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# PSYCHOTHERAPISTS' FORMULATIONS OF A PATIENT'S CORE CONFLICTUAL RELATIONSHIP THEME: THE EFFECTS OF LEVEL OF EXPERIENCE AND VARIATIONS IN MODE OF LISTENING

by

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

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Abstract

PSYCHOTHERAPISTS' FORMULATIONS OF A PATIENT'S CORE CONFLICTUAL RELATIONSHIP THEME: THE EFFECTS OF LEVEL OF EXPERIENCE AND VARIATIONS IN MODE OF LISTENING

by

Jessica G. Schairer

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Sixty-six psychotherapists ranging in experience from beginners to those with over 25 years of experience were given instructions either to listen in their usual way, or to "listen towards" (listen with critical attention) or to "listen away" (listen with free-floating attention). They then heard the same twenty-minute segment from a woman patient's third psychotherapy session. Afterwards, the subjects wrote down what seemed to them "her basic life problem--the core conflictual theme of her communication," rated 21 themes and affects for their presence in the session, and answered questions about their own experience as therapists and as patients, plus other demographic data.

Contrary to the work reported by Miller (1972), no measurable effect on mode of listening was found using his listening instructions. Therefore, this study was unable to study the effects of different ways of listening because no demonstrably different ways of listening were induced in the groups of subjects.

Over half the subjects were found to identify Luborsky's (1976)

"core conflictual relationship theme" (CCRT) in their formulation of the patient's "basic life problem--the core conflictual theme of her communication."

However, whether the subjects were considered divided into either of two or four levels of experience, or even into experience vs. no experience, one-way analysis of variance yielded no statistically significant differences between groups in either their ability to identify the CCRT, or accurately predict outcome, or in their assessment of pathology. Nor were there any differences between groups in their rating of any of the 21 themes or affects on the checklist.

In regard to the hypotheses this study proposed to test, it was concluded:

I. Verbal instructions to "listen away" did not lead to more accurate identification of basic themes than did verbal instructions to listen towards, for either students or practitioners. The two groups did equally well.

II. Sensitivity to high imagery words spoken by the patient was not significantly associated with following verbal instructions to "listen away." Sensitivity to low imagery words spoken by the patient was not significantly associated with following verbal instructions to "listen towards." Both students and practitioners, using all three listening plans, were more sensitive to high imagery words than to low imagery words.

III. More experienced therapists were not better able to identify the basic themes in clinical material than were less

experienced therapists. The two groups did equally well.

IV. Since no statistically significant differences were observed between listening plans, no conclusions may be drawn about how clinicians' listening styles compare to the theoretical concepts of "listening towards" and "listening away."

However, clinicians who had never been in personal psychotherapy identified the CCRT significantly less frequently than the rest of the sample, while the clinicians in the sample with between 16 and 150 hours of personal therapy identified it significantly more than the rest of the sample, clinicians with from 160 to over 2,000 hours of personal psychotherapy.

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Sixty-six psychotherapists at every stage of training generously gave their time to this experiment, and many thoughtful comments as well.

Ms. Jill Bellinson and Ms. Mary Miller rated the essays.

John O. Schairer wrote the computer programs necessary for data analysis.

My committee gave me the most helpful guidance imaginable.

In other words, this project could never have been completed without the generosity, concern and genuine helpfulness of over eighty people. I am deeply grateful to every one of them.

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# CHAPTER I

## INTRODUCTION

The object of this study was to investigate one component of clinical skill, listening, and how it influences one type of clinical judgment, the identification of basic themes from the raw material of therapy sessions.

What is there about the way the skilled clinician listens which enables him or her to apprehend aspects of the patient's experience of which the patient himself may be unaware? Is there a particular mode or modes of listening involved? How much is influenced by personality? By training and experience? Can the way clinicians listen be altered under experimental conditions?

How the clinician listens is the first step in clinical judgment in that the nature and extent of the information acquired determines subsequent understanding and behavior with the patient. Cognitive sets with which the clinician listens have been described and defined experimentally by Spence and Grief (1970) as "listening away" and "listening towards" and by Miller (1972) and Alpert and Cohen (in press) as "free-floating listening" and "critical listening."

Their ideas are based in part on Freud's listening technique which

> simply consists in making no effort to concentrate the attention on anything in particular, and in maintaining in regard to all that one hears the same measure of calm, quiet attentiveness--

> of "evenly-hovering attention". . . . For as soon as attention is deliberately concentrated to a certain degree, one begins to select from the material before one; one point will be fixed in the mind with particular clearness and some other consequently disregarded, and in this selection one's expectations or one's inclinations will be followed. This is just what must not be done, however; if one's expectations are followed in this selection there is the danger of never finding anything but what is already known, and if one followed one's inclinations anything which is to be perceived will most certainly be falsified. It must not be forgotten that the meaning of the things one hears is, at all events for the most part, only recognizable later on. (Freud, 1912, p. 118)

Both Miller and Cohen propose that "listening away" or "free-floating listening" is the equivalent of Freud's "evenly-hovering attention" and that it is the mode most commonly used by experienced clinicians in effectively listening to clinical material. Spence suggests that experienced clinicians combine both modes of listening flexibly for optimal information acquisition.

This study attempted to test these ideas.

The subjects were 66 psychotherapists who ranged in experience from novices who had never seen a patient to veterans of 25 years of experience in the field.

After being given a description of the experiment and signing a consent form, the subjects received specific listening instructions to either listen in their usual way, or to "listen toward" or to "listen away" (see Appendix I: Experimental Protocol). They then heard a twenty minute audio tape of a genuine psychotherapy session.

Spence (1975) has demonstrated the importance of using genuine clinical material for tests of clinical judgment. His careful analysis shows that cues and clues are present at every level

in the dynamically-motivated productions of real people in real clinical situations. There is no guarantee that the productions created by clinical researchers to imitate certain kinds of patient productions, such as the portion of an analytic session created by Spence et al. (1974) and used by Wolitsky (personal communication) and Alpert and Cohen (in press) really contain all the cues and clues a therapist might actually be using in his daily work.

After hearing the therapy tape, the subjects completed a test of memory for high imagery and low imagery words and spent up to twenty minutes writing down their view of the patient's "basic life problem--the core conflictual theme of her communication." They were also asked to describe their own age, sex, race, religion, and extent and type of training and personal therapy. Their view on their own style of listening and how it compared to the experimental one was also requested.

The study explored the effect of verbal instructions on the therapist's ways of listening in an attempt to examine how the listener's mental set affects what he hears and how he understands it. The study also explored differences in how therapists at different levels of experience hear and understand patients.

## CHAPTER II

## DERIVATION OF HYPOTHESES

Clinical judgment, in its broadest sense, dictates every decision a clinician at work makes and every professional action taken. Within this global category, we can discern many discrete cognitive skills and observable behaviors.

The process of diagnosis--of trying to get an overall picture of a person's personality and level of functioning--involves listening to a patient, understanding his or her problems, conceptualizing the sources of difficulties, giving these difficulties names and descriptions, and deciding on the best method of treatment.

The clinical skills involved in treatment itself also include listening, understanding, conceptualizing difficulties and giving names and descriptions to them--this time in language that makes sense to the patient as well as the professional. At the treatment level, all of these take place on a moment-by-moment basis, where at each moment the therapist must decide on his next action, keeping in mind both his long-term therapeutic goals and the immediate situation.

These skills are used by all clinicians, no matter what their theoretical persuasion--behaviorist, cognitivist, psychodynamic, psychoanalytic, whatever--who use verbal communication with the

patient as part of the process of diagnosis and/or treatment.

The diagnostician deals with a "fixed sample" of the patient--what he did in a limited number of diagnostic interviews. From this, he attempts to infer the larger sweep of the patient's life. Based on his view of the patient's diagnosis and prognosis, the clinician makes a few large-scale decisions with obviously far-reaching consequences, such as acceptance for treatment or hospitalization.

The therapist is himself embedded in the patient's larger life. He participates in the patient's life over a period of time, and is more aware than the diagnostician of the patient's daily fluctuations in mood and functioning. In a single therapy session, he makes many responses to the patient in the context of the immediate situation, some of which may have long-term consequences and some of which may not.

Yalom and Elkin (1974) have given a clear picture of this process in their presentation of an on-going therapy from both the patient's and therapist's points of view. As the therapist enters more deeply into his relationship with his patient, questions of diagnosis recede into the background. Motivating the patient to change becomes his main concern. Sometimes the patient and the therapist agree, but often they differ in their view of what was most central in a session--or even in whether the session was a good or bad one. But there is no doubt of the intense involvement of both parties in the treatment process--an involvement which generates a tremendous number of interpersonal events, in contrast to the diagnostician's single report.

Many aspects of the clinician's total functioning as a human

being are involved in his performance as a therapist.

That the personality and emotional qualities of the therapist as perceived by others are important components of his therapeutic effectiveness has been well-documented (Bergin, 1975). That therapist characteristics of warmth, accurate empathy and genuineness are important contributors to good therapeutic outcome has been empirically supported by a wide variety of studies (Truax & Mitchell, 1971).

Following this further, however, Bachrach, Luborsky and Mechanick (1974) summarized a series of their experiments as showing that a therapist's

> empathy and skill were so highly correlated . . . as to suggest that they may occur within a larger context of "goodness of psychotherapeutic work." This view finds support in multivariate studies of psychotherapy process variables in which judgments of [therapist's] empathy have been consistently highly associated with judgments of skill, security, good therapy, warmth, experientialness, niceness, strength and other ways of characterizing a good therapist. (p. 339)

However, the focus of this study is not on the clinician's emotional functioning, but on his cognitive functioning in his role as therapist: on an aspect of his judgment, the apprehension of basic themes in a therapy session.

## Person Perception and Clinical Judgment

Clinical judgment is a specialized type of person perception, a subject Asch (1946) and others in academic psychology have studied for the past thirty years or more. The questions of how we form an impression of another's personality and how we come to feel we know what another is feeling are extremely relevant to understanding how

the clinician functions. The clinician is, after all his specialized training, still a person perceiving other persons.

On the basis of findings in person perception research, it has been suggested that various aspects of the therapist's cognitive functioning should receive particular attention: cognitive complexity vs. cognitive simplicity; field dependence vs. field independence; predominantly verbal skill vs. predominantly quantitative skill. However, no such studies have been carried out on clinicians. They have all been done using college students as analogs for clinicians.

The literature on person perception, including most of the studies on clinical judgment, has been ably summarized by Tagiuri (1969). Harty (1971) has reviewed the clinical judgment literature in depth, including relevant person perception literature. Between these two articles, the fields are well-covered. Mischel (1968) has provided another overview which while comprehensive and thought-provoking is somewhat biased in summarizing individual research findings.

## Person Perception

For ten or fifteen years, clinical judgment and person perception were intensively researched areas in clinical, personality- and social psychology. Statistical methodology became more and more sophisticated as researchers (Anderson & Jacobson, 1965; Hammond, Hursh, & Todd, 1964; Jackson & Messick, 1963) unsuccessfully tried to verify hypotheses based on the common-sense theory that the ability to judge others accurately is a general personality trait, somewhat like intelligence. Interest in this approach gradually waned. Ten

years later, it appears that what happened was not that the experiments were methodologically inadequate, but that they rather conclusively demonstrated that the underlying theoretical formulation was too simplistic to support an explanation of the complexity of the phenomena under study.

Because of the importance of the question of how people understand others, researchers are again trying to explore this area. This time, the emphasis is on the process of "person perception" or "clinical judgment" in specific situations. Rather than trying to find "the good judge," researchers now focus on what particular judgments are based on and how they are made.

For many years, the main thrust in person perception research was the investigation of the ability, conceived of as a global personality trait, to be a good judge of others. At first, experimenters concentrated on teasing out how judges discerned the unique aspects of each person judged. Statistically sophisticated methods of differentiating "Stereotype Accuracy" from "Differential Accuracy" were devised (Cronbach, 1955) and Stereotype Accurace was subtracted from overall judgments as a response set.

However, when effective statistical methods of subtracting out Stereotype Accuracy were employed, it was found to be a very large component of most judges' total accuracy.

Cline and Richards (1960) concluded that there was indeed a general ability to judge others and that it had two components: Stereotype Accuracy, now also called "Sensitivity to the Generalized

Other," and Differential Accuracy, now also called "Interpersonal Sensitivity."

But four years later, Cline (1964) had come to the conclusion, after dealing extensively with the statistical problems inherent in research designed to differentiate and describe properties of these two components of accuracy, that a very different experimental approach should be attempted to circumvent the statistical problems inherent in this conceptualization. Judges should be asked to rank order on a number of traits people shown in filmed interviews. However, this suggestion still suffered from the problem of assuming that the average of a group of judges is the best judgment. At any rate, it was not implemented in further research.

Currently, it must be concluded that Stereotype Accuracy is not a general skill, but depends on the stereotype in question: how similar both perceived and perceiver are to the stereotype and their similarity to each other; how extensive the stereotype is in the behavior it describes; how well the person perceived actually fits the stereotype.

It was never possible to hold all these variables constant in order to explore "Interpersonal Sensitivity" (how we differentiate the personalities of two different "female undergraduate education majors at X State University").

Mischel (1968) has gone a step further and argued that research actually "produced even sharper and sharper evidence" that it was impossible to isolate general personality traits of any kind,

including a general trait of accurate person perception or good clinical judgment.

## Clinical Judgment

The debate over "clinical vs. statistical prediction" has been similar in nature to the debate over Stereotype vs. Differential Accuracy.

Stereotype Accuracy has its conceptual equivalent in the actuarial formula or the diagnostic category. When these are accurate and correctly applied, they may enable the clinician to make many accurate statements and predictions about a patient without even seeing him. For example, knowing a person is "depressed" may lead us to predict he feels sad, sleeps poorly, thinks bad thoughts about himself, etc. In many cases, these should be fairly accurate, if indeed current ideas about depression fit with reality.

In his review, Harty (1971) proposes an alternate approach to these questions which stresses "the clinician's uniquely human contribution." As Meehl (1954) and Holt (1958) both pointed out, most studies of clinical judgment have used already acquired data, suitable for actuarial formulation, to predict rather crudely defined social outcomes. It has been fairly well demonstrated (Goldberg, 1968) that where data of this kind is used, the clinician follows rules of data combination which can be expressed by linear, rather than configural, models, and that a computer following the clinician's rules can do at least as well as he can. Under some circumstances, a computer-program written by a clinician does better than a multiple-regression equation (Shinedling, 1973).

These findings have turned interest to the clinical judgment involved in how the clinician collects his data. Granting the lack of a general trait of "accurate judgment of others," person perception research has turned to the study of specific perceptual modes and cognitive styles which might influence people's understanding of others. Clinical judgment research has also focused its attention on these "uniquely human" methods of acquiring information about the personality of another.

Shrauger and Altrocchi (1964) were among the first to stress the importance of the judging process and the characteristics of the perceiver, such as differences in ability to judge same-sex and opposite-sex persons. A series of experiments by Fancher, two of which are relevant here (Fancher, 1966; Fancher, 1967) bridge the realms of person perception and clinical judgment research.

## Fancher's Studies

Fancher explored the interactions between cognitive styles and ability to predict and ability to conceptualize others' personalities. His data suggests that these are separate abilities and that different cognitive styles can achieve equal accuracy in different ways.

Fancher used students in undergraduate psychology courses as clinician-analogs, exposing them to genuine case materials. His measure of clinical judgment is a set of three programmed cases, based on material originally collected in the 1940's from a group

of normal Harvard sophomores. The cases are programmed in that after being given some initial demographic data, judges are asked to choose one of three responses as being a correct description of the case-subject. The judge is then given the correct answer before proceeding to the next response choice.

Previous studies have demonstrated that both sex and similarity between judge and person being judged have a strong influence on accuracy (Bronfenbrenner, Harding & Gallwey, 1958). In this light, it is interesting to note that Fancher has achieved his significant results first with male Harvard undergraduates as judges and then with male undergraduates at the University of Rochester. Wolitsky (unpublished paper) did not find above-chance predictive accuracy using a group of male and female NYU undergraduates as judges.

In his first study, Fancher (1966) found his judges as a group had a statistically significant, but only slightly better than chance, accuracy on this measure. The least accurate judge was accurate about 30% of the time and the most accurate judge about 70%. Judges' level of accuracy was consistent across the three cases.

He also assessed judges' cognitive complexity. He found a curvilinear relationship between accuracy and complexity: those judges who were at either extreme of the measure did better than those in the middle. It is interesting to note that an earlier study (Leventhal, 1957), which investigated the effect of judges' cognitive complexity vs. cognitive simplicity on judges' accuracy in predicting how others would fill out psychological tests, found that both types of judges

could be equally accurate, but achieved their accuracy in different ways. The cognitively simple judges assumed similarity between themselves and others; complex judges tended to differentiate themselves from others; both groups did equally well. Leventhal could not have found the curvilinear effect Fancher did because he selected his judges from the extremes of a much larger group.

Fancher found that for judges whose Quantitative scores on the GRE were higher than their Verbal scores, cognitive complexity was negatively correlated with accuracy; for judges whose Verbal scores were higher, complexity was positively correlated with accuracy.

> Mathematically oriented judges succeeded best if they emphasized the objective classification of persons into a relatively small number of well-defined categories, and if they de-emphasized the importance of individual uniqueness. . . .
>
> In contrast, the verbally oriented judges were accurate in their predicting if they stressed the complexity, purposiveness, and perhaps the uniqueness of each individual. . . . If these judges lost sight of the individual person they were trying to understand and stressed group determinants or sociocultural factors . . . their level of accuracy diminished. (1966, pp. 259-260)

Fancher's exposition clearly states how different cognitive styles might use different conceptual tools to reach equally accurate predictions.

In his next study, Fancher (1967) investigated the relationship between being able to predict well from his case material and being able to write a conceptualization of the case which would enable a new judge to be able to predict well on additional data about the same case. He found that the most accurate predictors tended to write the least valid (least helpful) conceptualizations, and vice versa. (These were apparently the same subjects as in the first study.)

The most useful measure in discriminating the two groups was the Kelly Role Construct Repertory Test, scored for evaluation vs. objectivity. The good predictors used primarily "objective" constructs, which were defined as those which could be verified by an external observer (e.g., "religious--goes to church every week"). The good conceptualizers used "evaluative" constructs, which were defined as containing clearly evaluative modifiers, or as making reference to mental health, or as having clearly evaluative connotations (e.g., "attractive," "stingy," etc.).

Fancher speculates that the difference in skills between good conceptualizers and good predictors found in his study may explain similar findings in Taft's (1955) and Smith's (1966) reviews of the person perception literature. Both concluded that psychologically trained judges were, on the average, somewhat less accurate in their predictions than non-psychologists. Taft thought the prediction of individual behavior calls for an empathic, "non-analytic" approach to case material, while the formulation of personality descriptions or conceptualizations calls for an inferential, "analytic" approach.

Fancher has studied three sets of variables:

1. Cognitive complexity vs. simplicity
2. Higher verbal vs. higher quantitative skill
3. Prediction vs. conceptualization of personality.

He has demonstrated relationships between pairs of each set of variables, but has not published a three-way analysis of variance. Thus we are left with the following:

Judges at the extremes of the cognitive complexity-simplicity scale can be equally good predictors of others' behavior, and do better than those in the mid-range. In addition, cognitive simplicity is a more successful cognitive style for predictors whose talents are predominantly quantitative (as measured by the GRE) and cognitive complexity better suits those predictors whose talents are predominantly verbal (on the GRE).

However, Fancher leaves unanswered the following question:

If most of the good predictors are found at the extremes of the cognitive complexity-simplicity dimension, and good prediction is negatively correlated with good conceptualization, does that mean that most of the good conceptualizers are found in the mid-range of the cognitive simplicity-complexity scale? Or does it mean that good conceptualizers are the opposite of good predictors: conceptualizers high in quantitative skill do best with a cognitively complex style and conceptualizers high in verbal skill do best with a cognitively approach?

Only a three-way analysis of variance could begin to clarify these issues.

In addition, the difficulty of finding judges who are good predictors on this task outside a group of male undergraduates makes it difficult to test these hypotheses in populations of clinicians using Fancher's measures.

## Clinical Listening

Reik stressed the importance of a therapist's "listening with the third ear":

> One of the peculiarities of this third ear is that it works two ways. It can catch what other people do not say, but only feel and think; and it can also be turned inward. It can hear voices from within the self that are otherwise not audible because they are drowned out by the noise of our conscious thought-processes. The student of psychoanalysis is advised to listen to those inner voices with more attention than to what 'reason' tells about the unconscious; to be very aware of what is said inside himself, <u>écouter aux voix interieures</u>, and to shut his ear to the noises of adult wisdom, well-considered opinion, conscious judgment. The night reveals to the wanderer things that are hidden by day.
>
> In other words, the psychoanalyst who hopes to recognize the secret meaning of this almost imperceptible, imponderable language has to sharpen his sensitiveness to it, to increase his readiness to receive it. When he wants to decode it, he can do so only by listening sharply inside himself, by becoming aware of the subtle impressions it makes upon him and the fleeting thoughts and emotions it arouses in him. (1948, pp. 146-47)

Singer (1971) has ably reviewed the role that such sensitivity to ongoing internal states in both patient and therapist plays in many forms of psychotherapy from traditional American and European psychoanalytic psychotherapy to behavior therapies.

The role perceptual sensitivity plays in clinical skill has only recently come under investigation.

Wolitsky (1973) found that, in undergraduates, field independence was related to higher accuracy in judging affect and implied meaning in taped passages. In the Feldstein Affect Judgment Test (1964) a neutral passage is read so as to convey a particular affect: anger, depression, fear, hate, joy, nervousness, sadness, and neutral conversation. The criterion of accuracy is the affect intended by the speaker and confirmed by the modal choice of a normal population. In the Sundberg Test of Implied Meanings (1964) statements are read so

as to express an implicit meaning and the subject is given a multiple choice format from which to choose the correct answer.

Bachrach, Luborsky and Mechanick (1974) included measures of this type in their study of psychiatric residents, whose performance as therapists was judged by both their supervisors and trained clinicians listening to tapes of their therapy sessions. In this study, various measures of perceptual sensitivity correlated with different measures of empathy and skill. Therapists' ability to detect implied verbal meanings as measured by Sundberg's scale was correlated with judgments of their empathy and skill obtained from the judges listening to four-minute segments of their treatment sessions, but not from supervisors' estimates of the same qualities. At the same time, the therapists' ability to detect subliminal cues in pictorial stimuli, as measured by the Spence-Rubin Double-Profile Test (1966), correlated with supervisors' estimates but not with judgments based on segments of therapy sessions. Neither were the two perceptual sensitivity measures correlated with each other.

This finding seems to reflect the same underlying mechanism as Mintz and Luborsky's (1971) finding that "Optimal Empathic Relationship" as measured from ratings of four-minute segments of therapy sessions was not equivalent to the same variable when measured from ratings of the whole sessions. In other words, even when using the same rating scale and the same judges, "empathy" is judged by different criteria depending on whether the behavior under consideration is taken in four-minute taped segments or over the entire hour. Apparently the

perceptual sensitivity (here, listening skills) correlated with minute-by-minute performance on the part of the therapist are somewhat different than those used to give coherence to the whole session, both on the part of the therapist and the judge.

Spence and Lugo's studies of clinical listening

Spence and Lugo (1972) summarize their series of studies investigating various aspects of listening, using undergraduates as judges of genuine clinical material.

In these studies, two dimensions of clinical listening are postulated, based on linguistic theory: mode and content.

"Mode" refers to the size of the language unit being processed. Depending on the mode of listening employed, attention is paid to every word or only to thematically related groups of words, to discrete words or only to words in context.

"Content" refers to the specific sets of meanings which are considered important. Content can be found in either single words or thematically related groups of words.

The authors stress that type of word affects size of unit chosen. Single words whose meaning is highly dependent on context are most easily listened to in terms of themes--linguistically, they are "symbols," vehicles for the abstract conception of objects. Single words whose meaning is independent of context are "signals." They indicate the same event or condition in any context. (Here linguistic usage runs contrary to psychoanalytic usage, where primary-process thought is

characterized as "symbolic," In linguistics, primary-process thought, the more primitive and direct sign, is called a "signal," while secondary-process thought is characterized linguistically by "symbolic" abstract words.)

In these studies, the clinical materials used were segments from the psychotherapy of a former ulcer patient. Half of the segments preceded a stomach symptom; half did not. These same segments had been used in a study by Luborsky and Auerbach (1969), in which two out of the three clinicians in the study were able to differentiate symptom from no-symptom (control) segments using a psychodynamic formulation of the ulcer-prone personality.

Spence and Lugo programmed a computer to detect all the words in these segments which fell into categories chosen on the basis of their understanding of Luborsky's (1969) and Alexander et al.'s (1968) psychodynamic formulations of the ulcer-prone personality. They found certain categories had a statistically significant correlation with segments preceding symptoms, while other categories were significantly correlated with segments not preceding symptoms. Their next step was to investigate how these categories were utilized by subjects attempting to differentiate the segments which preceded symptoms from the segments which did not.

In the first study described, undergraduate judges attempted to differentiate the segments preceding symptoms from those not, and rated their confidence in their judgments. While the judges did no better than chance, the judgments they were confident of were

significantly more accurate than those they were not confident of.

In the next two studies, the experimenters attempted to influence the judge's choice of categories by manipulating the mode and content of the style of listening. In one study, mode was influenced by distracting the judges by having them write a series of random numbers at fixed intervals while listening to the clinical material. The length of the intervals was changed midway through the listening session. In the second study, content was manipulated by priming the judges by telling them to listen for one of two categories.

Spence and Lugo found that the judges whose listening was broken first into long intervals (2.33 seconds) and then by short intervals (1.75 seconds) did better than those whose mode of listening was first broken by short intervals and then by long intervals. The undistracted group fell midway in accuracy. These results appear due to the fact that for this particular patient, the categories which were the best predictors were made up of longer words.

In the priming condition, the authors found that alerting judges to an appropriate content category of words which were "signals," words which do not depend on context for meaning, improved accuracy. Alerting judges to listen for a category of "symbolic" words which depended on context for meaning, lowered their accuracy, as they confused it with another symbolic category which was a poor predictor, and their overall sensitivity was lowered.

Spence and Lugo concluded:

> Instructions to listen for a particular theme (during supervision, for example) may be much less efficient than the instruction to adopt a new mode of listening or, more broadly, to become aware of the two main modes of listening and be prepared to change from one to the other. A particular mode alerts the therapist to a choice of categories (signal or symbol) and he can select from among them those that are most useful at the time. A particular theme, on the other hand, alerts him to a relatively specific set of meanings, and there is probably a limit to the number of items that a therapist can keep in mind.
>
> To sum up, it seems that listening mode is basic to the judgment process and must be controlled before specific content is selected. If mode of listening is determined, then content may be selected as well, but if content is selected without first controlling for mode, any change in content may have little or no effect on listening process. Further experiments will be necessary to devise ways of monitoring mode of listening that interfere less with the judgment process (less, for example, than random number generation) so that changes in mode may be studies in a naturalistic situation. Such studies could determine how thematic focus is influenced by listening mode, when changes in mode are triggered by changes in content, and how therapists with different amounts of experience vary in style of listening. Ultimately, it might be possible to devise ways of training therapists to become aware of, and rouse at will, the two basic modes of listening, so that they might become more sensitive clinicians. (1972, p. 130)

Other Studies of Clinical Listening

Miller (1972) experimentally altered college student judges' listening plans through verbal instructions, then presented a series of words as incidental stimuli while the subjects were listening to selections of poetry. He found differential recognition rates for high imagery, concrete words (Spence's "signals") and low imagery, abstract words (Spence's "symbols"). His Plan I instructions ("free-floating listening") emphasized the visual imagery-iconic symbolizing system, while his Plan II instructions ("critical listening")

emphasized the verbal-lexical symbolizing system.

In addition, each plan was shown to have a typically different rate of eyeblinks and vertical eye movements, Plan I having less than Plan II, suggesting different cerebral functions were being utilized. Miller observed that "each plan seemed to have a different 'general reality orientation.'"

Alpert and Cohen (in press) have done similar research, using medical students, psychiatric residents and attending psychiatrists as judges and Spence's "artificial" therapy session tape as the stimulus, rather than poetry. They found that high d' scores for high imagery words were highly correlated with successful recognition of the termination cues in Spence's constructed tape by the attending psychiatrists primed to listen for references to "termination," compared to a group of attending psychiatrists primed to listen for "grandiosity." This second group of attendings had significantly lower d' scores for high imagery words heard on the tape.

Alpert and Cohen assumed, based on Miller's work, that a high d' score for high imagery words indicated the subject was "listening away," since Miller, as summarized above, had reported high d' scores for high imagery words when subjects were instructed to "listen away" and high d' scores for low imagery words by subjects instructed to "listen towards."

They found that for unprimed psychiatric residents, d' scores for high imagery words were not significantly related to cue recall, but there was "a significant positive relationship between the listener's memory for high imagery words and [his] ratings for prevalence

of hostility and termination" in the tape.

For both the unprimed residents and the termination-primed attendings, eye-blink rate correlated negatively with high imagery cue detection, as it had with "listening away" in Miller's study. The grandiosity-primed attendings did not show this relationship.

## Identifying Basic Themes in Psychotherapy

At the June, 1975 meeting of the Society for Psychotherapy Research, Otto Kernberg suggested in commenting on papers presented there by Luborsky (1975), Horowitz (1975), and Spence (1975) that the detection of themes in psychotherapy is a basic clinical skill. Spence's paper on computer-assisted analysis of word frequencies in an initial interview demonstrated that the main structure of a patient's personality and difficulties is evident at the microscopic as well as the macroscopic level of analysis. In view of Luborsky's and Horowitz's work, Kernberg thought it would be helpful to our understanding of the processes of therapy to try to identify how therapists analyze these themes and how much the clinician's theory imposes certain themes on the patient.

Luborsky (1976) became interested in the concept of a basic relationship theme in the context of viewing therapy itself as a relationship, a helping relationship. He found a consistent pattern upon examining each patient's description in therapy sessions of his typical relationships with others. Luborsky calls this the "core conflictual relationship theme."

He drew his patient sample from the ten most improved and the

ten least improved of the 73 patients in the Penn Psychotherapy Research Project, a study of psychoanalytically-oriented psychotherapy.

He analyzed the first twenty minutes of the third and fifth sessions and of two sessions at the point where 90% of the treatment was completed. First he delineated "relationship episodes: present and past specifically described interactions with people, both outside of the treatment and with the therapist" (p. 5).

After delineating these separate episodes, they were inspected for consistencies in theme. Luborsky formulated the "core conflictual relationship theme" according to a standard structure:

> The structure might be described as a single tree with branching sub-themes. The main trunk of the tree is composed of the wish, need, or intention, and the branches are the consequences, as in Figure 1. The judge can write in the object of the wish, need or intention. The consequences can be divided into two main types, external and internal, and for each of these the main ones are listed in the order of the judge's expectation of their frequency. (p. 7)

Figure 1 gives Luborsky's suggested format for formulating the Core Conflictual Relationship Theme.

Luborsky was able to train a panel of independent judges to use this method. He reports the following findings:

1. A core recurrent relationship theme was detected when the relationship episodes were abstracted according to the suggested procedure. . . .

2. Independent scoring of the theme components in each of the relationship episodes were found to agree moderately well. . . .

3. The core conflictual relationship themes appear to be similar across virtually all types of objects. . . .

4. The same core conflictual relationship theme was identifiable in both the early and later sessions. . . .

FIGURE 1

THE SUGGESTED FORMAT FOR THE CORE CONFLICTUAL RELATIONSHIP THEME FORMULATION[a]

Wish, Need, Intention

A. I want (general theme)* from (object) but

a. _____

b. _____

c. _____

Consequence

1. Negative external response a. _____*

b. _____

c. _____

2. Negative internal response a. _____

b. _____

c. _____

3. Positive external response a. _____

b. _____

c. _____

4. Positive internal response a. _____

b. _____

c. _____

*List in order with the most frequent at the top

[a]Luborsky, 1976

5. Although the content of the core relationship theme was similar early and late, in the later sessions it became more deeply experienced in the relationship with the therapist. . . .

6. Although the core conflictual relationship theme in early sessions is similar to that in the later sessions, the high improvement patients showed a major difference from the low improvement patients in terms of a greater sense of mastery of the theme. . .

7. The core conflictual relationship themes for these 15 patients showed considerable diversity. (pp. 9-15)

Thus, Luborsky sees the core conflictual relationship theme as fairly constant throughout therapy. What varies is the way it is handled as the treatment progresses. In successful therapy, the theme is recognized and dealt with in an evolving way. In unsuccessful treatment, it returns again and again, unrecognized and unmastered. Therefore, it would be quite significant if certain factors could be shown to influence the identification of this basic theme.

## Hypotheses

From this previous research, two hypotheses were derived regarding mode of listening:

I. Sensitivity to high imagery words is associated with "listening away" and sensitivity to low imagery words is associated with "listening towards."

Therefore:

A. More experienced therapists will be more sensitive to high imagery words than less experienced therapists, using their own listening plan.

B. All therapists "listening away" will be more sensitive to high imagery words than to low imagery words.

C. All therapists "listening towards" will be more sensitive to low imagery words than to high imagery words.

D. One type of experimental listening plan may be more effective than the other with a particular patient, depending on the patient's own preferred use of high or low imagery words.

II. "Listening away" (listening with free-floating attention) will lead to more accurate identification of basic themes than "listening towards" (listening with critical attention) for both more and less experienced therapists.

One hypothesis was derived regarding level of experience:

III. More experienced therapists are better able to identify basic themes and relevant cues in clinical material than are less experienced therapists, when both groups use their own usual mode of listening.

One hypothesis was derived regarding the interaction of experience and mode of listening:

IV. A. More experienced therapists' ordinarily preferred mode of listening is more similar to "listening away" than it is to "listening toward."

B. Less experienced therapists' ordinarily preferred mode of listening is more similar to "listening towards" than it is to "listening away."

Therefore:

A-1. Instructing more experienced clinicians to "listen away" will not significantly affect their ability to identify basic themes or relevant cues.

A-2. Instructing more experienced clinicians to "listen towards" will decrease their ability to identify basic themes or relevant cues.

B-1. Instructing less experienced therapists to "listen sway" will enhance their ability to comprehend basic themes or relevant cues.

B-2. Instructing less experienced therapists to "listen towards" will not affect their ability to identify basic themes or relevant cues.

# CHAPTER III

## METHOD

### Subjects

The subject population consisted of 33 men and 33 women, at various stages of training as psychotherapists.

### Experience

Psychotherapists were considered to be "students" if they had 500 hours or less of experience as therapists. Seventeen of the men were students, 16 practitioners; sixteen of the women were students, 17 practitioners.

The student group's experience as therapists ranged from 0 to 500 hours, with a mean of 116 hours, acquired in less than three years. The practitioner group's experience ranged from 800 to over 30,000 hours, with a mean of 5285 hours, acquired over a span of 3 to 25 years. Twenty of the thirty-three practitioners had supervisory experience, ranging from 30 to 8100 hours, with a mean of 1289 hours.

The mean of the total subject population's hours of experience was 2700. This was also the median for the practitioner group: 16 had 2700 hours or more of experience, 17 had 2500 or less.

The student group's experience as patients themselves ranged from 0 to 1600 hours, with a mean of 207. Nine students had no experience as patients at all.

The practitioner group's experience as patients themselves

ranged from 0 to 2250 hours, with a mean of 546 hours. One practitioner had no experience as a patient.

Training

There were 42 clinical psychology students in the sample. Twenty-seven were classed as students, 15 as practitioners, on the basis given above. Two of these clinical psychology students already held M.S.W. degrees. Two more subjects had completed their training with an M.S.W.

There were 10 Ph.D.'s in clinical psychology, all practitioners, and two Ph.D.'s in other branches of psychology who were classed as students of psychotherapy.

There were 8 medical students serving clerkships in psychiatry, and 5 psychiatrists.

Of the M.D.'s and Ph.D.'s, four had been trained as psychoanalysts.

Age

The majority (26) of the student group was under 30, with four persons between 30-39, and three between 40-40. The largest single age group in the practitioner sample was also under 30 (12 persons), and three between 50-59 years of age.

Of the subjects under 30, 19 were men and 19 women; of the subjects over 30, 14 were men and 14 women.

Ethnicity

Fifty-eight of the subjects were white, five were black, and three Hispanic.

Thirty-eight of the subjects were Jewish; six were Catholic, five were Protestant, one "Other," and sixteen undetermined due to a problem in questionnaire format.

## Procedure

The experiment was designed to be administered to groups of clinicians at their place of work during staff or seminar meeting times. Fifteen subjects participated in groups of from two to four. Seven subjects participated individually.

Each subject, no matter what size group he was a member of, was given a description of the study and signed a consent from before he heard the listening instructions for all three subgroups. He then opened his own test booklet in which his listening instructions were reiterated. (See Appendix I: Experimental Protocol and Appendix II: Experimental Booklet.)

The subjects were randomly divided into the three listening groups by the distribution of the test booklets, which were arranged with the three listening plans in repetitive sequence.

The experimental design is shown in Figure 2. Those using their own usual listening plan are the control group. Those "listening away" or "listening towards" are experimental listening groups.

The Own Listening Plan group were instructed:

"Please listen to this patient the way you would usually listen to a patient of your own."

The Listening Away group was instructed:

"You are going to 'listen away' from the patient. This is an

FIGURE 2

EXPERIMENTAL DESIGN

| Therapists' Experience | Mode of Listening | | | |
|---|---|---|---|---|
| | Own Plan | Listening Away | Listening Towards | Total |
| Student | 11 | 11 | 11 | 33 |
| Practitioner | 11 | 11 | 11 | 33 |
| Total | 22 | 22 | 22 | 66 |

easy-going, open, receptive way of listening, where the focus is on the experience of listening. Be receptive to the ideas, thoughts, images and feelings which occur to you as you listen. Don't try to interpret what you hear--just relax and absorb what you hear and let yourself respond freely to it."

The Listening Towards group was instructed:

"You are going to 'listen towards' the patient. This is a problem-solving way of listening. Try to grasp, figure out and make connections about what the patient is saying. Try to conceptualize what is being said. Try to form and check hypotheses about what the patient is saying. Listen actively and critically."

The subjects were then told the names mentioned by the patient on the tape, her approximate age, and that the tape was from the third session of the treatment. They then listened to the tape for twenty minutes.

After hearing the tape, they were read a list of words and asked to circle on their answer sheet either Y if the patient had spoken the word or N if the patient had not spoken the word.

After completing this task, they were read the instructions on page 3 of their test booklets:

"(1) Write down what seems to you to be this patient's basic life problem--the core conflictual theme in her communication.

"(2) Give as many illustrations of this as you can from the tape you just heard.

"(You may continue your answer on the following blank page if

you wish. You will have 20 minutes to complete this part. If you should finish sooner, you may continue to Pages 5, 6, and 7. However, once you finish this section, please do not go back to it.)"

After completing the essay, the subjects were asked to rate, on a scale of 1 to 5, the relative frequency in the session of a list of themes and affects taken from Luborsky and Mintz (1974), Alpert and Cohen (in press) and Mann (1973) (see Appendix II: Experimental Booklet).

Last, the subjects were asked to fill out a questionnaire eliciting basic demographic information that previous studies of person perception and clinical judgment have found relevant in this context: age, sex, kind of training, years of experience, length and kind of personal psychotherapy, high Verbal or Quantitative scores on the GREs or SATs, and a set of items especially aimed at tapping the demographic similarity between the subjects and the taped patient (see Appendix II).

## Data Analysis

### Cognitive Measures

A cognitive test of listening mode was administered to verify the nature of listening mode used by the subjects in the experiment: memory for 10 high and 10 low imagery words spoken by the patient during the taped segment.

Each of these words was matched by two filler nouns equal in number of syllables, initial letter, frequency in the English language, and imagery evocation value, all as reported by Pavio et al. (1969) (see Appendix III). Thus, the subject was presented with 60 words and

asked whether or not each was heard on the tape.

A $\underline{d}'$ score (Kintsch, 1970), a measure of the rate of recognition of stimulus words, corrected for rate of false positive responses to filler nouns, was computed separately for each subject's response to high and low imagery words.

In addition, $\underline{L}_x$, a measure of response bias (Clark, 1974), was computed for each subject's response to high and low imagery words. $\underline{L}_x$ assesses how sure the subject feels he must be before he says, "Yes, I heard the patient speak that word." A high $\underline{L}_x$ score indicates the subject was cautious about saying Yes. A low $\underline{L}_x$ score indicated the subject was liberal with his affirmative responses.

$\underline{d}'$ and $\underline{L}_x$ are theoretically independent measures. $\underline{d}'$ measures the difference between the means of two populations of words (previously heard words and new words) in terms of a standard deviate score, or a continuum of signal-to-noise ratio. According to Clark (1974):

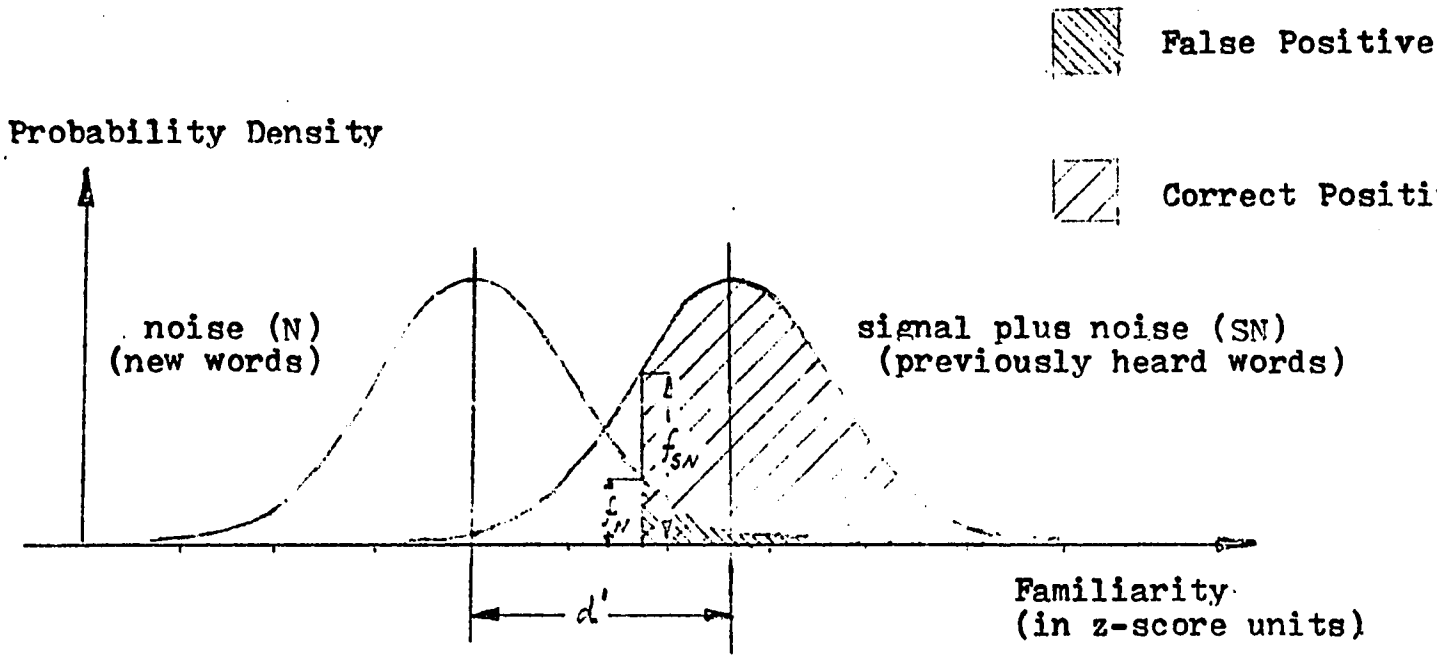
> Mathematically, $\underline{d}'$ is defined as the mean of theoretical signal-to-noise distribution [of previously heard words], minus the mean of the theoretical noise distribution [of the new words], divided by the standard deviation of the theoretical noise distribution [of the new words]. (p. 281)
>
> $\underline{L}_x$, the likelihood-ratio criterion, is the ratio of the ordinate of the signal-plus-noise distribution to the ordinate of the noise distribution, at the criterion locus defined by hits [correct positives] and false alarms [false positives] probabilities. (p. 283)

This is depicted in Figure 3.

For example, in this study an average subject correctly identified 9 out of 10 high imagery words the patient spoke (Correct Positives = 90%), and incorrectly believed he had heard the patient say

FIGURE 3

RELATIONSHIP OF d' AND Lx




$$\underline{d'} = \underline{Z}_N - \underline{Z}_N$$

$$\underline{L}_x = \frac{f_{SN}}{f_N}$$

5 out of 20 filler words (False Positives = 25%). To compute $d'$ and $L_x$, one turns to a published table which relates areas under the normal curve to values of the standard deviate, $Z$, and their respective probability densities (ordinates). Clark (1974, p. 283) provides such a table. Using his formula, $d' = Z_N - Z_{SN}$, one finds that for this example, $d' = Z_{.25} - Z_{.90} = .841 - (-1.281) = 1.987$. Using the formula, $L_x = \frac{f_{SN}}{f_N}$, we find that $L_x = \frac{f_{.90}}{f_{.25}} = \frac{.1756}{.3179} = .5523$.

Since $L_x$ scores are expressed as logarithmic functions, they must be transformed logarithmically before any statistical tests are performed on them which assume normal distributions, such as analysis of variance or multiple comparisons (Clark, personal communication). Therefore, each $L_x$ score has been multiplied by its logarithmic transform before statistical analysis.

Measures of Clinical Judgment

In this experiment subjects were asked for a variety of clinical judgments:

(1) Subjects were given 20 minutes to "Write down what seems to you to be this patient's basic life problem--the core conflictual theme in her communication. Give as many illustrations of this as you can from the tape you just heard."

(2) Subjects were asked to rate on a scale of 1 (None or Slight) to 5 (Very Much) how strongly present the following themes and affects were in the session they had just heard: Rejection (negative response

to patient by other person); Helplessness; Hopelessness; Separation Concern; Anxiety; Hostility to Therapist (Inferred); Hostility to Therapist (Direct); Hostility to Others; Sex and Affection; Guilt; Shame; Reference to Therapist (Explicit); High Involvement with Therapist; Grandiosity; Depression; Narcissism; Working Alliance; Independence vs. Dependence; Activity vs. Passivity; Adequate Self-Esteem vs. Diminished or Lost Self-Esteem; Unresolved or Delayed Grief.

(3) Subjects were asked to predict the patient's treatment outcome on a scale of 1 (Much Worse) through 4 (No Change) to 7 (Much Improved).

(4) Subjects were asked to assess the patient's level of pathology as either "Mild," "Moderate" or "Severe."

Scoring

With the exception of the essay on the basic theme, all of the above items were objectively scored by simply recording the number the subject had circled.

In addition, the presence or absence of notes at the beginning and comments at the end of the test booklet were recorded, as possible measures of interest or motivation on the part of the subjects.

Following Harty's (1972) methodological suggestions, Luborsky is considered the "designated expert" on this patient's basic theme. His judgment is the criterion of accuracy.

Luborsky is a recognized, undoubted judge of his material. He has been analyzing therapy sessions for basic themes for many years and

his methods are well-documented (Luborsky, 1967; Luborsky, 1975). In the case of the patient presented to subjects in this experiment, he has access to material from recordings over the entire course of treatment. He has validated his judgment of the theme of the individual session against the theme of the entire treatment. He has also validated his judgment with a panel of three expert judges, as described above in Chapter II.

The essays were scored for presence or absence of Luborsky's Core Conflictual Relationship Theme (CCRT) by three practitioner-level clinical psychology doctoral candidates.

The raters were instructed to read Luborsky's article describing how the CCRT was defined and derived in general, and for the particular patient the experimental subjects heard. They heard the tape and read a transcript of it. They studied three sample essays, two in which the theme was present, and one in which the theme was absent, in Luborsky's personal judgment (see Appendix IV: Sample Essays).

The raters scored only the essays. Two were completely blind as to the other data; the third judge was the experimenter, who scored the essays essentially blind, except in the cases where subjects had drawn particular attention to their essays during the course of administration.

They were then asked to sort the essays into three groups:

(1) Theme Present: Contains a complete exposition of the core conflictual theme (CCRT).

(2) Theme Possibly Present: Contains some part of the CCRT.

(3) Theme Absent: Contains no part of the CCRT.

The CCRT was defined by the thematic tree derived by Luborsky for this patient (Figure 4).

Using this procedure, raters' agreement on the Presence or Absence of the theme yielded a mean Kappa score of .82 where .6 is considered adequate (Cohen, 1966) (see Appendix V: Raters' Agreement).

Therefore, the CCRT was scored Present if at least one rater scored it Present. The CCRT was scored Absent if at least one judge scored it Absent. Scores of Possibly Present were disregarded. In the five cases where two judges scored the CCRT Present, and one scored it Absent, it was scored as Present. This yielded 35 essays in which the CCRT was scored Present, and 31 in which the CCRT was scored Absent.

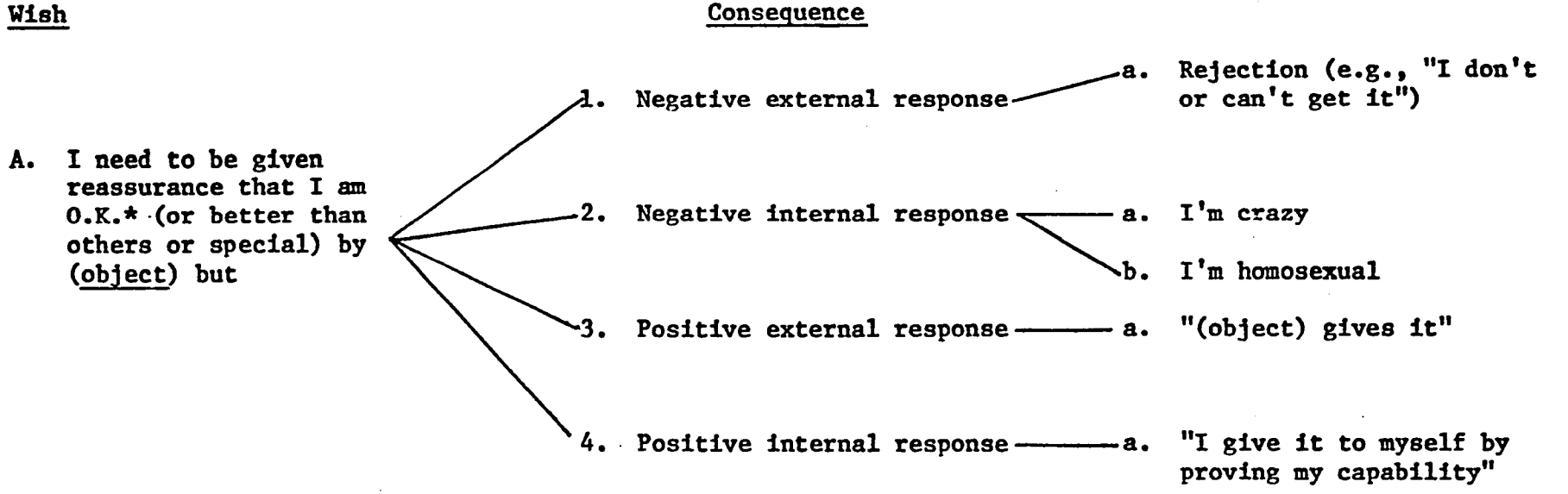
Even though "relationship" was not specified in the request for "the core conflictual theme," since over half the sample recognized the theme Luborsky considers of central importance, the question of whether listening plan or experience are related to identifying this theme may be legitimately explored.

In Appendix VI two essays in which Luborsky's CCRT were judged present and two in which it was judged absent are given. These essays are included to represent the quality at the extremes of the range of experience, as the sample essays in Appendix IV were written by pilot subjects at the lower end of the practitioner range (800-1000 hours of experience as therapists, 150 -450 hours as patients).

Essays 1 and 2 were written by medical students with no experience as therapists beyond a rotation through a psychiatry clerkship,

FIGURE 4

THE CORE CONFLICTUAL RELATIONSHIP TREE OF SUBTHEMES OF MS. X[a]




* (1) I am mentally O.K.
(2) I am sexually O.K., i.e., not homosexual
(3) I am professionally O.K., i.e., customers sppreciate me or I am "number one" with them
(4) I am appreciated by people, i.e., they think I am "number one" compared to other women (especially Jackie, and "I am as good as you (t) or better").

[a]From Luborsky, 1976

and no experience in personal psychotherapy. Essays 3 and 4 were written by psychoanalysts with 20 years or more experience as psychotherapists.

While no controlled study of other themes presented by the sample has been done, a rough count disclosed that 60 of the 66 subjects discussed the issue of homosexuality raised by the patient on the tape. Thirty believed it was a central conflict; thirty believed it was a "red herring," as one subject put it, drawing attention away from a more basic conflict.

Essay 3 in Appendix VI, in addition to Luborsky's CCRT, presents, in a clear and concise form which demonstrates their interrelatedness, almost every additional conflictual theme discerned by more than about five subjects: competitiveness, oedipal-triangular object-relations; narcissistic conflict resolution; dependence; anger; sense of deprivation; depression; fixation with the mother. However, the essayist makes quite clear how the more theoretical formulations and inferences are derived from observation of the patient's here-and-now relationships. Other essayists who failed to do this were scored Theme Absent. A diagnosis or inference, while perhaps true for the patient, was not scored as a theme unless the connection to the Core Conflictual Relationship Theme was spelled out in the essay.

# CHAPTER IV

# RESULTS

## Effects of Mode of Listening

The first hypothesis regarding mode of listening was:

HYPOTHESIS I: Sensitivity to high imagery words and cues is associated with "listening away" and sensitivity to low imagery words and cues is associated with "listening towards."

Therefore it was predicted that:

A. More experienced therapists would have higher d' scores for high imagery words than less experienced therapists would, using their own preferred listening plans.

B. All therapists "listening away" would have higher d' scores for high imagery words than for low imagery words.

C. All therapists "listening towards" would have higher d' scores for low imagery words than for high imagery words.

D. One type of experimental listening plan might be more effective than the other with a particular patient, depending on the patient's own preferred use of high or low imagery words.

This hypothesis was not supported by the data. For all subgroups, the ability to differentiate previously heard high imagery words from new high imagery words was greater than the ability to differentiate previously heard low imagery words from new low imagery

words, as measured by $\underline{d}'$ scores for subjects' recognition of each set of words (see Tables 1 and 2). In fact, there was a clear, but statistically insignificant, trend for both students and practitioners "listening away" to perform less well than the other groups on the recognition task for both high and low imagery words. For the sample as a whole, $\underline{d}'$ scores for low imagery words had a significant positive correlation ($\underline{r} = .22$, $\underline{p} < .05$). There were no significant differences between groups for total $\underline{d}'$ scores.

$\underline{L}_{\underline{x}}$ is a measure of the response bias involved in answering, "Yes, that word was spoken by the patient" (Clark, 1974). Subjects with a high $\underline{L}_{\underline{x}}$ do not answer Yes unless they feel quite sure. Subjects with a low $\underline{L}_{\underline{x}}$ are more liberal with their Yes, and more likely to guess. While all subjects tended to be more cautious about saying Yes to low imagery words, their caution did not vary significantly between subgroups, either by level of experience or by listening plan (see Tables 3 and 4).

The ratio of $\underline{L}_{\underline{x}}$ for low imagery words to $\underline{L}_{\underline{x}}$ for high imagery words ("preference ratio") was also examined to see if changes in listening plan made subjects more cautious about saying Yes to one set of words in comparison to the other (see Table 5). This did not vary significantly either. For the sample as a whole, $\underline{L}_{\underline{x}}$ for low imagery words was significantly and positively correlated with $\underline{L}_{\underline{x}}$ for high imagery words ($\underline{r} = .44$, $\underline{p} < .0005$). There were no significant differences between groups for total $\underline{L}_{\underline{x}}$ scores.

In addition, $\underline{d}'$ for high imagery words was significantly and negatively correlated with $\underline{L}_{\underline{x}}$ for high imagery words in this sample

TABLE 1

d' FOR HIGH IMAGERY WORDS AS A FUNCTION OF LISTENING PLAN AND EXPERIENCE

| Experience | Listening Plan | | | |
|---|---|---|---|---|
| | Own | Away | Toward | Total |
| Student | | | | |
| Mean | 1.968 | 1.746 | 2.008 | 1.907 |
| SD | 0.534 | 0.565 | 0.628 | 0.602 |
| Practitioner | | | | |
| Mean | 2.000 | 1.718 | 2.162 | 1.960 |
| SD | 0.605 | 0.515 | 0.752 | 0.639 |
| Total | | | | |
| Mean | 1.984 | 1.732 | 2.085 | 1.934 |
| SD | 0.605 | 0.528 | 0.681 | 0.617 |

Analysis of Variance

| | SS | DF | MS | F |
|---|---|---|---|---|
| Experience | 0.046 | 1 | 0.046 | 0.119 |
| Listening Plan | 1.452 | 2 | 0.726 | 1.884 |
| Interaction | 0.093 | 2 | 0.047 | 0.121 |
| Within Cell | 23.118 | 60 | 0.885 | |
| Total | 24.709 | 65 | | |

TABLE 2

d' FOR LOW IMAGERY WORDS AS A FUNCTION OF LISTENING PLAN AND EXPERIENCE

| Experience | Listening Plan | | | |
|---|---|---|---|---|
| | Own | Away | Toward | Total |
| Student | | | | |
| Mean | 1.498 | 1.460 | 1.495 | 1.483 |
| SD | 0.670 | 0.498 | 0.534 | 0.554 |
| Practitioner | | | | |
| Mean | 1.582 | 1.568 | 1.596 | 1.382 |
| SD | 0.517 | 0.518 | 0.594 | 0.527 |
| Total | | | | |
| Mean | 1.537 | 1.514 | 1.545 | 1.532 |
| SD | 0.586 | 0.499 | 0.594 | 0.539 |

Analysis of Variance

| | SS | DF | MS | F |
|---|---|---|---|---|
| Experience | 0.163 | 1 | 0.163 | 0.523 |
| Listening Plan | 1.012 | 2 | 0.006 | 0.019 |
| Interaction | -0.001 | 2 | -0.001 | -0.002 |
| Within Cell | 18.706 | 60 | 0.312 | |
| Total | 18.880 | 65 | | |

TABLE 3

LOG $\underline{L}_x$ FOR HIGH IMAGERY WORDS AS A FUNCTION OF LISTENING PLAN AND EXPERIENCE

| Experience | Listening Plan | | | |
|---|---|---|---|---|
| | Own | Away | Toward | Total |
| Student | | | | |
| Mean | -0.222 | -0.061 | -0.251 | -0.178 |
| SD | 0.387 | 0.130 | 0.477 | 0.361 |
| Practitioner | | | | |
| Mean | -0.250 | -0.335 | -0.246 | -0.277 |
| SD | 0.421 | 0.353 | 0.195 | 0.328 |
| Total | | | | |
| Mean | -0.236 | -0.198 | -0.249 | -0.228 |
| SD | 0.395 | 0.295 | 0.356 | 0.346 |

Analysis of Variance

| | SS | DF | MS | F |
|---|---|---|---|---|
| Experience | 0.162 | 1 | 0.162 | 1.323 |
| Listening Plan | 0.031 | 2 | 0.015 | 0.126 |
| Interaction | 0.257 | 2 | 0.129 | 1.051 |
| Within Cell | 7.342 | 60 | 0.122 | |
| Total | 7.792 | 65 | | |

TABLE 4

LOG L FOR LOW IMAGERY WORDS AS A FUNCTION OF LISTENING PLAN AND EXPERIENCE

| Experience | Listening Plan | | | |
|---|---|---|---|---|
| | Own | Away | Toward | Total |
| Student | | | | |
| Mean | 0.109 | -0.169 | -0.068 | -0.043 |
| SD | 0.341 | 0.284 | 0.397 | 0.353 |
| Practitioner | | | | |
| Mean | -0.127 | -0.253 | -0.109 | -0.163 |
| SD | 0.319 | 0.534 | 0.314 | 0.395 |
| Total | | | | |
| Mean | -0.009 | -0.211 | -0.088 | -0.103 |
| SD | 0.344 | 0.419 | 0.350 | 0.375 |

Analysis of Variance

| | SS | DF | MS | F |
|---|---|---|---|---|
| Experience | 0.240 | 1 | 0.240 | 1.714 |
| Listening Plan | 0.455 | 2 | 0.228 | 1.627 |
| Interaction | 0.115 | 2 | 0.057 | 0.410 |
| Within Cell | 8.397 | 60 | -.140 | |
| Total | 9.207 | 65 | | |

TABLE 5

PREFERENCE RATIO[a] AS A FUNCTION OF LISTENING PLAN AND EXPERIENCE

| Experience | Listening Plan | | | |
|---|---|---|---|---|
| | Own | Away | Toward | Total |
| Student | | | | |
| Mean | 0.331 | -0.109 | 0.184 | 0.135 |
| SD | 0.333 | 0.308 | 0.389 | 0.382 |
| Practitioner | | | | |
| Mean | 0.123 | 0.082 | 0.137 | 0.114 |
| SD | 0.400 | 0.464 | 0.303 | 0.383 |
| Total | | | | |
| Mean | 0.227 | -0.013 | 0.160 | 0.125 |
| SD | 0.375 | 0.396 | 0.341 | 0.375 |

Analysis of Variance

| | SS | DF | MS | F |
|---|---|---|---|---|
| Experience | 0.008 | 1 | 0.008 | 0.056 |
| Listening Plan | 0.676 | 2 | 0.338 | 2.460* |
| Interaction | 0.443 | 2 | 0.221 | 0.612 |
| Within Cell | 8.240 | 60 | 0.137 | |
| Total | 9.366 | 65 | | |

[a]Log $L_x$ for Low Imagery Words divided by Log $L_x$ for High Imagery Words

*$p < .10$

($r = -.30$, $p < .005$), although theoretically the two measures are independent (Clark, personal communication). $d'$ and $L_{\kappa}$ for low imagery words were not significantly correlated ($r = .19$). This means that there was a significant tendency for cautious subjects to have lower $d'$ scores for high imagery words.

In summary, sensitivity to high imagery words was not found to be especially associated with following instructions to "listen away." Sensitivity to low imagery words was not differentially associated with following instructions to "listen towards." "Listening towards" tended to elevate $d'$ scores for both high and low imagery words, and "listening away" tended to depress them both, but not to a significant extent.

There were no significant differences in sensitivity to either high or low imagery words, either between experience levels, using their own plans (Hypothesis IA), or between groups listening towards (Hypothesis IB) or listening away (Hypothesis IC). No one subgroup did better than any other on identifying the basic theme, or on any other task of clinical judgment (Hypothesis ID).

Thus, Hypothesis I is totally unsupported by the experimental findings. One must conclude that the experimental listening instructions did not significantly alter the subjects' processing of verbal information, as measured by their ability to discriminate new from previously heard high imagery or low imagery words, as measured by $d'$ or $L_{\kappa}$.

The second hypothesis regarding mode of listening was:

HYPOTHESIS II: "Listening away" will lead to more accurate identification of basic themes than "listening towards," for both levels of experience.

The experimental listening instructions did not result in any significant differences in ability to identify the patient's basic theme as defined by Luborsky (see Table 6) or in assessment of pathology (see Table 7) or in prediction of outcome (see Table 8).

The rating of only one of the twenty-one themes and affects was significantly affected by listening plan alone: "Reference to Therapist (Explicit)." Subjects using either of the experimental listening plans rated this more strongly present than did those listening their usual way (see Table 9).

Thus, there is no evidence that the experimental instructions had any significant differential effect on the subjects' clinical judgment. In the one case where listening plan made a difference, Scheffé contrasts were not significant between the experimental listening plans, but only between own listening plan versus the experimental listening plans combined ($F$ [2,65] = 3.71, $p < .05$).

## Effects of Level of Experience

This study tested one hypothesis regarding level of experience:

HYPOTHESIS III: More experienced therapists are better able to identify basic themes and relevant cues in clinical material than are less experienced therapists, using their ordinary mode of listening.

TABLE 6

IDENTIFICATION OF CCRT AS A FUNCTION OF LISTENING PLAN AND EXPERIENCE

| Experience | Listening Plan | | | |
|---|---|---|---|---|
| | Own | Away | Toward | Total |
| Students (n = 33) | | | | |
| Theme Present | 6 | 5 | 6 | 17 |
| Theme Absent | 5 | 6 | 5 | 16 |
| Practitioners (n = 33) | | | | |
| Theme Present | 6 | 6 | 6 | 18 |
| Theme Absent | 5 | 5 | 5 | 15 |
| Total | 22 | 22 | 22 | 66 |

Two-Way Analysis of Variance

| Experience | Listening Plan | | | |
|---|---|---|---|---|
| | Own | Away | Toward | Total |
| Student | | | | |
| Mean | 1.45 | 1.55 | 1.45 | 1.48 |
| SD | 0.52 | 0.52 | 0.52 | 0.51 |
| Practitioner | | | | |
| Mean | 1.45 | 1.45 | 1.45 | 1.45 |
| SD | 0.52 | 0.52 | 0.52 | 0.51 |
| Total | | | | |
| Mean | 1.45 | 1.50 | 1.45 | 1.47 |
| SD | 0.51 | 0.51 | 0.51 | 0.50 |

Analysis of Variance

| | SS | DF | MS | F |
|---|---|---|---|---|
| Experience | 0.015 | 1 | 0.015 | 0.055 |
| Listening Plan | 0.030 | 2 | 0.015 | 0.055 |
| Interaction | 0.031 | 2 | 0.016 | 0.057 |
| Within Cell | 16.364 | 60 | 0.273 | |
| Total | 16.440 | 65 | | |

TABLE 7

PATHOLOGY[a] AS A FUNCTION OF LISTENING PLAN AND EXPERIENCE

| Experience | Listening Plan | | | |
|---|---|---|---|---|
| | Own | Away | Toward | Total |
| Student | | | | |
| Mean | 1.73 | 1.64 | 1.36 | 1.58 |
| SD | 8.65 | 0.50 | 0.81 | 0.66 |
| Practitioner | | | | |
| Mean | 1.82 | 1.82 | 1.82 | 1.82 |
| SD | 0.40 | 0.60 | 0.40 | 0.46 |
| Total | | | | |
| Mean | 1.77 | 1.70 | 1.59 | 1.70 |
| SD | 0.53 | 0.55 | 0.67 | 0.58 |

Analysis of Variance

| | SS | DF | MS | F |
|---|---|---|---|---|
| Experience | 0.970 | 1 | 0.970 | 2.884* |
| Listening Plan | 0.394 | 2 | 0.197 | 0.886 |
| Interaction | 0.394 | 2 | 0.197 | 0.506 |
| Within Cell | 20.182 | 60 | 0.336 | |
| Total | 21.940 | 65 | 0.336 | |

[a]1 = Mild; 2 = Moderate; 3 = Severe

* $p < .10$

TABLE 8

OUTCOME[a] AS A FUNCTION OF LISTENING PLAN AND EXPERIENCE

| Experience | Listening Plan | | | |
|---|---|---|---|---|
| | Own | Away | Toward | Total |
| Student | | | | |
| Mean | 5.36 | 5.36 | 5.36 | 5.36 |
| SD | 0.67 | 0.50 | 0.67 | 0.60 |
| Practitioner | | | | |
| Mean | 5.18 | 5.09 | 5.45 | 5.24 |
| SD | 0.60 | 0.70 | 0.69 | 0.66 |
| Total | | | | |
| Mean | 5.27 | 5.23 | 5.41 | 5.30 |
| SD | 0.63 | 0.61 | 0.67 | 0.632 |

Analysis of Variance

| | SS | DF | MS | F |
|---|---|---|---|---|
| Experience | 0.240 | 1 | 0.240 | 0.578 |
| Listening Plan | 0.390 | 2 | 0.195 | 0.470 |
| Interaction | 0.400 | 2 | 0.200 | 0.482 |
| Within Cell | 24.910 | 60 | | |
| Total | 25.940 | 65 | | |

[a]4 = No Change; 7 = Much Improved

TABLE 9

RATINGS OF "REFERENCE TO THERAPIST"[a] AS A FUNCTION OF LISTENING PLAN AND EXPERIENCE

| Experience | Listening Plan | | | |
|---|---|---|---|---|
| | Own | Away | Toward | Total |
| Student | | | | |
| Mean | 2.09 | 2.64 | 2.64 | 2.45 |
| SD | 1.04 | 0.81 | 0.81 | 0.90 |
| Practitioner | | | | |
| Mean | 2.09 | 2.91 | 2.64 | 2.55 |
| SD | 1.04 | 0.94 | 0.50 | 0.90 |
| Total | | | | |
| Mean | 2.09 | 2.77 | 2.64 | 2.50 |
| SD | 1.02 | 0.87 | 0.66 | 0.81 |

Analysis of Variance

| | SS | DF | MS | F |
|---|---|---|---|---|
| Experience | 0.136 | 1 | 0.136 | 0.176 |
| Listening Plan | 5.727 | 2 | 2.864 | 3.706* |
| Interaction | 0.273 | 2 | 0.137 | 0.177 |
| Within Cell | 46.364 | 60 | 0.773 | |
| Total | 52.500 | 65 | | |

[a] 1 = None or Slightly Present; 5 = Strongly Present

*$p < .05$

There were no significant differences between Students and Practitioners, using their own usual way of listening, in their ability to identify the basic theme in the patient's communication as defined by Luborsky as the "core conflictual relationship theme" (CCRT). Six out of eleven Students, and six out of eleven Practitioners identified the CCRT (see Table 6).

Since the experimental listening instructions had shown no significant effects on clinical judgment, the results from the entire sample are considered. Seventeen out of the 33 Students and 18 out of the 33 Practitioners identified the CCRT (see Table 6).

The rating of only one of the twenty-one themes and affects was significantly affected by experience level alone: "Hostility to Therapist (Inferred)." Practitioners rated this affect strongly present to a significantly greater extent than Students did (see Table 10).

These negative findings raised the possibility that the cut-off point between Student and Practitioner was set inappropriately.

To test this possibility, the subject sample was divided into four levels of experience rather than two.*

The four levels were:

(1) 0-100 hours (16 subjects with a mean of 23 hours of experience; 7 of these with no experience)

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*Subjects were divided into groups and the groups assigned a rank order for these calculations because in this sample experience is clearly logarithmically distributed. Both analysis of variance and correlationn statistics assume variables with normal distributions.

TABLE 10

RATINGS OF "HOSTILITY TO THERAPIST (INFERRED)"[a] AS A FUNCTION OF LISTENING PLAN AND EXPERIENCE

| Experience | Listening Plan | | | |
|---|---|---|---|---|
| | Own | Away | Toward | Total |
| Student | | | | |
| Mean | 2.64 | 3.00 | 2.82 | 2.82 |
| SD | 0.92 | 1.00 | 1.25 | 1.04 |
| Practitioner | | | | |
| Mean | 3.09 | 3.18 | 3.73 | 3.33 |
| SD | 1.04 | 0.75 | 1.01 | 0.96 |
| Total | | | | |
| Mean | 2.86 | 3.09 | 3.27 | 3.08 |
| SD | 0.99 | 0.87 | 1.20 | 1.03 |

Analysis of Variance

| | SS | DF | MS | F |
|---|---|---|---|---|
| Experience | 4.379 | 1 | 4.379 | 4.314* |
| Listening Plan | 1.849 | 2 | 0.925 | 0.911 |
| Interaction | 1.484 | 2 | 0.742 | 0.731 |
| Within Cell | 60.910 | 60 | 1.015 | |
| Total | 68.622 | 65 | | |

[a] 1 = None or Slightly Present, 5 = Strongly Present

*$p < .05$

(2) 115-500 hours (17 subjects with a mean of 193 hours of experience)

(3) 800-2500 hours (17 subjects with a mean of 1457 hours of experience; two with experience as supervisors)

(4) 2700-30,000 hours (17 subjects with a mean of 9,351 hours of experience, 15 with experience as supervisors).

One-way analysis of variance showed no significant effects of level of experience on either identification of the CCRT, assessment of pathology, prediction of outcome, or rating of any of the themes or affects. This indicates that taken as groups, there were no significant differences between levels of experience in making these clinical judgments.

However, increasing level of experience was found to have a significant correlation with rating the patient as showing more Helplessness ($\underline{r}$ = .215, $\underline{p} < .05$), Hostility to Therapist (Inferred) ($\underline{r}$ = .232, $\underline{p} < .05$), Depression ($\underline{r}$ = .279, $\underline{p} < .05$), Narcissism ($\underline{r}$ = .270, $\underline{p} < .025$) and significantly less Anxiety ($\underline{r}$ = .237, $\underline{p} < .05$). Increasing experience was also correlated with assessing the patient's pathology as more severe ($\underline{r}$ = .234, $\underline{p} < .05$). Level of experience was not correlated with the identification of the CCRT or the prediction of outcome.

The last hypothesis was one regarding the interaction of experience and mode of listening:

HYPOTHESIS IV:

A. More experienced therapists' ordinarily preferred mode of

listening is more similar to "listening away" than "listening towards."

B. Less experienced therapists' ordinarily preferred mode of listening is more similar to "listening towards" than to "listening away."

Therefore, it was predicted in regard to identifying a basic theme, the CCRT, and identifying relevant cues, the twenty-one Themes and Affects:

A-1. Instructing more experienced clinicians to "listen away" will not significantly affect their ability to identify basic themes or relevant cues.

A-2. Instructing more experienced clinicians to "listen towards" will decrease their ability to identify basic themes or relevant cues.

B-1. Instructing less experienced therapists to "listen away" will enhance their ability to comprehend basic themes or relevant cues.

B-2. Instructing less experienced therapists to "listen towards" will not affect their ability to identify basic themes or relevant cues.

As noted above, there were no interaction effects between Listening Plan and Experience Level on memory for high imagery or low imagery words. Nor were there any interaction effects between Listening Plan and Experience Level for either identifying the CCRT, assessing pathology or predicting outcome.

Two of the twenty-one themes and affects did show an interaction effect with listening plan and experience level: Hopelessness and Separation Concern.

For Hopelessness, Students using their own listening plan rated the patient as showing the least amount of Hopelessness in the session and Practitioners using their own listening plan rated the patient as showing the most, of the six subgroups. Students Listening Towards and Listening Away gave the same responses as Practitioners using their own plan. Practitioners Listening Towards and Listening Away gave the same responses as Students using their own plan (see Table 11).

For Separation Concern, Students and Practitioners using their own listening plan gave the same ratings. For both Students and Practitioners, the subgroups Listening Away were statistically indistinguishable from the subgroups using their own plan. Only the subgroups Listening Towards were significantly different: the Practitioners Listening Towards rated Separation Concern significantly less present; the Students Listening Towards rated it significantly more present (see Table 12).

Thus, there was no support for Hypothesis IV. Out of 24 items calling for clinical judgment, only two showed any interaction effects between listening plan and level of experience. In one case, the two experimental listening plans were statistically indistinguishable for both Students and Practitioners and contrasted with Own Listening Plan. In the other case, Own Listening Plan and Listening Away were indistinguishable for both Students and Practitioners and contrasted with Listening Towards for both.

## Additional Findings

That experience has so little effect on the clinical judgments

TABLE 11

RATINGS OF "HOPELESSNESS"[a] AS A FUNCTION OF LISTENING PLAN AND EXPERIENCE

| Experience | Listening Plan | | | |
|---|---|---|---|---|
| | Own | Away | Toward | Total |
| Student | | | | |
| Mean | 2.18 | 2.09 | 2.73] | 2.93 |
| SD | 1.08 | 1.04 | 1.01 | 1.05 |
| Practitioner | | | | |
| Mean | 2.45 | 3.09 | 1.91 | 2.48 |
| SD | 1.13 | 1.04 | 0.94 | 1.12 |
| Total | | | | |
| Mean | 2.32 | 2.59 | 2.32 | 2.41 |
| SD | 1.09 | 1.14 | 1.04 | 1.08 |

Analysis of Variance

| | SS | DF | MS | F |
|---|---|---|---|---|
| Experience | 0.379 | 1 | 0.379 | 0.348 |
| Listening Plan | 1.091 | 2 | 0.546 | 0.501 |
| Interaction | 9.212 | 2 | 4.606 | 4.234* |
| Within Cell | 65.273 | 60 | 1.088 | |
| Total | 75.955 | 60 | | |

[a] 1 = None or Slightly Present; 5 = Strongly Present

*$p < .025$

TABLE 12

RATINGS OF "SEPARATION CONCERN"[a] AS A FUNCTION OF LISTENING PLAN AND EXPERIENCE

| Experience | Listening Plan | | | |
|---|---|---|---|---|
| | Own | Away | Toward | Total |
| Student | | | | |
| Mean | 2.64 | 3.45 | 3.73 | 3.27 |
| SD | 1.36 | 1.04 | 0.90 | 1.18 |
| Practitioner | | | | |
| Mean | 3.82 | 2.78 | 2.91 | 3.15 |
| SD | 1.17 | 1.62 | 1.45 | 1.46 |
| Total | | | | |
| Mean | 3.23 | 3.09 | 3.32 | 3.21 |
| SD | 1.38 | 1.38 | 1.25 | 1.32 |

Analysis of Variance

| | SS | DF | MS | F |
|---|---|---|---|---|
| Experience | 0.243 | 1 | 0.243 | 0.149 |
| Listening Plan | 0.576 | 2 | 0.288 | 0.176 |
| Interaction | 14.030 | 2 | 7.015 | 4.207* |
| Within Cell | 38.182 | 60 | 1.636 | |
| Total | 113.031 | 65 | 1. | |

[a] 1 = None or Slightly Present; 5 = Strongly Present

*$p < .025$

called for in this study is rather surprising. However, the effect of other factors must be examined before concluding that this another example of the "Chapman effect" (Chapman & Chapman, 1967), where common sense judgments of plausibility are found to overrule diagnostic information to the contrary, and all judges--regardless of experience--come to the same, sometimes erroneous, conclusions.

The conflictual theme "Adequate Self-Esteem vs. Diminished or Lost Self-Esteem" was included in the list of themes and affects as a check on whether people who did not recognize the CCRT in their essays would still rate it as strongly present when given the opportunity. And indeed, only "Narcissism" was rated more strongly present by the sample as a whole, with a mean rating of 3.92 on the 5-point scale, compared with a mean rating of 3.86 for "Adequate vs. Inadequate Self-Esteem." Those who identified the CCRT gave it a mean rating of 4.03 as a group; those who did not gave it a mean rating of 3.55.

Interestingly, a high rating of this conflictual theme correlated significantly only with identification of the CCRT and two other items from the themes and affects checklist: "Rejection (negative response to patient by other person)" ($r = .239$, $p < .05$) and "Independence vs. Dependence ($r = .438$, $p < .0005$). Rejection by others is one of the relationship consequences listed by Luborsky in this patient's CCRT tree (see Figure 4). The extremely high correlation between "Adequate vs. Inadequage Self-Esteem" and "Independence vs. Dependence" suggests that for many people in the sample, the two conflicts are almost synonomous, at least in the case of this patient. (The

correlation between "Narcissism" and "Grandiosity" was .423.)

Personal Psychotherapy

Having been in personal therapy appears to be necessary but not sufficient for identifying the CCRT. Only one of the ten subjects who had never been in psychotherapy identified the CCRT, even though this group ranged in experience from 0 to 2500 hours ($F$ [4,65] = 3.12, $p < .025$).

Using Scheffé contrasts, those with between 1-150 hours of personal psychotherapy were found to do significantly better than the other groups of clinicians who had also been in personal psychotherapy ($F$ [4,65] = 3.12, $p < .025$). The groups of therapists with over 150 hours of personal psychotherapy were not significantly different from one another, even at the $p < .05$ level (see Table 13).

Demographic Similarity to Patient

Demographic similarity to the patient was not related to identification of the CCRT or accurate prediction of outcome. The patient was a white Jewish woman in her late forties. However, whites did not do better than non-whites.* Jews did not do better than non-

*Black and Hispanic clinicians were significantly more successful than white clinicians in identifying the CCRT and in accurately predicting outcome. Seven out of eight identified the CCRT ($\chi^2 = 4.22$, $p < .05$). (The one subject who did not was the only one who had not been in personal psychotherapy.) Six out of eight were in the group predicting the most improvement, which was the correct prediction for this patient ($F$ [1,65] = 9.58, $p < .025$). However, this relationship between correctly identifying the CCRT and accurately predicting outcome did not hold for the rest of the sample.

While their $d'$ scores for high and low imagery words did not differ from those of white clinicians, their $L_x$ scores were significantly

TABLE 13

PRESENCE (1) OR ABSENCE (2) OF CCRT AS A FUNCTION OF HOURS IN PERSONAL PSYCHOTHERAPY

| Group | Hours | N | Mean | SD |
|---|---|---|---|---|
| 1* | 0 | 10 | 1.900 | .316 |
| 2* | 16-150 | 14 | 1.214 | .426 |
| 3 | 160-300 | 14 | 1.429 | .514 |
| 4 | 350-600 | 15 | 1.467 | .516 |
| 5 | 600+ | 13 | 1.462 | .519 |
| Total | | 66 | 1.470 | .503 |

One-Way Analysis of Variance

| | SS | DF | MS | F |
|---|---|---|---|---|
| Means | 2.790 | 4 | 0.697 | 3.12** |
| Within | 13.650 | 61 | 0.224 | |
| Total | 16.439 | 65 | | |

*Groups 1 and 2 are significantly different from each other and Groups 3, 4 and 5 at a confidence level of 97.5%, calculated by Scheffe's method. Groups 3, 4 and 5 are not significantly different from each other, even at a confidence level of 95%.

**$p < .025$

Jews, women did not do better than men, and people over 40 did not do better than people under 40. Of the nine subjects who could be identified as white Jewish and over 40, seven out of nine identified the CCRT ($F$ [1,65] - 2.59, $p < .10$), but none predicted a better outcome than 5 on the 7-point scale, and one predicted "No Change."

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higher (for Log $L_x$ for high imagery words, $F$ [1,65] = 8.83, $p < .005$; for Log $L_x$ for low imagery words, $F$ [1,65] = 9.58, $p < .005$). This indicates that the Black and Hispanic clinicians were much more cautious about giving affirmative answers. Apparently they did not say "Yes, I heard that word" unless they felt quite sure.

It is interesting to note that while this did not significantly lower their $d'$ scores, which are measures of memory in which there is a correction for response bias, their raw scores for Correct Positives (their absolute number of "right answers") was significantly lower than those of the white clinicians ($F$ [1,65] = 11.50, $p < .005$).

However, white subjects with high $L_x$ scores did not perform better on these tasks of clinical judgment than white subjects with low $L_x$ scores.

In order to better understand what factors might be contributing to their ability to perform so well on these tasks of clinical judgment, the Black and Hispanic clinicians were matched with a sample of eight white clinicians for age, sex, hours of experience, kind of training, whether or not they had been in personal psychotherapy, and experimental listening plan. The matched sample did much less well: only three out of eight idnetified the CCRT and only two out of eight predicted the more positive outcome. However, this comparison can only be suggestive, since the numbers involved are too small for statistical analysis.

Since the subjects in this study were only asked to identify one patient's CCRT, the question remains open whether there was something about this patient's core conflictual relationship theme which gave Black and Hispanic clinicians a special affinity and empathy for it, or whether this group of clinicians, defined by their coming from ethnic backgrounds different from the majority of the sample, are generally more astute clinical judges. Woule they do as well with another patient with a different CCRT? Are they always optimistic regardless of the patient's actual outcome? Or do they predict outcome accurately even when the outcome is not a good one?

In order to better understand these phenomena a larger sample than eight Black and Hispanic clinicians would be necessary. Since none of the Black and Hispanic clinicians in this sample were over 30, or had more than 300 hours of personal psychotherapy, or more than 1500 hours of experience as psychotherapists, a broader sample is necessary as well.

While tangential to this study, it would be quite interesting to determine if minority students' low scores on tests such as GRE's and SAT's are due to higher criteria for affirmative responses on those tests (refusal to guess and leaving blanks instead), rather than purely lack of knowledge of the material.

electrodes, as Miller's subjects and Alpert and Cohen's subjects did.

However, it is not the one-to-one relationship by itself. In this study, of the seven practitioners who were tested individually, in their own offices in six cases, three fell above the median for d' scores for high imagery words, and four fell below.

Even when the non-white clinicians, with their tendency toward lower d' scores, were removed from consideration, d' scores for high imagery did not vary by listening plan of have a significant relationship with the correct identification of the CCRT.

d' is a measure of attention and memory, expressed as a z-score. A person obtains a high d' score by accurately discriminating between words he has heard from words he has not heard before. When the experimental stimuli are incidental, as in Miller's experiment, the average subject's d' score is low: Miller reported an average d' score of about 0.4 for both high imagery and low imagery words. When the experimental stimuli are central to the experiment as perceived by the subject, as in Alpert and Cohen's study, the subjects' average d' is much higher; Alpert and Cohen report an average d' of about 1.5 for high imagery words and of about 1.0 for low imagery words.

In this study, the mean d' for high imagery words was 1.9 and for low imagery words 1.5. These high d' scores indicate that these subjects had little difficulty in discriminating between words spoken by the patient and words not spoken by the patient after hearing the tape. Listening plan and level of experience had no statistically significant effect on these already high d' scores.

In this study, all subgroups had higher d' scores for high imagery

words (Kintsch, 1970). Alpert and Cohen's population of clinicians also showed this difference. Only d' for high imagery words was found to correlate with their measure of clinical judgment. In the present study, listening instructions did not affect the difference between d' scores for high and low imagery, as Miller reported being able to do in his study of incidental stimuli.

Neither did this study replicate Alpert and Cohen's finding that high d' scores for high imagery words were associated with success at a clinical task. The correlation between d' for high imagery words and identification of the theme was insignificant, and in the negative direction ($r = -.17$), as it was for Severity of Pathology ($r = -.16$). The correlation was insignificant, though positive, for the prediction of outcome ($r = .02$).

In the light of these results, d' for high imagery words appears to be a measure of attention, as reported in other contexts (Kintsch, 1970) when verbal stimuli on which the subjects are later tested are imbedded in the material on which the subjects are asked to focus their attention.

Alpert and Cohen report their significantly high correlation between d' for high imagery and successful detection of cues only for the group of clinicians who were primed to listen for termination. Clinicians of equal experience primed to listen for grandiosity had much lower d' scores, both for d' for high imagery and d' for low imagery. Thus, d' for high imagery appears to be correlated with detecting cues only when the clinicians' attention is directed to the cues in advance, and the cues their attention is directed to are actually there.

# CHAPTER V

# DISCUSSION

## Effects of Listening Plan

Pavio et al. (1968) and Miller (1972) found that subjects with relatively high d' scores for high imagery words tend to mediate cognitive tasks with imagery, as called for in "listening away." Alpert and Cohen (in press) found a high correlation ($r = .73$, $p < .025$) between recognition of high imagery words on this task and success at cue detection in listening to the analytic tape created by Spence et al. (1974).

In the experiment reported here, subjects were given the same listening instructions Miller's subjects were, and then asked to listen to a tape of a patient and perform a clinical task. Alpert and Cohen's subjects were not given Miller's instructions.

This study tested Alpert and Cohen's assumption that a high d' score for high imagery words is associated with successfully approximating the experimental listening plan of "listening away," and a high d' score for low imagery words is associated with the successful approximation of the experimental listening plan of "listening towards," as put forth in Miller's instructions.

The results of this study cast doubt on this assumption.

Perhaps it is only possible to get the effect Miller did in a setting where the experimenter has a one-to-one relationship with the subject who sits in a extremely comfortable chair while fitted with

## Experience and Clinical Judgments

Over half the subjects were found to identify Luborsky's "core conflictual relationship theme" (CCRT) in their formulation of the patient's "basic life problem--the core conflictual theme of her communication."

However, whether the subjects were considered divided into either two or four levels of experience, or even into experience vs. no experience, one-way analysis of variance yielded no statistically significant differences between groups in their ability to identify the CCRT, or accurately predict outcome, or assessment of pathology. Nor were there any differences between groups in their rating of the 21 themes and affects on the checklist.

Miltiple comparison tests found a significant relationship between increasing experience and assessment of the patient's pathology as more severe. Increasing experience was also correlated with rating the patient as showing more Helplessness, Hostility to Therapist (Inferred), Depression, and Narcissism, and significantly less Anxiety. It was not related to identifying the CCRT or accurately predicting outcome.

Thus, in regard to the hypotheses this study proposed to test, we can conclude:

I. Verbal instructions to "listen away" (to listen with free-floating attention) did not lead to more accurate identification of basic theme than did verbal instructions to "listen towards" (listen with critical attention), for either students or practitioners. The two groups did equally well.

II. Sensitivity to High Imagery words spoken by the patient

was not significantly associated with following verbal instructions to "listen away." Sensitivity to Low Imagery words spoken by the patient was not significantly associated with following verbal instructions to "listen towards." Both students and practitioners, using all three listening plans, were more sensitive to high imagery words than to low imagery words.

III. More experienced therapists were not better able to identify the basic themes in clinical material than were less experienced therapists. The two groups did equally well.

IV. Since no statistically significant differences were observed between listening plans, no conclusions may be drawn about how clinicians' listening styles compare to the theoretical concepts of "listening towards" and "listening away."

The Effect of Personal Psychotherapy

Although none of the hypotheses about mode of listening or experience were supported by the data, personal psychotherapy was found to have the following effect:

Clinicians who had never been in personal psychotherapy identified the CCRT significantly less than the rest of the sample, while the clinicians in the sample with between 16 and 150 hours identified it significantly more than the rest of the sample.

Psychotherapists with less than 150 hours of personal psychotherapy may still be in treatment, and at the relative beginning of treatment, since the mean for the entire sample was 380 hours. Thus, it is

possible that either being at the beginning of therapy or being currently in treatment, or both, may have the effect of making the CCRT especially salient to subjects.

While many of the subjects with over 150 hours of personal therapy may still be in treatment, no information was collected which could be used to determine whether or not it is being in treatment, no matter what the stage, which is the relevant factor. This must be clarified through further research.

This relationship between personal psychotherapy and being able to identify the CCRT is interesting in the light of how Luborsky initially derived the CCRT: He sees it as a recurrent theme throughout therapy which is identified early in successful treatment by patient and therapist both, as a result of their work together, and is never recognized in unsuccessful treatment, although it continues to recur.

The results of this study suggest that learning to identify the core conflictual relationship theme is something which is learned by being a patient more than through any other aspect of training or experience. In comparison, whether subjects were trained as clinical psychologists, psychiatrists, or social workers, or how far they were in their training, had no significant effect.

Further research is necessary to establish if the reason that those with under 150 hours of personal psychotherapy do so well at this task is a function of being in the early stages of treatment, or is related to currently being in therapy at the time of the experiment.

This could be clarified simply by asking subjects if they are currently in treatment at the time of the experiment, as well as the number of hours they had spent in psychotherapy.

It would also be important to ask subjects to listen to other patients and see if the effect can be replicated. This should be done including more psychotherapists who have not been personal psychotherapy.

Another interesting avenue to follow would be to compare the performance on this task of people who are not psychotherapists, some of whom have and some of whom have not been in psychotherapy.

## Limitations

This study was limited by the following factors:

(1) It was limited to judgments based on information available from an audio tape of a therapy segment early in treatment. A great deal of the non-verbal information available to a person interacting with another person was therefore not available to the clinicians in the experiment. Neither was the kind of information they might have been accustomed to gaining from others' particular reaction to them as unique individuals. They only had as data the patient's reactions to the therapist on the tape.

(2) The subjects' mode of listening was influenced solely by verbal instructions to listen in a particular way, not as reported by Spence and Grief (1970) and Spence and Lugo (1972).

(3) Since the study used an analytic psychotherapy session as the stimulus and analytically-oriented therapists as subjects, it

applies directly only to the kinds of themes expressed in analytically-oriented therapy and discerned by analytically-oriented therapists. Perhaps therapists trained in other modalities would consistently elicit different themes from this patient, or find different themes in this material.

(4) Since the therapists in this study only responded to one patient, the ability of therapists to identify themes of patients of both the same sex and the opposite sex as themselves was not investigated. Nor were the subjects exposed to material from the patients whose basic themes varied in their difficulty to identify.

(5) The fact that a segment rather than a whole session was used was a limitation imposed by the limited time available for therapists to serve as experimental subjects.

Obviously, a whole session contains more information. However, Kendell (1973) demonstrated that clinicians can get enough information out of a five-minute filmed interview to achieve a 75% rate of agreement on a diagnosis. Bachrach et al. (1974) found good agreement between segment and session measures on all variables except Empathy. All other studies of clinical judgment have used 10-15 minute segments of an experimenter-composed session, as described above, or five-minute to thirty minute sound films (Kendell, 1973; Strupp & Jenkins, 1963; Stoller & Geertsmas, 1958). The most recent studies have used the shortest films, as research demonstrated that increased length did not lead to increased accuracy. The work of Spence (1975; 1968), Luborsky (1975) and Horowitz (1975) all showed a great deal of redundancy in

patients' communications.

(6) That the therapists were asked to write their responses was a limitation imposed by both the time and expense involved in transcription. Although Strupp (1973) reported that best results were obtained by having clinicians tape-record their responses and then having them transcribed, rather than asking the therapists to write them out, financial considerations made that approach impossible in this study.

## Conclusion

Miller's listening instructions did not work in this study. Instead, mechanical ways of enforcing "listening away" such as the random number generation used by Spence and Lugo (1972) and Spence and Grief (1970) might be more effective.

Yet even within these limitations, Luborsky's CCRT proved to be a reasonable criterion for clinical judgment, a scorable task that asks the clinician to formulate an aspect of the patient's functioning which is important to treatment.

If the relationship discovered here between identifying the core conflictual relationship theme and being in personal psychotherapy oneself is replicated in further research, the implications for training would be clear. However, these results must be viewed as only suggestive until they are replicated and the mechanisms involved more clearly elucidated.

## APPENDIX I

### EXPERIMENTAL PROTOCOL

This study explores the different ways different therapists can listen to a patient. Together we will be looking at how experimentally defined ways of listening are similar to and different from therapists' usual way of listening. At no point will you be asked to identify yourself or your work in this experiment. Your responses will be anonymous.

This experiment is open and involves no deception. Following the guidelines for informed consent, I'm providing you with a copy of the consent form I'm asking you to sign, which describes this study. I believe the risks involved in participating in this study are minimal--on a par with attending a clinical case conference or seminar. You may withdraw your participation at any time before you hand in your test booklet--but I doubt that you would want to. However, part of the guidelines for ethical research with human subjects stresses the fact nothing is 100% risk-free and that there should be no possibility of subjects feeling coerced.

(HAND OUT CONSENT FORMS AND BOOKLETS)

Please don't open your booklets until it's time to begin.

(PAUSE TO READ, SIGN AND COLLECT CONSENT FORMS)

Basically, this is a study of different ways of listening. This group will be divided randomly into three subgroups. Each will listen

a different way to the same 20 minute tape taken from the third psychotherapy session of a woman patient.

One subgroup will listen the way you would usually listen to a patient of your own.

Another subgroup will "listen towards" the patient. This is a problem-solving way of listening in which you try to grasp, figure out and make connections about what the patient is say8ng. You try to conceptualize what is being said and try to form and check out hypotheses, by listening actively and critically.

Another subgroup will "listen away" from the patient. This is an easy-going, open, receptive way of listening where the focus is on the experience of listening, in which you are receptive to the ideas, thoughts, images and feelings which occur to you as you listen. Let your attention float freely--don't try to interpret what you hear--just relax and absorb what you hear and let yourself respond freely to it.

Instead of criticizing or trying to interpret what you hear, the group that "listens away" will just experience, rather than worry about being able to repeat or summarize or even give some verbal response. That's the goal of the "listening towards" group. That group will focus on being able to summarize, conceptualize and interpret.

If you will now turn to page one of your booklet, you will see which way of listening you will be using while you listen to the tape. I'm going to give you a few minutes to read your individual listening instructions.

(PAUSE TWO MINUTES)

Are there any questions?

(REVIEW LISTENING INSTRUCTIONS)

Let me emphasize again that the aim of this experiment is to explore the effects of different ways of listening. This is not a test of you, but of the listening plan, with those using their own listening plan serving as a control group.

It isn't necessary to take notes, but if it makes you feel more comfortable to do so, you may take notes on Page 1 of your booklet, below your listening instructions. Do not turn to page 2 until the tape is completed. Please try to keep your thoughts and reactions to yourself while listening--try to keep a therapeutic neutrality--enough to avoid influencing those around you.

You will now hear the first 20 minutes of the third session in the psychotherapy of a Pennsylvania woman in her 40's. The woman's name is _____. She discusses her relationship with a man named _____ and his wife _____. Her husband's name was _____.

The therapist is a man. Try to listen to the patient and not to the therapist's style or technique. Parts of the tape may be difficult to hear, but don't worry if you can't hear everything. Any questions?

PLAY TAPE

Now, turn to page 2 of your booklet. I am going to read a list of nouns. Some were spoken by the patient, some were not. If you believe the word was spoken by the patient, circle Y for Yes. If you do not believe the word was spoken by the patient, circle N for No. Do not hesitate to gues. You must circle either Y or N. Any questions?

## D.R. Word List

| | | |
|---|---|---|
| 1. incidents | 21. paper | 41. quantity |
| 2. competition | 22. background | 42. water |
| 3. queen | 23. children | 43. ticket |
| 4. valley | 24. lake | 44. clothing |
| 5. toy | 25. workhouse | 45. inducements |
| 6. fate | 26. coffee | 46. honor |
| 7. dresses | 27. hotel | 47. hall |
| 8. hours | 28. fact | 48. opinion |
| 9. flag | 29. patent | 49. forms |
| 10. village | 30. trouble | 50. bosom |
| 11. life | 31. injuries | 51. officer |
| 12. truce | 32. contribution | 52. dollars |
| 13. table | 33. piano | 53. furs |
| 14. duties | 34. ceremony | 54. truth |
| 15. length | 35. blessing | 55. woman |
| 16. origin | 36. contract | 56. circle |
| 17. quality | 37. home | 57. tree |
| 18. pepper | 38. power | 58. charter |
| 19. virtue | 39. friends | 59. party |
| 20. health | 40. thought | 60. time |

Now, on page 3 of your booklet, write down what seems to you to be this patient's basic life problem--the core conflictual theme of her communication. Give as many illustrations of this as you can remember from the tape you just heard. You may answer in outline form if you wish. Do not go back to your notes if you took them. Do this from memory.

You may continue your answer on the following blank page if necessary. Please don't write on the back of pages 2 or 3.

You will have twenty minutes to complete this part. If you should finish sooner, just continue to pages 5, 6 and 7. However, once you finish this section, please do not go back to it. There is space on page 7 specifically for any additional thoughts you might have after completing this section.

Any questions?

If you should have any questions as you proceed through the booklet, feel free to ask me. When you complete page 7, just hand in your booklet and quietly depart. Thank you very much for your participation in this experiment!

SUBJECT'S CONSENT STATEMENT

NAME OF INVESTIGATOR: Jessica Schairer
Title of Project: The effect of variations in mode of listening on therapists' understanding of a patient's communication.

I hereby acknowledge that on _____(date), I was informed by Jessica Schairer of a project having to do with how the conscious modification of the way a therapist listens may influence how he or she understands a patient's communication.

I understand that this experiment involves listening to a 20 minute segment from a psychotherapy session using an experimental listening modality, and then filling out some questionaires tapping the effect of the listening instructions and some general demographic variables (age, sex, clinical experience, etc.).

I understand that my contribution to this experiment will be anonymous and will be used for research purposes only.

I am fully aware of the nature and extent of my participation in said project and the possible risks involved,or arising therefrom. I hereby agree, with full knowledge and awareness of all the foregoing, to participate in said project. I further acknowledge that I have received a complete copy of this statement. I also understand that I may withdraw my participation in this project at any time.

Date:_____

Place: _____
(City & State)

_____
(Signature of Subject)

_____
(Printed Name of Subject)

_____
(Residence Address of Subject)

_____

## APPENDIX II

## EXPERIMENTAL TEST BOOKLET

Page 1

### YOUR LISTENING INSTRUCTIONS

Please listen to this patient the way you would usually listen to a patient of your own.

OR

Page 1

### YOUR LISTENING INSTRUCTIONS

You are going to "listen away" from the patient. This is an easy-going, open, receptive way of listening, where the focus is on the experience of listening. Be receptive to the ideas, thoughts, images and feelings which occur to you as you listen. Don't try to interpret what you hear--just relax and absorb what you hear and let yourself respond freely to it.

OR

Page 1

### YOUR LISTENING INSTRUCTIONS

You are going to "listen towards" the patient. This is a problem-solving way of listening. Try to grasp, figure out and make connections about what the patient is saying. Try to conceptualize what is being said. Try to form and check hypotheses about what the patient is saying. Listen actively and critically.

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| 1. | Y | N | 21. | Y | N | 41. | Y | N |
| 2. | Y | N | 22. | Y | N | 42. | Y | N |
| 3. | Y | N | 23. | Y | N | 43. | Y | N |
| 4. | Y | N | 24. | Y | N | 44. | Y | N |
| 5. | Y | N | 25. | Y | N | 45. | Y | N |
| 6. | Y | N | 26. | Y | N | 46. | Y | N |
| 7. | Y | N | 27. | Y | N | 47. | Y | N |
| 8. | Y | N | 28. | Y | N | 48. | Y | N |
| 9. | Y | N | 29. | Y | N | 49. | Y | N |
| 10. | Y | N | 30. | Y | N | 50. | Y | N |
| 11. | Y | N | 31. | Y | N | 51. | Y | N |
| 12. | Y | N | 32. | Y | N | 52. | Y | N |
| 13. | Y | N | 33. | Y | N | 53. | Y | N |
| 14. | Y | N | 34. | Y | N | 54. | Y | N |
| 15. | Y | N | 35. | Y | N | 55. | Y | N |
| 16. | Y | N | 36. | Y | N | 56. | Y | N |
| 17. | Y | N | 37. | Y | N | 57. | Y | N |
| 18. | Y | N | 38. | Y | N | 58. | Y | N |
| 19. | Y | N | 39. | Y | N | 59. | Y | N |
| 20. | Y | N | 40. | Y | N | 60. | Y | N |

(1) Write down what seems to you to be this patient's basic life problem--the core conflictual theme in her communication.

(2) Give as many illustrations of this as you can from the tape you just heard.

(You may continue your answer on the following blank page if you wish. You will have 20 minutes to complete this part. If you should finish sooner, you may continue to Pages 5,6,and 7. However, once you finish this section, please do not go back to it.)

Below is a list of themes and affects. Please rate each one independently on how strongly present it is in the session you just heard. Circle the number closest to your own judgment on the adjoining scale.

| | 1 none or slight | 2 some | 3 moderately present | 4 much | 5 very much |
|---|---|---|---|---|---|
| 1. Rejection (negative response to patient by other person) | 1 | 2 | 3 | 4 | 5 |
| 2. Helplessness | 1 | 2 | 3 | 4 | 5 |
| 3. Hopelessness | 1 | 2 | 3 | 4 | 5 |
| 4. Separation Concern | 1 | 2 | 3 | 4 | 5 |
| 5. Anxiety | 1 | 2 | 3 | 4 | 5 |
| 6. Hostility to Therapist(Inferred) | 1 | 2 | 3 | 4 | 5 |
| 7. Hostility to Therapist(Direct) | 1 | 2 | 3 | 4 | 5 |
| 8. Hostility to Others | 1 | 2 | 3 | 4 | 5 |
| 9. Sex and Affection | 1 | 2 | 3 | 4 | 5 |
| 10. Guilt | 1 | 2 | 3 | 4 | 5 |
| 11. Shame | 1 | 2 | 3 | 4 | 5 |
| 12. Reference to Therapist(Explicit) | 1 | 2 | 3 | 4 | 5 |
| 13. High Involvement with Therapist | 1 | 2 | 3 | 4 | 5 |
| 14. Grandiosity | 1 | 2 | 3 | 4 | 5 |
| 15. Depression | 1 | 2 | 3 | 4 | 5 |
| 16. Narcissism | 1 | 2 | 3 | 4 | 5 |
| 17. Working Alliance | 1 | 2 | 3 | 4 | 5 |
| 18. Independence vs. Dependence | 1 | 2 | 3 | 4 | 5 |
| 19. Activity vs. Passivity | 1 | 2 | 3 | 4 | 5 |
| 20. Adequate self-esteem vs. diminished or lost self-esteem | 1 | 2 | 3 | 4 | 5 |
| 21. Unresolved or delayed grief | 1 | 2 | 3 | 4 | 5 |

22. What treatment outcome do you predict for this patient ? Circle one:

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Much Worse | | | No Change | | | Much Improved |

23. How serious is the patient's pathology? (Circle one:)

1. Mild 2. Moderate 3. Severe

PLEASE CONTINUE TO PAGE 6.

## QUESTIONAIRE

1. Age: __1. 20-29 __3. 40-49 __5.60+
   __2. 30-39 __4. 50-59
2. Sex: __Male __Female
3. Ethnicity: __White __Black __Other
   Religion: __Protestant __Catholic __Jewish
4. Training: (Check as many as apply)

   __B.A. __Clinical Psychology Graduate Student (Circle Year: 1 2 3 4 5 6 7 8)
   __M.A.;M.S. __Ph.D.
   __M.D.
   __M.S.W.
   __Post-Graduate(Specify Type: _____)

5. Personal Psychotherapy:

   Type: _____

   Approx. number hours spent as a patient: Hours/Week: ___ # Years: ___

6. Current Orientation as a therapist:

   _____

7. Years of experience as a therapist: _____

8. Approximately how many hours have you spent seeing patients --in all therapy modalities--since starting clinical work? _____ (For example, a therapist who works eleven months--48 weeks-- and sees patients for 15 hours a week, would have spent approximately 720 hours seeing patients that year.)

9. Approximately how many hours have you spent supervising since starting to supervise? _____

10. If you have ever taken SAT's or GRE's or MCAT's, which type of aptitude test did you score higher on?

    __Verbal __Quantitative

PLEASE CONTINUE TO PAGE 7.

11. Please place your own usual way of listening on the continuum below by circling a number:

Listening Towards 1 2 3 4 5 6 Listening Away

12. If you used an experimental listening style, please comment on how it compares to your usual listening style.

OR

If you used your own style, please speculate on how your own style compares to the experimental styles.

THANK YOU FOR YOUR PARTICIPATION IN THIS PROJECT!

## APPENDIX III

### IMAGERY VALUES FOR TARGET WORDS AND FILLER WORDS[a]

| High Imagery Words | | High Imagery Fillers | | Low Imagery Fillers | |
|---|---|---|---|---|---|
| woman | 6.53 ± 0.61 | water | 6.60 ± 0.70 | workhouse | 4.00 ± 1.92 |
| coffee | 6.73 ± 0.56 | clothing | 6.17 ± 1.17 | charter | 3.83 ± 1.81 |
| friends | 6.37 ± 0.90 | furs | 6.23 ± 1.07 | forms | 4.30 ± 1.78 |
| home | 6.50 ± 0.97 | hall | 6.37 ± 1.18 | health | 4.10 ± 1.74 |
| table | 6.50 ± 1.01 | ticket | 6.20 ± 1.17 | trouble | 3.53 ± 1.75 |
| piano | 6.70 ± 0.63 | pepper | 6.27 ± 1.19 | patient | 3.43 ± 1.93 |
| party | 6.27 ± 0.84 | paper | 6.30 ± 1.46 | power | 4.47 ± 1.77 |
| children | 6.50 ± 0.97 | circle | 6.23 ± 1.38 | contract | 4.50 ± 1.75 |
| valley | 6.57 ± 0.79 | village | 6.50 ± 1.55 | virtue | 3.33 ± 1.96 |
| dresses | 6.53 ± 0.83 | dollars | 6.50 ± 1.04 | duties | 3.17 ± 1.74 |
| $\bar{X}$ = | 6.52 | $\bar{X}$ = | 6.34 | $\bar{X}$ = | 3.87 |

| Low Imagery Targets | | High Imagery Fillers | | Low Imagery Fillers | |
|---|---|---|---|---|---|
| incidents | 2.90 ± 1.67 | injuries | 5.70 ± | inducements | 2.93 ± |
| hours | 3.60 ± 2.26 | hotel | 6.40 ± 0.97 | honor | 3.50 ± 1.83 |
| opinion | 3.23 ± 1.84 | officer | 6.23 ± 1.04 | origin | 2.30 ± 1.53 |
| quality | 3.10 ± 1.92 | queen | 6.57 ± 0.70 | quantity | 3.47 ± 1.74 |
| thought | 2.27 ± 2.06 | toy | 6.17 ± 0.95 | truth | 2.73 ± 1.88 |
| fact | 2.20 ± 1.63 | flag | 6.60 ± 0.86 | fate | 2.37 ± 1.55 |
| time | 4.13 ± 2.28 | tree | 6.77 ± 0.55 | truce | 4.80 ± 1.63 |
| life | 4.07 ± 2.09 | lake | 6.67 ± 0.53 | length | 3.73 ± 1.58 |
| competition | 4.53 ± 1.60 | ceremony | 5.37 ± 1.49 | contribution | 3.67 ± 1.91 |
| background | 4.03 ± 1.82 | bosom | 6.57 ± 0.61 | blessing | 4.43 ± 1.66 |
| $\bar{X}$ = | 3.41 | $\bar{X}$ = | 6.31 | $\bar{X}$ = | 3.39 |
| | | Total $\bar{X}$ = | 6.33 | Total $\bar{X}$ = | 3.63 |

[a]Matched for number of syllables, initial letter, frequency in English language according to values determined by Pavio et al. (1968)

## APPENDIX IV

## SAMPLE ESSAYS

### Sample A: Theme Present

Her basic view of herself and her self-image is dependent on her relationships with other people--particularly with men.

She began by asking her therapist about a report about her--i.e., what he thought about her by having read about her. She showed further evidence of her need for her therapist's regard when she frequently asked him to respond and said "I wish you'd say something" after she had spoken about some difficult material. She also called him on a Sunday, after an apparently unsuccessful date with a man.

She needs people's approval for her to accept herself--note her feelings that she herself is "just me" while other people think she is interesting and intelligent. Also her negative feelings about her overweight date, and the emphasis on her own and J_____'s physical appearance.

She feels a need to show herself better than those around her in everyone else's eyes. She has a major rival who may outdo her. So she tells a story about cake where her rival, according to the patient, acted ridiculously, compared her mode of dress to her rival and decides she's better, calls her rival masculine (after announcing that women should be more feminine). In spite of this, her rival has her husband and the patient does not, which is devastating to the patient's self-image. She seems to feel her only hope is to replace her lost lover with her new therapist and, in gaining the therapist's attention, thereby be better able to accept herself.

### Sample B: Theme Present

Narcissistic personality with poor self-esteen. Poorly individuated; measures self in terms of others' opinions and how they treat her; wants people's admiration and adulation, yet is not comfortable with her own exhibitionistic, competitive or narcissistic strivings; thinks a woman should be submissive. Has to outshine somebody else to feel OK about herself.

1. What do I feel? (query to therapist)
2. Maybe I only want M. because he is J.'s--I'm really attracted to her.
3. It's a way of protecting yourself when you love someone who doesn't

love you back. (Rationalizing choice of love object.)
4. Does every woman? (Has little sense of self, doesn't know who she is.)
5. Mutual friend thinks J. and I are so similar--both feminine--both's presence felt in the room but I don't think she's feminine--masc voice, body, trashness, freedom.
6. (We're both stars) I play the piano--I'm a terrific dancer, taught by my husband--she wears seductive necklines (I do too) has strong political opinions, dirty language, loud voice. Having M. is a way of beating her.
7. Not getting the piece of cake she wanted was a narcissistic injury yet she couldn't fight for it.
8. Wants to take M. away from J. to win over J., yet is sure she'll fail and that M. doesn't love her and wants to leave her. Probably doesn't love M. at all--he's not a real person to her, but a property to be struggled over between J. and herself--which fight she'll lose.
9. Doesn't know whether or not she's a lesbian.

Sample C: Theme Absent

1. Patient' basic problem is penis envy, e.g., her sexual ambivalence, coupled with intense rivalry with other women and desire to be the powerful phallic woman who can be in control of others.

2. a) she was intensely competitive with her girl friend 15 years ago, wanting to get her piece of cake

b) she is in competition with her girlfriend for the husband

c) she is more interested in winning against the other woman than having her husband. Perh ps in fantasy she wants to take this woman's phallus from her. This results in homosexual anxiety.

d) she wants to be the center of attention in clothes, in cake, in restaurants. There is a demanding need to be the center of attention and a rage at having to give this position up.

## APPENDIX V

### Raters' Agreement on Presence or Absence of Core Conflictual Relationship Theme (CCRT)

$$\text{Kappa} = \frac{\text{Agreement Observed - Agreement Predicted by Chance}}{\text{Total Number of Observations - Agreement Predicted by Chance}}$$

Rater 1

| | | CCRT Present Observed | (Expected) | CCRT Absent Observed | (Expected) | Total |
|---|---|---|---|---|---|---|
| Rater 2 | CCRT Present | 26 | (14.12) | 0 | | 26 |
| | CCRT Absent | 0 | | 16 | (6.95) | 16 |
| | | 26 | | 16 | | 42 |

$$\text{Kappa} = \frac{42-14.12}{42-14.12} = 1.0$$

Rater 2

| | | CCRT Present Observed | (Expected) | CCRT Absent Observed | (Expected) | Total |
|---|---|---|---|---|---|---|
| Rater 3 | CCRT Present | 13 | (7.09) | 0 | | 13 |
| | CCRT Absent | 5 | | 16 | (10.18) | 21 |
| | | 18 | | 16 | | 33 |

$$\text{Kappa} = \frac{29 - 17.27}{33 - 17.27} = .75$$

Rater 3

| | | CCRT Present Observed | (Expected) | CCRT Absent Observed | (Expected) | Total |
|---|---|---|---|---|---|---|
| Rater 3 | CCRT Present | 18 | (9.75) | 0 | | 18 |
| | CCRT Absent | 8 | | 22 | (13.75) | 30 |
| | | 26 | | 22 | | 48 |

$$\text{Kappa} = \frac{40 - 23.5}{48 - 23.5} = .70$$

$$\bar{X}_K = \frac{1.0 + .75 + .70}{3} = .82$$

## APPENDIX VI

## REPRESENTATIVE ESSAYS FROM SAMPLE

Essay 1: Theme Present (No Experience as Patient or Therapist)

The patient's basic problem seemed to be her very low self-esteem and a concomitant inability to make demands on herself or others.

1. She came in feeling that she could not trust her own description of herself.
2. In her description of M.'s wife, she uses the wife as a measure against which to judge herself, seems to be able to define herself only by contrast, and is constantly vacillating as to which of them is "bad" and which one is "good."
3. She ridicules her own thought that the affair was aimed somehow at J., and then goes on to imply that she is "incurable" anyway--"I was just trying to give you a problem you could do something about."
4. The cake incident--an insult remembered with enormous resentment for 15 years--shows how easily wounded this woman is.
5. Her unwillingness to admit that she just didn't like the blind date and didn't want to go out with him made it impossible for her to change the situation in any way that would improve it.

Essay 2: Theme Absent:(No Experience as Patient or Therapist)

The core conflictual theme in her communication was thoughts and fears of homosexuality.

She ended the relationship with her husband for reasons not elucidated. In starting up with the husband of her close-friend-rival, she questions her motivations for doing this. He no longer wants the patient, and she's not sure if she wants him. She speculates if her relationship with him was just to get her closer to his wife, since much of the time they spend together is passed talking about his wife. She picked up on conversations on male homosexuality in her business, and gave considerable thought to why she hadn't heard much about female homosexuality. She also spent a lot of time describing M.'s wife, physically and with regard to personality, and sounded envious.

She also seemed concerned about her "date," and didn't want to be alone with him, possibly because she was not interested in starting a relationship. Another possibility is that she wanted people to see her in a heterosexual relationship, and thereby allay her own fears ofher homosexual feelings.

Essay 3: Theme Present (Psychoanalyst with over 20 years experience)

This is a lonely, competitive woman whose style of contact is alternatingly through appeals, seduction, intimidation and exhibition. The form of her object relations is oedipal-triangular in that she competes with a woman for a man and tries to supplant the woman in the man's life--that is, she not only wants the man but wants him to regard her as a superior replacement for his wife. She thus uses the relationship with him to solve her conflict with the woman--this involves her wish to be loved and admired by the woman, as she admires her. Both with cake and husband the object is to get it from the woman. Her own husband and now boyfriend were and are unsatisfactory because they do not enhance her value in the eyes of others--presumably women. The form of her conflict resolution is narcissistic. The appeal in the transference is on the level of a coy 4-5 year old girl with her father. Dependence and narcissistic feminity are the goals.

One might make all kinds of inferences about her anger and her sense of deprivation--expressed in her controlled angry and demanding tone at various times in the interview. Guilt is evidently an important issue, as well--possibly accounting for her depression, and for her preoccupation with being all right. Some of this is most evidently on the narcissism-shame-exhibition axis, but her need for support of both men and women suggests the guilt as well.

Other relevant mechanisms are related to defiance and withholding, adding to the idea that the fixation is with the mother.

Essay 4: Theme Absent (Psychoanalyst with over 20 years experience)

Conflicts over object loss. Attempts to make contact with a person she loves and who loves her have been disappointing, contributing to depression. Currently, she is exploring the possibility of certain homosexual conflicts where she seeks a woman via the man. This object choice is narcissistically based, and also an attempt to regain esteem through contact with a maternal object who is just like her, and just what she wishes to be. Realization of these needs and longings is producing considerable depression. Hostility toward men from whom she is withdrawing is evident as she moves toward women. Appears to be part of a midlife crisis and self-re-evaluation.

1. Hostility towards therapist in beginning of session.
2. Depressive affect and sighing.
3. Acknowledgment that M. may be a bridge to J.
4. Focus of interest on J.'s clothing and surface attributes.
5. Sense of loss at being cheated of piece of cake by J.
6. Hopes for therapist to provide her with magical answers.

7. Sees J. as masculine, herself as feminine.
8. Disinterest in blind date.
9. Wish for crowds of people she knows as attempt to withdraw cathexis in 1-to-1 man-woman relationship.
10. Overt reference to male fairies and woman queers, the latter of which she denies.
11. Wish for crowds as counter-depressive attempt.
12. Ease of having woman "mutual friend" as confidant.
13. Frequent references to sameness of herself and J.
14. Long history of attachment to couple.
15. Recent breakthrough of homosexual longings probably reactive to advancing age, loneliness.

BIBLIOGRAPHY


Alexander, F., French, T., & Pollock, G. Psychosomatic Specificity, Vol. I. Chicago: University of Chicago Press, 1968.

Alpert, M. & Cohen, N. L. (1976) Style of listening and clinical sensitivity. J. of Nervous and Mental Disease (in press).

Anderson, N. H. & Jacobson, A. Effect of stimulus inconsistency and discounting intructions in personality impression formation. J. Pers. Soc. Psych., 1965, 4:531-539.

Asch, S. E. Forming impressions of personality. J. Abn. Soc. Psych., 1946, 41: 258-290.

Bachrach, H., Luborsky, L., & Mechanick. The correspondence between judgments of empathy from brief samples of psychotherapy, supervisors' judgments and sensitivity test. Brit. J. of Med. Psych., 1974, 4(4): 337-340.

Bergin, A. E. & Suinn, R. M. Individual Psychotherapy and Behavior Change. Annual Review of Psych., 1975, 26: 509-556.

Bronfenbrenner, J., Harding, J., & Gallwey, M. The measurement of skill in social perception. In D. C. McClelland, A. L. Baldwin, U. Bronfenbrenner, & F. L. Strodbeck (Eds.), Talent and Society. Princeton: Van Nostrand, pp. 29-111, 1958.

Chapman, L. J. & Chapman, J. P. Genesis of popular but erroneous diagnostic observations. J. Abn. Psych., 1967, 72: 193-204.

Clark, W. C. Pain sensitivity and the report of pain: An introduction to sensory decision theory. Anesthesiology, 1974, 40: 272-287.

Cline, V. B. Interpersonal perception. In B. A. Maher (Ed.), Progress in Experimental Personality Research, 1964, 1: 221-284.

Cline, V. B. & Richards, J. M. Accuracy of interpersonal perception--a general trait? J. Abn. Soc. Psych., 1960, 60: 1-7.

Cohen, J. Kappa: A nominal scale measure of rater agreement. Ed. Psych. Measurement, 1960, 20: 37-46.

Cronbach, . J. Processes affecting scores on "understanding of others" and "assumed similarity." Psych. Bull., 1955, 52: 177-193.

Fancher, R. E. Explicit personality theories and accuracy in person perception. J. Pers., 1966, 34: 252-261.

_____. Accuracy vs. validity in person perception. J. Consulting Psych., 1967, 31: 264-269.

Feldstein, S. Vocal patterning of emotional expression. In J. H. Masserman (Ed.), Science and Psychoanalysis, Vol. VII. New York: Grune & Stratton, pp. 193-208, 1964.

Freud, S. Recommendations for physicians on the psychoanalytic method of treatment. In Therapy and Technique, trans. Joan Riviere, New York: Collier Books, 1963. (Originally published, 1912.)

Goldberg, L. R. Simple models or simple processes? Some research on clinical judgments. Am. Psychologist, 1968, 23: 483-496.

Hammond, Hursch, & Todd. Analyzing the components of clinical inference. Psych. Rev., 1964, 71: 438-456.

Hammond, K. R. & Summers, D.A. Cognitive control. Psych. Rev., 1972, 79: 58-67.

Harty, M.K. Studies of clinical judgment. Part I: A critique. Bulletin of the Menninger Clinic, 1971, 35: 335-352.

Holt, R. R. Clinical and statistical prediction: a reformulation and some new data. J. Abn. Soc. Psych., 1958, 56: 1-12.

Horowitz, L. Two kinds of changes observed in a psychoanalysis. Paper presented at the Society for Psychotherapy Research, June 13, 1975.

Jackson, D. N. & Messick, S. J. Individual differences in social perception. Brit. J. Soc. Clin. Psych., 1963, 2: 1-10.

Kendell, R. E. Psychiatric diagnoses: a study of how they are made. Brit. J. Psychiat., 1973, 122: 437-445.

Kintsch, W. Learning, Memory and Conceptual Processes. New York: Wiley and Sons, 1970.

Leventhal, H. Cognitive processes and interpersonal prediction. J. Abn. Soc. Psych., 1957, 55: 176-180.

Luborsky, L. Momentary forgetting during psychotherapy and psychoanalysis: a theory and research method. In R. R. Holt (Ed.), Motives and thought: psychoanalytic essays in honor of David Rappaport. Psych. Issues, 1967, 5: 177-217.

_____. Generalizability of the psychoanalytic concept of the working alliance: psychoanalytic perspective. Paper presented at the Society for Psychotherapy Research, June 12, 1975.

_____. Measuring a pervasive psychic structure in psychotherapy: the core conflictual relationship theme. In N. Freedman (Ed.), Communicative Structures and Psychic Structures. Plenum Press, 1976, in press.

Luborsky, L. & Auerbach, A. The symptom-context method: qualitative studies of symptom formation in psychotherapy. J. of Am. Psychoanalytic Assoc., 1969, 17: 68-99.

Luborsky, L. & Mintz, J. What sets off momentary forgetting in a psychoanalysis? Investigations of symptom-onset conditions. Psychoanalysis and Contemporary Science, 1974, 3: 233-268.

Mann, J. Time-Limited Psychotherapy. Harvard University Press, 1973.

Meehl, P. E. Clinical vs. Statistical Prediction. Minneapolis: University of Minnesota Press, 1954.

_____. The cognitive activity of the clinician. Am. Psychologist, 1960, 15: 19-27.

Miller, T. Some characteristics of two different ways of listening. (Doctoral Dissertation, New York University, 1972.)

Mintz, J. & Luborsky, L. Segments vs. whole session: which is the better unit for psychotherapy process research? J. Abn. Psych., 1971, 78: 180-191.

Mischel, W. Personality and Assessment. New York: John Wiley & Sons, 1968.

Pavio, A. Yuille, J. C. & Madigan, S. Concreteness, imagery and meaningfulness values for 925 nouns. J. Exper. Psych. Mono. Suppl, 1968, 76, No. 1, Pt. 2: 1-25.

Reik, T. Listening with the third ear. New York: Farrar, Straus & Co., 1948.

Shinedling, M. Is clinical judgment worthwhile? APA, 1973, 8: 489.

Shrauger, S. & Altrocchi, J. The personality of the perceiver as a factor in person perception. Psych. Bull., 1964, 62: 289-308.

Singer, J. L. Imagery and daydream techniques employed in psychotherapy: some practical and theoretical implications. Current Topics in Clinical and Community Psychology, 1971, 3: 1-151.

Smith, H. C. Sensitivity to People. McGraw Hill, 1966.

Spence, D. Investigations of therapeutic sensitivity, 1966.(Unpublished manuscript.)

_____. The processing of meaning in psychotherapy: some links with psycholinguistics and information theory. Beh. Sci., 1968, 3: 349-361.

_____. The prediction of cancer diagnosis from interviews. Paper presented at the Society for Psychotherapy Research, June 13, 1975.

_____. Clinical interpretation: some comments on the nature of the evidence. 1976. (Unpublished manuscript.)

Spence, D. & Grief, B. An experimental study of listening between the lines. J. of Nervous and Mental Disease, 1970, 151: 179-186.

Spence, D. & Lugo, M. The role of verbal clues in clinical listening. In R. R. Holt & E. Peterfreund (Eds.), Psychoanalysis and Contemporary Science: An Annual of Integrative and Interdisciplinary Studies, 1972, 1: 109-131.

Spence, D., Lugo, M. & Youdin, R. Cardiac correlates of cognitive processing. Psychosomatic Med., 1974, 36: 420-437.

Stoller, R. J. & Geerstma, R. H. Construction of a final examination to assess clinical judgment in psychiatry. J. Med. Ed., 1958, 33: 837-840.

Strupp, H. H. Psychotherapy: Clinical Research and Theoretical Issues. New York: Jason Aronson, 1973.

Strupp, H. H. & Jenkins,J. The development of six sound motion pictures simulating psychotherapeutic situations. J. Nervous and Mental Diseases, 1963, 136: 317-328.

Sundberg, N. D. A method for studying sensitivity to implied meanings. Paper presented at APA, Los Angeles, 1964.

Taft, R. The ability to judge people. Psych. Bull., 1955, 52: 1-23.

Tagiuri, R. Person perception. In G. Lindzey & E. Aronson (Eds.), The Handbook of Social Psychology, Vol. III. Reading, Mass.: Addison-Wesley Publishing Co., pp. 395-449, 1969.

Triandis, H. C. & Fishbein, M. Cognitive interaction in person perception. J. Abn. Soc. Psych., 1963, 67: 446-453.

Truaux, C. B. & Mitchell, K. M. Research on certain therapist interpersonal skills in relation to process and outcome. In A. E. Bergin & S. L. Garfield (Eds.), Handbook of Psychotherapy and Behavior Change: An Empirical Analysis. New York: John Wiley & Sons, pp. 299-344, 1971.

Wolitsky, D. L. Cognitive controls and person perception. Percept. Mot. Skills, 1973, 36: 619-623.

_____. Accuracy in predicting behavior. Report from the Research Center for Mental Health. (Unpublished manuscript.)

Yalom, I. D. & Elkin, G. Every Day Gets a Little Closer: A Twice-Told Therapy. New York: Basic Books, 1974.