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FACTORS BEARING ON ROLE DEFINITION AND DILEMMAS OF THERAPISTS IN TRAINING

City University of New York PH.D. 1979

FACTORS BEARING ON ROLE DEFINITION AND DILEMMAS OF THERAPISTS IN TRAINING

by

JUDITH SCHWEIGER LEVY

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To My Parents

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CHAPTER 1

INTRODUCTION

The practice of psychotherapy makes unique demands upon, and offers unique rewards to its practitioners. It is perhaps the only kind of work in which ones "self" or "person" is used exclusively as a tool in which to effect change, and it entails as part of its very nature, an involvement with the most profound existential and philosophical issues. If doing psychotherapy is "the vocation of being human" (Burton 1972, page 318), then the interface between the personal and professional development of the therapist is highly significant. The importance of how the exigencies of the therapist's outer and inner life affect his work has been readily acknowledged in the literature; however, there has been much less focus on how the therapist's work affects his personal life, and thereby reaffects the quality of his work. Within recent years there has been increasing recognition of the importance of investigating the effect that doing psychotherapy has on the therapist's behavior, and of understanding the personal vicissitudes involved in <u>being</u> a psychotherapist (Bergin & Strupp, 1972; Burton, 1972; Roeback, Webersinn & Guion, 1971). Equally as important is an understanding of the processes involved in <u>becoming</u> a psychotherapist and learning to do therapeutic work. What is the novice's subjective experience of becoming a therapist? What are the strains and stresses involved in taking up the therapeutic role? How does the novice come, slowly and by degrees, to experience and to use himself authentically as a psychotherapist? While there are

problems that are particular to the therapeutic role and to the doing of therapeutic work, there is also a set of difficulties and dilemmas which are specifically related to the beginning stages of being a psychotherapist.

Practically everything written about the problems and dilemmas associated with therapeutic training, has been written about the resident psychiatrist. There often appears to be an assumption that what holds true for the psychiatrist also holds true for the other primary professions in which psychotherapy is a major area of training: psychology and social work. Henry, Simms, and Spray's (1971) study of various demographic similarities among therapists of different primary professions would appear to support this presumption. (The "typical" therapist is white, Jewish, middle class and male.) However, the fact that therapists from differing primary professions may share certain personal and social characteristics does not necessarily mean that they experience the same quality or degree of difficulty in their training. Eckstein and Wallerstein (1953) note that "...elaboration of the specific problems related to their more primary professional identification, which people have in acquiring their additional professional identity as psychotherapists, might give us some better understanding of the special training problems involved" (p. 67). While in fact it is quite probable that many of the problems attributed to psychiatrists in training are generalizable to the other professions, it seemed of potential value to examine the kinds of stresses encountered by psychologists training to be therapists, as well as their attitudes about the roles which they

are in the process of acquiring, since there has been a dearth of research in this area. In addition, little work has been done on examining how demographic differences (i.e. personal and social characteristics of the individual) as well as how aspects of the training experience itself, relate to beginning therapists' attitudes regarding their training and work. It is also noteworthy that in general, what has been written about the training experience, has been anecdotally written by more experienced therapists or supervisors based on their retrospective accounts of their own training, or based on their observations and perceptions of how trainees deal with taking up the role of therapist. Few, if any studies have attempted to ascertain directly from therapists in training, and psychologists in particular, how they experience the process and problems associated with becoming a psychotherapist. It was in response to this lack of information that the present study was designed.

CHAPTER II

REVIEW OF THE LITERATURE

The following material which deals with the experiences and dilemmas of beginning therapists, reflects the focus in the literature on psychiatric residents. Speculations about how and to what extent these experiences may or may not apply to psychologists will be presented in context.

The stresses and tensions related to training to be a therapist have been described as resulting in a constellation of symptoms and behaviors on the part of residents referred to as the "Beginning Psychiatry Training Syndrome" (Merklin & Little, 1967; Waring, 1975). According to Merklin & Little, development of this syndrome is essential to the making of a therapist. Ekstein & Wallerstein (1958) also concur that some of the symptoms described as part of this syndrome, particularly anxiety, are necessary for professional development. According to Merklin & Little, the syndrome consists of three stages: the prodrome phase appears as a change in the resident's attitudes towards his patients, peers, and instructors. He may exhibit signs of withdrawal, spend an excessive amount of time with paperwork, and evidence signs of dependence on his instructor; in the reaction phase the resident exhibits symptoms of depression, anxiety, or psychosomatic disorders, and secondary symptoms such as anorexia, insomnia, excessive fears, fatigue, indecision, inability to concentrate, irritability, and exaggerated masochistic attitudes or behavior; in the resolution phase the resident takes on a new interest in his patients and is better able to

handle patient pathology and his own weaknesses.

The stresses and dilemmas of the novice which may lead to this syndrome revolve around several overlapping areas: the development of a professional identity as a psychotherapist, the development of psychological mindedness, the loss of a valued model, dilemmas concerning the treatment process, stresses of supervision, and institutional stresses related to the beginner's student status. While these areas will be presented separately, it should be remembered that they are all interrelated.

Development of Professional Identity as a Psychotherapist

Taking on the name "psychotherapist" means having to come to terms with societal, professional, and personal attitudes and prejudices concerning the role. Ekstein & Wallerstein (1958) have remarked on the ambivalent attitude toward psychotherapy which exists in the general public and in somatic medicine and non-clinical psychology. While magical expectations exist as to the miracles of therapeutic cure, disappointment is often severe when therapy does not turn out to be the panacea for mental disturbances which is hoped for. The general public's attitudes towards therapists vacillate between awe and envy in which therapists are viewed as omnipotent mind readers who are the "authorities" and healers expected to impart beneficial information to mankind, and suspicion, fear and distrust in which therapists are pictured as bungling or even malevolent "head shrinkers" who may suffer from even worse pathology than those they attempt to treat. (Daniels, 1974; Fisher, 1967; Marmor, 1953). Taking on a role in which one is viewed

as either omnipotent or impotent by society, a role in which one's humanness is at one moment extolled and at an other denied, is difficult, and exacerabates the beginner's inner doubts.

Ekstein & Wallerstein (1958) remark that many members of the medical profession view psychiatric work as smacking of the "machinations of the charlatans" (p. 69), because it is considered to be unscientific. This criticism occurs for clinical psychologists as well, who are often chided by other psychologists for the qualitative, non-empirical nature of their insights.

The taking on of the therapeutic role also has important implications for the individual's relationship with family and friends. Besides having prejudices of their own, close relations may react negatively to the beginner's new ways of viewing things, and may become threatened by his commitment to and involvement with various aspects of treatment and training (Hallack & Woods, 1962; Seashore, 1975). According to Seashore (1975) close relations of the beginning therapist are faced with the often disconcerting notion that they too will have to grow and change, and often perceive the training program as a "lover" who has stolen the "dear one" away. The beginner must learn to divide his energies between demands of family and friends, and demands of his training, often, not an easy job.

According to Ekstein & Wallerstein (1958), clinical psychologists who are therapists face an additional problem not encountered by psychiatrists. While resident psychiatrists are readily able to accept their therapeutic work as part of a long healing tradition stemming from the

Hippocratic Oath, clinical psychologists often experience themselves in the position of Prometheus, who stole the sacred fire from the Gods. Having to fight for the right to do psychotherapy creates feelings of doing something heroic, albeit wrong, and a climate of second rate status for many clinical psychologists. Thus the development of professional identity as a therapist for psychologists as a group, seems to have attendent with it, even if covertly, a basic assumption of "fight-flight" (Bion 1959).

Another difficulty which beginning therapists who are psychologists have, at least more overtly than psychiatrists, involves the issue of lack of credentials. The pre-doctoral beginner's anxieties about his competence and lack of experience is often exacerbated by his not having his Ph.D. and hence the title "doctor" (Ekstein & Wallerstein, 1958; Rioch, 1976). Obviously, residents in training are already doctors and do not have this additional worry. Taking on the status of doctor in relation to one's colleagues and patients may be comforting for the resident, even if the comfort is temporary. In addition, residents are often more decisive and authoritative in their approach to patient problems, and because of their previous medical training, more easily assume therapeutic responsibility. It seems likely that psychologists are initially more timid in their therapeutic work, especially with regard to situations in which quick decisions are necessary (Brody, 1956, Ekstein & Wallerstein, 1958).

The above issue is related to the more general dilemma encountered by many therapists, in acknowledging and exercising their authority

which is attached to the position of therapist. Marmor (1953) views therapy as "the constant exercise of authority (p. 370)." Newton (1973) defines this authority as necessarily including both managerial and helping functions, and views the therapists legitimate exercise of authority and the patients' reactions to it as a crucial part of the work. He sees the beginning therapist in particular as having difficulty exercising authority. Rather than feeling comfortable with both managing and helping, the beginner may attempt to engage purely in helping without taking the responsibility for making decisions about how the therapy and the transactions involved in it (e.g.times, payments) will be organized, or for defining for the patient his part in the work. As stated earlier, this may be more problematic for psychology students who, unlike residents, generally have not previously been in positions with the extent of authority given to physicians.

The Development of Psychological Mindedness

Several writers have compared the process of becoming a therapist to the process of growth which occurs in the patient in psychotherapy (Ekstein & Wallerstein, 1958; Ford, 1963; Seashore, 1975). A giving up of many conventional ways of seeing things and an appreciation of the complexities of behavior are inherent in each. According to Rioch et al. (1975) beginners must learn to "be willing to do the most arduous of all psychological work--to face unpleasantness, evil, and even terror as part and parcel of their own make-up (p. 3)." According to Sharaf and Levinson (1964) the development of psychological mindedness for the resident involves the following: grasping and accepting patients'

emotions and understanding their motives, defenses, and fantasies, while at the same time being aware of one's own wishes and feelings and how they interact with one's effectiveness as a therapist. The learning of psychotherapy is thus extremely problematic because it entails a "transformation of the self"...involving "a long and intricate journey that exacts a considerable price in terms of time, effort and pain (p. 138)."

Kubie (1971) remarks that residents must contend with their own fear of, and anger at mental illness, and by virtue of treating someone else are forced to examine in themselves the same issues they are dealing with in their patients. While the resulting self awareness the beginner may attain is a positive goal which may enhance his therapeutic flexibility, the process of achieving this goal can be confusing and frightening since the novice may begin to question his ability, and his right to treat patients whose problems often do not seem to be too much different from his own (Book, 1973; Ekstein & Wallerstein, 1958; Halleck & Woods, 1962; Merklin & Little, 1967). Further, he may begin to so overidentify with his patients' problems, or with the disturbances he reads about in the literature, that he may begin to doubt his own sanity, forgetting the real differences between himself and his patients, and the "ego strength" it took for him to become a psychiatric resident (Ekstein & Wallerstein, 1958). Donner & Schonfield (1975) attempted to measure the impact of patients' feelings on the beginner. They concluded that the patient's feelings are contagious and that the beginner is likely to be influenced by them.

What makes the initial encounters with mental disturbance for the resident even more problematic is the lack of clear cut and objective

"litmus tests" for mental illness, so that the uncertainty about ones own and others' sanity remains (Merklin & Little, 1967). Not only does this lack of certainty increase self doubt, but it makes having to make decisions unsettling, since there is some degree of risk involved in each decision. Dealing with a body of material in which there are no "definites" increases anxiety. Lakovics (1976) concluded from his own psychiatric training, that recognition that therapy and being a therapist must entail ambiguity is the most important lesson for the novice.

Berger & Freeburg (1973) describe how as part of the process of becoming a therapist, the resident vacillates between his curiosity about the nature of the individual, and his need to defend against issues which may be emotionally overwhelming. His treatment and learning periodically switch back and forth between the two poles of over-identifying with a patient, and being overly distant with a patient. Kubie (1971) remarks that the pain of therapeutic involvement often causes residents to want to retreat. This retreat, distancing, and denial may become severe enough to become an impediment to further learning (Merklin & Little, 1967).

One of the ironies related to the development of psychological mindedness is that the beginning therapist may feel called upon to demonstrate his competence and confidence in himself and his decisions just at the point in which he feels himself to be most confused, conflicted, and vulnerable (Seashore, 1975). Klagsbrun (1967) remarked that one of the major dilemmas of his training involved struggling through his frustrations and doubts in an attempt to maintain integrity, insight, and

perspective at a time when he felt these qualities were at a premium. Rioch et al.(1976) also discuss the pressure upon the novice to appear to be in command of various situations, despite his inner confusion. They believe that "there is an unspoken demand on students to act as if they were wise men who have found the truth, when in fact they are searching in the wilderness for small glimmers of light (p. 229)."

It appears that for the resident it is the sudden impact of being faced with one's own and other's psychodynamics which creates so much anxiety. Often the strains involved in the development of psychological mindedness induce the resident to enter treatment of his own, so that he can better understand and deal with his inner life. Clearly, psychological mindedness is not such a problem in those who are already in their own personal therapy because they are used to an introspective style of thinking, and because they have a place to bring their concern about the ambiguities of their work. Henry, Simms, & Spray (1971) surveyed over 4,000 therapists across the country, representing the four primary professions of psychiatry, psychoanalysis, social work, and psychology, on their personal and work lives. They report that personal therapy is an important mechanism of socialization in all four mental health professions. One of their findings was that of the three professional groups—social work, psychology, and psychiatry—clinical psychologists were the most likely to have undergone personal therapy. Clinical psychologists had the highest proportion (75%) of practitioners receiving therapy of the three groups. Psychiatrists had a proportion of 66% and social workers had a proportion of 64%. Further, psychiatrists not

only were less likely than other mental health professionals to enter therapy, but also more likely to allow it to be interrupted. Henry et al. explain these differences as consistent with the different emphasis placed on a psychodynamic perspective in the training of the different professional groups. They state that clinical psychology is closer to psychoanalysis than is psychiatry in terms of its emphasis on unconscious forces in the individual, while this emphasis is tempered in psychiatry by the medical-biological model. Undergoing psychotherapy thus may seem less relevant to psychiatrists who balance their "psychological mindedness" against the weight of the medical model. It is questionable whether the anxieties about psychological mindedness which are experienced by residents, are experienced to anywhere near the same degree by psychologists who are training to be therapists. It would appear that the development of psychological mindedness is more gradually developed in psychologists, who have contact with a much smaller number of patients during their graduate training than do residents, and therefore do not experience being "imploded" by psychopathology to the extent that residents do. It is also likely that predoctoral clinical psychologists in training are more psychologically sophisticated than beginning residents because they are more likely to be in their own treatment, either for personal or professional reasons.

Loss of a Valued Model

The limitations of the applicability of the medical model in engaging in psychotherapy is a hard lesson for the resident to learn. Having

to switch from a model where there are tangible, definite relationships between symptoms, diseases, and treatment, where a patient is cured by having things done to him, to a model in which talking is the modality for change, and in which "cure" itself is not very clear cut, is quite disconcerting (Sharaf & Levinson, 1964). In addition, according to Lakovics (1976), in medicine one knows when one is doing something wrong, while in therapy this can be quite unclear. This leads to a dilemma for the resident in terms of figuring out exactly how he should behave with patients, and on a broader scale, what the psychotherapeutic role as compared to the medical role is all about. Book (1973) discusses how the medical model relies on, and can activate various defense mechanisms such as intellectualization and isolation to keep in check the physician's feelings of fear, anxiety, disgust, and lust concerning his patients. The resident, trained under this model in which he has learned to keep a personal distance from his patients, may be overwhelmed at the unique personal and emotional demands made by psychotherapeutic work, and may retreat back to the medical model when he experiences these new emotional demands as too heavy. In addition, Book notes that the loss and partial giving up of the medical model involves a mourning process which will inevitably result in the resident's feeling depressed, angry and helpless. This sense of helplessness and anger is exacerbated by the fact that the resident feels that his medical training has ill prepared him for his psychiatric responsibilities. Although he may have the status of being the doctor, the kind of skills and the knowledge he has learned in the past do not seem relevant to the therapeutic work he is doing, and so he

finds he cannot lean on his previous training for support. His feeling of competence, developed during his medical training, is therefore threatened (Halleck & Woods, 1962; Sharaf & Levinson, 1964).

It seems then, that the essential dilemma for the resident involves having to replace a model and a way of thinking where there are a set of externally provided, concrete solutions for various problems which one applies logically and consistently, for a way of thinking which is much more internally generated, intuitive, and emotionally directed, and which necessarily entails a greater degree of paradox and inconsistency.

It is easy to assume that beginning psychologists, who are not trained under the medical model do not have the above kind of problems. However, it may be that psychologists have particular models of their own which are of little support in working with patients, and must be partially replaced. For example, psychologists are trained in an academic environment in which logically consistent thinking about scientific and theoretical considerations and research are highly valued. Simply put, most clinical psychologists are very good students who have learned to think in ways which have made them successful as students. However, it seems likely that psychologists will soon find that their finely tuned intellectual approach to problems may be of little help to them when faced with the compendium of their patients' and their own emotions. It seems then that the psychologist too must learn to shift his usual way of thinking, and the kind of "tools" he previously has relied on to attain a sense of competence, to a new and less "well travelled" and less strictly logical way of thinking. Being the best academically

obviously does not guarantee therapeutic success. Frustration, loss of confidence, anxiety, and helplessness may ensue when logical interpretations of the various meanings of patients' verbal productions do not lead to changes as quickly as is expected. And perhaps, psychologists, with their more extensive training in psychological issues come to learn a painful truth somewhat more quickly than residents, that, as Wheelis (1963) has stated, even insight is limited in its effects, and "the elusive anguish remains (p. 142)."

Concerns over the loss of a supportive, logical model would also seem to be a result of an attempt to learn different orientations to treatment. Rioch et al. (1976) for example, mention the difficulty beginning therapists who are trained to do behavior therapy, have with learning more psychodynamic treatment, since the behavioral model of the "contract" cannot be used as clearly and specifically in psychodynamic therapy, in which, to a great extent the "goal" is also the process.

Clearly, how one defines one's role as a therapist, and how one limits one's behavior based on that role definition, is very much a matter of theoretical and treatment orientation. A big dilemma, then, for the beginner, concerns not merely coping with the loss of particular models, but learning how to integrate various, apparently disparate paradigms, and how to translate that integration into useful therapeutic behavior. Psychotherapeutic training is often replete with contradictions among various "authorities," leaving the beginner in a state of uncertainty and confusion about which one to follow (Klagsbrun, 1967; Lakovics, 1976;

Rioch et al. 1976). Ornstein (1968) has mentioned that the unfortunate effects of this uncertainty may result in the beginner either rigidly and dogmatically accepting the tenets of a particular perspective, or engaging in an "uncritical eclecticism." The tendency for beginners to limit their viewpoints as a way of avoiding anxiety has also been mentioned by Book (1973), Chessick (1971), Sharaf & Levinson (1964), and Wheelis (1958). It is possible that this dilemma is more intense for clinical psychologists than for psychiatric residents. Psychologists, because of their more intense psychological training may be exposed to more theoretical viewpoints and treatment models with which they must grapple.

Dilemmas Concerning the Treatment Process

One set of treatment dilemmas faced by the beginner revolves around the question of "how to act," or "what to do" with a patient in therapy (Wyatt, 1948). The beginner often finds himself conflicted about how involved he should be. Halleck & Woods (1952) remark that when he does become involved, he tends to over-act and over-identify with his patients, and if he does not become involved, he sees himself as being cold and aloof. Similarly, Klagsbrun (1967) comments about his guilt during his training over assuming a distant attitude toward his patients without a guarantee that such an attitude helps. Many beginners misinterpret psychodynamic principles of psychotherapy, and like Klagsbrun, end up feeling inauthentic: "I spent three years attempting to bury a part of myself that expresses concern, warmth, and involvement with patients...(p. 286)."

Dymond & Lerner (1963) did a study on therapist empathy. In a group which was divided between experienced and inexperienced therapists it was found that in general, inexperienced therapists saw their patients as less like themselves than the patients' own views showed them to be. Dymond & Lerner suggest that the new therapist may be more open to threats and more easily be made anxious by seeing patients as more similar to himself, and so engages in defensive distancing. Berger & Freeburg (1973) discuss how the beginner's urge to "move toward" the patient often results in his holding onto the patient, condoning acting out and being overpermissive, while the urge to "move away" results in early termination, intellectualization, and authoritarianism on the part of the therapist. Saccuzzo (1976) factor-analyzed beginner's responses to the "Therapy Session Report" a structured self-report response questionnaire, and found that they experienced considerable affective discomfort during sessions. Dimensions like "ambivalent," "uneasy closeness," and "perplexed" appeared.

Ekstein & Wallerstein (1958) describe how in his dilemma over "what to do," the beginner may vacillate between efforts to control the patient through confronting and making clever interpretations, and an attitude of "overcompensating directionlessness" (p. 163), in which he merely reflects the patient's communications and feelings. To Rioch et al. (1976) much of the difficulty over "what to do" has to do with the beginner's wish to fulfill his patient's needs--to reparent his patient and perhaps also himself--by "giving." The beginner will often feel guilty if he finds he cannot give enough; he then fears losing his patient. According to Rioch, it is often the therapist's wish to be liked by the

patient which contributes to his preoccupation with what to do rather than with what is going on between himself and the patient. Ornstein (1968) believes that premature indoctrination in theory contributes to a loss of spontaneity and too much preoccupation with content rather than process, in the beginner.

Rioch et al. (1976) have enumerated some of the covert needs and responses of the beginning therapist which interact with his work with patients. Rioch is one of the only writers to have illustrated the problems of the beginner from the vantage point of psychologists in training. She believes, however, that the dilemmas she discusses are applicable for all beginning therapists, regardless of their primary professional affiliation. According to Rioch, the beginner has to work through his intense ambivalence about whether to give or withhold from his patients, this, despite intellectual awareness of the problem. One of the beginner's most difficult problems is learning to tolerate the anxiety which is generated in the therapeutic situation; this means superceding one's natural tendency to defend against anxiety. A related issue involves the beginner's fear of somehow hurting the patient with interpretations or confrontations. To go further, there appear to be a variety of typical fantasies which beginning therapists have about their patients and themselves, which contribute to their behavior during the treatment. Bruch (1974) for example, mentions the beginner's tendency to see the patient as someone on whom one performs "psychological operations," and "gives" interpretations. Sharaf & Levinson (1964) mention the beginner's fantasy of therapy as a chess game, in which making the right "moves" is thought

to "checkmate" the illness.

Rioch et al. also mention beginner's anxiety over the assumption of responsibility for patients. Particularly problematic is the issue of potential patient suicide. Halleck & Woods (1962) also noted that patient suicide, while placing great stress on any therapist, is especially traumatic for the beginner. Ironically, for residents at least, most hospitals assign the most disturbed and risky patients to the most inexperienced staff (Chessick, 1971; Merklin & Little, 1967; Ungerleider, 1965). This policy, according to Chessick, exacerbates residents' doubts about the efficacy of psychotherapy, because they rarely get to the point of seeing any substantial improvement in the most disturbed of patients. Psychologists may feel more optimistic about treatment success since they see less disturbed patients during their graduate training, and hence see greater change occurring as a result of their work.

Rioch et al. further discussed beginners' fantasies about appropriate behavior and affects in therapy. Many beginners believe that in order to be good therapists they must be eternally tolerant of their patients, and eternally in control. They thus fear their anger at patients who are particularly frustrating or who arouse dislike. Related to this, is the beginner's notion that it is bad to be anxious, when in fact, a total lack of anxiety on the part of the therapist would indicate that he was being too defensive. To Rioch et al. the beginner's over concern about his competence keeps him from using his own insecurity to further the therapeutic process.

The results of the beginner's preoccupation with technique may

result in his becoming a "therapist in quotes," wherein he does what he has been taught will be evaluated as good therapy. He maintains a superficial image of doing therapy, and "handles" patients' problems rather than working through his experience of them (Wolstein, 1972). The beginner's self consciousness about what he is doing deadens his intuition (Moulton, 1969). He may then rely on therapeutic cliches, which protect him from the anxiety of having to come to terms with the therapeutic process (Bruch, 1974). Alarcon (1972) enumerates some of these cliches toward the patient as, "express your feelings, openly, as they are," "I won't make any decision for you," "You don't communicate meaningfully," and "You aren't working responsibly in therapy."

The over-valuation on technique may be exacerbated in beginning behavior therapists. According to Levine & Tilker (1974) behavioral trainees are seduced into believing that technique alone will produce change; they thus devalue interpersonal skills such as empathy, sensitivity and concern.

Finally, for most beginners, concern about their lack of experience, and perhaps concern about their relatively young age, coupled with a need to split off and to project what is threatening outside of themselves, cause them to deal with their patients either in a superior, self righteous manner, or in an overly compliant manner, offering interpretations with the implicit message "please accept this." (Bruch, 1974; Berger & Freedburg, 1973; Ekstein & Wallerstein, 1958; Levine & Tilker, 1974; Marmor, 1953).

Stresses of Supervision

Supervision promotes particular kinds of expectations and behaviors on the part of the beginner. It is aimed at developing the therapeutic personality of the supervisee through the encouragement of self awareness (Caoni & Neumann, 1974). It has been repeatedly pointed out in the literature that in this respect, the supervisory process has many parallels with the therapeutic process, which is one reason why it is often experienced as conflictual and ambiguous (Ekstein & Wallerstein, 1958; Halleck & Woods, 1962). Because of the parallels between therapy and supervision, personal and professional boundaries overlap, and it is often quite unclear to both the supervisee and the supervisor where supervision ends and therapy begins.

Various problems may ensue. For example, the beginner may experience himself as a patient with his supervisor, and thus hear his supervisor's remarks as criticisms of his personality (Spiegel & Grunebaum, 1977). Or, he may use his supervision to speak honestly about his fears, dilemmas, and "countertransference difficulties," but he will feel anxious about revealing personal issues since the supervisor is also seen as an evaluator (Szasz, 1958; Thompson, 1958). Fear of the supervisor's criticism may impede the supervisee's ability to think flexibly and to recreate the patient's emotional experience. Instead, he may become obsessively concerned with note taking, taping, etc., in order to remain uninvolved (English, 1968; Moulton, 1969). The supervisee may try to turn supervision into personal therapy in a defensive attempt to ward off anxieties directly related to treating the patient (Ekstein & Wallerstein, 1958).

Ekstein & Wallerstein discuss the parallel process which exists between the beginner's relationship with his patient, and his relationship with his supervisor. Thus, what the beginner sees and presents about his patient closely parallels comparable problems he experiences himself in supervision. "It is as though we were with a constant "metaphor" in which the patient's problem in psychotherapy may be used to express the therapist's problem in supervision--and vice-versa (p. 180)." As the beginner gains more experience and expertise and is helped in the resolution of his own supervisory difficulties, the parallel process diminishes.

According to Ekstein & Wallerstein, beginners in supervision exhibit characteristic patterns and problems in learning. In the pattern of "learning by vigorous denying," the student needs to ward off the impact of the supervisory experience and attempts to reduce it to the familiar. Despite constant denying, the student learns, albeit in a truncated way. In the pattern of "learning by submission" the student relates to patients as "below" him and to supervisors as "above" him. He submissively accepts everything his supervisor says, but continues to experience it all as external to himself. In this pattern, there is an implicit assumption on the part of the student that supervision is an aggressive assault in which one will be "beaten," but for one's own good. Another pattern involves "the problem of finding a problem" in which the student externalizes responsibility for his own learning by assuming that it is the supervisor's job to point out his "blind spots" to him, since because they are blind spots by definition, he cannot possibly see them

himself. Here, there is a magical expectation of learning by spoon-feeding.

One of the typical ways that the beginner experiences his supervisor, is as a God-like figure who has all the right answers. While several writers have mentioned this phenomenon (e.g. Ekstein & Wallerstein, 1958; Ornstein, 1968; Rioch, 1976), Sharaf & Levinson (1964) discuss it most extensively, calling it a "quest for omnipotence." They describe how the young therapist, because of his own feelings of inexperience, excessively admires his mentors in a quest for their perceived knowledge and power. In his striving for professional competence, the beginner hopes that his supervisor will somehow "bestow his treasures" upon him. Hence, the supervisor is not admired merely as a role model, but as a magical, charismatic figure, who will help him to join a special, secret club available only to "guild" members. As part of this quest, the novice also over-exaggerates his relative lack of competence to the point where he experiences himself as completely empty and devoid of any inner resources or knowledge. The overall quest for omnipotence involves, according to Sharaf & Levinson, first a quest for omniscience, then omnisentience (complete warmth, empathy, flexibility of responsiveness), and finally, omnifacience (the ability to effect socially significant changes). Naturally, as a result of this fantasy, many supervisees believe that they are not getting enough and are constantly searching for more theoretical, technically sharper, i.e. more "perfect" supervision. Obviously this quest serves a variety of positive and negative purposes for the beginner. It helps him to deal with the ambiguity of doing

psychotherapy by believing that there is a right way; he may use it to avoid responsibility, and the overwhelming nature of therapeutic work by feeling that he is merely an extension of his supervisor; in his quest to "know all" he may avoid knowing anything well, or he may become a parrot of his supervisor, unable to think for himself. In this regard, Ornstein (1968) comments on how important it is for the supervisor to allow the beginner to have "the courage of his own stupidity." Rioch et al. (1976) also mention the danger of allowing students to imagine that they can't think for themselves. Wolstein (1972) however, underscores the fact that the idea of passive dependency is often built into the student-supervisor relationship.

Abramowitz & Abramowitz (1976) present the idea that passive dependency is particularly problematic for the female beginning psychotherapist to overcome, due to the fact that passive dependency has been a conventional female sex role. According to Abramowitz & Abramowitz

> The supervisory encounter poses a critical developmental hurdle for the aspiring female psychotherapist. In symbol and in fact, it is a rite of passage from the sanctuary of book learning to real-world decision-making. Since the skills required by the former endeavor more closely fit the feminine sex role convention of passive-dependency than do the assertive and risk-taking demands of decision-making, the transition for the female supervisee can be fraught with ambivalence and ego-protective maneuvering...Satisfactory working through of the conflict activated by the role pressures for assumption of responsibility would appear to be crucial to relatively autonomous and conflict-free functioning as a professional clinician. Moreover, the amount of working through accomplished in supervision has implications for the ultimate quality of the trainee's interprofessional relations with her predominantly male colleagues (p. 583-584).

In a related vein, Taylor et al. (1977) in discussing women's behavior in groups, point out that one of the cultural consequences of women's not

being socialized to compete for leadership roles is that they may unconsciously separate the notions of power and authority from the notion of femaleness altogether.

Abramowitz & Abramowitz go on to discuss the strategies used by some women that serve ego-protective needs but ultimately block full professional functioning. They claim that certain "hostile-dependent" tactics are used which have worked for the woman in the past to nullify the power of men who exercised prerogatives over her life. The woman may engage in intellectual seductions of her male supervisor (e.g. borrowing his books, favorably comparing him to other supervisors, asking to observe him conducting therapy) all in an attempt at avoiding conducting and facing responsibility for her own cases. Abramowitz & Abramowitz point out that, paradoxically, the female trainee may grossly undersell her level of clinical expertise, when according to them, she often has "an initial edge in interpersonal sensitivity and intuitive dynamic sophistication" as compared to men.

The female beginner may also be more invested than the male beginner in getting explicit advice about "what to do" in sessions. Abramowitz & Abramowitz believe that women who have not worked through their conflicts concerning their sex role heritage are often more susceptible than men to having problems in other areas of training and treatment. They may more readily overidentify with patients, underestimate pathology, react viscerally to clinical labels, be more prone to especially hostile bids for attention from patients, covertly encourage patient acting out, be less comfortable taking charge of the treatment and controlling its

pace, and have difficulty separating from supervisor and patient. It might be noted here that the relatively small literature on the dilemmas of the beginning therapist has focussed almost exclusively on the experiences of men, and what has applied to women has been purely by implication. There has been a dearth of literature on how women perceive, and deal with their training, roles, and on whether their dilemmas and difficulties are any different in quality or degree than are those of men. It appeared useful, then, to look more closely at the experiences of women who are training to be therapists.

A final supervisory dilemma mentioned in the literature relates to the question of which authority to follow, mentioned earlier. This dilemma can be exacerbated if the trainee has many different supervisors at the same time, or switches to different supervisors for the same treatment case, all of whom present equally viable but perhaps conflicting ways of thinking about and doing therapy. In these kinds of situations, issues that supervisors disagree upon can tend to be highlighted, so that the student is left to figure out for himself where there may be significant areas of agreement (Lakovics, 1976). Moulton (1969) has written that for her, one of the most difficult aspects of being in supervision was the job of integrating her learning from various supervisors. Clearly, this process cannot be looked at simply as a "problem" (in the negative sense) since integrating differing points of view is a useful and necessary task. However, it can be a painful task for the beginner especially if he has to negotiate among the prejudices and personalities of the supervisors who are espousing the differing points of view he is attempting to integrate.

Since the trainee is in the status of student, supervisors are "authorities" in both the figurative and literal sense.

Institutional Stresses Related to the Beginner's Student Status

Being in the role of student creates additional dilemmas for the beginning therapist which are related to the overt and covert expectations and demands made, and the pressures put on him in his role as student by his training institution as a social system. Pressures from the social system can interfere with his learning in several ways. As mentioned above, students can easily get caught in a cross-fire among supervisors of differing views. They can unwittingly be "used" by supervisors to "carry" the conflicts supervisors have among each other, and may end up as casualties of the system as a result. "When, in addition to the problems of interaction with supervisors, the student is subjected to the emotional effects of unstated or unclearly expressed differences of opinion and feeling among and between the several authority entities in the supervisory situation, he suffers not only from confusion but also from psychic inhibitions which can sometimes be disastrous in their consequences to himself and to his patients" (Emch, 1955, p. 303).

Besides having to negotiate with people in various positions of authority, student therapists are also faced with coming to terms with their own and their peers' competition with, and interdependence on each other. The experience of being de-skilled may be exacerbated by the student's tendency to underplay his competence because of fears of being rejected or envied by peers (Rioch et al. 1976; Seashore, 1975). In

addition, he may also fear competing with faculty. Clearly, being in a position of constantly being judged and evaluated is one of the most unsettling aspects of being a student. Wishes to please supervisors, to achieve prestige among peers, and in general to feel accredited by the system may interfere with the student's wish to be effective for the sake of the patient, and efforts to save face may occur at the cost of learning (Chessick, 1971).

Beginning therapists who are also students in a training program are in the double-binding and paradoxical position of having to combine two roles, which in many ways are diametrically opposed (Seashore, 1975). While as students they may often experience themselves in the position of being dependent or infantalized, as therapists they are in positions of great authority and responsibility, requiring high levels of personal competence and maturity. Pulls to be either students or therapists may make it difficult for them to be student therapists with clear and relatively objective views of their strengths and weaknesses.

CHAPTER III

HYPOTHESES AND METHODOLOGY

Aim of the Study

An overview of the literature suggests that the basic issue to be worked through for the therapist in training involves the question of how to assume the role of therapist, and integrate one's concept of oneself in the role with one's concept of oneself as a person. That is, one of the beginner's major struggles is to attain a sense of "fit" or authenticity in the role, and thereby to experience a sense of being acceptable to oneself as a therapist. The other dilemmas with which the therapist in training must grapple may either contribute to or result from this process. Obviously, the ease with which one assumes one's role and feels comfortable with it depends on several factors. Of particular significance are the personal and idiosyncratic meanings, both conscious and unconscious, which the individual attributes to the role. These meanings may in part be influenced by a variety of personal and/or social characteristics of the individual, such as sex, age or race. Moreover, these meanings may in part be derived from and influenced by the individual's past experiences in relation to the role, and may be modified by his experiences in assuming the role himself. Concurrently, the pre-conceived meanings which the individual brings to the role may affect the way in which he experiences himself in it and may influence the quality and intensity of problems or dilemmas that he encounters. It should be noted here, that the notion of "role" as used in this dissertation is sociopsychological

in nature, following from Newton (1973). In this conception, "roles encircle deep aspects of the personality and of the social structure within which the person works (p. 500)." According to this view the role of therapist undergoes as do other social roles, a process of internalization in which both the personality and social structure are altered. Newton states, "the beginning psychotherapist's role behavior is typically imitative. Increasingly, however, the role moves inward and he gives it personal definition (my italics). Ultimately, the psychotherapeutic role becomes an important part of him and he is to some extent different as a result of having become a psychotherapist. (p. 500)"

Therapeutic training, through formal courses, direct therapy experience, and supervision is implicity designed not only to modify the trainee's notions about therapeutic techniques, but perhaps more profoundly, to modify his conceptions of what it means to be a therapist. Because there has been a dearth of formal research into the training experience itself, it remains unclear as to how or if, trainees' conceptions of the role of therapist and of themselves in that role change over the course of their training experience. This dissertation was designed to begin to investigate those issues, and as such is heuristic in approach. The aim of the dissertation was to examine the relationships (if any) between amount of supervised experience doing therapy, conceptions of the role of therapist and kinds of dilemmas experienced by therapists in training. Furthermore, since there is some suggestion in the literature that women and men may deal with the process of becoming a therapist differently, this dissertation also attempted to examine any possible

relationship between gender of therapists in training, conception of the role of therapist, and dilemmas which are experienced. This study was particularly meant to raise questions with regard to the therapy training experiences of psychologists. The six primary hypotheses follow:

Hypotheses

1. When the concepts "me" and "me as therapist" are compared in terms of the meanings attributed to them by therapists in training, there will be a difference in how alike these concepts are viewed, as amount of experience doing therapy increases.
2. When the concepts "me as therapist" and "therapist" are compared, there will be a difference in how alike they are viewed as amount of experience doing therapy increases.
3. When the concepts "me" and "me as therapist" are compared, there will be a difference in how alike they are viewed by women vs. men.
4. When the concepts "me as therapist" and "therapist" are compared, there will be a difference in how alike they are viewed by women vs. men.
5. There will be differences in the kinds and intensity of dilemmas identified by women trainees vs. men trainees.
6. There will be differences in the kinds and intensity of dilemmas identified by trainees as experience level increases.

In the first four hypotheses, "me" was intended to represent the self concept; "me as therapist" was used to represent the concept of self in role;

and the concept "therapist" was used to represent a general or abstract notion of the role to be acquired.

As stated earlier, since this study was meant to be of heuristic value, it in addition attempted to examine the following questions for predoctoral clinical psychologist training to be therapists:

1. How do clinical psychology students as a group conceive of themselves in their roles as therapists and how do those conceptions compare to their conception of the role of therapist in general?
2. What dilemmas are most intense and least intense?
3. What types of patient behaviors are most and least anxiety-provoking?

Finally, although not part of the formal hypotheses, other factors were included in the investigation which may contribute to how therapists in training conceive of the role of therapist, and of themselves in the role, and which may relate to the kinds of dilemmas experienced. These were race, age, amount of personal therapy, year in the training program, number of patients seen, and number of supervisors. In addition, other roles related to the therapy and training experience were included: supervisor, me as supervisee, and therapy patients.

Subjects

Subjects for the study were all doctoral students in the Clinical Psychology Program of City University of New York. They ranged from first year students to students on internship. Forms were sent to 58 students, 35 women and 23 men. Forty-five were returned by 28 women and 17 men.

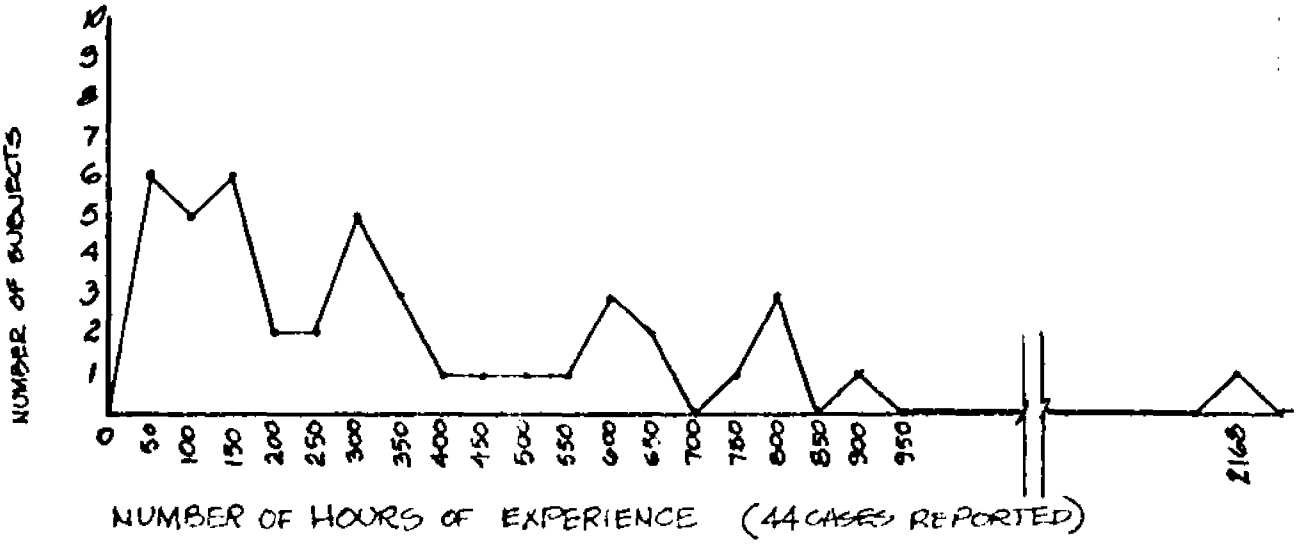
of the 45 returned, 20 were from second year students, 13 were from third year students, 4 were from fourth year students still in residence, 7 were from students on internship, and 1 was from a first year student. All of the respondents were in the process of doing psychotherapy under supervision of either a Ph.D. level psychologist or a senior psychiatrist. Female respondents ranged in age from 23 to 38 years old. Male respondents ranged in age from 24 to 47 years old. All of the subjects were of a generally equal intellectual level and all aspired to do therapy in the future. All reported their theoretical orientations to be some form of psychoanalytic or psychodynamic treatment (e.g. object relations, interpersonal, etc.). Number of hours of experience doing therapy ranged from five to 2,168, with the mean number of hours being 360.6. Number of months of experience ranged from one to 72, with the mean number of months being 24.9. (See graphs 1 and 2 below, which indicate the experience distributions of the group, in both hours and months of experience.) The group consisted of 34 whites and eleven non-whites. Number of supervisors ranged from one to 20 with a mean of 4.6. Number of hours of personal therapy ranged from zero to 1800, with the mean being 328.6 hours. Number of patients seen ranged from one to 37, with the mean being 9.9. This included patients seen in groups of families. (See graph 3 and 4 below, which indicate distribution of patients seen, and hours of personal therapy.)

Materials

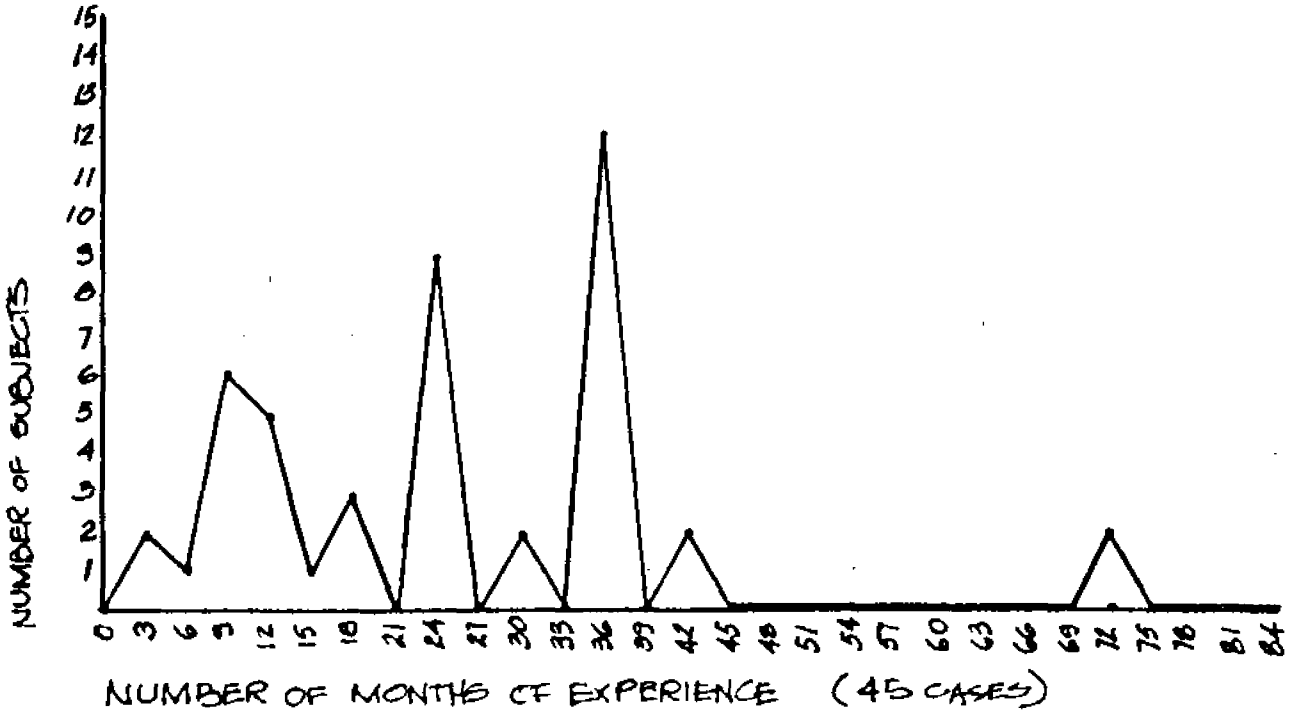
A set of forms was administered, consisting of a cover sheet requesting demographic information, and two self-report scales: a dilemma rating

FREQUENCY DISTRIBUTIONS OF SUBJECTS

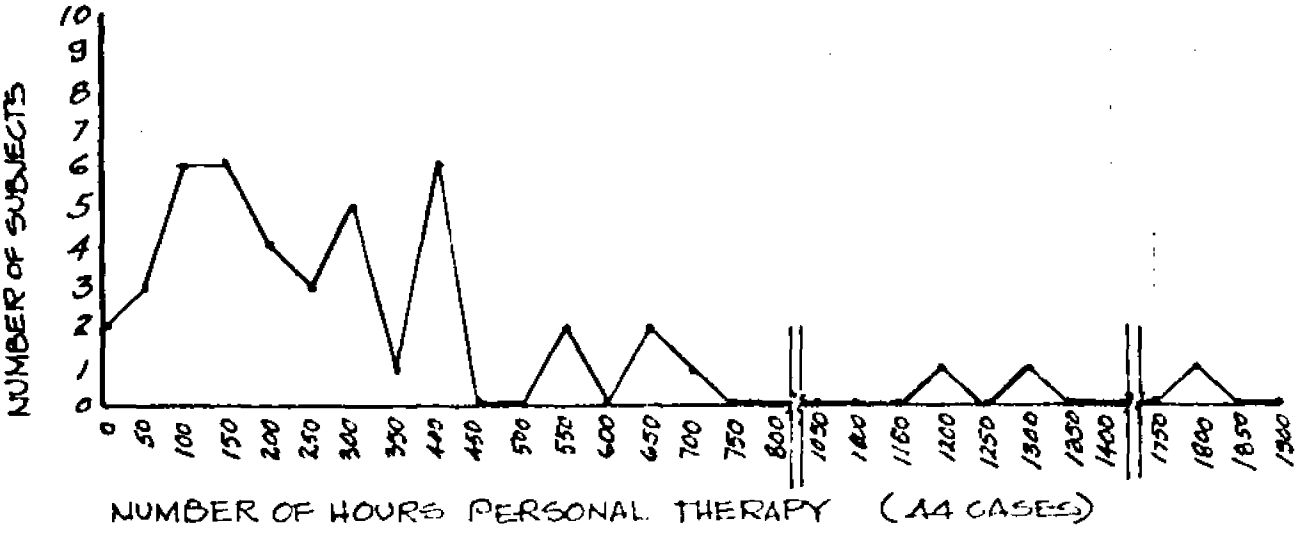
Graph 1 (read as 0-50, 51-100, 101-150 etc.)



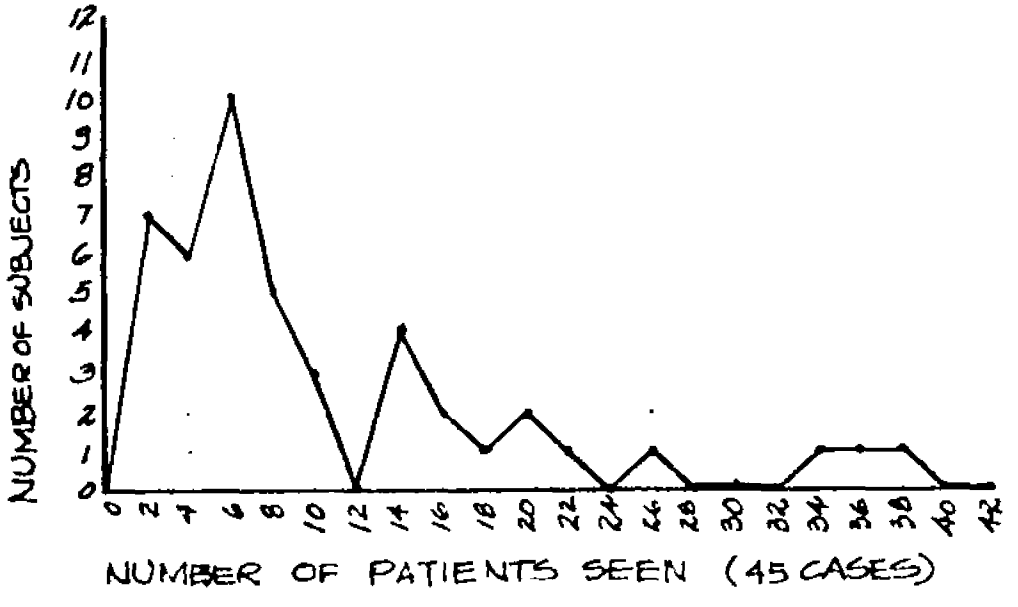
Graph 2 (read as 0-3, 4-6, 7-9, etc.)



Graph 3 (read as 0-50, 51-100, 101-150, etc.)



Graph 4 (read as 0-2, 3-4, 4-5, etc.)



scale, and a semantic differential scale. (See appendix)

The dilemma rating scale consists of a list of 54 statements describing difficult situations or problems encountered by therapists in training, and an additional 23 items involving patient behaviors which may be anxiety-provoking, making a total of 77 items in all. Respondents were instructed to indicate how true each statement was for them, using a 1-6 scale, where 1 equals least true and 6 equals most true. The items on the scale were extrapolated from taped interviews with three doctoral students concerning their dilemmas, from extensive informal discussions with several other doctoral students, and from the dilemmas suggested by the literature. Content areas covered by the items included supervisory difficulties, insecurities and confusions involving role boundaries and role models, concerns about competence and experience level, questions of theory and of technique, and problematic feelings toward or about patients or the therapeutic interaction.

An original trial version of the scale was formulated, which included both sentence completion items (e.g. "Being a therapist is like____"; "My biggest problem as a novice therapist___") and declarative statements similar to those of the final version. (See appendix) In the original version, statements were worded in terms of positive feelings (e.g. "I feel competent about my work") and negative feelings ("I am anxious with my patients"). Fifteen predoctoral and postdoctoral psychologists outside of the City University Clinical Psychology program were given the trial version of the dilemma scale and were asked to indicate in writing what they felt the scale was tapping, and to give

general comments. There was general agreement that the statements concerned situations related to dilemmas about comfort, security, or competence in the role of therapist. In addition, brief discussions were held with respondents concerning their general reactions to the scale, e.g., items which were felt to be redundant, too strongly worded, unclear, too specific or general, contradictory, etc. The scale was then reformulated, taking these critiques into account. In the final version, the sentence completions were eliminated, and all statements were worded in a negative direction for the sake of continuity.

The Semantic Differential, designed by Osgood (1957) is a generally recognized instrument, and has been used extensively in psychological research for exploring the meanings attributed to a variety of concepts by different types of groups. It has proven to be an accurate and sensitive instrument for recording affective associations to stimuli (Heise, 1965; Jenkins, Russell, and Suci, 1958). The subject is given a concept and asked if it is more closely related to either one word or another, where the two words are paired opposites (i.e. the scale is bi-polar). The subject is asked to indicate on a seven point scale how close the association is to one word or the other. Thus, for example, the subject may be given the concept "mother," and the paired opposites "good-bad," with seven spaces in between the two words. The more closely associated he feels one of the two words is to the concept "mother," the nearer will be his mark to one or the other of the two words, "good" or "bad."

It has been demonstrated that affective judgments on bi-polar

adjective scales resolve into three major factors: Evaluation, Potency and Activity (Heise, 1965; Osgood, Suci and Tannenbaum, 1957). In the present study six concepts were rated on 20 scales. Scales were selected to represent the three factors: Evaluation, eight scales; Potency, four scales; Activity, four scales. Four other scales were added for their clinical interest. Effort was made to find scales which loaded highest on the particular factor being sampled. Factor loadings were taken from an unrotated square root factor analysis table included in Osgood et al.'s (1957), The Measurement of Meaning. Concepts chosen consisted of the following: "me," "me as therapist," "psychotherapist," "therapy patients," psychotherapy supervision," and "me as supervisee."

Procedure

Forms were distributed to the mailboxes of all students in residence in the clinical program, and were mailed to the homes of all students not in residence (i.e. on internships). A cover letter was included requesting participation from all students presently conducting psychotherapy, or who previously conducted therapy under supervision. (See Appendix) Students in residence were asked to fill out the forms anonymously, deposit them in a box set up for this purpose and check off their names on a separate master list of all students in the program. Students not in residence were requested to mail their forms to my home. After a few weeks a follow-up letter was sent, again requesting participation from those people who had not replied. (See Appendix)

CHAPTER IV

ANALYSIS OF THE DATA AND RESULTS

The two different sets of data (i.e. the Semantic Differential data and the dilemma data) were analyzed separately. Statistical tests done for both sets of data involved various correlations, to be described. In this study, intercorrelations of variables as opposed to t-tests or analyses of variance between discrete groups, were done because the majority of variables to be analyzed (e.g. various levels of experience) were continuous multi-valued variables, and it was felt that it would not make sense arbitrarily to divide the sample into separate groups (except in the case of a variable like gender in which there is a natural division) because detail concerning changes occurring within these groups would be lost. All data were punched onto IBM cards and analyzed at the City College Computer Center using a PSTAT program. PSTAT (Princeton Statistical Package) is a computer program written by Roald Buhler, a statistician at Princeton. It was used to calculate means, standard deviations and intercorrelations of variables.

In this section, the analysis corresponding to each set of data will be discussed in order, together with the results obtained, for the sake of clarity. The first four hypotheses were tested by analyzing the Semantic Differential data. Scores on the Semantic Differential were analyzed in order to obtain information about the meanings attributed to the six concepts used. According to Osgood, et al. (1957), the meaning of a concept may be operationally defined as "that point in the semantic space identified by its coordinates on several factors (p. 89)." Each

coordinate gives the distance of a concept from the origin (or neutral position on the scale) in one direction or the other along an axis which represents one of the scales or factors. Difference in meaning for two concepts is operationally defined by the distance between their positions in the semantic space, as computed by the generalized distance formula $D = \sqrt{d^2}$, in which d is the difference in allocation of the two concepts on a single scale. Thus, the more alike any two concepts are in connotative meaning, the smaller will be the value of D (Osgood & Luria, 1954).

In the present study the semantic data were analyzed in order to determine if there were differences in the meanings of particular concepts on the basis of experience and gender. This was done by obtaining the generalized distance functions between each pair of concepts (making a total of 15 concept pairs) and correlating them with the subject variables in question, in this case gender and level of experience. The latter was measured in two ways, i.e. number of hours of experience doing therapy and number of months of experience doing therapy. Experience was measured in these two ways because it was felt that each may represent a qualitatively different type of experience. In other words, number of hours of experience relates directly to circumscribed amounts of time which may be accumulated over a relatively shorter or longer time span. For example, a person may have obtained 50 hours of experience over the course of a few months or over the course of many months. Is it the actual time spent that is relevant, or how the time spent has been distributed? It was felt that it would be useful to determine if either one or both measures of experience would correlate with the variables in question,

thus providing more specific information as to the quality of experience which may influence trainees' perceptions of their work.

In addition to the above, other subject variables previously mentioned were included in the analysis: race, number of patients seen, year in the program, number of hours of personal therapy, number of supervisors, and age. Thus, there were a total of nine subject variables, including gender and experience level which were included in the analysis of 15 concept pairs.

In the course of examining the results a nominal significance level of ($p < .05$) generally used in psychological research, was used to test all hypotheses. A correlation was considered interpretable if it achieved a nominal 2-tail significance level of at least $\pm$ .288 for 2 and 45 degrees of freedom (.288 is the critical value corresponding to an alpha level of .05). It should be noted, however, that significance tests may not have been independent in many cases, so findings must be interpreted cautiously.

The following results were obtained:

Hypothesis 1. When the concepts "me" and "me as therapist" were compared, there was no difference in how alike they were viewed as trainees' experience increased. No significant correlation was found between either of the measures of experience and the distance between the two concepts. Thus, the hypothesis was not supported.

Hypothesis 2. When the concepts "me as therapist" and "therapist" were compared, there was no difference in how alike they were viewed, as trainees' experience increased. No significant correlation was found between

the experience measure and the distance between the concepts in question. Thus, this hypothesis was not supported.

Hypothesis 3. When the concepts "me" and "me as therapist" were compared, there was no difference in how alike they were viewed by women vs. men. No significant correlation was found between the gender of the trainees and the distance between the two concepts in question. Thus, this hypothesis was not supported.

Hypothesis 4. When the concepts "me as therapist" and "therapist" were compared, it was found that women viewed the two concepts as less alike than men did. A positive correlation of +.355 was found between gender and the distance between "me as therapist" and "therapist," indicating that for women there was a significantly greater distance between the two concepts in question. A significant correlation of -.364 between the evaluative factor of "therapist" and gender, contributed to the aforementioned result. This indicates that women conceived of "therapist" as significantly better than men did. This hypothesis was, therefore, supported.

Since other concepts and subject variables were analyzed besides those of hypotheses 1-4, a variety of serendipitous results were also obtained. The following additional correlations between subject variables and concept pairs were found to be significant, and are summarized in Table 1, below.

Table 1

SERENDIPITOUS CORRELATIONS

Subject Variables	Concept Pair	Significant Correlation
No. of patients seen	Therapy patients-me	.429
No. of hours of personal therapy	Me as supervisee-supervisee	-.294
No. of hours of personal therapy	Me-me as therapist	.310
No. of supervisors	Therapy patients-me	.333
No. of hours of experience	Therapy patients-me	.396
No. of hours of experience	Me as supervisee-me	.295
No. of hours of experience	Me as supervisee-me as therapist	.313
No. of months of experience	Me as supervisee-me as therapist	.425
No. of months of experience	Therapy patients-me	.392
Gender	Me as supervisee-me	.-289

Extrapolating from the table we find the following for the sample as a whole:

1) The concepts "therapy patients" and "me" were seen as less alike by trainees with more patients, a larger number of supervisors, and a larger number of both hours and months of experience.
2) Trainees viewed "me as supervisee" and "me as therapist" as less alike, the more hours and months of experience they had.
3) Trainees viewed "me" and "me as therapist" as less alike the more experience they had in their own personal therapy. In addition, the more the hours of personal therapy experienced, the more alike were the concepts "me as supervisee" and "supervisor."
4) The larger the number of hours of experience, the less alike were "me as supervisee" and "me."
5) Women viewed the concepts "me as supervisee" and "me" to be more alike than did men.

In addition to testing hypothesis 1-4, the data was examined to compare how the entire sample viewed the concept "me as therapist" as compared to "therapist." This was done by comparing the two concepts in terms of the mean scores obtained for each factor (activity, potency, evaluation) for the group as a whole. Table 2, below, indicates the mean scores obtained, where the lower the score, the more active, potent, and good the concept in question is judged.

Table 2

COMPARISON OF MEAN SCORES OF SEMANTIC DIFFERENTIAL FACTORS

Concept	Factor	$\bar{X}$	Standard Deviation
Me as Therapist	Activity	13.8	2.2
	Potency	15.3	2.8
	Evaluation	21.6	5.0
Therapist	Activity	14.1	1.8
	Potency	14.3	2.4
	Evaluation	18.5	5.2

Thus, for the group of psychology trainees as a whole the concept "therapist" was judged to be somewhat less active, more potent and better than the concept "me as therapist." Additional findings of interest show that the group as a whole judged "me" to be the most active and potent, "therapist" to be the most good, "supervisor" to be the least active, "me as supervisee" to be the least potent, and "psychotherapy patients" to be the least good.

The data were also analyzed to compare differences between the meanings of different concepts for the entire group. This was done by comparing the general distances between each concept with every other concept for the sample as a whole. A heirarchy of 15 concept pairs was thus obtained, and is presented in Table 3 below in descending order, where the first pair is the pair with the largest relative distance

between concepts (i.e. concepts viewed as least similar) and the last pair is the pair with the smallest distance between concepts (i.e. concepts viewed as most similar).

Table 3

PERCEIVED SIMILARITY OF CONCEPT PAIRS

Concept Pair	Mean Distance
Therapy patients-therapist	8.642
Therapy patients-supervisor	8.199
Therapy patients-me	7.865
Therapy patients-me as therapist	7.111
Therapy patients-me as supervisee	6.875
Me-supervisor	6.666
Me as supervisee-supervisor	6.242
Me as supervisee-therapist	6.139
Me as therapist-supervisor	5.781
Me-therapist	5.508
Me-me as supervisee	5.315
Supervisor-therapist	4.938
Me as therapist-therapist	4.709
Me as therapist-me as supervisee	4.686
Me as therapist-me	4.628

Hypotheses 5 and 6 were tested by analyzing the data obtained from the dilemma rating scale. The subject variables of "gender" and "number of hours of therapy experience," and "number of months of therapy experience," were correlated with each of the 77 dilemmas listed. In addition, the other subject variables previously mentioned (such as race, age, etc.) were correlated with the dilemmas. Means and standard deviations for each dilemma were also obtained as indicators of how important each dilemma was judged for the group as a whole (i.e., the degree of intensity with which each was related to). Again, a correlation was considered interpretable if it achieved a nominal significance level of $\pm$ .288, this being the critical value for an alpha level of .05, with a sample of the size in this study.

The following results were obtained:

Hypothesis 5. Out of the 77 listed dilemmas only one dilemma correlated with gender. A positive correlation of + .332 was found between dilemma number 47 (relating to dependence) and gender, indicating that women identified this dilemma as relatively more true,or relatively more of a problem for them, than men did. Dilemma 47 states "I feel dependent on my supervisors." Other than this one item there was no significant difference in the dilemmas identified by women vs. men. In sum, both men and women in this sample generally appear to face the same dilemmas.

Hypothesis 6. Thirty-one listed items out of 77 were negatively correlated with level of experience as measured by combining both number of hours of experience and number of months of experience. Of these, seven items correlated specifically with "hours of experience" but were also included in the group of 31 which correlated with "months of experience." Items which

were negatively correlated with level of experience are those which were rated as less true, and therefore less problematic, by therapists, as their level of experience increased. In other words, less experienced therapists found these items to be relatively more problematic for them, while more experienced therapists found these items to be relatively less problematic for them. Of the 31 items, 20 were listed as dilemmas per se, and 11 were listed as anxiety provoking patient behaviors. The 20 dilemmas and 11 patient behaviors are listed below. (See appendix for items which the numbers below refer to.)

Dilemmas: 8, 9, 10, 13, 14, 15, 17, 24, 25, 26, 27, 28, 29, 33, 41, 42, 43, 46, 48, 49.

Patient Behaviors: 55, 56, 59, 60, 62, 66, 68, 69, 70, 74, 77.

None of the listed items were positively correlated with experience level, indicating that there were no differences in kinds of dilemmas identified as experience increased.

The findings described above for hypotheses 5 and 6 should be interpreted in light of the overall findings for the group as a whole. Of the 77 listed dilemmas, on the average, 71 of the dilemmas were rated with a score in the range of 2 - "Usually not true," or 3 - "Tends to be not true." In other words, on the average, the group as a whole tended <u>not</u> to identify the vast majority of dilemmas listed as particularly true. This included item 47, which was negatively correlated with gender but was rated by the group with an average score of 2.4, i.e., not particularly true. The standard deviations for all the dilemmas ranged from 0.8657 to 1.5754, indicating

that there was a relatively minimal amount of variability in how the items were rated. Four of the listed items - numbers 27, 35, 54, 56 - received a rating which averaged in the range of about 4 - "tends to be true." These then, must be considered to be those dilemmas which were experienced by the group most intensely:

27 - "As a therapist in training I feel a pressure to appear in control and competent even when I'm feeling confused and vulnerable." (4.1)

35 - "I feel I don't understand my patients as well as I could." (4.0)

54 - "training to be a therapist is a painful process." (4.8)

56 - (I would feel anxious in response to) "suicidal statements" (by patients). (4.7)

Of these, item 54 received the highest rating. It should be noted that item 27 and 56 were also negatively correlated with experience level. Therefore, while the above four items were most identified as difficult by the group as a whole, items 27 and 56 were considered to be less of a problem as amount of experience increased. Two of the listed items - number 3 and 37 - received an average rating by the group in the range of about 1 - "definitely not true." These then were experienced with the "least intensity," since they were not identified as dilemmas at all:

3 - "I wish I weren't so psychological minded." (1.9)

37 - "I wish my supervisors would more often address my patients' problems rather than mine." (1.6)

Of these, item 37 received the lowest rating. As part of the dilemma items,

anxiety provoking patient behaviors all received an average score in the range of 2 or 3 except for item 56, "suicidal statements," which has already been discussed above. The patient behavior which received the lowest rating and which therefore can be considered as the relatively least anxiety provoking for the group, was item 58 - "crying." These scores should also be seen in the context of the fact that the group as a whole tended not to identify any of the patient behaviors listed (except item 56) as being particularly anxiety provoking.

Again, findings regarding other subject variables were obtained serendipitously. They follow: (See appendix to determine items which the numbers below refer to).

1) It was found that "year in the program" was negatively correlated with: 9, 13, 15, 17, 24, 29, 33, 41, 42, 48, 49, 55, 62, 66, 74, 77. All of these were also negatively correlated with experience level. The following were correlated negatively with year in the program but not with experience level as well: 38, 39, 44, 45, 47, 64, 71, 75.
2) It was further found that "number of hours of personal therapy" was negatively correlated with: 18 and 70. Of these, number 18 was not also negatively correlated with experience.
3) "Number of patients seen" was found to be negatively correlated with: 8, 9, 10, 13, 15, 17, 24, 27, 29, 33, 43, 48. All of these were also negatively correlated with experience.

4) It was found that "number of supervisors" was negatively correlated with: 5, 9, 15, 17, 24, 29, 33, 48, 55, 56, 59. Of these, number 5 was not also negatively correlated with experience.

5) "Age" was found to be negatively correlated with: 41 and 42. These were also correlated with experience. The following were negatively correlated with "age" but not with experience level as well: 23, 40, 61, 67.

6) Finally, it was found that "race" was positively correlated with: 4, 13, 20, 23, 26, 28, 36, 37, 44, 45, 49, 61. The positive correlations indicate that the above items were rated as more true or problematic for whites.

CHAPTER V

DISCUSSION

The purpose of this dissertation was to begin to examine the experience of becoming a psychotherapist, from the direct perspective of psychologists training to be therapists. Specifically, the study was an attempt to look at factors--particularly experience level and gender--which may have some bearing on both the ways in which trainees define themselves in their training roles, and the dilemmas they experience as part of the training/defining process itself. Research concerning therapists' attitudes about their work, or concerning therapy trainees' attitudes about their work and training, has been relatively limited. Therefore, this dissertation was conceived of as being heuristic in nature. A discussion of the findings presented in the previous chapter, the implications of and questions raised by these findings, and some tentative directions for future research are presented in the following pages. In general, the discussion will focus on the results directly related to the formal hypotheses; however, some of the serendipitous results which indirectly relate to or amplify the results of the hypotheses will also be discussed where applicable.

Before going directly to the hypotheses it is necessary to discuss various general considerations which arise in attempting to interpret the results, and to make more explicit the assumptions which contributed to the formation of the hypotheses.

The first consideration has to do with the nature of the sample. As noted, the sample consisted of a group of City College graduate psychology students who, by the very nature of their choice of profession and training are relatively sophisticated about the nuances and subtleties of human behavior and thinking. In other words, they are psychologically minded (and the results indicate that the sample did not find this to be a dilemma) and because of that fact are probably not apt to commit themselves to an extreme point of view with regard to their own, or other's behavior or attitudes. This would be particularly true on a self-report measure of the kind used in this study because this kind of measure requires conscious reflection. In fact, the results indicate that while there was individual variability, the sample studied generally tended to stay in the middle or more neutral ranges in terms of its response patterns (except on the evaluative factor of the Semantic Differential) thus making it difficult to obtain a "true" view of the subjects' attitudes.

Another consideration involving the group has to do with the fact that every subject in it was in the same training program. While it was originally felt that this group would provide a fairly representative sample of psychology trainees in general, because of the rather broad range of backgrounds of the individuals in it, it is possible that a certain "acculturation" to, or socialization by the training program itself might have occurred, thereby influencing the attitudes of the respondents and hence leading to a certain sameness in responding. Clark (1973) has discussed the ways in which clinical psychologists in the Columbia

Teacher's College Clinical Psychology program were socialized to develop certain professional attitudes and behaviors. He discussed how the culture of that program exerted a strong pull on the students to develop openness, individuality and the conveyance of competence. Since all of the respondents in this study, except one, were at least at the end of their second year (the data was collected in May), it is highly likely that both the overt and covert attitudes regarding professional functioning and training which reflect the culture of the City College Clinical program had an effect on people's response patterns. A more specific discussion of what appears to have occurred will appear at a later point. In addition, it is possible that admission procedures of the program subtly encourage acceptance of people who already have a particular set of attitudes in common with each other, and perhaps with the faculty.

A third consideration mentioned in the previous chapter involves the fact that in analyzing the data, the variables were treated as if they were independent when in fact this was not true in all cases. Thus, any attempt to isolate any one variable becomes confounded by the possibility that this one variable is affected by other variables. For example, when we look at the sub-group of women, we are looking at a sub-group with a range of experience, age, race, etc., which may also play a part in how this sub-group responded.

The size of the sample used mitigated against examining each variable while holding other variables constant. The sample size was too small to subdivide it practically into different groups on the basis of particular variables being held constant or not. Despite this limiation it was

felt that results obtained from this sample could still shed light on which variables relate to dilemmas experienced in assuming the role of therapist. It might be noted here that the analysis of the data shows retrospectively that the subject variables involved in the primary hypotheses (experience and gender) may be interpreted as being essentially independent of each other since there was minimal correlation between either gender and hours of experience (.026) or gender and months of experience (.052). Nevertheless, since the same overall group was used to examine several variables, results must be interpreted with caution, as noted in the previous chapter. A related issue involves the fact that the distributions of experience levels (as well as those of other variables) were somewhat skewed in this particular sample. Whether a more even distribution of, for example, hours of experience or patients would have made the results more valid is, open to question, since it is unclear whether there is a particular "normal" pattern of accumulation of amounts of experience either for individuals or groups of therapy trainees. In order to make this determination, replications of this type of study with other samples would be needed.

To turn to the concept pairs used in the hypotheses, it was felt that the comparison of "me" and "me as therapist" would provide information about the process of integration or differentiation which may occur in acquiring the role. The hypotheses were not formulated in a directional way (i.e. that one group would view the concepts as either more or less alike) since the implicit question of the hypotheses was in what ways do trainees conceive of themselves in role as compared to how they conceive

of themselves as persons, and what factors may relate to changes or differences in these conceptions. The information sought, was whether there would be a difference in either direction on the basis of particular variables. For example, with regard to the experience variables, if the two concepts were seen as either more similar or less similar, this would have indicated that some change occurred over the course of experience in either one's self definition or one's definition of oneself in role, or both.

If the two concepts were seen as very similar, this may have suggested some sense of role "fit" but also some possible blurring of boundaries between self concept and concept of self in role. If they were seen as less similar, it would have suggested more of a differentiation of role from self. Whether in fact, the assumption of the therapeutic role occurs as a linear process or as a circular process in which there is a continual fluctuation between blurring and clarity of role-self boundaries is open to question.

The comparison between "me as therapist" and "therapist" was thought to involve the question of how trainees' concepts of self-in-role vary from an abstract concept or model of the role, on the basis of particular variables. It was assumed that this general notion of "therapist" would become idealized by the group and that it would be seen as a model which is aspired to. That this did occur is born out by the result which indicates that the group as a whole viewed "therapist" as less active, more potent and better than "me as therapist," and further, that "therapist" was viewed as the best concept of the entire group of six concepts used.

The fact that "therapist" was judged as less active yet more potent and better, seems to fit the model of the orthodox psychoanalytic therapist, a model used by the majority of students in this particular training program. All respondents identified themselves as psychoanalytic in orientation, or some variant thereof. Further, the orientation of the majority of the clinical faculty in the program is largely psychoanalytic or psychodynamic.

This particular result also appears to reflect the kind of idealizations toward supervisors described by Sharaf & Levinson (1964) and Ornstein (1968). Ornstein in particular discusses trainees' views of their supervisors as sorcerers. By definition, sorcerers are those who, with very little effort or activity are able to effect great changes in events and people. There is likely a strongly transferential element to this notion of "therapist" as less active, yet more potent and good, related to a childlike conception of the good father. The above conception of "therapist" may have less to do with trainees' notions of the actual role behavior of therapists per sé, and more to do with the transferential qualities projected onto the particular abstraction, "therapist." In addition, this conception of "therapist" may be a reflection of the way in which trainees experience their own therapists.

The hypotheses concerning self in role and role definition were also not formulated in a directional way; however it was assumed that the closer the comparison, the more like the aspired-to role model the trainee perceived himself in role to be. Again, closeness or dissimilarity in meaning could be the result of a change in definition of either one or both concepts.

To turn now to the hypotheses, as noted in the previous chapter, both hypothesis 1 and hypothesis 2 were not confirmed. Since many of the issues involving these two hypotheses are identical, they will be discussed together, with individual issues pointed out where applicable. The fact that hypothesis 1 was not confirmed suggests that experience as defined did not have a bearing on the degree of similarity perceived between self and self-in-role. The two concepts were not viewed to be significantly more alike or less alike as experience increased. Results of hypothesis 2 indicate that amount of actual experience doing therapy also had no bearing on whether trainees conceived of themselves in role as significantly more or less similar to their conceptions of the role model. These results are rather surprising, since it would seem probable that actually doing the work would provide trainees with the opportunity to test out and reflect upon their behavior in and out of role, and to compare behavior in role with notions of ideal role behavior. In fact, these results seem to contradict those of Perlman (1972) who found that doing psychotherapy resulted in a greater congruence of self and ideal-self concepts in beginning therapists. In addition, anecdotal reports like that of Klagsbrun (1967) suggest that with experience the novice therapist's image of himself in role does change.

There are several possible explanations for these results. The first, which relates to both hypotheses, is that the Semantic Differential as used in this study provides only a quantitative measure of overall similarity or difference between concepts, as opposed to a more qualitative measure. For example, it is possible that over the course of experience, conceptions of <u>both</u> self and self as therapist, or self as therapist and

therapist are modified, and if they are modified in relatively equal proportion to each other, the Semantic Differential would not pick this up, since it only picks up general distance. This speaks to the relative crudeness of any self-report scale which is used in an attempt to measure subtle variations in attitudes. In light of this point, the results indicate that the sample as a whole perceived all three concepts (i.e. "me," as therapist," and "therapist") as relatively quite similar to begin with. Therefore, it is likely that differences in meaning which may have occurred on the basis of experience would hardly be discernable since there was little room for modification. This point fits with Clark's (1973) observation that for the group of clinical psychology students he studied, clinical training was "natural," from the beginning since it fit with students' sense of personal growth, and that training was more a process of "polishing than of transforming (p. 331)."

In addition, the present study measured change over a broad range of experience. It is possible that had there been enough people in the sample to exclude those falling within the middle of the range, and the author simply had compared the more extreme ends of the experience range, statistically significant results would have been obtained. Furthermore, the results indicate that in one case a significant change in one of the factors for one of the concepts did occur. It was found that the more months of therapy experience, the better were the trainees' concepts of themselves (i.e. "me") on the evaluative factor. However, this was not a powerful enough change to effect the concept as a whole, in which three factor measures were involved, nor was it powerful enough to effect a difference in the comparison of the two concepts "me" and "me as therapist"

in which six factor measures were involved. Changes in how the concept pairs were viewed might have been measured more effectively by doing a longitudinal rather than a cross-sectional study. Measuring the conceptions of the same people over different periods of time would also have eliminated some of the problems occurring as a result of the possible interdependency of some of the variables.

Other possibilities exist for why there was such little change in the comparison of concepts. The first has to do with the paradoxical effects of being in the dual role of both therapist and trainee. It is possible that the effects of being in the status of student are powerful enough to outweigh the effects of experience. As Seashore (1975) has noted, the fact of being a student in a professional development program may create levels of stress that effectively impede learning during phases of the program which the faculty regard as critical. Perhaps being in the role of trainee precludes the possibility of developing a different sense of oneself in the role of therapist. No matter how much actual experience the trainee has, the therapist role may be experienced as somewhat artificial as long as the individual is also a "trainee." In other words, it is possible that the professional context in which the experience is gained is more influential than the experience qua experience. One could speculate that one's sense of oneself as a therapist changes most dramatically when one is actually working as a professional rather than as a trainee, since there may be more social sanction and external pressure to alter one's conceptions in the former case.

A final issue which is related to that of the particular context in which the experience is gained, has to do with how one's individual

wishes, fantasies and covert assumptions regarding the role interrelate with the reality requirements of the role in determining how one conceives of it. Active reflection concerning the relationship between these inner and outer realities would appear to be essential in influencing changes in self and role conceptions. It is assumed in most training programs that the experience of doing therapy in and of itself does not have built within it enough of an opportunity for self-reflection on the part of the trainee. That is one of the reasons why supervision is provided. But the results of this study suggest that even supervision does not provide the necessary context to influence significantly the trainee's sense of himself in role, or his sense of the role in general. The results of this study do indicate that the personal therapy experience of the trainee had a bearing on difference in definition between self-concept and concept of self in role. This experience is "extra professional" and yet is inextricably bound up with the professional training of the therapist in that it provides a context for active reflection regarding personal motivations and behaviors, including what it means to be training to be a therapist. We would assume that part of what went on in the personal therapy of the subjects in this example was an attempt to understand and work through what acquiring the therapeutic role means. It will be recalled that the larger the number of hours of personal therapy experienced, the more dissimilarity there was between "me" and "me as therapist" within the context of the fact that the entire sample viewed those two concepts as most similar. This suggests that the personal therapy experience of the trainees in this group may have had a bearing on their ability

to maintain a non-defensive distance between role and person, while maintaining a sense of "fit" in the role. In the context of conceiving of self and self in role as similar, people with many hours of personal therapy saw more of a differentiation between themselves and themselves in role than those who had fewer or no hours of personal therapy. One can speculate from this, that this ability to maintain a relatively clear boundary between one's sense of self and one's sense of self in role may aid these therapists in dealing with countertransference issues and dilemmas encountered in their treatment of others. In sum, then, experience doing therapy in and of itself did not bear on role or self definition while experience in therapy did. These results lend strong support to the notion that personal psychotherapy is an important, if not necessary, component of therapeutic training.

Before leaving the first two hypotheses, it is of additional interest to take note of those concept pairs which experience did relate to. It will be recalled that the greater the amount of experience, the more dissimilarity was perceived between "therapy patients" and "me," "me as supervisee" and "me," and "me as supervisee" and "me as therapist." A serious issue implicit in these findings (and particularly in the "therapy patients"--"me" dichotomy) is that experience seemed to have promoted defensive distancing and splitting, rather than reducing it. This again contradicts findings like those of Dymond & Lerner (1963) in which distancing was attributed to less experienced therapists. These results are enigmatic, but they do suggest that the relatively low status which both the position of patient and the position of supervisee have in the division of authority which is

built into the structure of the therapeutic and supervisory relationships, may have contributed to the distinctions drawn between the concept pairs in question. Whether in fact the same results would be found if the study were replicated with another sample is open to question.

To turn now to hypothesis 3, it was found that the comparison between self concept and concept of self in role was not significantly different for women vs. men. This suggests that for this particular group of women and men there was no particular gender-linked difference in the attainment of a sense of "fit" in the role. As indicated earlier, there is little information in the literature which would either support or refute the notion that gender has a bearing on how people experience the process of assuming the therapeutic role. The issue therefore remained an open question for the author. For example, since many of the behavioral requirements of the therapeutic role are often associated with traditionally female functions, it was considered possible that assuming the therapeutic role might be experienced as qualitatively different for women and men as a result of differential sex-role learning. It was thus felt to be important to develop hypotheses to test for possible gender differences. As with the first two hypotheses, the fact that no difference was found may be a result of certain methodological problems. For example, it is unclear whether the same results would have been obtained in a more homogeneous sample of women and men in which there was a very limited range of experience. And again, differences occuring between the two groups may have been impossible to obtain since the two concepts in question were conceived of as very similar by both groups to begin with. Therefore, it would seem

premature to reject the question implied by this hypothesis on the basis of these results alone, particularly in light of the findings of the next two hypotheses, which will be presented in the discussion which follows.

To turn now to hypothesis 4, it will be recalled that women perceived a significantly greater difference between themselves as therapists and their model of therapist, than did men. This suggests that while women do not evidence differences in taking up the therapeutic role per sé (re: hypothesis 3) they may have more trouble living up to their ideal notions of the role than men do. The results lend further support to this notion since they indicate that the difference between the two groups was due to women's having defined "therapist" as significantly better (i.e. on the evaluative factor) than men. In other words, their conceptions of "therapist" were more idealized than men's were. This finding lends support to the contention of Abramowitz & Abramowitz (1976) that women may grossly undersell their level of clinical expertise. Women trainees may feel relatively less competent as therapists than men because their idealized images of the role are more unobtainable. Why would this be the case? One possibility has to do with the fact that despite the traditionally maternal functions associated with the role, the societal model of "therapist" is that he is male. If women's notions of "therapist" have, in part, associations of maleness attached to them, then they would perceive a wider gap between themselves as therapists and the abstract idea of therapist, than men would. Moreover, Newton (1973) points out that certain personal qualities such as being male, carry with them a "natural authority" which is related to high status categories of social membership;

as a result, "psychotherapists who do not evidence all or most of these properties may encounter special difficulties in establishing their authority... despite the fact that such characteristics bear no inherent relationship to task--competence (p. 510)." If "therapist" is associated with authority and if women, due to the nature of their socialization, don't associate authority with femaleness, as for example, the Abramowitz's (1976) and Taylor et al.(1977) contend, then the ideal of "therapist" would seem even more unobtainable. Further, Newton (1973) points out that the therapeutic role encompasses a dual set of constellations: the helping role, which most resembles the maternal role and the managerial role which resembles the paternal role. Thus women, traditionally unschooled in exercising "masculine" managerial functions would find the "real world decision making" involved in exercising traditionally masculine managerial authority to be quite problematic, and as the Abramowitz's contend, this may lead to greater dependence on supervisors. The results of hypothesis 5 also appear to lend support to this idea and will be discussed next.

The final two hypotheses deal with the broad range of dilemmas encountered by trainees. Before going directly to them, it is necessary to comment briefly about the group results as a whole. It will be recalled that the group tended not to identify the vast majority of dilemmas listed as being particularly true for them. Possible reasons for why this occurred, and implications which come out of it will be discussed later in this chapter. At this point, however, the reader is reminded that while a set of dilemmas may have come out in the analysis as being "more intense" for a particular sub-group, this occurred in the context of the entire

group's not having identified them as problematic to begin with.

As noted earlier, the results of hypothesis 5 appear to lend further support to the contention of Abramowitz & Abramowitz that issues concerning authority and dependency are more problematic for women in their training. Again, though,while women identified feeling dependent upon supervisors as more problematic for them than men did, they did not identify this as a problem in the absolute sense. Thus,it is impossible to conclude on the basis of this one statement that Abramowitz's contentions are completely correct. Furthermore, this result may be equally interpreted to mean that women were simply more able to acknowledge their feelings of dependency in supervisors than men were. However, these results taken in combination with those of hypothesis 4 certainly suggest that women may have some very different issues to deal with as part of their training. Further support for this notion is also suggested by the fact that women perceived the concepts "me" and "me as supervisee" to be more closely related than men did. This suggests that at least this group of women may have experienced themselves as fitting more comfortably into the supervisee role, which is, relatively speaking,a position of lower status and authority,and is one which pulls for dependency.

The results of hypothesis 5 also indicate that while there was a difference in the intensity with which one particular dilemma was identified by women vs. men, there were no differences in either the intensity or kinds of other dilemmas listed. Specifically, dilemma items which related to claims that women may be more invested than men in getting advice about what to do, that they may more readily overidentify with patients or

react viscerally to clinical labels, were not identified by women, nor were other items which related to dependence. Thus, the results of the hypotheses involving gender are equivocal at best. Whether in fact women and men experience different kinds of dilemmas as part of their training is still open to question, especially since the general negative response pattern of the group as a whole mitigated against obtaining significant results.

With regard to hypothesis 6, there was a set of dilemmas and patient behaviors which were identified as more problematic or intense for trainees with less experience (in the context of not being identified as problematic in the absolute sense). However, trainees with different levels of experience did not identify different kinds of dilemmas. As with hypothesis 5, this may have been due to the negative response pattern of the entire group. A consideration of the set of patient behaviors identified as relatively more anxiety provoking, appear for the most part to involve actions or demands by the patient which may be experienced by the therapist as transgressions of the role boundary into the more personal sphere, as compared to behaviors which relate more directly to patient anxieties or fantasies, or which are more generally symptomatic of patient pathology. These results imply that experience doing the work does seem to make the trainee somewhat more comfortable and confident about engaging with patients.

It is also interesting to note that "suicidal statements" (item 56) was identified as less anxiety provoking as level of experience increased, although this item was identified as one of the most problematic for the group as a whole. This corresponds with Halleck & Woods' (1962) contention that the issue of patient suicide is most traumatic for the beginner.

A consideration of the set of dilemmas identified as relatively more problematic for less experienced trainees, suggests that they generally fell into three categories: concern about level of experience as reflected by lack of clinical expertise, confusions about the ambiguity of therapeutic work, including not having a clear sense of what the therapeutic role entails, and most primarily, anxieties regarding the patient-therapist interaction.

It is striking that a category generally not included in the set of dilemmas which correlated with experience had to do with evaluation by, and interaction with supervisors. This is especially surprising since the experience in question is supervised experience. Whether there is any real significance to this fact is unclear. One may speculate about whether it may be easier for the trainee to feel more confident in his relationships with patients over the course of time than in his relationships with supervisors, because in the former relationship he is in a higher position of authority which encourages competence and "rationality," and in the latter, he is in a lesser position, very much resembling that of the patient in that it may stimulate regression, strong conflict, and transference problems. On the other hand, perhaps a more direct measure of number of supervisory hours would have related to a lessening of supervisory difficulties.

At this point, a discussion of the group response pattern and results is in order. One reason for why the group tended to respond negatively to the dilemmas may be that the items were worded in such a way as to pull for denial, or possibly the very nature of the items (i.e. that they were all problems) pulled for denial. In other words, the tone of the items might have touched off denfensiveness. Another possibility is that there simply

was a good deal of defensiveness involved in the way many people in the group responded to the items, irrespective of the way they were worded. This may perhaps have been exacerbated by responding to a peer (i.e. the author) even though the scales were filled out anonymously. An examination of two of the items which were rated as dilemmas by the group appears to shed some further light on the matter. It is quite striking that of the four items acknowledged to be dilemmas, the one which received the highest overall rating by the group was, "Training to be a therapist is a painful process." This statement seems strongly to be belied by the overall non-identification of dilemmas which occurred. Furthermore, one other highly rated item concerned a feeling of "pressure to appear in control and competent even when I'm feeling confused and vulnerable." These two items, taken together, appear to underscore a strong paradox which seems to have affected the way people responded. This paradox may in fact reflect the major training dilemma which exists for the group: despite the fact that people experience pain as part of their training, they feel unable to acknowledge the extent or specifics of that pain because of a pull to appear "competent." The group culture strongly appears to support the myth that it is unacceptable for the trainee to express anxiety, as described by Rioch et al. (1976). If this is so, it indicates that at least for this particular group of psychologists, the most difficult issue to be worked through is how to use one's vulnerability and doubt in the service of the task of both the learning and doing of therapy. A general question for training, then, might be how to create atmosphere in which dilemmas can genuinely be shared and worked on in a more open and accepting manner,

without the additional fear that anxiety or uncertainty equals incompetence.

There are a variety of directions in which future research might be taken. For example, in order to get a clearer idea of how (or if) primary professional affiliation effects the training experience, it might be useful to compare psychologists, psychiatrists, and social workers along the lines of this study in order to see similarities or differences in how the therapeutic role is experienced, and in the kinds of dilemmas which are important for each group. An investigation of how therapeutic orientation (e.g. dynamic vs. behavioral) effects the types of difficulties experienced as part of training, might also be done. In addition, it would be interesting to examine differences in role definition and in dilemmas experienced by a group of highly experienced therapists (e.g. supervisors) as compared to a very inexperienced group, or by those who are actually no longer students as compared to those who are.

The results of this study suggest that personal psychotherapy for the trainee plays an important part in how the trainee defines himself in the role of therapist. More detailed and descriptive examination of the effects of personal therapy on the training experience might be done. What qualitative differences in attitudes concerning the task or the role might there be in a group of trainees with the same amount of experience doing therapy, but differences in whether or not they were in or had been in their own treatment? For example, on a measure such as

the Semantic Differential, what differences might there be in how trainees with or without personal therapy view "me as therapist" in terms of evaluation, activity or potency? What differences might there be in the way one particular aspect of training is viewed, such as supervision? Moreover, the same types of more descriptive differences might be examined for gender.

The present study, although very broadly conceived, does suggest at the Abramowitz's contend, that women may have particular kinds of dilemmas of their own in taking up the therapeutic role. Certainly, further research into how women and men perceive the various roles related to therapy and therapy training is necessary. For example, it might be interesting to examine differential responses and attitudes toward same sex vs. opposite sex supervisors or patients.

As noted earlier, this study was conceived in part out of many discussions with other students concerning their dilemmas, including intensive, formal interviews with three students. These interviews, each of which lasted about two hours, had a compelling quality of vitality, immediacy and lack of defensiveness which came out of the flow of interaction. Future research might rely more heavily on the use of the "free interview" as used by Levinson and others in doing adult development research. This technique might provide a richer body of information about how different variables (such as gender, age, race, etc.) connect and interpenetrate with how therapists experience their training.

It is hoped that more researchers will attempt to learn about the

personal vicissitudes involved in the experience of training and becoming a therapist. Some of the difficulties experienced seem to be indigenous to the "becoming" process itself. Others may be artifacts of training experiences which lay a heavy emphasis on theory and technique, but do not emphasize enough that the "pain" of the becoming process is to be expected, is acceptable, can be worked through, and more importantly, can enhance the work. If dilemmas of the latter kind could be minimized, then therapy training might be an even more enriching and growth producing enterprise than it already is.

APPENDIX

ORIGINAL VERSION OF THE DILEMMA SCALE

The following items are sentences which are incomplete. Please fill in each sentence as quickly as possible. Do not ponder over each sentence; rather, make an effort to write the first impression that occurs to you. Your answer may be one word, or as long as a sentence. It's up to you. Try to limit your responses to as few words as possible. I'm interested in your associations to the particular items, so feel free to be metaphorical, and do your best not to edit out your initial gut reactions. (If you have not yet actually started seeing patients in therapy, fill in your answers based on your impressions of how you would respond if you were seeing patients in therapy. As a reference point, you might think about how you felt about the contacts you have had with patients, e.g., doing intakes).

Doing therapy is like

My patients experience me as

My supervisors experience me as

Being a therapist is like

Patients who see beginning therapists

Learning to be a therapist is like

Student therapists

Being a patient in therapy is like

Being in supervision is like

Being with a patient in a therapy session is like

My biggest problem as a novice therapist is

The most important advice I'd give to a novice therapist is

I'll stop feeling like a beginner when

When my supervisors disapproves

After a day of seeing patients I feel

While waiting for a patient to arrive for a session I feel

When a session is over I feel

The most uncomfortable feeling I have toward a patient is

What makes me most anxious with a patient is

In choosing a therapist, a person should consider

My supervision would be much better if

The most disillusioning thing about becoming a therapist is

The most important quality for a beginning therapist to have is

In the field of therapy it's best to be thought of as

In the field of psychology it's best to be thought of as

I would be a better therapist if

A therapist should be careful

My peers probably see me as

The following statements concern issues which may be involved in the process of becoming a therapist. For each listed item please put a number (from 1 to 6) in the space provided next to the item, indicating how true this statement is for you. The numbers mean:

1=Definitely not true (never true)
2=Not true (usually not true)
3=Tends to be not true (moderately untrue)
4=Tends to be true (moderately true)
5=True (usually true)
6=Especially true (always true)

Remember, the higher the number you put, the more true the statement is for you. Please try to answer every item, but do not spend a long time pondering over every item. I am interested in your general impression of where you stand with regard to each of the items. Please try to be as honest as you possibly can. (If you have not yet started seeing patients in therapy, mark your answers based on how you think you would respond based on the kinds of experience you have had with patients, e.g., intakes.)

____I look forward to seeing my patients.
____My patients are aware of my level of experience.
____I feel doubtful about entering the field of psychotherapy.
____I feel competent about my work.
____I feel I'm similar to my patients.
____I am comfortable working with patients of my own sex.
____I am comfortable working with patients of the opposite sex.
____I am comfortable working with patients who are older than me.
____I am comfortable working with patients of different races.
____I feel competent about my work right now.
____I feel too involved with my patients.
____I am anxious with my patients.
____My patients feel I don't understand them.
____I think and behave like a therapist outside of work.
____I find it difficult to "be myself" in my role as therapist.
____I was anxious in my most recent session with a patient.
____I'm comfortable with my anger toward patients.
____I'm comfortable with my sexual feelings toward my patients.
____As a therapist, I wish I were more understanding.
____I feel incompetent and empty concerning therapeutic work.
____I experience a conflict between being a therapist and a psychologist.
____I am satisfied with my supervision.
____I am honest in supervision - even about my mistakes.
____It helps to discuss problems with peers.
____Personal therapy is necessary for the therapist.
____I'm more like my own therapist than my supervisor(s) in the way I do therapy.
____My concerns about my patients spill over into my personal life.
____I feel depleted by the work.
____I feel conflict between personal therapy and supervision.
____I secretly feel I really don't know too much more than my patients.
____I believe I'm treating my patients successfully.
____I feel my supervisors don't understand my motives.
____I am comfortable with male supervisors.
____I am comfortable with female supervisors.
____I am comfortable with supervisors of different races.
____My supervisors are too controlling.
____My supervisors are not supportive enough.
____I am anxious in supervision.
____My supervisors are competent.
____When I do therapy, I secretly feel that I'm playing at a role.
____I wish I weren't so psychological minded.
____I feel that I'm neglecting my family and/or friends because of the emotional demands of the work.
____When I make a decision about a patient I worry about it.
____My personal therapy has been successful.
____I feel competent with my supervisors.

____I'm afraid of mental illness.
____I'm able to handle ambiguity.
____It's important to me to be liked by my patients.
____I worry that I might unintentionally hurt my patients by something I say.
____I'm so busy watching myself as a therapist I have trouble really listening to my patients.
____I feel I'm not getting enough in supervision.
____I respond more intuitively to my patients than intellectually.
____I feel dependent on my supervisors.
____I feel competitive with my peers.
____I'm concerned about my level of experience.
____If I knew more I'd be a better therapist.
____When my patients cancel a session, I secretly feel relieved.
____I am unsatisfied with the degree of my warmth, empathy, and flexibility as a therapist.
____When I meet a person socially for the first time, I feel rather anxious.
____When a session is over, I secretly feel relieved.
____When I'm waiting for a patient to arrive I feel rather nervous.
____After a day of work with patients, supervisors and seminars, I emotionally "close down."
____I feel disillusioned about this work.
____Trying to figure out which model or authority to follow is a dilemma for me.
____It's hard for me to be honest in supervision because I'm concerned about being judged.
____When I discuss my feelings and reactions toward patients in supervision, I find that the boundary between supervision and my personal therapy gets blurred.
____I feel a conflict between who I am as a person, and how I behave in my role as therapist.
____I have trouble integrating theory and practice.
____When I meet a patient for the first time, I feel rather anxious.
____It bothers me the way people respond to me in social situations when they find out I'm a therapist.
____When my supervisor cancels a session I feel anxious.
____I feel a pressure to appear in control and competent even when I'm feeling confused and vulnerable.
____I wonder if I should be warm or distant with my patients.
____I'm concerned about what to do when I'm with a patient in therapy.
____I'm concerned about how I should behave as a therapist.
____With what I know about psychopathology, I get concerned about the degree of my own "craziness."

I feel (or think I would feel) anxious as a result of the following patient behaviors. (Rate from 1 to 6, using the same key as with the other statements).

____threats to leave before the end of the hour.
____suicidal statements.
____insulting, challenging or sarcastic statements.
____crying.
____extremely complimentary remarks about me.
____dependent statements.
____agitated anxiety.
____questions about my competence.
____depressive silence.
____statements suggesting severe thought disorder.
____paranoid statements.
____questions about my level of experience.
____questions about my age.
____questions about my personal affairs and values.
____demands for evaluation.
____threats to terminate.
____excessive silence despite my interventions.
____expressions of sexual fantasies about me.
____expressions of hostile aggressive fantasies about me.
____comments about my physical characteristics.
____acting out.
____expressions about losing control.
____over-verbalization; not allowing me to talk.

Comments: What do you feel this scale was tapping? general criticism, etc. Use the back page if you need more room.

May 17, 1978

Dear Friends,

As you may know, I'm doing my dissertation on the dilemmas experienced by therapists in training, and I've spoken to many of you about filling out forms which are to be used as my data. Well - finally - here they are.

I would greatly appreciate it if you would take some time to fill these forms out as soon as possible, since the term is ending soon and I won't be around much in June. The whole thing should take you only about a half hour to do (at most) and I think you'll find it relevant and interesting. I'll be glad to discuss the project with anyone who is interested once I get the data collected.

After you complete the forms please deposit them in the box on top of the brown file drawers on Nurith's desk (to the left, when you fact the desk) and check off your name on the class list provided at the box, so I can keep track of who has turned them in. (Nurith does not want to be bothered with this, so if you have any questions or problems, ask me).

I am hoping to receive responses from as many of you as possible, and again...thanks for your help.

Judi Levy

P.S. If you are a first year student, and have done therapy under supervision previously - or have just begun - please fill these out. If not, this doesn't apply to you, so return it to my mailbox. Thanks.

May 18, 1978

Dear Friends,

As you may know, I'm doing my dissertation on the dilemmas of beginning therapists. I would, therefore, greatly appreciate it if you would take some time to fill out the enclosed forms and mail them back to me in the enclosed envelope. The whole thing should take you about a half hour to do at most. I'll be glad to discuss any questions or comments with anyone who is interested. Thanks for your cooperation.

Judi Levy

P.S. Please address the enclosed envelope to:

Judi Levy
860 E. 18 St.
Brooklyn, N.Y. 11230

May 31, 1978

Dear Friends,

About two weeks ago I asked you to fill out some forms related to my dissertation. Some of you have not responded as yet. If you have not, I would appreciate your doing so as soon as possible. Thank you again for your time and effort.

Judi Levy

FINAL VERSION OF SCALES USED

THERAPIST BACKGROUND

Directions: Please fill out this and the following sheets as completely as possible. All information will be entirely anonymous, and will be used only as part of the analysis of the data. DO NOT PUT YOUR NAME ON THE SHEET.

Sex_____

Age_____

Race_____

Year in the clinical program:

_____ 1

_____ 2

_____ 3

_____ 4

_____ internship

Approximate amount of experience doing psychotherapy (not intake, etc.) under supervision: (Please fill in both lines below)

Approx. no. of years_____(if months, please indicate)

Approx. no. of hours_____

Approximate number of therapy supervisors you have had thus far in your training:_____

Approximate number of patients you have seen in therapy thus far in your training:

Number of adults_____

Children or adolescents_____

Groups_____

Families or couples_____

Total_____

Number of hours of personal psychotherapy experience_____

Which kind of treatment do you see yourself primarily oriented toward?

Therapy with adults_____

Therapy with children_____

Theoretical orientation_____

Part 1 - Instructions

On each of the following pages you will find a concept or idea printed at the top of the page, with a set of scales beneath it. You are to rate the concept on each of these scales in order. Here is how you are to use these scales:

If you feel that the concept at the top of the page is very closely related to one end of the scale, you should place your check-mark as follows:

fair__X__:____:____:____:____:____:____unfair

OR

fair____:____:____:____:____:____:__X__unfair

If you feel that the concept is quite closely related to one or the other end of the scale (but not extremely), you should place your check-mark as follows:

fair____:__X__:____:____:____:____:____unfair

OR

fair____:____:____:____:____:__X__:____unfair

If the concept seems only slightly related to one side as opposed to the other, then you should check as follows:

fair____:____:__X__:____:____:____:____unfair

OR

fair____:____:____:____:__X__:____:____unfair

If you consider the concept to be neutral on the scale, both sides of the scale equally associated with the concept, or if the scale is completely irrelevant to the concept in your opinion, then you should place your check-mark in the middle space;

fair____:____:____:__X__:____:____:____unfair

IMPORTANT: Place your check-marks in the middle of spaces, not on the boundaries. Be sure to check every scale for every concept. Do <u>not</u> omit

any. Never put more than one check-mark on a single scale.

You may feel as though you've had the same or a similar item before on the test. This will not be the case, so do not look back and forth through the items. Do not try to remember how you checked similar items earlier in the test. Make each item a separate and independent judgment. Do not worry or puzzle over individual items. I am interested in your first "gut" impressions, and your immediate feelings about the items. On the other hand, please do not be careless, because I want your true impressions.

ME

good____:____:____:____:____:____:____bad

complex____:____:____:____:____:____:____simple

comfortable____:____:____:____:____:____:____uncomfortable

stable____:____:____:____:____:____:____changeable

strong____:____:____:____:____:____:____weak

hot____:____:____:____:____:____:____cold

constrained____:____:____:____:____:____:____free

active____:____:____:____:____:____:____passive

sane____:____:____:____:____:____:____insane

kind____:____:____:____:____:____:____cruel

hard____:____:____:____:____:____:____soft

tense____:____:____:____:____:____:____relaxed

authentic____:____:____:____:____:____:____facsimile

competitive____:____:____:____:____:____:____cooperative

cautious____:____:____:____:____:____:____rash

leading____:____:____:____:____:____:____following

wise____:____:____:____:____:____:____foolish

safe____:____:____:____:____:____:____dangerous

rational____:____:____:____:____:____:____intuitive

tenacious____:____:____:____:____:____:____yielding

PSYCHOTHERAPIST

good ___:___:___:___:___:___:___ bad

complex ___:___:___:___:___:___:___ simple

comfortable ___:___:___:___:___:___:___ uncomfortable

stable ___:___:___:___:___:___:___ changeable

strong ___:___:___:___:___:___:___ weak

hot ___:___:___:___:___:___:___ cold

constrained ___:___:___:___:___:___:___ free

active ___:___:___:___:___:___:___ passive

sane ___:___:___:___:___:___:___ insane

kind ___:___:___:___:___:___:___ cruel

hard ___:___:___:___:___:___:___ soft

tense ___:___:___:___:___:___:___ relaxed

authentic ___:___:___:___:___:___:___ facsimile

competitive ___:___:___:___:___:___:___ cooperative

cautious ___:___:___:___:___:___:___ rash

leading ___:___:___:___:___:___:___ following

wise ___:___:___:___:___:___:___ foolish

safe ___:___:___:___:___:___:___ dangerous

rational ___:___:___:___:___:___:___ intuitive

tenacious ___:___:___:___:___:___:___ yielding

THERAPY PATIENTS

good ___:___:___:___:___:___:___ bad

complex ___:___:___:___:___:___:___ simple

comfortable ___:___:___:___:___:___:___ uncomfortable

stable ___:___:___:___:___:___:___ changeable

strong ___:___:___:___:___:___:___ weak

hot ___:___:___:___:___:___:___ cold

constrained ___:___:___:___:___:___:___ free

active ___:___:___:___:___:___:___ passive

sane ___:___:___:___:___:___:___ insane

kind ___:___:___:___:___:___:___ cruel

hard ___:___:___:___:___:___:___ soft

tense ___:___:___:___:___:___:___ relaxed

authentic ___:___:___:___:___:___:___ facsimile

competitive ___:___:___:___:___:___:___ cooperative

cautious ___:___:___:___:___:___:___ rash

leading ___:___:___:___:___:___:___ following

wise ___:___:___:___:___:___:___ foolish

safe ___:___:___:___:___:___:___ dangerous

rational ___:___:___:___:___:___:___ intuitive

tenacious ___:___:___:___:___:___:___ yielding

ME AS THERAPIST

good ___ : ___ : ___ : ___ : ___ : ___ : ___ bad

complex ___ : ___ : ___ : ___ : ___ : ___ : ___ simple

comfortable ___ : ___ : ___ : ___ : ___ : ___ : ___ uncomfortable

stable ___ : ___ : ___ : ___ : ___ : ___ : ___ changeable

strong ___ : ___ : ___ : ___ : ___ : ___ : ___ weak

hot ___ : ___ : ___ : ___ : ___ : ___ : ___ cold

constrained ___ : ___ : ___ : ___ : ___ : ___ : ___ free

active ___ : ___ : ___ : ___ : ___ : ___ : ___ passive

sane ___ : ___ : ___ : ___ : ___ : ___ : ___ insane

kind ___ : ___ : ___ : ___ : ___ : ___ : ___ cruel

hard ___ : ___ : ___ : ___ : ___ : ___ : ___ soft

tense ___ : ___ : ___ : ___ : ___ : ___ : ___ relaxed

authentic ___ : ___ : ___ : ___ : ___ : ___ : ___ facsimile

competitive ___ : ___ : ___ : ___ : ___ : ___ : ___ cooperative

cautious ___ : ___ : ___ : ___ : ___ : ___ : ___ rash

leading ___ : ___ : ___ : ___ : ___ : ___ : ___ following

wise ___ : ___ : ___ : ___ : ___ : ___ : ___ foolish

safe ___ : ___ : ___ : ___ : ___ : ___ : ___ dangerous

rational ___ : ___ : ___ : ___ : ___ : ___ : ___ intuitive

tenacious ___ : ___ : ___ : ___ : ___ : ___ : ___ yielding

THERAPY SUPERVISOR

good___:___:___:___:___:___:___bad

complex___:___:___:___:___:___:___simple

comfortable___:___:___:___:___:___:___uncomfortable

stable___:___:___:___:___:___:___changeable

strong___:___:___:___:___:___:___weak

hot___:___:___:___:___:___:___cold

constrained___:___:___:___:___:___:___free

active___:___:___:___:___:___:___passive

sane___:___:___:___:___:___:___insane

kind___:___:___:___:___:___:___cruel

hard___:___:___:___:___:___:___soft

tense___:___:___:___:___:___:___relaxed

authentic___:___:___:___:___:___:___facsimile

competitive___:___:___:___:___:___:___cooperative

cautious___:___:___:___:___:___:___rash

leading___:___:___:___:___:___:___following

wise___:___:___:___:___:___:___foolish

safe___:___:___:___:___:___:___dangerous

rational___:___:___:___:___:___:___intuitive

tenacious___:___:___:___:___:___:___yielding

ME AS SUPERVISEE

good____:____:____:____:____:____:____bad

complex____:____:____:____:____:____:____simple

comfortable____:____:____:____:____:____:____uncomfortable

stable____:____:____:____:____:____:____changeable

strong____:____:____:____:____:____:____weak

hot____:____:____:____:____:____:____cold

constrained____:____:____:____:____:____:____free

active____:____:____:____:____:____:____passive

sane____:____:____:____:____:____:____insane

kind____:____:____:____:____:____:____cruel

hard____:____:____:____:____:____:____soft

tense____:____:____:____:____:____:____relaxed

authentic____:____:____:____:____:____:____facsimile

competitive____:____:____:____:____:____:____cooperative

cautious____:____:____:____:____:____:____rash

leading____:____:____:____:____:____:____following

wise____:____:____:____:____:____:____foolish

safe____:____:____:____:____:____:____dangerous

rational____:____:____:____:____:____:____intuitive

tenacious____:____:____:____:____:____:____yielding

Part 2 - Instructions

The following statements concern dilemmas which may be encountered by therapists in training. For each listed statement, please fill in a number (from 1 to 6) in the space provided, indicating how true the statement is for you. The numbers mean:

1 = Definitely not true
2 = Usually not true
3 = Tends to be not true
4 = Tends to be true
5 = Mostly true
6 = Especially true

Remember, the higher the number you indicate, the more applicable or true the statement is for you. Please try to answer every item, indicating only one number per item. Do not spend a long time pondering over any item; rather, try to stay with your initial gut response. Please try to be as honest, spontaneous and undefensive as you possibly can.

1.____ I have doubts about wanting to become a psychotherapist.

2.____ I question if I can handle the responsibility of therapeutic work.

3.____ I wish I weren't so psychological minded.

4.____ I have trouble integrating theory and practice.

5.____ I worry about my competence to do psychotherapy.

6.____ I over-identify with my patients.

7.____ If I had my Ph.D. I'd feel more secure as a therapist.

8.____ I have difficulty trusting my own clinical judgment.

9.____ I worry that I may touch on something with a patient that I can't handle.

10.____ I feel I'm too invested in my patients.

11.____ When my patients cancel a session, I secretly feel relieved.

12.____ My wishes to be liked by my patients interfere with my attending to the processes going on between us.

13.____ I am anxious with my patients.

14.____ I am concerned about my level of experience and training.

15.____ I have difficulty deciding how to behave as a therapist.

16.____ I feel I'm not getting enough in supervision.

17.____ I have difficulty trying to figure out which model or authority to follow.

18.____ When I discuss my feelings and reactions toward patients in supervision, I find that the boundary between supervision and therapy gets blurred.

19.____ I am uncomfortable with my anger toward patients.

20.____ I feel I'm too distant with my patients.

21.____ I feel my supervisors' influence on me overly limits my spontaneity and flexibility as a therapist.

22.____ I'm uncomfortable with my sexual feelings toward my patients.

23.____ I experience a conflict between being a therapist and a student.

24.____ I secretly worry that I really don't understand too much more about my patients than they do.

25.____ I'm so busy watching myself as a therapist, that I have trouble really listening to my patients.

26.____ When waiting for a patient to arrive for a session I feel tense.

27.____ As a therapist in training I feel a pressure to appear in control and competent even when I'm feeling confused and vulnerable.

28.____ I have difficulty deciding what to do when I'm with a patient.

29.____ I wonder if my patients are being shortchanged due to my level of training.

30.____ My supervisors are too controlling.

31.____ I feel like a patient in supervision.

32.____ I am anxious in supervision.

33.____ I worry that I might unintentionally hurt my patients by something I say.

34.____ I feel my supervisors' understanding of my patients is far superior to mine.

35.____ I feel that I don't understand my patients as well as I could.

36.____ I worry that I too often fit patients into theory rather than hear them on their own terms.

37.____ I wish my supervisors would more often address my patients' problems rather than mine.

38.____ I'm conflicted about sharing personal details of my life with patients.

39.____ I question if I should be myself, or like my therapist or supervisors in my role as therapist.

40.____ When a session is over, I secretly feel relieved.

41.____ I'm conflicted about sharing my personal feelings with patients.

42.____ When I do therapy, I secretly feel that I'm playing at a role.

43.____ I get confused and frustrated about what the role of therapist actually entails.

44.____ My supervisors are too unstructured.

45.____ My supervisors are not supportive enough.

46.____ My knowledge of psychopathology exacerbates my concern about the degree of my own "craziness."

47.____ I feel dependent upon my supervisors.

48.____ I feel unsettled by the ambiguity inherent in therapeutic work.

49.____ I wonder if my wish to please my supervisors outweighs my wish to work well for my patients' sake.

50.____ After a day of work with patients, supervisors, and seminars, I emotionally "close down."

51.____ When I'm in a session with a patient, I wonder what my supervisor would think about what I'm doing.

52.____ I have difficulty being open and honest in supervision because I worry about being judged.

53.____ The process of becoming a therapist has made me more vulnerable to depression.

54.____ Training to be a therapist is a painful process.

I feel, or think I would feel, anxious in response to the following patient behaviors (rate from 1 to 6).

55.____ threats to leave before the end of the hour.

56.____ suicidal statements.

57.____ insulting, challenging or sarcastic statements.

58.____ crying.

59.____ extremely complimentary remarks about me.

60.____ dependent statements.

61.____ agitated anxiety.

62.____ questions about my competence.

63.____ depressive silence.

64.____ statements suggesting severe thought disorder.

65.____ paranoid statements.

66.____ questions about my level of experience or training.

67.____ questions about my age.

68.____ questions about my personal affairs and values.

69.____ demands for evaluation.

70.____ threats to terminate.

71.____ excessive silence despite my interventions.

72.____ expressions of sexual fantasies about me.

73.____ expressions of hostile aggressive fantasies about me.

74.____ comments about my physical characteristics.

75.____ expressions about losing control.

76.____ over-verbalization; not allowing me to talk.

77.____ demands to know my feelings.

THE END...THANKS ALOT.

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