Fiske (1951) in their research on the selection of clinical psychologists. Typically, the attributes mentioned were: capacity for understanding, empathy, flexibility, breadth of interests, respect for the dignity and integrity of the individual, etc. Arbuckle (1966) examined a number of counseling experts in an attempt to illustrate levels of "freedom" within the therapist. On a purely empirical basis, he presented excerpts from taped counseling sessions portraying different aspects of "inner freedom" which were defined as "empathy, honesty, and flexibility."

Most recently, Plutchik, Klein, and Conte (1970) in their investigation of factors related to the selection of clinical psychology interns, developed rating scales dealing with the success potential of intern candidates. These scales were developed from information provided by the supervising staff of two large metropolitan hospitals. The supervisors were asked to describe those qualities they believed

should be possessed by potentially successful clinical interns. The information obtained yielded a twenty-one-item rating scale. Among the qualities thought desirable for a clinical psychology intern were "openness," "self-awareness," "personal appearance," "sense of humor," "general range of knowledge," etc. Some of the items that appeared to be most highly correlated with acceptance into the internship program were "sensitivity to others," "intellectual grasp of psychology," "general range of knowledge," and "ability to work with staff."

Wyatt (1948) summarized the importance of a psychotherapist's self-experience: "He (the therapist) should be able to accept himself as well as his patients; he must learn to do therapy in his own way, not through an adopted pseudo-personality (role) and without a protective set of gestures. Therapeutic understanding of others will be effective only if the therapist maintains a constant scrutiny of his own self...Nobody has so much reason, so much obligation, and so much plain need to know himself as the therapist."

Thus, therapists have long been aware of the importance of what have been termed "therapist variables" in determining "outcome" for patients in psychotherapy. However, it is only within the last five years or so that experimental work of merit has been forthcoming in this area (Bergin, 1966; 1967; Gardner, 1964; Lorr, 1965; Rogers, Gendlin, Kiesler, & Truax, 1967; Strupp et al., 1964; Truax & Carkhuff, 1967). Although the major part of this research has been focused on those characteristics of the therapist that effect outcome for patients, for the purposes of the present investigation, the various researchers have highlighted the important aspects of personality that are essential

for the practicing psychotherapist.

In an excellent integration of the recent literature, Bergin (1967) suggested, "Therapeutic progress varies as a function of therapist characteristics such as warmth, empathy, adequacy of adjustment, and experience." As has been noted earlier, these qualities have been viewed as highly desirable ingredients in practicing mental health professionals (Arbuckle, 1966; Holt & Luborsky, 1958; Plutchik et al., 1970; Shakow et al., 1947; Wyatt, 1948). The recent experimental investigations have served to give solid support to the convictions of many of the previously quoted theorists. It is of additional interest to note that the characteristics under discussion are not only necessary and highly desirable for effective psychotherapists, but are also the same qualities that grow and develop in an individual who has undergone psychotherapy (Rogers & Dymond, 1954).

The quality of warmth has been investigated by Lorr (1965) who broke down this characteristic into five clusters and found significant correlations between high "warmth" factors within the therapist and patient improvement. He related his findings to those of Rausch and Bordin (1957) who discussed, in a similar vein, the importance of "commitment, understanding, and spontaneity."

Using eleven therapists in a questionnaire survey of 44 of their former patients, Strupp et al. (1964) found that perceived warmth from the therapist was the quality most highly correlated with therapeutic success. Another interesting finding was that the therapists were "reasonably successful in gauging the degree of warmth their patients felt toward them."

The centrality of the therapist's empathic capacities has also received a great deal of attention. Cartwright and Lerner (1963) have presented us with the classic work in the area of empathy. Using a pre- and post-therapy measure of discrepancy between the patient's view of his self and the therapist's view of the patient, they found a significant relationship between therapeutic progress and post-therapy empathy. Sixteen therapists were divided into experienced and inexperienced groups. In the latter group were five therapists seeing their first patient. In general, the inexperienced therapists saw their patients as less like themselves than the patients' own views showed them to be. Cartwright and Lerner suggested that perhaps the new therapist is more open to threat and more easily made anxious by seeing patients as similar to himself and so does more defensive distancing. Stein's (1967) feeling about himself as a new therapist was similar. Frieda Fromm-Reichman (1950) in her discussion about the necessity of a therapist understanding his own interpersonal functioning as well as that of the patient, underscored the importance of the therapist's realization "that his patient's difficulties in living are not too different from his own."

To return to Cartwright and Lerner's work (1963), it must be pointed out that one of the drawbacks of their experiment was that the measure of empathy was highly ambiguous and did not occur in the context of the ongoing therapy process.

With a population of eleven graduate student counselors and twenty-two of their patients, Lesser (1961) explored the relationship between counseling progress and empathic understanding. In addition to

a scale based on Fiedler's formulation of empathic understanding, he employed the _Q_-sort technique of 100 self-referent items devised by Butler and Haigh (1954). Both clients and counselors were asked to sort the items; thus the self-concepts of the two members of the therapeutic dyad could be compared. Lesser found a significant negative relationship between counseling progress and similarity in counselor and patient self-concepts. Similarity alone was not the central issue; rather, he found the therapist's _correctly perceived similarity_ between himself and his patient to be highly correlated to counseling progress. Lesser's finding is closer to the concept of "accurate empathy" (Truax, 1963) than is the concept of empathy as defined by Cartwright and Lerner (1963). But here again, measures of empathy were taken out of the _in vivo_ situation.

A third characteristic of the therapist which has deservedly received much attention is the therapist's adequacy of adjustment. Seeman (1950) analyzed the responses of 70 clinicians to nine questions he posed regarding the influence of therapist adjustment on effectiveness of therapy. His findings were inconclusive. More recently, several studies have indicated that supervisor and patient ratings of the therapist's ability are negatively related to his degree of anxiety or maladjustment. Bandura (1956) found a significant negative relationship between therapists' anxiety level and their competence. Russell and Snyder (1963) using a number of objective measures of anxiety found that hostile behavior from patients created more anxiety for both experienced and inexperienced therapists than did friendly behavior. Furthermore, Bandura, Lipsher, and Miller (1960) found that therapists' "hos-

tility-anxiety" was directly associated with avoidance responses to their patients' expressions of hostility. Bergin (1966) confirmed from his own research that therapists who are more anxious, conflicted, defensive, or unhealthy, are least likely to promote change in their clients.

In the last decade, the three characteristics reviewed above have received special attention. Predominantly, Truax, Carkhuff, and their associates have been involved in formulating and pursuing explorations into the "effective ingredients" in psychotherapy (Berenson, Carkhuff & Myrus, 1966; Truax, 1963; Truax & Carkhuff, 1963; 1967). Truax and Carkhuff (1967) have published scales which measure "unconditional positive regard" (warmth), "accurate empathy" and "genuineness" (or "congruence": self-awareness and lack of a professional facade). In studies with schizophrenics (Rogers, Gendlin, Kiesler & Truax, 1967; Truax, 1963) when therapists were high on all three variables (warmth, empathy, and genuineness), positive results were obtained; whereas when therapists were low on these measured qualities, patients got worse.

Berenson et al. (1966) hypothesized that a group of volunteer college students, given a quasi-therapeutic experience and familiarization with the research scales developed by Truax and Carkhuff (1967), would show a greater amount of change in the dimensions of empathy, warmth, and genuineness than did the members of two control groups. Thirty-six undergraduate students were each assigned to one of the following three groups: (I) the training group proper which employed (_a_) the Truax scales as a training device and (_b_) a quasi-therapeutic

experience; (II) the training control group which did everything Group I did except for familiarization with the Truax scales and the group therapy experience; and (III) a control group proper which received no training experience. Pre-post measures on the Truax scales revealed that Group I demonstrated the greatest amount of positive change in empathy, warmth, and genuineness.

Martin and Carkhuff (1968) had 24 graduate students meeting for a summer training session divided into two groups. The experimental group was enrolled in a practicum, and the control group was enrolled in a child development course. In artificially programmed interviews conducted before and after the summer session, the subjects were given instructions to "be as helpful as you would ordinarily be if someone came to you for help." From randomly selected excerpts of these tape recorded interviews, the counselors were assessed on their empathic understanding, positive regard, genuineness, etc. Each subject filled out an MMPI before and after the period of training; also, self-ratings and ratings by "significant others" were obtained. The results, of this fairly well controlled study, showed that the training group demonstrated significantly greater positive change in the central variables than the control group as well as significantly more constructive personality changes as measured on the MMPI.

The central therapist characteristics or variables discussed here have been shown to increase in clients who have undergone psychotherapy; witness the initial research in the area of change due to therapy which was published by the Chicago School under the aegis of Carl Rogers (Rogers & Dymond, 1954). A variety of hypotheses concern-

ing change in the self as a result of therapy were formulated. Changes in personality characteristics and structure, attitudes towards others, as well as changes in personal integration and adjustment were postulated. A number of psychological tests were employed; the instruments varied from projective techniques to specially devised _Q_ sorts.

The findings of this major research effort are fairly well known. Rogers reported that during the process of client-centered therapy and afterwards, there was a significantly greater similarity between the perceived-self and the ideal-self; the change comes from a movement of the former toward the ideal, which remains fairly constant. This is similar to the self-description reported above by Klagsbrun (1967). The most recent support of Rogers' hypotheses and findings comes from Truax, Schuldt, and Wargo (1968) who studied self/ideal-self concept congruence in relation to progress in group psychotherapy. Using sample groups of psychotics, neurotics, and juvenile delinquents, Truax et al. found a positive relationship between increased self/ideal congruence and positive therapeutic outcome. They also found a negative relationship between self/ideal congruence and measures of anxiety or maladjustment. Furthermore, for all cases, excepting the severely disturbed psychotic sample, Truax et al. found that changes in self/ideal-self congruence were more related to changes in self than to changes in ideal-self concept. Finally, Truax et al. stated, emphatically, that congruence of the two _Q_ sorts occurs only with successful therapy.

Rogers (1954) maintains that with psychotherapy clients feel changes in themselves in the direction of greater self-understanding, increased inner comfort, greater confidence, increased self-direction and

self-responsibility, and they feel more comfortable in relationships with others. In terms of attitudes towards others, changes were noted in the direction of seeing the "ordinary person" as more of a separate individual with his own standards and values. The mutual liking and respect of the patient and therapist were positively linked with favorable outcome.

The only research, found in the literature, which has some very direct bearing on the problem under scrutiny in this paper is that of van der Veen (1967). He performed an analysis of variance of the therapist's and patient's influence on each other's "therapeutic behavior." Therapeutic behavior was defined as "the behavior of the therapist, insofar as it promotes personality growth in the patient..., and the behavior of the patient, insofar as it promotes his own personality growth." Operationally, it was defined by the rated variables of "problem expression" and "experiencing" on the part of the patient as they were effected by the patient, the therapist, and the interaction effect of the two. He found that levels of "problem expression" and "experiencing" of the patient were a function of the therapist as well as of the patient, the latter's effect being greater.

Conversely, van der Veen found that there were main effects of patients' and therapists' influences on therapist related scales of congruence and empathy; the variation due to the therapist was greater than that due to the patient.

The results supported the general hypothesis that the patient and the therapist influence each other's therapeutic behavior as well as their own. It should be noted, however, that van der Veen investi-

gated changes in therapeutic behaviors of the therapist as influenced by the patient; he did not investigate personality growth in the therapist which may have been influenced by his interaction with a patient. In addition, he pointed out many shortcomings of his experiment. Primarily, the study was limited by the fact that the sample was comprised of only three patients and five therapists.

Now it becomes evident that both patient and therapist give and receive something from psychotherapy. In a discussion of the development of a psychotherapist, English (1968) stated that it took him several years before he realized the degree to which each patient contributed to his growth and knowledge. He stated, "I thought I was helping him, but I was not working with the concept that he was helping me." English calls for a "partnership" between therapist and patient in which each member of the therapeutic dyad contributes to the other's growth.

Strupp and Bergin (1969) compiled the most recent and comprehensive investigation of the literature pertaining to research in psychotherapy in the last decade. They maintain that therapy is a transaction in which the patient may affect and change the therapist. Furthermore, they wrote that "No one seems to have studied this problem in a systematic way."

It is this investigator's contention that the beginning therapist manifests personality changes consequent upon his doing psychotherapy, and it is to this problem that the present investigation is addressed.

Chapter II

Method

Comparison of Personality Characteristics of Beginning Psychotherapists at Initial and Later Stages of Training

Mental health professionals have long held the impressionistic view that what occurs in the therapeutic process influences the therapist as well as the patient. Most of the research in psychotherapy, however, has focused on the changes patients have experienced as a result of receiving therapy. The present investigation focuses on the therapist and the effect doing therapy has on him.

The widely shared feeling that doing therapy effects the therapist is studied in a systematic way by comparing a number of personality variables at initial and later stages in the therapist's training. The *initial stage* of training is defined as the first month of a psychotherapy training program. The *later stage* in training is defined, in this research, as about nine months after training has begun, or approximately at the end of one academic year.

The investigator proposes that increases occur in ratings of therapists' empathy, warmth, and genuineness as a result of doing psychotherapy. Increases in personal, role-related, self-esteem also ensue. In addition, increases in overall self/ideal-self congruence occur.

Subjects

The experimental design for testing these propositions embraced three groups of subjects: *A*, *B*, and *C*. Group *A* was an experimental group comprised of twenty-three third year graduate students in clinical psychology enrolled in psychotherapy practica at two major universities in New York City. Of the twenty-three subjects in this group, one was asked to leave the program in which he was enrolled, and two others were excluded from the study since they had previous experience as therapists; this left a total of twenty subjects in this group. Experimental Group *B* consisted of ten first year residents in psychiatry at two large metropolitan hospitals. Altogether, Groups *A* and *B* comprised an experimental group of thirty subjects.

As in any study which involves pre- and post-testing, a group was necessary to control for effects due simply to the passage of time. In the present investigation, there was a control Group, *C*, which was comprised of sixteen second year graduate students in clinical psychology at the two universities from which the experimental Group *A* was obtained. These subjects had an opportunity to acquire experience with intake interviewing in personal contacts with patients, but had not had a supervised psychotherapy training experience. One of these subjects left the clinical program in which he was enrolled, and two others were found to have had previous therapy experience. Thus, the final control group contained thirteen subjects.

Changes in Therapeutic Qualities of Beginning Psychotherapists

There are certain basic qualities of humanness which people share

in common to a greater or lesser degree. Empathy, warmth, and genuineness are such qualities. For a psychotherapist these characteristics are essential, in a goodly measure, if he is to be successful at his work. The first hypothesis focuses on the development of these three attributes.

Hypothesis I. Doing psychotherapy under supervision results in increases in ratings of "accurate empathy," "nonpossessive warmth," and "genuineness" as defined by Truax and Carkhuff (1967) in their research on effective psychotherapy.

This hypothesis gets its impetus from much of the discussion in Chapter I which demonstrates not only that these are key variables in psychotherapeutic competence, but, in addition, that experience as a therapist should enhance these qualities (Pierece, Carkhuff, & Berenson, 1967; Martin & Carkhuff, 1968). Rogers (Rogers & Dymond, 1954; p. 4) has intimated that these variables are important qualities in all individuals and that a therapeutic experience should enhance these qualities in a person.

Truax and his associates (Truax & Carkhuff, 1967) have labored for more than a decade to develop scales which would measure the central therapeutic ingredients. They began with scales linked to Rogerian statements about empathy, warmth, and genuineness. It became apparent, however, that these qualities by themselves were unrelated to therapeutic success; rather, accurate empathy, nonpossessive warmth, and non-defensive genuineness, on the part of the therapist, seemed most related to patient improvement. Those therapists who were rated low on these scales proved to be harmful to their patients (Truax & Carkhuff, 1963).

The scales have proven to be moderately to highly reliable, and appear to have a high degree of face and predictive validity. All three scales have been used effectively with counselors and therapists in group or individual psychotherapy. Furthermore, they have proven quite effective regardless of the diagnostic category of the patients being treated.

Instruments and Their Application. The method employed to test the first hypothesis was that constructed and validated by Truax and his associates (Truax & Carkhuff, 1967). Objective ratings of ramdomly selected excerpts of tape-recorded therapy sessions, of beginning therapists, along a nine-point scale for "empathy" and five-point scales for "warmth" and "genuineness" were made by three independent expert raters at the Arkansas Rehabilitation Research and Training Center under the supervision of Dr. G. Frank Lawlis, director of research and associate of Dr. Truax.[1]

The selection of excerpts from tape-recorded therapy sessions was made in the following manner: Two 4-minute segments were taken from the first and last third of a 45-minute therapy session. More specifically, the investigator edited out the sixth-to-tenth minute segment, and the thirty-sixth-to-fortieth minute segment for rating. If these segments proved to be unusable, the very next usable four-minute segment was edited out and rated. The excerpts were collected at the initial

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and later stages of training from the experimental groups. Changes were derived from the ratings of the therapy tapes from the initial as contrasted with the later stage of training. Comparison of these changes were made with the control group of students in the mental health field who had available intake interviews tape-recorded at the same time periods, and in the same manner, as the experimental groups had therapy interviews taped.

In all cases ratings were made from typed protocols of the edited tape segments by expert raters who were not familiar with the purpose of the study. As a safeguard of confidentiality, all names mentioned in the tape were changed or deleted and merely represented by an initial. Furthermore, no typed protocol had the name of the subject attached to it. Each sample was assigned a random number. Experimental and control samples were presented for rating randomly as were initial and later training stage sample protocols.

Changes in Self-Esteem of Beginning Psychotherapists

The first hypothesis concentrates on certain key elements of the individual's interactional behavior which are important tools of the practicing psychotherapist. In the second hypothesis, the focus is on the subject's own view of himself and change in his self-esteem in his role as a psychotherapist.

Hypothesis II. Doing psychotherapy under supervision results in a greater feeling of self-esteem in regard to the role of psychotherapist.

Relevant to this hypothesis is Erikson's (1956) view that one's sense of identity derives from a mutual interaction between the individual and his social environment. He maintains that an individual's sense of

identity, and hence, self-esteem, fluctuates according to his sense of role consistency. White (1960) asserts that every interaction with another person can be said to have an aspect of competence. He defines competence as an "organism's ability to carry on those transactions with the environment which result in its maintaining itself, growing, and flourishing." In human beings competence is achieved largely through learning, and contributes to our ever growing sense of self.

Instrument and Its Application. An adaptation of an instrument used by Slagle (1965) in her study of self-esteem and patterns of defense was applied. "The Good Clinician Inventory" (GCI) is a self-rating inventory based on fifteen dimensions of a "good clinical psychologist" listed by Shakow et al. (1947). Each dimension, such as "originality," "sense of humor," "appearance," "industry," etc., is presented graphically by a line with 20 segments. Above the line appears the definition of one of the dimensions, and at the two ends of the line the words "high" and "low" are appended to adjectives specific to the dimension. (The high and low ends were alternated at random to counteract response sets.)

The Ss were asked to rate themselves three ways on each of the dimensions. First, they indicated by an X the position on the scale which represented what they were like generally. Then they wrote a Y on the segment indicating where they could realistically aspire to be. Finally, they placed a Z on the segment that indicated what they were like on their worst days. The Ss then divided the scale into ranges indicating the degree of the trait they found "highly desirable" (HD), "acceptable" (A), and "unacceptable" (UA). Such divisions provided a scale weighted in terms of the S's own values. Weights of 2, 1, and 0

were assigned to HD, A, and UA segments, respectively. Thus when the locations of aspired, actual, and worst self-judgments were weighted according to the value segments in which they fell, it was possible to derive a composite score based on the three judgments which had a total range from 0-to-6 on each dimension. The scale and accompanying instructions are presented in Appendix B.

All subjects, both experimental and control, were asked to fill out the GCI at the initial stage of training and again at the later stage of training. Using the derived composite scores, tests of significance were employed to determine if changes from initial to later training stage rating occurred at a significant level (.05) in either the experimental group or the control group; and further, if a significant difference in amount or direction of change took place between the experimental subjects and the control subjects.

Changes in Self-Concept of Beginning Psychotherapists

The phenomenon under consideration here is at a still higher level of generality than the phenomena in either of the first two hypotheses. A more global aspect of change, above and beyond change in clearly defined therapeutic qualities or change in role-related self-esteem is probed here.

Hypothesis III. Doing psychotherapy under supervision results in a greater congruence between one's self-concept and one's ideal-self concept.

The third hypothesis is strongly supported by the work of Butler and Haigh (1954) with persons receiving psychotherapy. Furthermore, Klagsbrun (1967) suggested, from his self-evaluation, that with increased

experience the novice therapist approaches his own idealized self-image.

Instrument and Its Application. The Butler-Haigh *Q* sort of 100 self-referent statements was used. (The entire list of statements is presented in Appendix C.) Statements such as "I am a competitive person," "Self control is no problem to me," "I am just sort of stubborn," etc., were printed on 3" X 5" cards which the subject sorted to describe (*a*) himself (the self-sort), and (*b*) how he would like to be (the ideal-sort). Instructions for the self-sort were:

> "Sort these cards to describe yourself as you see yourself today, from those that are least like you to those that are most like you."

For the ideal-sort, the instructions were changed to:

> "Now sort these cards to describe your ideal person--the person you would most like within yourself to be."

The subject was instructed to place each card in one of nine piles arranged along a continuum from "least like" to "most like." A specified number of cards had to be placed in each of the nine piles so as to achieve a quasi-normal distribution and the ready assignment of scale values. The final array of cards assumed the following distribution with its respective scale values:

Number of cards in each pile:	2	6	12	18	24	18	12	6	2
Scale values:	0	1	2	3	4	5	6	7	8

Because the same distribution is used for all *sorts* in a particular study, Nunnally (1959, p. 433) suggests using the following formula for computing the congruence between the self and ideal-self *sorts*:

$$\underline{r} = 1 - \frac{\Sigma d^2}{2N\sigma^2},$$

where r = the product-moment correlation between two sorts,

N = the number of items in the sample (100 in the sample used in this study),

σ = the standard deviation of the forced distribution, which is the same for all sorts using the distribution,

d^2= the squared difference between the pile value for an item in two sorts.

The term $2N\sigma^2$ is a constant for all correlations computed with a particular forced distribution. After the constant is determined, it is only necessary to obtain the sum of squared differences between item placements to compute the correlation.

The discrepancy between the two sorts on the initial administration was compared to the discrepancy (or congruence) found in the retest situation at a later stage in psychotherapy training. Changes in discrepancy scores over time between the experimental and control groups were also compared.

Objections have been raised in the past to using the above instrument with a psychologically sophisticated population. However, Lesser (1961) has recently used this technique with psychologically sophisticated subjects in small numbers and obtained meaningful results. Other investigators have employed scales, inventories, and Q sorts with sophisticated subjects without obtaining response styles slanted toward social desirability. For example, Streitfeld (1959) used Berger's Scale of Expressed Acceptance of Self and Others and obtained results which ranged from 93 to 174 with a standard deviation of 9.3. Vogel (1961) had mental health professionals fill out the F scale and obtained results which were not

contaminated by a social desirability factor. Truax et al. (1968) presented a very cogent argument against the likelihood of the *Q* sort being contaminated by a social desirability factor. They concluded that the *Q* sort instrument, as a measure of self/ideal congruence, is of value in studies of personality change. Snyder (1959) pointed to the problems of analyzing the personal characteristics of experienced counselors. However, he stated that perhaps the structured *Q* sort was the most valid method used in his research on the relationship in psychotherapy.

Therapists' Self-Disclosure of Training Experience, and Relevant Variables

In addition to investigating whether or not changes in self occur in beginning therapists as a result of doing psychotherapy, this research is concerned with some of the processes that may be involved in such changes.

It was felt that (*a*) the therapist's own involvement or non-involvement in personal therapy, (*b*) the diagnostic category of the patient seen, (*c*) the therapist's own sense of success or failure in his first therapeutic endeavors, (*d*) his impression of his supervisor's warmth and competence, and (*e*) his own report of felt changes resulting from doing psychotherapy, are important variables to be considered in the growth of a psychotherapist.

At the later training stage, after all the data pertaining to the three major hypotheses was collected, the subjects were given mimeographed sheets of paper on which were printed questions pertaining to their (*a*) involvement in personal therapy, (*b*) diagnosis of the patient

seen, (c) sense of therapeutic success, (d) impression of supervisor's warmth and competence, and (e) felt changes in self as a result of doing psychotherapy. All responses were written on the form provided by the investigator, as described below and located in Appendix D.

Self-Report of Therapists' Own Psychotherapy

A confounding factor exists in research in this area of psychotherapy. Some trainees are themselves receiving psychotherapy. This variable was controlled for in the overall design of the study.

Approximately equal proportions of Ss in the experimental and the control groups were in therapy themselves. About three fifths of each group was comprised of Ss who were in some sort of personal psychotherapy. Eighteen of the thirty experimental subjects (60%), and eight of the thirteen control subjects (61.53%) were undergoing psychotherapy during the time the study was conducted.

Instrument and Its Application. On the mimeographed questionnaire provided, the subjects were asked to note whether or not they were presently receiving psychotherapy, or had received therapy at any time before or during the investigation period. Even though the effect of personal psychotherapy on the overall design of the study was controlled for, this variable was isolated out of the experimental group. In order to investigate the effect of this dichotomized variable on the results obtained, a nonparametric contingency analysis was made.

Diagnostic Category of the Patient Seen in Conjunction with this Investigation

Another variable which might have some bearing on the beginning

therapist's growth and development was the diagnostic category of the patient he was seeing in connection with this research project. Although Truax & Carkhuff (1967) maintain that the diagnostic category of the patient does not effect the central ingredients of a psychotherapist (empathy, warmth, and genuineness), it is conceivable that for beginning therapists, especially, one type of patient may present greater difficulties than another; this could, in turn, effect him both personally and professionally.

Instrument and Its Application. On the mimeographed form provided, each subject was asked to indicate the diagnosis of the patient whose interviews had been used for this study. The various diagnostic labels were reduced to two categories: Psychotic and nonpsychotic. A nonparametric procedure was employed to investigate what effect this dichotomy of diagnostic categories may have had on the three main hypotheses under investigation.

Self-Report of Psychotherapeutic Success

Understandably, a neophyte therapist's felt success or failure at his initial therapeutic endeavors may have varying effects on his self. A therapeutic failure may cause a change in the beginning therapist's view of himself as a person and as a therapist in a negative direction.

Instrument and Its Application. The subjects were asked to relate the general progress of the patient whose sessions had been tape-recorded for this research. The rating was done along an eight-point scale which was printed on the mimeographed sheet mentioned above. The scale ranged from "very poor" to "excellent."

The effect of this appraisal of therapeutic success or failure on the three major hypotheses was obtained by using the Spearman rank correlation statistical design with the experimental subjects ranked on the basis of highly favorable to highly unfavorable self-judgments of therapeutic progress.

Self-Report of Therapists' Feelings About the Warmth and Competence of Their Supervisors

A beginning psychotherapist is, understandably, quite uncertain about his new role. He looks to his supervisor, not only as a possible model, but also for feedback and encouragement, and often for help with personal matters which may be spotlighted as a result of doing psychotherapy. It is, therefore, possible that the trainee's impression of his supervisor's expressed warmth and competence may be variables of great significance in evaluating the novice therapist's report of personality changes.

Instrument and Its Application. Each subject rated his therapy supervisor on dimensions of warmth and competence. The first quality was rated along an eight-point scale which was printed on the mimeographed sheet. The scale ranged from "very warm" to "cold." On the same form, the subject rated his supervisor's level of competence along an eight-point scale that ranged from "very competent" to "incompetent."

The effect of these two variables on the three major hypotheses was calculated by ranking the ratings from highest to lowest on each variable and separately comparing these rankings with the changes that occurred on the measured personality characteristics of concern in this study.

Self-Report of Felt Changes Resulting from

Doing Psychotherapy

Up to this point, the study had proceeded along fairly classical lines of investigation using well established methods of measurement and analysis of data. Gordon Allport (1953) has suggested, however, that if you want to know if a man is hungry, "ask him." In this regard, the subject's own feelings about what, if any, changes he felt as a result of doing therapy were thought to be invaluable. This is a highly subjective level of inquiry which yields clues about significant areas of change and growth as they are directly felt by the neophyte therapist.

Instrument and Its Application. On the mimeographed sheets provided were the following questions, to which all experimental subjects were asked to respond:

> "Describe the most important changes, if any, internal as well as external, that you have experienced as a result of doing psychotherapy. Try to list in order of importance and be as specific as possible. Also try to discuss any critical incidents which you feel had a great impact on you."

Attached to the mimeographed sheet of questions were blank sheets of paper on which the subject wrote his responses; he was permitted to use as much, or as little, of the paper provided as he chose.

Receiving an open-ended question permitted the subject the freedom to state in his own way whatever changes he had felt. For this reason, Strupp's et al. (1964) item #74 (p. 12) modified as above to pertain to the therapist rather than the patient, offered the greatest freedom for the subject to respond.

The obtained responses allowed for a qualitative analysis of the subjectively felt changes which accompany doing psychotherapy. The actual

responses obtained were coded and categorized. This treatment enabled the investigator to cull some of the major experiences shared in common by many of the subjects and in this way get a clearer understanding of some of the processes involved in the growth and development of the beginning psychotherapist.

Summary of Procedure

Each of the forty-three Ss, both experimental and control, was seen, separately, for approximately one hour and forty minutes, on two separate occasions. The first time the subjects were seen was during the first month of their psychotherapy training. The subjects were seen again at the end of that academic year.

At the initial interview, the subjects were asked to perform two Q sort tasks. When this was finished, each subject completed the GCI. Finally, each S was asked for a tape-recorded interview he had with a patient during the first month of the therapy practicum.

At the end of the academic year, the subjects were asked to repeat the procedure above. They were asked to supply tapes of interviews with the same patient who had been taped for the initial interview. In addition, this time, each experimental subject was asked to fill out a questionnaire asking about his personal therapy experience, and the diagnosis of the patient who had been taped for this study. Furthermore, the Ss were asked to rate the general therapeutic progress of the patient, the warmth they felt their supervisor expressed, and the competence they felt their supervisor possessed. Finally, each S was asked to answer an open-ended question about the changes he may have felt as a result

of doing psychotherapy.

Except for the question relating to personal therapy, the control group was not asked to fill out the questionnaire.

Chapter III

Results

Findings Related to Hypothesis I

It was hypothesized that as a result of doing psychotherapy, increases in "central therapeutic ingredients" would ensue, i.e., ratings in accurate empathy (AE), nonpossessive warmth (NPW), and genuineness (GEN) would increase.

The reliability of the three measures dependent on raters is presented first. Following this, within-group analyses are described for the experimental and control groups, respectively. These two groups are then compared at initial and later stages of training. Finally, the changes noted in the experimental group are investigated in relation to five potentially relevant variables.

Reliability of Ratings. As reported in Chapter II (Pp. 18-19), the ratings of the three therapist scales were done by three independent expert raters at the Arkansas Rehabilitation Research and Training Center where the scales were developed.

The three ratings were averaged, for each characteristic, and served as the raw scores to be analyzed. Guilford (1954, p. 395) suggests using Ebel's intraclass correlation for estimating the reliability of the mean of *k* ratings for each subject. This, too, is the procedure most often used by Truax and his associates (Truax & Carkhuff, 1967) in estimating the reliability of their instruments.

Ebel's formula, which essentially yields an average intercorrela-

tion, is

$$r_{kk} = \frac{V_s - V_e}{V_s},$$

where r_{kk} = the reliability for mean ratings from k raters,

V_s = the variance for subjects,

V_e = the variance for error.

The reliability coefficients are a very respectable .89, .81, and .83 for the mean of the three judges' ratings of the therapists' AE, NPW, and GEN, respectively. The obtained reliabilities, via Ebel's intraclass method, are very much in keeping with the reliability coefficients, from many studies, presented by Truax and Carkhuff (1967, p. 43).

Findings from the Experimental Group. The range of AE ratings at the initial stage of training, for the experimental group, is 2.67 to 4.00. Although the range is substantial, it is skewed to the lower end of this nine-point scale. The ranges for ratings of NPW and GEN are 2.83 to 4.00, and 2.67 to 4.50, respectively. Again, the ranges are both ample, especially for these two five-point scales.

At the later training stage, the ranges for ratings of AE, NPW, and GEN are 3.00 to 4.17, 3.17 to 4.33, and 3.00 to 4.17, respectively.

Table 1 shows the means and standard deviations for the average ratings of the three "central therapeutic ingredients," at both stages of training.

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Insert Table 1 about here

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When the means of the initial stage ratings of the three scales are compared to their counterparts at the later stage of training, direct

TABLE 1

Comparison of Empathy, Warmth, and Genuineness Ratings of Experimental Subjects at Initial and Later Training Stages

	Empathy (AE)		Warmth (NPW)		Genuineness (GEN)	
Stage	Initial	Later	Initial	Later	Initial	Later
Mean	3.355	3.606	3.417	3.756	3.356	3.666
SD	.306	.321	.448	.335	.311	.330
SE	.056	.058	.081	.061	.057	.060
t	4.328		4.021		4.103	
p	$<.001$		$<.001$		$<.001$	

support for Hypothesis I is obtained. The mean difference between initial and later training stage AE ratings is .251; this same comparison for NPW and GEN ratings yields respective mean differences of .311, and .339. All of these mean differences are significant in the hypothesized direction at the .001 level. The *t* values for AE, NPW, and GEN, reported in Table 1, are 4.328, 4.021, and 4.103, respectively.

There is some question about the normality of the distribution of the Truax scales. As noted above, the AE ratings, especially, are skewed to the lower end. The possibility, therefore, remains that not all the assumptions for using the *t* statistic are met. Thus, Wilcoxon's signed-ranks test for differences between matched pairs, a distribution-free technique, was employed (Peatman, 1963, p. 373).

In Wilcoxon's test the smaller of the two signed-rank sums is used to test the significance of the difference between the matched groups. The sum of ranks for the 23% of the experimental subjects who show no increase in AE scores is 33, which is significant. When *n* is greater than 25, the distribution of Wilcoxon's *T* (the smaller sum of ranks) is approximately normal, hence a *z* deviate test of significance is used instead of the tables provided for smaller samples. For the above *T* of 33, *z* is 3.59 and significant at the .001 level. This confirms the finding of the above *t* test of the difference between initial and later stage mean AE ratings.

The 22% of the subjects who do not show increases in NPW scores have a *T* value of 44.0 which yields a result significant at the .001 level, z=3.77. Twenty-three percent of the experimental subjects show no positive change in GEN ratings; their corresponding sum of ranks is 48.5.

The resultant z value is 3.51 which is beyond the .001 level of significance.

The results from both the parametric and nonparametric tests of significance support Hypothesis I. It seems reasonable to state that nonrandom increases occur in ratings of therapists' empathy, warmth, and genuineness as a result of doing psychotherapy.

Findings from the Control Group. The range of initial stage AE ratings in the control group is 3.33 to 3.83; this is a rather narrow range, more constricted than its counterpart in the experimental group. For NPW and GEN ratings, again, the ranges are somewhat narrower than they are for the experimental group; 3.17 to 4.00 for NPW scores, and 3.00 to 3.83 for GEN scores.

At the later training stage, the range of AE scores shows an increase from the initial stage, 3.00 to 4.00. The range of NPW scores is identical at both stages. GEN ratings show a minimal widening in range at the later stage, 2.83 to 3.83.

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Insert Table 2 about here

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The findings from significance tests of differences between initial and later stage ratings on the three scales are presented in Table 2, along with the means and standard deviations for the distributions of each scale at both stages of training. It is apparent that there are no significant differences between initial and later stage mean ratings on any of the three scales used. It can be deduced that the mean differences between initial and later stage AE scores is .050. The mean differences, over time, for NPW and GEN scores are .038, and .037, respectively. The

TABLE 2

Comparison of Empathy, Warmth, and Genuineness Ratings of Control Subjects at Initial and Later Training Stages

	Empathy (AE)		Warmth (NPW)		Genuineness (GEN)	
Stage	Initial	Later	Initial	Later	Initial	Later
Mean	3.576	3.526	3.462	3.425	3.462	3.501
SD	.175	.318	.226	.317	.320	.272
SE	.048	.088	.066	.088	.088	.075
t	.344		.320		.366	
p	n.s.		n.s.		n.s.	

resultant _t_ values are presented in Table 2.

Again, nonparametric tests were employed as a double check. Forty-six percent of the control group show an increase in AE scores. The corresponding sum of ranks is 34.5. Wilcoxon's table of critical values (Peatman, 1963, p. 422) indicates that when _n_=13, any _T_ value greater than 17 is not significant. The 38% of the control subjects who show an increase in NPW scores yields a _T_ of 45.5, not significant. Also not significant is the _T_ value of 28.5 resulting from the 54% who show a gain in GEN scores. The obtained findings here support those of the _t_ tests.

It may be observed that in the experimental group _decreases_ in AE, NPW, and GEN ratings were used in calculating nonparametric tests of significance. While in the control group _increases_ were employed in similar calculations. This is because in all cases the smaller of the two signed-rank sums yields Wilcoxon's _T_ statistic. In the experimental group decreases in ratings yielded the smaller sum of ranks; whereas in the control group increases in ratings yielded the smaller sum of ranks.

Comparison of Experimental and Control Groups. It seems apparent that there are gains in AE, NPW, and GEN ratings, as hypothesized for the experimental group and that no significant positive changes in these characteristics, from the initial to the later stage of training, can be established for the control group. The possibility exists that statistical artifacts, of a borderline nature, may lead to erroneous conclusions. In order to rule out this possibility, initial and later stage comparisons between groups is necessary (Guilford, 1965).

Accurate Empathy. A difference in means of .211 is obtained when the initial mean score of AE in the experimental group is compared with

that of the control group. The resultant *t* for unrelated samples, 2.440, is significant at the .02 level. Apparently, the control group, as a whole, possesses a significantly greater ability to express accurate empathy than does the experimental group prior to the introduction of the experimental variable.

At the later stage, the same comparison yields a mean difference of .080 which is not significant, $t=.758$.

Findings from the nonparametric Mann-Whitney *U* test, corrected for ties (Siegel, 1956, p. 123), support the *t* test findings. When the AE scores of the experimental and control groups are considered together initially, the sum of ranks in the control group is 383. As both groups contain more than 8 subjects, a *z* deviate test of significance was made. The obtained *z* is 2.60 and significant at the .01 level. A similar comparison at the later stage yields a sum of ranks for the control group of 265. The *z* value obtained is not significant, .540.

What appears obvious from the parametric and nonparametric tests of significance is that initially the control group scores higher on AE than the experimental group. However, as noted previously, the control does not show any increase in AE at the later stage, whereas the experimental group does; the latter change helped to bridge the initial gap between the groups leading to no significant difference between the two groups at the later stage of training.

The above findings, however, cast some doubt on the conclusions drawn in relation to Hypothesis I, thus far. Guilford (1965) states that when working with experimental and control groups, if the two groups differ initially, the final results cannot be considered conclusive. In order to

avoid this pitfall, he maintains that it is necessary to compare the net difference in change, over time, for the experimental and control groups, i.e., the differences between the change scores of both groups.

The experimental group shows a mean AE change score of .251. The mean change score in the control group is -.050. Simple subtraction shows the remainder to be .301. The difference between the two means is significant at the .01 level, t=2.795. It may be safely concluded, then, that as a result of doing psychotherapy, there is an increase in the experimental group's expression of AE significantly greater than that found in the control group which did not practice psychotherapy. Further support is given to this finding when the change scores for each group are combined and ranked along magnitude of positive change. The resultant sum of ranks for the control group yields a Wilcoxon T of 197. The z deviate value is 2.09 and significant at the .05 level. This indicates a significant difference in the hypothesized direction between changes in AE ratings in the experimental group as compared to the control group.

Nonpossessive Warmth. The difference between experimental and control group means for NPW at the initial stage of training is .107 and not significant, t=1.027. The Mann-Whitney U test for these data yields a control group sum of ranks of 322.5 which is not significant; z, corrected for ties, is .97. These findings suggest that both groups are initially quite similar in regard to judges' ratings of their nonpossessive warmth.

Comparison of mean ratings of the two groups at the later stage, shows a mean difference of .165, t=1.597. From this finding it can be

seen that the experimental group has shown a greater increase in ratings of NPW than the control group in the hypothesized direction.

The findings of the distribution-free Mann-Whitney U test suggest that the median difference of the two groups is significant at the .05 level. The sum of ranks for the control group, 267.5, yields a z deviate value of 2.17. This finding adds support to the major hypothesis and the trend noted above with a borderline t value of 1.597.

Genuineness. A comparison of Tables 1 and 2 reveals that the mean difference between initial GEN scores in the experimental and control groups is .044. The obtained t value of .334 is not significant. The sum of ranks of the control group is 185. The resultant z value is .267, when corrected for ties. The findings from this Mann-Whitney U test suggest that prior to the introduction of the experimental variable, the experimental and control groups are similar in regard to ratings of their genuineness in a psychotherapy session.

That gains in GEN, as a result of practicing psychotherapy, are quite evident is given additional support by the comparison of the experimental and control groups at the later training stage. The difference between later training stage GEN means is .332. The obtained t value is significant beyond the .01 level, 3.029. Confirmation of this finding is evidenced by the sum of ranks for the control group, 189, which is significant at the .01 level, z=2.58.

To sum up, in support of Hypothesis I, the within-group analyses of the data show that experimental subjects produce quite a significant increase in AE, NPW, and GEN scores from initial to later stages of training. The control subjects, on the other hand, remain unchanged in

regard to these measured characteristics. The between-groups analyses indicate that except for AE ratings initially there is no difference between the groups. However, the control group, as a whole, appears to be rated significantly higher than the experimental group on AE at the initial stage of training.

Comparison between groups, at the later stage, shows that the gap between the initial difference in AE scores is closed, i.e., whereas the control group shows no significant positive change in AE ratings, the experimental group shows gains in AE which brings it up to the control group's initial level of AE ratings.

The initial between-groups difference for NPW scores is not significant. However, the major hypothesis is somewhat weakened by the finding of no significant difference between groups at the later stage. The findings suggest a cautious confirmation of the hypothesis qualified by stating that hypothesized increase in ratings of NPW is evidenced, however it is not of sufficient magnitude to produce a significant difference in comparison to the control group at the later stage. The original hypothesis, however, is given more solid support from the significant difference found between the two groups at the later stage when a distribution-free statistic is used.

Firm support is given to the hypothesized increase in GEN when the experimental and control groups are compared at initial and later stages of training. Initially, there is no significant difference between the two groups; however, a substantial significant difference between groups for mean ratings of genuineness is obtained at the later training stage.

Investigation of Several Relevant Variables. As discussed in Chapter II (Pp. 24-27) of the present study, five variables were singled out as having potential influences on the three major hypotheses under investigation. The relationship between these variables and the hypothesized gains in the three central therapeutic ingredients is presented in Tables 3 and 4.

Insert Table 3 about here

Table 3 shows the association of two dichotomized variables (1) personal psychotherapy vs. no personal psychotherapy, and (2) diagnosis of patient seen in juxtaposition to change (increase vs. no increase) in ratings of AE, NPW, and GEN. As can be seen, none of the obtained phi coefficients, for the six 2 by 2 crosstabulations, is significant.

Point biserial correlations with the same data (taking into account the magnitude of change) support the stated findings. AE score changes in juxtaposition to the personal therapy variable yields an r_p of .074. The resultant t value is .393, not significant. The same variable in relation to NPW and GEN yields respective point biserial correlations of .10 (t=.512), and .080 (t=.424). Neither correlation is significant.

The diagnostic category of the patient in contrast to the degree of change in ratings of AE, NPW, and GEN result in point biserial correlations of .150 (t=.803), .222 (t=1.204), and .080 (t=.424), respectively. All values are not significant.

From Table 4 it can be seen that there are no significant Spearman rank correlations between changes in AE, NPW, and GEN, and the

TABLE 3

Phi Coefficients of Change in Ratings of Empathy, Warmth, and Genuineness in the Experimental Group as Contrasted with Two Dichotomized Variables: Subjects' Involvement or Non-involvement in Personal Therapy, and the Diagnostic Category of the Patient Seen

	Empathy (AE)		Warmth (NPW)		Genuineness (GEN)	
Variables	Pers. Ther.	Diag.[a] of Pt.	Pers. Ther.	Diag.[a] of Pt.	Pers. Ther.	Diag.[a] of Pt.
Phi Coef.	.032	.111	.031	.111	.032	.223
z	.166	.616	.171	.616	.166	1.226
p	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.

[a]Psychotic vs. Nonpsychotic

TABLE 4

Spearman Rank Correlations[a] Between Changes in Ratings of Experimental Subjects' Empathy, Warmth, and Genuineness and Three Variables: Felt Therapeutic Success, Impression of Supervisors' Warmth, and Impression of Supervisors' Competence

	Empathy (AE)			Warmth (NPW)			Genuineness (GEN)		
Variables	Felt Success	Imp. of Superv. Warmth	Imp. of Superv. Comp.	Felt Success	Imp. of Superv. Warmth	Imp. of Superv. Comp.	Felt Success	Imp. of Superv. Warmth	Imp. of Superv. Comp.
Spearman r	.272	-.119	-.028	.086	.127	.019	-.203	.082	.303
t	1.496	.625	.148	.470	.695	.103	1.096	.449	1.666
p	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.

[a]corrected for ties (Siegel, 1956, p. 206)

three variables of felt therapeutic success, impression of therapy supervisors' warmth, and impression of supervisors' competence.

Insert Table 4 about here

In brief, none of the five variables considered appears to have any significant association with the changes noted in the experimental group in regards to accurate empathy, nonpossessive warmth, and genuineness.

Findings Related to Hypothesis II

Hypothesis II states that doing psychotherapy results in a greater feeling of self-esteem as regards one's role as a psychotherapist.

The results of within-group analyses are presented for both the experimental and control groups, respectively, followed by a comparison of the two groups at initial and later stages of training.

Changes evidenced in the experimental group are then viewed in relation to five possibly relevant variables.

Findings from the Experimental Group. The range of scores from the Good Clinician Inventory (GCI) for the experimental group is 46 to 69 at the initial stage of training. At the later training stage, the range of scores is wider, 36 to 74. The means and standard deviations of these two distributions are presented in Table 5.

A comparison of the two means reported in Table 5 yields a mean difference of 2.80 in the hypothesized direction which is significant

TABLE 5

Comparison of GCI Scores in The Experimental Group at Initial and Later Training Stages

	Initial Stage	Later Stage
Mean	55.43	58.23
SD	6.09	7.02
SE	1.11	1.28
t	2.12	
p	$<.05$	

at the .05 level (t=2.12).

Insert Table 5 about here

The array of GCI scores is not normally distributed. As a precaution, Wilcoxon's test of signed-ranks was employed. Thirty percent of the experimental group show either no change or a decrease in GCI scores; for this subgroup, the sum of ranks is 130. The z deviate test of significance for large samples yields a z value of 2.11 which is beyond the .05 level of significance. This confirms the t test findings.

From the above results, it appears likely that the increase in GCI scores from the initial as compared to the later training stage is not based on random changes. Evident is a positive change of a significant nature supporting the hypothesis that an increase in role-related self-esteem occurs as a result of doing psychotherapy.

Findings from the Control Group. The GCI scores in the control group during the initial stage range from 46 to 73. The post-test GCI scores for this group have a range of 48-71, noticeably similar to the initial stage range.

As can be seen from Table 6, the mean at the initial training stage in comparison with the later stage mean yields a mean difference of 1.46. A t test for mean differences of related pairs results in a non-significant value of 1.68. It is evident from Table 6 that some gains in GCI scores occur in the control group, but not enough to reach significance.

Thirty-nine percent of the control subjects show no positive

TABLE 6

Comparison of GCI Scores in the Control Group at Initial and Later Training Stages

	Initial Stage	Later Stage
Mean	55.08	56.54
SD	7.83	6.21
SE	2.17	1.72
t	1.68	
p	n.s.	

change in GCI scores. The Wilcoxon sum of ranks for this subpopulation is 20.5. The critical value of *T* at the .05 level is 17 for an *n* of 13; the obtained result is, therefore, not significant and supports the findings of the *t* test.

Insert Table 6 about here

Comparison of Experimental and Control Groups. The findings thus far indicate that there are nonrandom increases in GCI scores in the experimental group from the initial testing period to the later stage. There is no such significant increase evident in the control group.

If the two groups are compared initially, it is evident that their respective ranges and means are quite similar. The difference between the means of the two groups, initially, is .35. The ratio of this difference to its standard error yields a *t* value of .15 which is obviously not significant. This result suggests that prior to the initiation of the experimental variable, the two groups are essentially equivalent in their self-ratings of role-related self-esteem.

The Mann-Whitney *U* test for these data confirm the above findings. The sum of ranks for the control group is 270.5. The obtained *z* value, corrected for ties, is .41, which is not significant.

Comparison of the mean GCI scores of the two groups at the later stage shows a mean difference of 1.70. The *t* value for such a difference in means of unrelated samples is .79 and is not significant.

The Mann-Whitney sum of ranks for GCI scores, at the later stage, in the control group is 229; the *z* deviate value, when corrected for ties,

is 1.51, not significant. These results suggest that there is a difference between the experimental and control groups of some magnitude, but not quite enough to reach significance.

To sum up, in partial support of Hypothesis II, the within-group analyses indicate that experimental subjects show a significant increase in GCI scores from initial to later stages of training; this is not so for the controls. The between-groups analyses suggest that the two groups are initially quite alike. The same comparison at the later stage shows no significant difference. The results suggest that there is movement in the hypothesized direction for the experimental group, however, it is not large enough to significantly differentiate it from the control group which also shows increase in self-esteem even though not statistically significant. The possibility exists that some other factors are operating within each group which contribute to increases in role-related self-esteem. Some of these factors are investigated in the next section.

Investigation of Several Relevant Variables. Tables 7 and 8 present correlations of changes in GCI scores, in the experimental group, with respect to five relevant variables. Two of the variables are dichotomized and crosstabulated with changes in GCI scores. The dichotomy of receiving personal therapy vs. not receiving personal therapy, when crosstabulated with the dichtomy of increase in GCI scores vs. no increase in GCI scores yields a phi coefficient of .342 which is not significant (z=1.88, $p<.07$).

The point biserial correlation for the same data is .474; this value is significant at the .02 level (t=2.72) and supports the trend observed above. One may infer from this that gains in role-related

TABLE 7

Phi Coefficients of Change in GCI Scores in the Experimental Group as Contrasted with Two Dichotomized Variables: Subject's Involvement or Non-involvement in Personal Therapy, and the Diagnostic Category of the Patient Seen

Variables	Involvement in Personal Ther.	Diagnosis of[a] Patient
Phi Coefficients	.342	.154
z	1.88	.845
p	$<.07$	n.s.

[a]Psychotic vs. Nonpsychotic

self-esteem are associated with being in psychotherapy as well as learning it.

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Insert Table 7 about here

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When the diagnosis of the patient seen for this study is divided between psychotic and nonpsychotic, and crosstabulated with the change dichotomy, the resultant phi coefficient, reported in Table 7, is not significant.

Taking into account the degree of change, these same data yield a point biserial correlation of .179 which is not significant (t=.98).

From Table 8, it is evident that Spearman rank correlations of changes in GCI scores with respect to felt therapeutic success, and impression of therapy supervisors' warmth are not significant.

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Insert Table 8 about here

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In Table 8, however, it can also be seen that there is a significant negative association between positive changes in GCI scores and the subjects' impressions of their supervisors' competence (t=2.266, $p<.05$). It is fair to assume, then, that there is a negative relationship between a beginning therapist's view of his own growth as a therapist and his view of his therapy supervisor's competence.

Of the five variables considered, two appear to have some relationship to the change observed in role-related self-esteem. A novice therapist's undergoing his own psychotherapy would appear to be an important

TABLE 8

Spearman Rank Correlations[a] Between Changes in Experimental Subjects' GCI Scores and Three Variables: Felt Therapeutic Success, Impression of Supervisors' Warmth, and Impression of Supervisors' Competence

Variables	Felt Therapeutic Success	Impression of Supervisors' Warmth	Impression of Supervisors' Competence
Spearman *r*	.087	-.202	-.394
t	.460	1.09	2.266
p	n.s.	n.s.	$<.05$

[a]corrected for ties (Siegel, 1956, p. 206)

variable related to his growth as a clinician. The second finding, of interest, is the inverse relationship of the subjects' perceived competence of their therapy supervisors and their feelings about change in themselves as therapists.

Findings Related to Hypothesis III

The expectation here was that doing psychotherapy would result in a greater congruence between self-concept and ideal-self concept.

The findings are presented in the following order. First, within-group comparisons are presented. Then between-groups comparisons are investigated. The changes within the experimental group are then examined in conjunction with several relevant variables. Having made all within- and between-groups comparisons, the experimental group is further studied in order to delineate whether greater movement is observed in the self-concept or the ideal-self concept.

Findings from the Experimental Group. From Table 9, it can be seen that the initial stage self/ideal correlations, in the experimental group, range from -.304, quite a marked discrepancy between self and ideal, to .853, a considerable degree of congruence.

Since there is serious question about the normality of a Pearson *r* distribution, each correlation was transformed into a *z* score (Antrobus, 1969[1]; Peatman, 1963); this allowed for the use of more powerful parametric tests of significance.

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Insert Table 9 about here

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[1] personal communication

TABLE 9

Self/Ideal Correlations in The Experimental Group

Therapist (Random No.)	Initial-training Stage r	Later-training Stage r
229	.345	.601
721	.368	.122
866	.841	.665
906	.832	.837
443	.603	.746
713	.351	.597
301	.475	.258
299	.561	.731
778	.823	.835
322	.596	.738
019	-.304	.033
774	.543	.548
279	.379	.681
331	.733	.675
280	.340	.735
575	.574	.551
431	.660	.727
071	.399	.807
259	.164	.636
646	.290	.298
113	.853	.921
162	.515	.363
152	.689	.617
603	.696	.724
573	.831	.917
693	.581	.582
423	.353	.623
455	.660	.593
119	.122	.306
895	.753	.845
Mean z	.640	.787
Corresponding r	.565	.657

The mean z of the transformed self/ideal correlations, in the experimental group, is .640, and its corresponding r is .565, which is significant at the .01 level (t 3.62).

The question arises whether or not the mean self/ideal correlation is based merely on randomness of associations. To test for the significance of individual differences, Tippett (Butler & Haigh, 1954, p. 62) suggests using the following formula for mean correlations which have been found to be significant.

$$\chi^2 = (N-3)\ \Sigma(z-\bar{z}),\ \text{with } n-1\ df,$$

where n is the number of subjects,

N is the number of items sorted in each Q sort,

$\bar{z}$ denotes the mean value of z.

For the initial stage self/ideal correlations of the experimental group, the value of chi-square for magnitude of association is 396.12, which is well beyond the value at the .001 level of significance, 58.3. This result indicates that there are significant individual differences in self/ideal correlations in this population.

The self/ideal relationship in the experimental group, at the later training stage, may also be observed in Table 9. This time the range is from .033 to .921, i.e., an almost zero-order relationship to a very substantial similarity. The t value for the mean r is significant at the .001 level, 4.54, indicating that there is a true association between self and ideal-self concepts.

In order to determine whether there were significant individual differences, the chi-square was again employed. The obtained value is 396.05, which is far beyond the .001 level of significance. This

result, again, suggests that there are true individual differences in the magnitude of self/ideal correlations.

Thus, it can be concluded of the experimental group at both initial and later stages of training that there are significant degrees of congruence between the perception of the self and the perception of the valued self. There is also a wide and significant range of individual differences in the degrees of self/ideal similarity which exists at both stages.

For a direct assessment of Hypothesis III, a comparison of the above findings is needed. From Table 9, it can be seen that the mean difference between the initial and later stage self/ideal correlations, expressed in terms of $\underline{z}$, is .147. The $\underline{t}$ value of this mean difference is 2.934 which is significant at the .01 level. This would indicate a significant change in the hypothesized direction.

Since there might still be some question as to whether the data meet all the assumptions necessary for using the $\underline{t}$ test for paired differences, the Wilcoxon test was also used. The sum of ranks for the 27% of the experimental subjects who do not show an increase in self/ideal congruence is 101. The obtained $\underline{z}$ value of 2.70 is significant at the .01 level; this result confirms the findings from the $\underline{t}$ test.

From these results, it seems unlikely that the increases in self/ideal correlations from the initial as contrasted to the later training stage in the experimental group is based on random changes. On the contrary, it seems that directional changes of a significant nature are evident, and that these provide confirmation of the hypothesis that the congruence between self and ideal are increased as a result of doing

psychotherapy.

Findings from the Control Group. The data from the control group are presented in Table 10. It can be seen that, at the initial training stage, the self/ideal correlations range from .179 to .737, a minimal to quite a large similarity between self and ideal.

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Insert Table 10 about here

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Again, the r's were converted to z scores in order to normalize the sampling distribution. The mean z for the initial stage has a corresponding r of .489 which is significant at .10 for 12 degrees of freedom (t 1.86).

The chi-square for individual differences is 70.33 which is beyond the .001 level of significance, 32.9. It can, therefore, be concluded, as in the case of the experimental group, that there are distinct subclasses of individual self/ideal relations in the control group.

The self/ideal relationship of the control group, at the later stage, may be observed in Table 10. At this point, the range of self/ideal correlations is from .268 to .756. The t value for the mean r is significant at the .10 level, 1.98.

The chi-square for magnitude of individual differences is 53.45 which is well beyond the .001 level of significance.

The results at the final testing period are very similar to those at the initial stage. An investigation of Table 10 indicates that the control group is quite consistent over time, though there are some individual changes which indicate that changes in self/ideal congruence

TABLE 10

Self/Ideal Correlations in The Control Group

Therapist (Random No.)	Initial-training Stage *r*	Later-training Stage *r*
265	.325	.593
792	.408	.476
147	.179	.268
809	.722	.659
738	.496	.756
268	.737	.386
333	.437	.463
630	.691	.603
303	.363	.398
826	.281	.379
011	.618	.417
990	.426	.362
276	.403	.674
Mean *z*	.534	.567
Corresponding *r*	.489	.513

do occur at times. The overall findings, however, are clear that no significant change has occurred in the control group.

The difference between the mean *z*'s of the initial and later stages is .033. The obtained *t* ratio is .43 and is not significant. Thus, there is little reason to believe that the control group correlations, initial and later stages, are from populations with different means and variances.

The Wilcoxon test yields a sum of ranks, corresponding to the negative changes in self/ideal congruence in the control group of 40. The critical value for the smaller sum of ranks at the .05 level is 17; the obtained sum is, therefore, not significant, and confirms the findings of the *t* test.

Comparison of Experimental and Control Groups. It has been established that there are nonrandom increases in the self/ideal correlations of the experimental group from initial to later stages and that similar increases cannot be found in the control group.

The results cannot be considered conclusive however, unless initial differences between the groups can be ruled out. Table 11 shows a comparison of the two groups at both stages of training. As can be seen, the *t* value for difference of mean *z*'s between the groups, at the initial point of testing, is 1.12 which is not significant. This suggests that there is some variation between the two groups before the experimental variable became operative, but not enough difference to forestall making the above comparisons.

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Insert Table 11 about here

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TABLE 11

Comparison of Self/Ideal Correlations

Between Experimental and Control Groups at Initial and Later

Stages of Training

	Initial Stage		Later Stage	
Group	Exp. Grp.	Cont. Grp.	Exp. Grp.	Cont. Grp.
Mean *z*	.640	.534	.787	.567
SD	.330	.246	.375	.214
SE_z	.067	.068	.068	.059
t	1.12		2.31	
p	n.s.		$< .05$	

The Mann-Whitney *U* test for these data yields a sum of ranks for the control group of 253. A *z* deviate test of significance for large groups yields a *z* value of .87 which is not significant; this adds support to the result of the *t* test.

Further support is given to Hypothesis III when the two groups are compared at the later training stage. Table 11 shows that the mean *z* of the self/ideal correlations in the experimental group is significantly greater than that of the control group at the later stage. The obtained *t* for the difference between unrelated means is 2.31 which is significant at the .05 level.

Another Mann-Whitney *U* test for independent samples was conducted at the later stage of training; the sum of ranks for the control group is 212. The obtained *z* deviate value is 1.98 and significant at the .05 level. This nonparametric statistical analysis confirms the result obtained with the *t* test.

To sum up, in firm support of Hypothesis III, the within-group analyses of the data suggest that experimental subjects show a significant increase in self/ideal congruence from initial to later stages of training. This is not true for the control group. The between-group analyses indicate that initially there is no significant difference between the experimental and control groups. When compared at the later stage, however, a significant difference is found between the self/ideal correlations of each group in the hypothesized direction.

Investigation of Several Relevant Variables. There appears to be some movement toward greater self/ideal congruence in both the experimental and control groups, although the mean increase in self/ideal

correlations of the experimental group is significantly greater than that of the control group. In addition, large individual differences are evident. Tables 12 and 13 show the relative effects of five variables on changes in self/ideal correlations in the experimental group.

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Insert Table 12 about here

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For purposes of analysis, the experimental group was segmented into a 2 by 2 bivariate distribution. The columns were divided between those who were in therapy and those who were not. The rows were divided between those subjects who showed a gain in self/ideal congruence and those who did not. Table 12 shows that the phi coefficient for this crosstabulation is .408. The obtained z deviate value, for large samples, is 2.23 which is significant at the .05 level. This suggests the likelihood that gains in self/ideal correlations are, at least in part, contingent upon a person's being in psychotherapy himself.

A point biserial correlation, with the same data, supports the above finding. The obtained r_{pb} is .307 which yields a t of 1.71 ($p < .10$).

Table 12 shows that the dichotomy of psychotic vs. nonpsychotic patients, when crosstabulated with positive change vs. no change or decrease in therapists' self/ideal correlations, yields a phi coefficient of .213, not significant (z=1.17).

The point biserial r for these data is .221 which, also, is not significant (t=1.20). These results suggest that there is little if any relationship between the diagnosis of the patient and change in therapists' self/ideal correlations over time.

TABLE 12

Phi Coefficients of Change in Self/Ideal Correlations in the Experimental Group as Contrasted with Two Dichotomized Variables: Subject's involvement or Noninvolvement in Personal Therapy, and the Diagnostic Category of the Patient Seen

Variables	Involvement in Personal Ther.	Diagnosis of[a] Patient
Phi Coefficients	.408	.213
z	2.23	1.17
p	$< .05$	n.s.

[a]Psychotic vs. Nonpsychotic

The Spearman rank correlations between the changes in self/ideal correlations and the novice therapists' felt therapeutic success is presented in Table 13. The obtained $\underline{r}_s$ is .369, a relatively low correlation, which nevertheless, for a population of this size, is significant at the .05 level ($\underline{t}$=2.096). Thus there appears to be some relationship between changes in self/ideal correlations and felt therapeutic success.

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Insert Table 13 about here

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Table 13 also presents the results obtained from Spearman rank correlations between changes in self/ideal correlations and the subjects' impressions of their therapy supervisors' warmth and competence. Neither correlation attains a level of significance, suggesting that these two qualities of supervisors are not related to changes in self/ideal congruence.

As in the case of increase in GCI scores, personal psychotherapy seems to bear a direct relationship to changes observed in self/ideal correlations. Except for the significant relationship observed between felt therapeutic success and change in self/ideal congruence, none of the other variables considered appears to have any bearing on the development of self/ideal congruence observed in the experimental group.

Change in Self vs. Change in Ideal. Finally, the question arises, is the change noted in self/ideal congruence due to a change in the self- or a change in the ideal-self concept? To answer this question, the self-concept at the initial stage was compared to the self-concept at the later stage of training; the same comparison was made for the

TABLE 13

Spearman Rank Correlations[a] Between Changes in Experimental Subjects Self/Ideal Correlations and Three Variables: Felt Therapeutic Success, Impression of Supervisors' Warmth, and Impression of Supervisors' Competence

Variables	Felt Therapeutic Success	Impression of Supervisors' Warmth	Impression of Supervisors' Competence
Spearman *r*	.369	.111	-.102
t	2.096	.589	.542
p	$<.05$	n.s.	n.s.

[a]corrected for ties (Siegel, 1956, p. 206)

ideal-self concept; and finally, the difference between these two obtained correlation means was compared.

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Insert Table 14 about here

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Table 14 shows that the range of correlations between self-concepts at the initial and later stages is .478 to .872. The mean *z* of this distribution is .910; its corresponding *r* is significant at the .001 level. The chi-square for homogeneity of correlations is well beyond the .001 level of significance, 144.34.

The range of ideal-concept correlations is .454 to .902. The mean *z* of this distribution, presented in Table 14, is 1.120. The corresponding *r* is significant beyond the .001 level. The chi-square for individual differences is 144.43 which is well beyond the .001 level of significance. Both self/self, and ideal/ideal correlations appears to be made up of distinct subclasses.

Even though the two mean *z*'s presented are quite large, and their corresponding *r*'s are quite significant, it is evident from Table 14 that the ideal-self concept varies less than the self-concept from the initial to the later training stage. A *t* test for the comparison of matched pairs yields a *t* value for the difference between the two means of 5.29 which is significant at the .001 level. The result suggests that, although there are relatively small variations in the subjects' self-concept and ideal-concept, over time, the latter varies significantly less than the self-concept.

Fourteen percent of the experimental subjects obtained correla-

TABLE 14

Self/Self and Ideal/Ideal Correlations from Initial to Later Stages of Training in The Experimental Group

Therapist (Random No.)	Self/Self r	Ideal/Ideal r
229	.628	.785
721	.428	.729
866	.671	.724
906	.859	.885
443	.781	.847
713	.637	.802
301	.514	.756
299	.644	.698
778	.872	.891
322	.691	.786
019	.746	.746
774	.828	.847
279	.763	.795
331	.761	.748
280	.714	.454
575	.636	.782
431	.706	.860
071	.535	.891
259	.637	.807
646	.743	.785
113	.853	.891
162	.702	.702
152	.704	.807
603	.670	.733
573	.871	.902
693	.831	.899
423	.608	.844
455	.676	.841
119	.525	.750
895	.802	.857
Mean z	.910	1.120
Corresponding r	.722	.807

tions between their self-concepts at the two stages of training, which were equal to or lower than the correlations obtained between their ideal-concepts at the two testing periods. Wilcoxon's test for matched pairs yields a sum of ranks, for this segment of the population, of 26. The z value derived is 4.02, which is significant at the .001 level. Support is given to the findings from the t test that changes in self/ideal correlations are more likely to occur as a result of changes in the self-concept than from changes in the ideal-self concept.

Findings Related to Reported Changes Resulting from Doing Psychotherapy

Table 15 represents an attempt to group subjects' responses to an open-ended question aimed at delineating some of the subjectively felt changes they experienced as a result of practicing psychotherapy for the first time. The responses collected were grossly subdivided into categories relating to the three major hypotheses of this study.

The majority of changes noted are related to feelings about oneself as a person. While several subcategories fall under this heading, by far the one most often mentioned by the novice therapist appears to be that of a greater awareness of one's feelings and needs (66.67%). In the course of doing psychotherapy most respondents seem to have

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Insert Table 15 about here

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achieved more self-awareness and emotional insight than they felt they had before that experience. As seen in Table 15, many of the subjects were able to pin-point personal problem areas. One first year psychi-

TABLE 15

Summary of Changes Resulting from Doing Psychotherapy Reported by Beginning Psychotherapists

Category	n	%[a]
<u>Changes Related to Self</u>		
Greater awareness of one's own problems and conflicts in general	20	66.67
Greater awareness of specific[b] problem areas as follows:		
dependency needs	5	16.33
fear of closeness	5	16.33
fear of aggression	3	10
need to control	3	10
need for perfection	3	10
feelings of inadequacy	2	6.67
sexual conflicts	2	6.67
More confidence in one's self	6	20
Increased respect for and tolerance of others	5	16.33
More accepting of one's self	4	13.33
<u>Changes Related to Therapist Role</u>		
More aware of the difficulties in doing therapy and the complexities of motivation and human behavior	7	23.33
Questionning role identity; "Is this job for me?"; "Should I be myself or like my therapist or supervisor?"	6	20
Less anxious, more comfortable with patients and new role	4	13.33
<u>Changes Related to Therapy Technique</u>		
More aware of and trusting in one's own feelings instead of relying on intellectual defenses	10	33.33
Increased feeling of empathy and being "tuned-in"	10	33.33
Less pontifical, value oriented, and judgmental	5	16.33
Talk less, more articulate, clearer	2	6.67

[a]Exceeds 100% because of multiple classification
[b]Exceeds 66.67% because of multiple classification

atric resident said, "Doing therapy has been a deeply unsettling and confusing experience."

Half of the therapists made specific references to increments in self-confidence, self-acceptance, and acceptance of others.

In regard to changes related to their new role, 23.33% of the respondents stated that they had become increasingly impressed with the difficulty of the job. Twenty percent of the subjects related having difficulty in defining their roles as therapists. Several neophyte therapists were concerned with whether or not to continue in the field. More often the subjects reported that as a result of going through the experience of doing therapy, they were now freer to follow their own feelings and intuitions as opposed to relying on pat phrases and structures borrowed from their supervisors or private therapists.

In addition, several new therapists (13.33%) stated that they felt less anxious with patients and generally more comfortable with their new roles by the end of the year's experience.

Specific changes related to therapy techniques were reported by over a third of the experimental subjects. Ten of the respondents revealed that as a result of doing therapy they were now more aware of and trusting in their own "gut reactions;" whereas, initially, they had relied on intellectual "games" while working with patients.

A fair percentage of subjects (33.33%) mentioned feeling more empathic than before. One clinical psychology graduate student wrote, "I'm more able to 'hear' a patient now." Another psychology student related, "I became aware of my own pontifical approach." Altogether, 16.33% of the sample reported feeling less judgmental and value oriented.

Finally, 6.67% of the neophyte therapists mentioned that their communicative skills, in the context of a therapy session, had increased as a result of their doing psychotherapy.

CHAPTER IV

Discussion

Review of General Findings

The present study was undertaken to evaluate the effect of doing psychotherapy on the psychotherapist. Many theorists have postulated that the therapist is influenced by the therapeutic process as is the patient (English, 1968; Fromm-Reichmann, 1950; Lennard, 1962; Lennard & Bernstein, 1960; Rogers, 1961; Strupp & Bergin, 1969). However, to date, Strupp and Bergin (1969) note that little if any systematic investigation of this phenomenon has been reported in the literature.

The present investigation delineated three major areas of potential growth in the beginning psychotherapist that might have occurred as a result of transacting in the psychotherapeutic relationship. Hypothesized were increases in (I) three "central therapeutic ingredients," (II) role-related self-esteem, and (III) self/ideal congruence. All three major hypotheses were supported.

Hypothesis I. Increases in accurate empathy, nonpossessive warmth, and genuineness were obtained by novice psychotherapists; whereas no such significant gains were found in the control group. These findings, in general, are very much in keeping with those of Martin et al. (1968) who found that a program of didactic and experiential aspects of psychotherapy training can lead to significant improvement in interpersonal functioning. Similar findings were obtained by Berenson et al. (1966).

There are two principal differences, however, between the present

study and the two just cited. First, in this project, tape-recorded interviews from real ongoing therapy or intake interviews were obtained; whereas Berenson et al. (1966) and Martin et al. (1968) employed artificially programmed interviews with "mock" patients. The second major difference between this investigation and those by Truax' associates is that their experimental groups were not only familiarized with, but given intensive training with the scales upon which they were rated. The present experimental group was not at all aware of Truax' scales.

It is Truax and Carkhuff's (1967) contention that the scales are a useful technique in the training of good clinicians, the latter being defined by their scales; however, as stated, equivalent results were obtained without the use of the scales as a teaching device. This does not necessarily indicate that the experience of doing therapy by itself is as beneficial for clinical training as the combination of clinical experience and familiarization with the scales. As has been pointed out in the introductory chapter, most theorists and investigators feel that empathy, warmth, and genuineness are essential characteristics of a good clinician. It must be remembered that all the subjects had therapy supervisors. We may assume, therefore, that most of these supervisors hold similar views regarding the importance of these qualities in the developing psychotherapist. In light of this probability, it is conceivable that during the course of therapy supervision the values espoused by Truax and his associates (as well as a host of other people in the field) are transmitted by supervisors to their trainees, albeit in a less formalized manner than reported in the literature.

Pierce et al. (1967) showed that supervisors with greater degrees

of AE, NPW, and GEN produced trainees who demonstrated significant improvement in all conditions; whereas the trainees assigned to what were termed "low level functioning counselors" showed no significant changes.

Future research might be aimed at this problem, investigating the differences derived from ratings of AE, NPW, and GEN between one group of novice therapists who would have specific didactic training with the Truax scales plus the experience of doing therapy and a second group that would be matched except for the didactic experience.

Each of the three "central therapeutic ingredients" studied has been viewed separately by a wide variety of investigators (Strupp & Bergin, 1969). Unfortunately, there has been as wide a variety of definitions of these characteristics as there have been studies; and most of these studies have focused on therapy outcome for the patients. Thus it is difficult to relate the present findings (which deal with the development of these qualities in the therapist) to previous experiments involving empathy, warmth, and genuineness which relate to effectiveness of therapy.

Cartwright and Lerner's study (1963), even though concerned with outcome, permits some comparison. They found that inexperienced therapists tended to be more defensively distant from patients than did more experienced therapists. This finding can be viewed in terms of the present investigation. Apparently, experience in doing therapy allows the therapist to get closer to the similarities between himself and the patient. Thus he is, perhaps, able to be more accurately empathic, warmer in a nonpossessive mode, and less defensive (more genuine) as a result of practicing psychotherapy.

Barrett-Lennard (Truax & Carkhuff, 1967, p. 83) studied forty-two patients' perceptions of their therapists' levels of AE, NPW, and GEN. The outcome was that experienced therapists were perceived as offering significantly higher levels of empathy, warmth, and genuineness than less experienced therapists. Again, these findings can be viewed as related to the findings of the present investigation. In the present investigation, the assumption is that the therapeutic interaction is, in large part, responsible for the growth and development of empathy, warmth, and genuineness.

If we conclude, as do many investigators, that psychotherapy is indeed a transaction of mutual affect between patient and therapist, then the results of much therapy outcome research is given support by the findings herein. Especially relevant support is given to van der Veen's (1967) finding that therapist and patient influence each other's "therapeutic behavior." He defined the latter term in regard to "problem expression" and "experiencing" which is not too far removed from what are considered "therapeutic ingredients."

In addition, almost all patient outcome research, from Rogers' and Dymond's (1954) monumental work to the most recent collaboration of Strupp and Bergin (1969) has pointed to the growth of patients' empathy, warmth, and genuineness as a result of undergoing psychotherapy. It is, therefore, quite interesting to find that the other member of the therapeutic dyad--the therapist, should experience similar growth.

Hypothesis II. A gain in role-related self-esteem was observed in the experimental group; a matched control group showed no significant difference, over time, in ratings of themselves as clinicians. As was

stated previously, this major hypothesis is somewhat weakened by the finding that although significant movement in the hypothesized direction was observed, the difference from pre- to post-testing was not sufficient to significantly differentiate the experimental from the control group. The latter group also showed some increases in their feelings about themselves as clinicians, but the overall increase was not significant.

The findings just noted are not surprising when one examines the constellation of the experimental and control groups in accordance with the measure involved. Subjects of both groups were enrolled in clinical programs. It makes sense to assume that subjects from both groups increased their clinical knowledge and skills as a result of another academic year's training. Thus, one would expect both groups to show increases in their feelings of self-esteem as regards their newly acquired professional roles, which they do. However, only the experimental group changes significantly. One may reason that doing psychotherapy is the high point of a clinical trainee's experience, and the one that will demand the most of him. It is therefore reasonable to assume that an experience of this magnitude would give one a deeper feeling about himself and his accomplishments in his new role than any of the other aspects of a clinical training program.

As White (1960) points out, competence, in human beings, is achieved largely through learning, and contributes to our ever growing sense of self. In Erikson's (1956) terms, one's identity evolves out of a mutuality between the individual and his social environment. The therapeutic condition may be seen as a microcosm of the social environment; in this respect, both White's and Erikson's theoretical viewpoints

lend themselves to an understanding of the findings relative to Hypothesis II. The new therapist's interaction with the patient permits a mutual feedback system of adaptation and active molding of one another, which, in turn, leads to a greater sense of self-esteem. This appears to be so for the therapists investigated in this study. Strupp et al. (1964) point out that patients in psychotherapy, similarly, report increases in self-esteem based on their identifications with and interactions with their therapists.

The findings in relation to Hypothesis II are in accord with previous findings from studies of a similar nature. Holt and Luborsky (1958) reported that therapy supervisors found that the greatest movement in psychiatric residents was in the area of self-confidence as clinicians. Modlin et al. (1959) expressed like findings with psychiatric residents.

From a personal vantage point, Stein (1967) related that as a result of having gone through a clinical internship, he felt more self-confident and generally more capable as a therapist. He specifically relates these feelings to his growing ability to interact with patients. This view is validated by Fisher (1967) and Klagsbrun (1967) from their own personal experiences as developing psychotherapists.

The GCI as presented here is a new instrument. The framework of the device derives from Slagle's (1965) work with Daniel Miller on self-esteem. As Slagle and Miller define self-esteem it relates to different public roles. Therefore any attributes of a specific role felt to be desirable by significant members of a profession, club, etc. may be placed within the structure of the self-esteem inventory.

For purposes of the present investigation, highly desirable characteristics of a practicing clinician were culled from the literature (Holt & Luborsky, 1958; Kelly & Fiske, 1951; Shakow et al., 1947). These characteristics were then fit into the format of Slagle's inventory. The result is the author's inventory in regard to self-esteem as a practicing clinician.

The results of the present investigation suggest that this instrument is a useful one for the purpose stated and might be used in future psychotherapy research concerned with therapist variables. In addition, the inventory might be useful as a screening device in selecting candidates into clinical psychology or psychiatric residency programs.

<u>Hypothesis III</u>. Positive changes in self/ideal congruence were produced in the experimental group of neophyte therapists. The control group showed no significant change between their perceived self and valued self, from the initial to the later stage of training.

Hypothesis III gets its impetus from the major research project carried out under the leadership of Rogers and Dymond (1954). The difference between that project and the present investigation is primarily the point of concentration. Butler and Haigh (1954), who contributed to that major effort, concentrated on the changes in the relationship between self-concepts and ideal-self concepts of clients consequent upon client-centered psychotherapy; whereas this study is concerned with the effects of therapy on the therapists' self- and ideal-self concepts.

The similarity of findings between the two studies is astounding.

Butler and Haigh (1954), using the identical *Q* sort technique as employed in the present investigation, found that both their experimental (*n*=25), and control groups (*n*=16) exhibited significant individual differences at each point tested and that the degree of self/ideal congruence had a wide range in each group. Furthermore, they found that their client group showed a significant increase in self/ideal congruence, whereas no such increase was observed in an equivalent-control group, over time.

Butler and Haigh concluded that significant increases in the self/ideal correlations in the client group were consequent upon receiving counseling. The conclusion stated here is similar for the other member of the therapeutic dyad.

In the original Butler and Haigh study (1954), the experimental (client) group received an initial mean *z*, of self/ideal correlations, of zero, and a final stage mean of .33. Noticeably, these means are quite divergent from the comparable means in the present experimental group of .640 and .787, respectively. However, the initial mean of Butler and Haigh's control group, .66, very closely approximates the initial means found for both the experimental and control groups of the present investigation. These differences and similarities are understandable if the reader recalls that the Butler and Haigh control group was a non-patient sample who had volunteered to participate in "research on personality."

The differences between the experimental group of the 1954 study and the present experimental group may lead one to infer that the population of therapists is probably quite different from a patient popula-

tion but not so different from a non-patient lay population. In either case, whether patient or therapist, interaction in the therapeutic encounter seems to lead to an increase in self/ideal congruence although from somewhat different initial levels.

A group from the University of Chicago has since been involved in factor analyzing the 100 self-referent items which comprise the Q sort. Future systematic analyses of a similar nature might be aimed at delineating the factors involved in the growth and development of beginning psychotherapists.

Other investigators have used the self/ideal Q sort for measuring therapy outcome for patients and have obtained similar results to those reported. Lesser (1961) found the self/ideal Q sort to be an adequate instrument in differentiating measures of counseling progress. He also had counselors perform the Q sort tasks. Unfortunately, the counselors did only the initial stage task, so that no comparison to a later stage was made and hence no change measure was available.

One of the by-products of the present investigation was the finding that increased self/ideal congruence is more dependent on positive change in the self-concept than it is on change in the ideal-self concept. The above finding confirms the conclusions drawn by previous researchers. Lesser (1961) found that the difference between initial and final self correlations and initial and final ideal correlations differed significantly from zero; the same results are obtained in the present study. In addition, Lesser found that the self moved significantly (.01) more than the ideal-self from initial to final testing periods. Again, results from the present study confirm this

finding at the .001 level of significance.

Most recently, Truax et al. (1968) found that positive changes in self/ideal congruence were more related to positive changes in the self as opposed to the ideal-self in neurotics and juvenile delinquents. This was not so for psychotic patients.

From a purely personal basis, Klagsbrun (1967) stated that doing psychotherapy allowed him to come closer to his own image of a "proper" psychiatrist.

Review of Other Findings

Five potentially relevant variables were singled out for investigation of their possible effects on the major hypotheses.

Of particular importance is the variable of personal psychotherapy. The results suggest that there is a positive relationship between increases in self-esteem and self/ideal congruence, and involvement in personal psychotherapy. These findings seem perfectly in keeping with previous studies of therapy outcome which have already been mentioned, i.e. persons undergoing psychotherapy tend to increase their feelings of self-esteem and self/ideal congruence. There is no reason to assume that therapists in psychotherapy should display indices of outcome different from the lay public in therapy. This finding is especially significant in light of the ongoing controversy about the importance of personal therapy for practicing clinicians. Frieda Fromm-Reichmann (1950) has always been in the forefront of the argument for the need of personal psychotherapy. Findings from the present investigation suggest that there is an interaction effect between receiving psychotherapy and doing psychotherapy which enhances a novice therapist's

self-esteem as a therapist and his total personal self-concept. Future research might be directed toward exploring this interaction more directly and with more sophisticated methods of analysis, e.g. factor analyses of the statements comprising the _Q_ sort and the GCI.

Although the personal therapy variable seems to bear a relationship to Hypotheses II and III, it does not have a significant relationship to Hypothesis I. The reason for the latter findings may lie in the fact that accurate empathy, nonpossessive warmth, and genuineness are qualitatively different characteristics from the more global qualities of self-esteem and self/ideal congruence. Empathy, warmth, and genuineness, as defined by Truax (1967) are specific interactional _therapeutic techniques_ which may not change as a result of receiving therapy, but perhaps, may only be learned as a result of being in a specific role relationship and doing psychotherapy; that is, AE, NPW, and GEN, as defined, may be specific only to the therapist in the context of the therapeutic encounter. Van der Veen (1967) has shown that specific therapeutic behaviors, on the part of the therapist, are effected by patient-therapist interaction.

Here is a case in point in which the definitions of variables has been a hindrance in relating one piece of research to another. Previous investigators have employed a variety of definitions for empathy, warmth, and genuineness in a rather global manner; whereas, Truax has set down explicit stages of each variable as it operates in a therapy or counseling setting.

Another significant finding was that positive changes in self/ideal correlations are related to therapists' felt therapeutic success with a

patient. One may simply infer from this that as neophyte therapists felt more successful in their jobs, they consequently felt better about themselves.

Finally, a negative relationship was found between novice therapists' feelings of role-related self-esteem and their impression of their supervisors' levels of competence. It is not clear whether the inference drawn might be that as new therapists' feel better about themselves as clinicians, they tend to view their supervisors as less omnipotent and competent; or from the other side of the coin, novice therapists tend to over idealize their supervisors and, in contrast, see themselves as much less competent. From the qualitative data obtained, the former inference seems the more likely. Several respondents to the open-ended question regarding changes resulting from doing psychotherapy, stated that they felt they could be more themselves now, rather than imitations of their supervisors or own therapists.

The qualitative findings, in general, support the three major hypotheses, which, in turn, seem all to be related to each other. It is interesting to note that none of the respondents reported not having realized some changes, in some aspect of his behavior or personality, consequent upon practicing psychotherapy for the first time.

The three major hypotheses attempted to tap different aspects of a new therapist's make-up. The quantitative and qualitative findings suggest that as a result of doing psychotherapy, under supervision, positive changes ensue in relation to specific therapeutic techniques, feelings about one's new role as a psychotherapist, and feelings about

one's self on a more global level. Martin and Carkhuff (1968) similarly found that as a result of training with the Truax scales and having a therapy training experience, graduate students showed significant increases in central therapeutic ingredients, as well as more global personality changes as measured on the MMPI.

Limitations of the Present Study

Most of the data obtained in the present investigation came from self-reports. And despite the words of Allport (1953) and Murray (Wyatt, 1948) who say that psychology's forgotten instrument is the subject and his subjectively related experience, the conclusions drawn herein must be viewed with caution. The dangers in drawing too broad a conclusion are those inherent in all self-reports, primarily the problem of the social desirability factor.

Comparability to other studies is further hampered by the age-old problem of inconsistency in terminology from one study to another. All too often, the same measure is labelled differently from researcher to researcher, and similarly, different measures are called the same things.

As in the case of inconsistent definitions of measures , several of the relevant variables investigated might have been differently, or more rigidly, defined with possibly different results. For example, the variable of felt therapeutic success was a purely subjective statement on the part of the therapist-subject. Quite different results might have been forthcoming if somewhat more objective measures of patient progress were obtained. Another very important limitation with this variable, as with the diagnosis of the patient seen in conjunction with this study, is a very obvious one. Although only one patient's interviews were taped,

and responses from therapists were in terms of this particular patient, most neophyte therapists in the study saw more than that one patient. Thus, we cannot know what affect the interaction with other patients had on the novice therapists. Truax and Carkhuff (1967) maintain that different patients do not evoke different levels of central therapeutic ingredients from the same therapist. Nevertheless, the subject may have felt successful in working with the patient whose interviews were taped and less successful with others of his patients, or vice-versa. In this respect, we cannot be certain of the effect of this specific variable on the three major hypotheses.

In connection with the personal therapy variable, no distinction was made as to what kind of therapy the subject was in, whether it was analytic or Rogerian, or individual or group. Nor was there a distinction made between subjects who had been in therapy for seven years as opposed to those who had just begun. The only criterion used to qualify, in regard to this variable, was that the subject had been in therapy for the duration of the study. Thus, he may have begun the day before the initial period and terminated the day after the later stage.

Again, impressions of supervisors' warmth and competence were subjective judgments, by the therapist-subjects, with no stringent definitions attached.

As with any experiment employing a control group, we cannot be certain of the matching. In terms of age, intelligence, and occupation, the groups were well matched. On all of the measures obtained, except for accurate empathy, the groups were well matched prior to the introduction of the experimental variable. Be that as it may, the two groups

were at different levels of professional development, learning different skills. The control group conducted intake interviews, while the experimental group did therapy interviews. Truax and Carkhuff (1967) maintain that their scales are reliable and valid in intake interviews as well as counseling sessions; however, they do state that in intake interviews, nonpossessive warmth has been observed, at times, to vary from patient to patient. And whereas the experimental subjects saw the same patients at the initial and later stages, this was not true for the control group.

Finally, the size of the control group used might have been larger. Although other studies (Berenson et al., 1966; Butler & Haigh, 1954; Lesser, 1961; Martin & Carkhuff, 1968; Pierce et al., 1967; Truax et al., 1968; van der Veen, 1967) have used similar size, if not smaller, samples, it is felt that more conclusive results might have been forthcoming with the use of a larger control group. Since many variables operate within the therapeutic interaction, and since many of the present measuring devices and definitions might have been more precise, a large control sample would have added greatly to the confidence placed in the present results.

Implications for Future Research

Most research leads to further research and questions to be answered. One of the questions which this study, and several theorists raise, is, does one continue to grow in the areas measured? Fisher (1967), in an eloquent description of his own personal and professional development, maintains that a therapist shows ebbs and flows in certain person-

ality characteristics. Fisher suggests that we have a steady growth and development until the constant attack of patient problems, concurrent with our own, causes us to take pause and reevaluate our present condition.

Truax (Truax & Carkhuff, 1967) contends that his scales measure certain given abilities, which can develop with specific instruction; however, he does affirm that, at least with the quality of nonpossessive warmth, change is not likely. The present study, and others, shows Truax' statement not to be so. In any case, an important area of research might be the investigation of changes in personality characteristics of practicing psychotherapists at different chronological points in their professional lives. Admittedly, this is an extremely long term project. An alternative might be the comparison of novice therapists with more experienced therapists, and of course the appropriate controls. Studies of this nature have been done often in the past, but not to this investigator's knowledge with the focus on the personal characteristics of concern in this study.

Perhaps one of the most important implications of this research project has to do with the training and selection of psychotherapists in a clinical psychology or psychiatric residency program.

The relevancy of a psychotherapist's undergoing his own personal psychotherapy has emerged as an important variable. Frieda Fromm-Reichmann (1950) states that, in the end, the patient's self-understanding and respect are, in large part, contingent upon the therapist's self-understanding and respect for himself.

The need of personal psychotherapy, for a practicing clinician,

is given fairly strong support from the present findings. Future degree granting requirements might include personal psychotherapy as a prerequesite for the doctorate. Many schools have initiated the use of *T*-groups in order to meet this need. More systematic research is necessary to determine (*a*) if, indeed personal psychotherapy is beneficial to a practicing clinician, and if so, (*b*) at what point should it be introduced, and (*c*) what kind of psychotherapy is best suited to meet the needs of the individual and the profession.

One of the problems raised earlier involves the techniques of clinical training. Truax and his associates (Truax & Carkhuff, 1967) suggest that maximal output evolves from clinical experience and didactic familiarization with their scales. The research findings presented here suggest a more systematic approach to this problem is required. The suggestion has been made to compare groups with (1) therapy experience alone, (2) therapy and didactic experience together, and (3) no experience in the experimental variables at all. The findings of such an investigation may point out the better approach to training.

Since the Boulder Conference of 1949, clinical psychology has been concerned with future training needs; yet little systematic research has been conducted in this area. Recently, Plutchik et al. (1970) investigated some of the factors related to the selection of psychology interns. They found that many of the qualities measured in the present study were used as criteria for candidacy although they had not been previously formalized.

The members of the Concord Conference (NYSPA, 1969) questioned the relevance of GRE and MAT scores in selecting future clinical psy-

chologists. Perhaps some of the measures used in the present investigation, which tap interaction, and inter- and intra-personal phenomena, might supersede the more traditional academic methods involved in the selection of clinical psychology candidates or psychiatric residents. Two subjects were discarded from this study because they were asked to leave their respective programs. Only initial stage data were obtained from these two subjects. Both had initial stage self/ideal correlations which were skewed to the lower end of the range (.062, and .198, respectively). Thus, the possibility exists that some of the scales used in this study might not only be good teaching devices, but equally effective selective and predictive indices.

Finally, the present study points up the fact that psychotherapy is, indeed, an interactional process. However, it is not clear what factors in the interaction are responsible for change. Here is where a great deal more systematic research is needed. Perhaps, answers lie in future factor analytic studies of the more global aspects of personality and interaction studied herein.

Chapter V

Summary

This study was designed to explore the growth and development of beginning psychotherapists; in essence, it was an investigation of the effects on the psychotherapist, consequent upon his doing psychotherapy.

The major test procedures employed were (1) Truax' scales of therapists' accurate empathy, nonpossessive warmth, and genuineness, as gleaned from tape-recorded interviews, (2) the Good Clinician Inventory which measured the therapists' self-esteem as related to his professional role, and (3) *Q* sorts tapping self/ideal-concept congruence. Each procedure was individually administered to each subject during the first month of his new training (the initial stage), and again at the end of that academic year (the later stage); *t* tests and related nonparametric devices were computed to determine the significance of differences from initial to later stages of training within an experimental group of 30 subjects and within a control group of 13 subjects who conducted intake interviews as opposed to ongoing therapy interviews.

Variables such as (*a*) the therapists' own involvement or non-involvement in personal psychotherapy, (*b*) the diagnostice category of the patient seen in connection with this study, (*c*) the therapists' own sense of success or failure in their first therapeutic endeavors, (*d*) their own impression of their supervisors' warmth and competence, and (*e*) their own reports of felt changes resulting from doing psychotherapy, were related to changes observed on the measured characteris-

tics in the experimental group.

It was hypothesized that, as a result of doing psychotherapy, under supervision, increases would ensue in accurate empathy, nonpossessive warmth, and genuineness. In addition, it was hypothesized that role-related self-esteem, and self/ideal congruence would increase.

Increases in the hypothesized direction were found in all cases, i.e., significant increases were obtained for all conditions in the experimental group, whereas no such findings were found in the control group. And except for nonpossessive warmth, and role-related self-esteem, there were significant differences between groups at the later stage of training.

In addition to significant correlations between increases in self/ideal congruence of beginning psychotherapists and their felt therapeutic success, a significant negative relationship was found between feelings of self-esteem as a therapist and one's impression of his supervisor's competence.

Finally, involvement in personal psychotherapy was shown to be an important variable in relation to the growth and development of beginning psychotherapists.

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Appendix A

Scales of Empathy, Warmth, and Genuineness

A Tentative Scale for the Measurement of Accurate Empathy

Stage 1

Therapist seems completely unaware of even the most conspicuous of the client's feelings; his responses are not appropriate to the mood and content of the client's statements. There is no determinable quality of empathy, and hence no accuracy whatsoever. The therapist may be bored and disinterested or actively offering advice, but he is not communicating an awareness of the client's current feelings.

Stage 2

Therapist shows an almost negligible degree of accuracy in his responses, and that only toward the client's most obvious feelings. Any emotions which are not clearly defined he tends to ignore altogether. He may be correctly sensitive to obvious feelings and yet misunderstand much of what the client is really trying to say. By his response he may block off or may misdirect the patient. Stage 2 is distinguishable from Stage 3 in that the therapist ignores feelings rather than displaying an inability to understand them.

Stage 3

Therapist often responds accurately to client's more exposed feelings. He also displays concern for the deeper, more hidden feelings, which he seems to sense must be present, though he does not understand their nature or sense their meaning to the patient.

Appendix A cont.

Stage 4

Therapist usually responds accurately to the client's more obvious feelings and occasionally recognizes some that are less apparent. In the process of this tentative probing, however, he may misinterpret some present feelings and anticipate some which are not current. Sensitivity and awareness do exist in the therapist, but he is not entirely "with" the patient in the current situation or experience. The desire and effort to understand are both present, but his accuracy is low. This stage is distinguishable from Stage 3 in that the therapist does occasionally recognize less apparent feelings. He also may seem to have a theory about the patient and may even know how or why the patient feels a particular way, the therapist may be diagnostically accurate, but not empathically accurate in his sensitivity to the patient's current feelings.

Stage 5

Therapist accurately responds to all of the client's more readily discernible feelings. He also shows awareness of many less evident feelings and experiences, but he tends to be somewhat inaccurate in his understanding of these. However, when he does not understand completely, this lack of complete understanding is communicated without an anticipatory or jarring note. His misunderstandings are not disruptive by their tentative nature. Sometimes in Stage 5 the therapist simply communicates his awareness of the problem of understanding another person's inner world. This stage is the midpoint of the continuum of accurate empathy.

Appendix A cont.

Stage 6

Therapist recognizes most of the client's present feelings, including those which are not readily apparent. Although he understands their content, he sometimes tends to misjudge the intensity of these veiled feelings, so that his responses are not always accurately suited to the exact mood of the client. The therapist does deal directly with feelings the patient is currently experiencing although he may misjudge the intensity of those less apparent. Although sensing the feelings, he often is unable to communicate meaning to them. In contrast to Stage 7, the therapist's statements contain an almost static quality in the sense that he handles those feelings that the patient offers but does not bring new elements to life. He is "with" the client but doesn't encourage exploration. His manner of communicating his understanding is such that he makes of it a finished thing.

Stage 7

Therapist responds accurately to most of the client's present feelings and shows awareness of the precise intensity of most of the underlying emotions. However, his responses move only slightly beyond the client's own awareness, so that feelings may be present which neither the client nor therapist recognizes. The therapist initiates moves toward more emotionally laden material, and may communicate simply that he and the patient are moving towards more emotionally significant material. Stage 7 is distinguishable from Stage 6 in that often the therapist's response is a kind of precise pointing of the finger toward emotionally significant material.

Appendix A cont.

Stage 8

Therapist accurately interprets all the client's present, acknowledged feelings. He also uncovers the most deeply shrouded of the client's feelings, voicing meanings in the client's experience of which the client is scarcely aware. Since the therapist must necessarily utilize a method of trial and error in the new uncharted areas, there are minor flaws in the accuracy of his understanding, but these inaccuracies are held tentatively. With sensitivity and accuracy he moves into feelings and experiences that the client has only hinted at. The therapist offers specific explanations or additions to the patient's understanding so that underlying emotions are both pointed out and specifically talked about. The content that comes to life may be new but it is not alien.

Although the therapist in Stage 8 makes mistakes, these mistakes are not jarring, because they are covered by the tentative character of the response. Also, this therapist is sensitive to his mistakes and quickly changes his response in mid-stream, indicating that he has recognized what is being talked about and what the patient is seeking in his own explorations. The therapist reflects a togetherness with the patient in tentative trial and error exploration. His voice tone reflects the seriousness and depth of his empathic grasp.

Stage 9

The therapist in this stage unerringly responds to the client's full range of feelings in their exact intensity. Without hesitation, he recognizes each emotional nuance and communicates an understanding of

Appendix A cont.

every deepest feeling. He is completely attuned to the client's shifting emotional content; he senses each of the client's feelings and reflects them in his words and voice. With sensitive accuracy, he expands the client's hints into a full-scale (though tentative) elaboration of feeling or experience. He shows precision both in understanding and in communication of this understanding, and expresses and experiences them without hesitancy.

A Tentative Scale for the Measurement of Nonpossessive Warmth

Stage 1

The therapist is actively offering advice or giving clear negative regard. He may be telling the patient what would be "best for him," or in other ways actively approving or disapproving his behavior. The therapist's actions make himself the locus of evaluation; he sees himself as responsible for the patient.

Stage 2

The therapist responds mechanically to the client, indicating little positive regard and hence little nonpossessive warmth. He may ignore the patient or his feelings or display a lack of concern or interest. The therapist ignores client at times when a nonpossessively warm response would be expected; he shows a complete passivity that communicates almost unconditional lack of regard.

Stage 3

The therapist indicates a positive caring for the patient or

Appendix A cont.

client, but it is a <u>semipossessive</u> caring in the sense that he communicates to the client that his behavior matters to him. That is, the therapist communicates such things as "It is not all right if you act immorally," "I want you to get along at work," or "It's important to me that you get along with the ward staff." The therapist sees himself as <u>responsible for</u> the client.

<u>Stage 4</u>

The therapist clearly communicates a very deep interest and concern for the welfare of the patient, showing a nonevaluative and unconditional warmth in almost all areas of functioning. Although there remains some conditionality in the more personal and private areas, the patient is given freedom to be himself and to be liked as himself. There is little evaluation of thought and behaviors. In deeply personal areas, however, the therapist may be conditional and communicate the idea that the client may act in any way he wishes--<u>except</u> that it is important to the therapist that he be more mature or not regress in therapy or accept and like the therapist. In all other areas, however, nonpossessive warmth is communicated. The therapist sees himself as <u>responsible to</u> the client.

<u>Stage 5</u>

At Stage 5, the therapist communicates warmth without restriction. There is a deep respect for the patient's worth as a person and his rights as a free individual. At this level the patient is free to be himself even if this means that he is regressing, being defensive, or

Appendix A cont.

even disliking or rejecting the therapist himself. At this stage the therapist cares deeply for the patient as a person, but it does not matter to him how the patient chooses to behave. He genuinely cares for and deeply prizes the patient for his human potentials, apart from evaluations of his behavior or his thoughts. He is willing to share equally the patient's joys and aspirations or depressions and failures. The only channeling by the therapist may be the demand that the patient communicate personally relevant material.

A Tentative Scale for the Measurement of Therapist Genuineness or Self-Congruence

Stage 1

The therapist is clearly defensive in the interaction, and there is explicit evidence of a very considerable discrepancy between what he says and what he experiences. There may be striking contradictions in the therapist's statements, the content of his verbalizations may contradict the voice qualities of nonverbal cues (i.e., the upset therapist stating in a strained voice that he is "not bothered at all" by the patient's anger).

Stage 2

The therapist responds appropriately but in a professional rather than a personal manner, giving the impression that his responses are said because they sound good from a distance but do not express what he really feels or means. There is a somewhat contrived or rehearsed quality or air of professionalism present.

Appendix A cont.

Stage 3

The therapist is implicitly either defensive or professional, although there is no explicit evidence.

Stage 4

There is neither implicit nor explicit evidence of defensiveness or the presence of a facade. The therapist shows no self-incongruence.

Stage 5

The therapist is freely and deeply himself in the relationship. He is open to experiences and feelings of all types--both pleasant and hurtful--without traces of defensiveness or retreat into professionalism. Although there may be contradictory feelings, these are accepted and recognized. The therapist is clearly being himself in all of his responses, whether they are personally meaningful or trite. At State 5 the therapist need not express personal feelings, but whether he is giving advice, reflecting, interpreting, or sharing experiences, it is clear that he is being very much himself, so that his verbalization match his inner experiences.

Note.--An even more detailed explanation and presentation of the three scales with accompanying examples may be found in Truax and Carkhuff (1967, Pp. 43-73).

Appendix B

G. C. Inventory

Name______________________ Institution____________________

Date_____________

Directions: Below is a sample of a trait and its associated scale as they appear in this form. On each scale you are asked to compare yourself to other mental health professionals and to make four (4) judgments. For each trait make a complete set of four judgments before moving on to the next trait.

How punctual a person is in meeting his obligations and appointments.

High |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| Low

On time Late

First, put an "X" in that segment of the scale which indicates the degree of the trait which you feel is characteristic of you. For example, if you think you are average in punctuality, mark the scale somewhere toward the middle. See the example below.

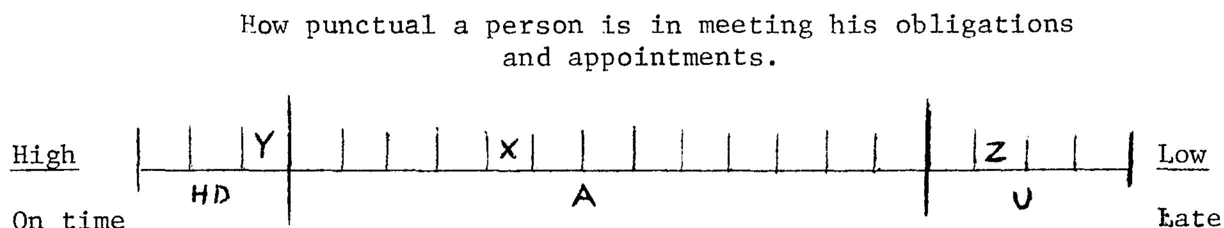
Second, put a "Y" in that segment of the scale which represents the level you hope to attain; the point you feel you should strive to attain and have a realistic chance of reaching. For example, if you feel that you should strive to be a little more punctual and that this is a realistic goal, show how much by the number of segments you shift from "X" to "Y." See the example below.

Appendix B cont.

Third, put a "Z" in the segment of the scale that describes you when you are having a bad day; the point that indicates your poorest performance on that trait. For example, if you feel that you are sometimes less punctual than indicated by your placement of "X," show how much by the size of your shift from "X" to "Z." See the example below.

Fourth, various parts of a scale obviously differ in desirability. Scales can be divided into highly desired, acceptable, and undesirable ranges. Divide each scale into ranges by drawing vertical lines through the scale to delimit each range. Label the highly desired range, HD, the acceptable range, A, and the undesired range, U. For example, if you consider being "On time" highly desired, and being "Late" undesired, you might mark the scale in some manner such as the following:

How punctual a person is in meeting his obligations and appointments.



Consider another example. For a trait like courage, you may think it undesirable to be very high or low and highly desirable to have an average amount. This is true if you think very low courage is cowardly and very high courage is foolhardy. A moderate amount of courage might be considered to be indicative of bravery or heroism. If the aforegoing describes your conception of courage, you might divide the scale in this way.

Appendix B cont.

How courageous a person is.

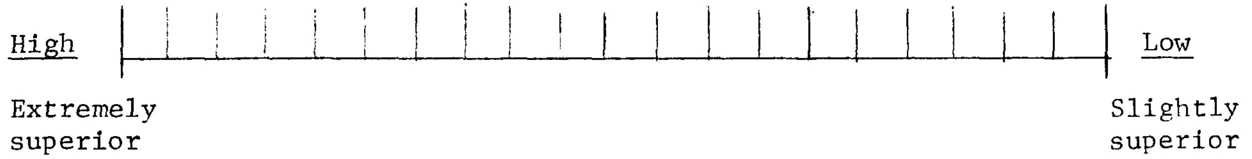
High	U	A	HD	A	U	Low
Foolhardy						Cowardly

The discussions of PUNCTUALITY and COURAGE have been intended to familiarize you with the scales and their use. The locations and divisions of traits in the examples may be similar to or unlike your picture of the traits you consider in the remainder of this booklet. The X's, Y's, and Z's may be located at any point on the scale and may fall within any of the ranges. Try to select the locations and divisions of lines that depict most accurately your actual conceptions of the traits.

Now, turn the page and begin. Remember that there are four (4) judgments to make for each trait before you move on to the next trait.

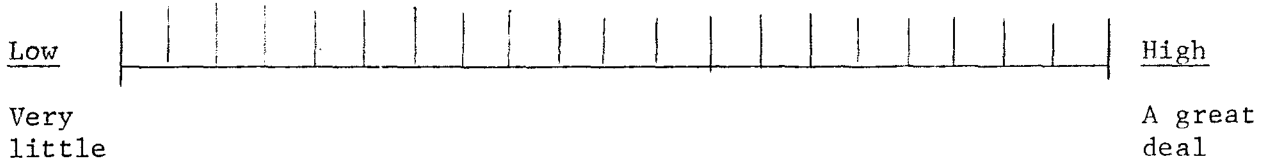
Appendix B cont.

How superior a therapist's intellectual abilities are.

High  Low

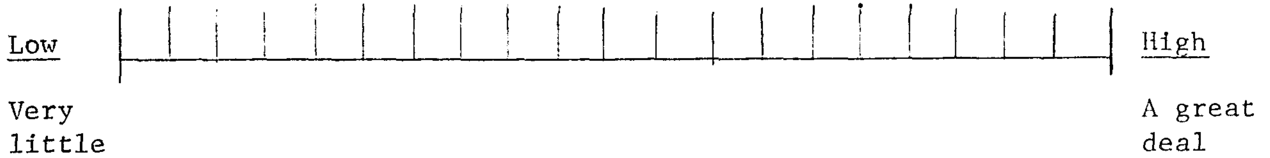
Extremely superior — Slightly superior

How original, resourceful and versatile a therapist is.

Low  High

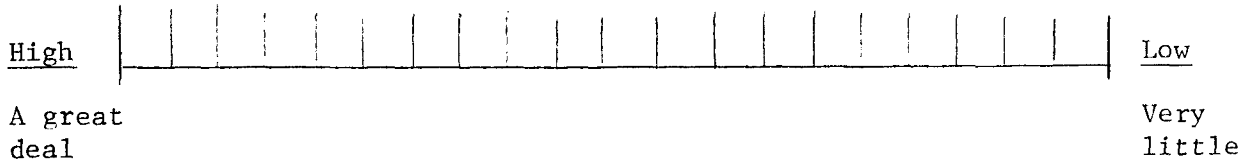
Very little — A great deal

How much "fresh and insatiable" curiosity a therapist has; how much of a "self-learner" he is.

Low  High

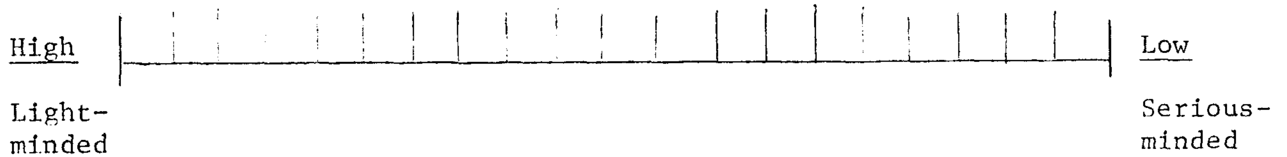
Very little — A great deal

How much insight a therapist has into his own personality characteristics.

High  Low

A great deal — Very little

How much of a sense of humor a therapist has.

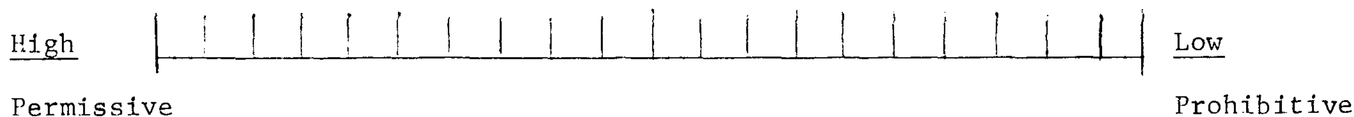
High  Low

Light-minded — Serious-minded

Appendix B cont.

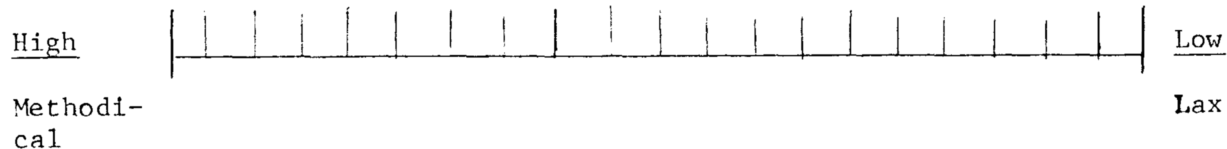
How sensitive a therapist is to the complexities of motivation.

How much tolerance a therapist has.

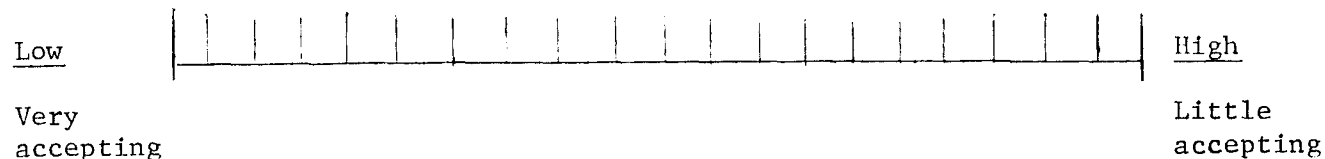


How able a therapist is to establish warm and effective relationships with others.

How industrious and methodical a therapist's work habits are.



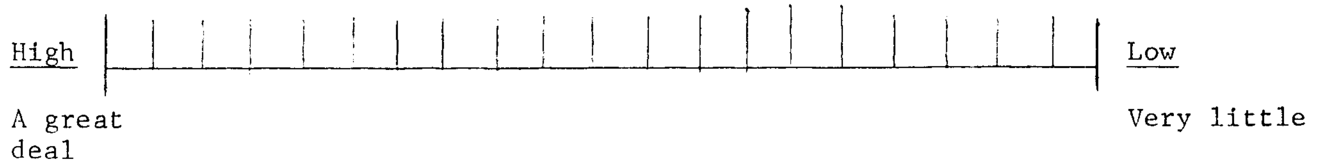
How accepting of responsibility a therapist is.



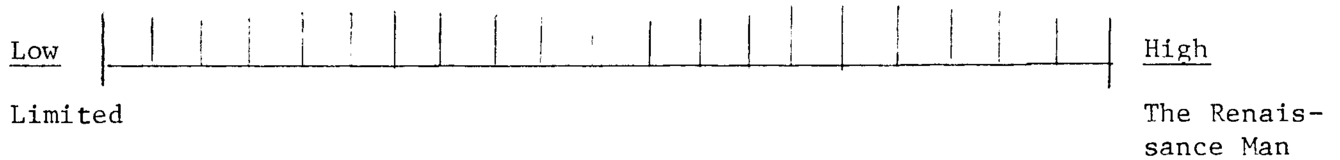
Appendix B cont.

How tactful and cooperative a therapist is.

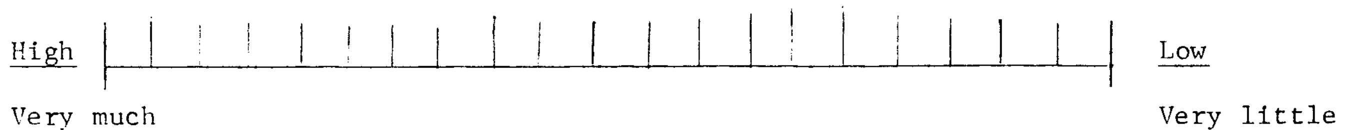
How much self-control and stability a therapist has.



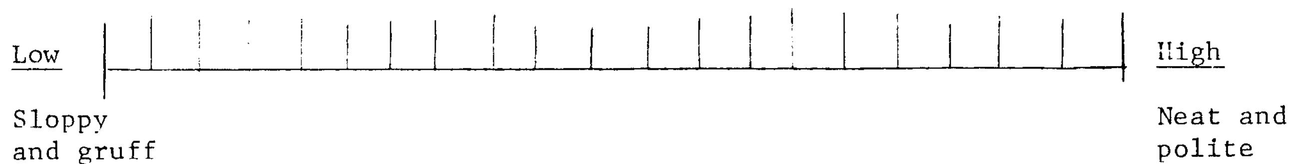
How broad a therapist's cultural background is.



How able a therapist is to tolerate pressure.



How a therapist's general appearance and manner are.



Appendix C

100 Self-Referent Statements from the Butler-Haigh Q Sort

1. I feel uncomfortable while talking with someone.
2. I put on a false front.
3. I am a competitive person.
4. I make strong demands on myself.
5. I often kick myself for the things I do.
6. I often feel humiliated.
7. I doubt my sexual powers.
8. I am much like the opposite sex.
9. I have a warm emotional relationship with others.
10. I am an aloof reserved person.
11. I am responsible for my troubles.
12. I am a responsible person.
13. I have a feeling of hopelessness.
14. I live largely by other people's values and standards.
15. I can accept most social values and standards.
16. I have few values and standards of my own.
17. I have a hard time controlling my sexual desires.
18. It's difficult to control my aggression.
19. Self-control is no problem to me.
20. I am often down in the dumps.
21. I am really self-centered.
22. I usually like people.
23. I express my emotions freely.
24. usually in a mob of people I feel a little bit alone.
25. I want to give up trying to cope with the world.

Appendix C cont.

26. I can live comfortable with the people around me.

27. My hardest battles are with myself.

28. I tend to be on my guard with people who are somewhat more friendly than I had expected.

29. I am optimistic.

30. I am just sort of stubborn.

31. I am critical of people.

32. I usually feel driven.

33. I am liked by most people who know me.

34. I have an underlying feeling that I'm not contributing enough to life.

35. I am sexually attractive.

36. I feel helpless.

37. I can usually make up my mind and stick to it.

38. My decisions are not my own.

39. I often feel guilty.

40. I am a hostile person.

41. I am contented.

42. I am disorganized.

43. I feel apathetic.

44. I am poised.

45. I just have to drive myself to get things done.

46. I often feel resentful.

47. I am impulsive.

48. It's important for me to know how I seem to others.

49. I don't trust my emotions.

50. It is pretty tough to be me.

Appendix C cont.

51. I am a rational person.
52. I have the feeling I'm just not facing things.
53. I am tolerant.
54. I try not to think about my problems.
55. I have an attractive personality.
56. I am shy.
57. I need somebody else to push me through on things.
58. I feel inferior.
59. I am no one. Nothing really seems to be me.
60. I am afraid of what other people think about me.
61. I am ambitious.
62. I despise myself.
63. I have initiative.
64. I shrink from facing a crisis or difficulty.
65. I just don't respect myself.
66. I am a dominant person.
67. I take a positive attitude toward myself.
68. I am assertive.
69. I am afraid of a full-fledged disagreement with a person.
70. I can't seem to make up my mind one way or another.
71. I am confused.
72. I am satisfied with myself.
73. I am a failure.
74. I am likeable.
75. My personality is attractive to the opposite sex.

Appendix C cont.

76. I am afraid of sex.
77. I have a horror of failing in anything I want to accomplish.
78. I feel relaxed and nothing really bothers me.
79. I am a hard worker.
80. I feel emotionally mature.
81. I am not accomplishing.
82. I am naturally nervous.
83. I really am disturbed.
84. All you have to do is just insist with me and I give in.
85. I feel insecure within myself.
86. I have to protect myself with excuses, with rationalizing.
87. I am a submissive person.
88. I am intelligent.
89. I feel superior.
90. I feel hopeless.
91. I am self-reliant.
92. I often feel aggressive.
93. I am inhibited.
94. I am different from others.
95. I am unreliable.
96. I understand myself.
97. I am a good mixer.
98. I feel adequate.
99. I am worthless.
100. I dislike my own sexuality.

Appendix D

Self-Report Questionnaire

Name (Code)________________________ Date____________

Institution________________________ Patient's Diagnosis____________________

1. Are you now receiving, or have you ever received your own personal psychotherapy? (Check one).

   Yes_______ No_______

   If you answered "Yes," please note the following:

   a) When did you begin your own therapy? ________/________ (month / year)

   b) When did you terminate, or ________/________ (month / year)

   Are you still going? (Check one). Yes_______ No_______

   If you answered "No" to question #1, please note the following:

   a) Do you intend beginning personal therapy? (Check one).

   Yes_______ No_______ Undecided_______

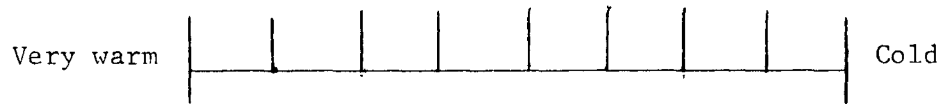
2. With regard to the patient you saw, whose sessions were tape recorded for this research, please place a check (✓) mark on that part of the scale below which best describes your response to the following question:

   "I feel that the general therapeutic progress of this patient has been..."

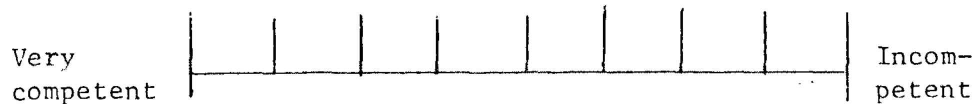
   Excellent |___|___|___|___|___|___|___|___| Very poor

Appendix D cont.

3. How warm you feel your therapy supervisor is.



4. How competent you feel your therapy supervisor is.



5. "Describe the most important changes, if any, internal as well as external, that you have experienced as a result of doing psychotherapy. Try to list in order of importance and be as specific as possible. Also try to discuss any critical incidents which you feel had a great impact on you." (In answering this question, please feel free to use as much of the paper provided as you want.)

Note: Please be assured that all your responses are confidential and will be seen only by blind raters unattached to your institution.