Openness and awareness of communication during psychotherapy.

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OPENNESS AND AWARENESS OF
COMMUNICATION DURING
PSYCHOTHERAPY

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A Thesis
Submitted to the Faculty of Graduate Studies through the
Department of Psychology in Partial Fulfillment
of the Requirement for the Degree of
Doctor of Philosophy at the
University of Windsor

Windsor, Ontario
1972
ACKNOWLEDGEMENTS

The author wishes to express his sincere appreciation to Dr. Frank Auld for his patient exposition of psychoanalytic principles and techniques, and for his assistance and guidance from the initial planning to the completion of this investigation; to Drs. W. Balance, R. Frisch, G. Namikas, and S. Selby for their assistance, interest and constructive comments over the course of this study; to Dr. M. Hyman for his generous instruction in psychoanalytic theory; to Mr. A. Finlayson and Mr. W. McDermott for their help in carrying out the research in this project; and to Cynthia for her encouragement, support and assistance throughout the course of this dissertation.
ABSTRACT

Two scales were constructed to measure the openness and awareness of a patient's communication during psychotherapy. The importance of these variables in psychoanalytic theory was discussed, and the findings of previous investigations of patient communication during psychotherapy were reviewed.

A pilot study was conducted to assess the reliability of the scales, then two independent judges rated 125 five-minute segments excerpted from the psychotherapy of five neurotic patients.

Significant individual differences were found between the overall levels of openness and awareness in the communication of the patients. These differences were related to the relative success of therapy in each case. Some evidence was found for a tendency of ratings of openness and awareness to increase monotonically within individual sessions, but no evidence was found for any increase in these variables over the entire course of treatment.

Finally, an attempt was made to demonstrate the independence of the two rating scales. The results suggested that if properly used, each scale will account for variance unrelated to the other scale.

The findings were discussed in terms of their theoretical implications, and recommendations were made regarding further investigation. It was pointed out that the study is considered exploratory and that restrictions in sampling limit the generality of the findings.
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Mean Openness Scores for Each Patient in Each Session
Chapter 1

Introduction

General Introduction

This study grew out of an initial interest of the investigator in the proposition that experiential learning is a crucial component in the process of psychotherapy, and that progress within psychotherapy is a function of both cognitive and affective patient experience. This interest was sparked during reflections on the inaccuracy of the widespread characterization of psychoanalytic therapy which suggest that as a patient recounts the events of his life, the therapist teaches him the reasons for his discomfort; that the patient, thus enlightened about the origins of his conflicts, adopts the therapist's dynamic explanations; and that the patient's increased self-knowledge enables him to control his disturbed and disturbing feelings.

In spite of the fact that Freud (1910) cautioned against its inaccuracy, this caricature of psychoanalysis has hung on with amazing tenacity within the popular media as well as within some communities of academic and professional psychology. The ingredient that is missing from this intellectualized view of the psychoanalytic process is, of course, the patient's living through or emotionally experiencing his conflicts within the therapy situation itself. In fact, psychoanalytic theory postulates that both cognitive and affective patient variables are important mediators of personality and behaviour change within the process of psychotherapy, neither of which is sufficient without the other.
Statement of the Problem

The present research addresses itself to the question: "How does the patient's openness to and awareness of his own experience change in the course of therapy?" If, as is postulated, personality and behaviour change occurs as a function of both cognitive and affective changes in a patient's functioning, it should be possible to demonstrate such changes and examine their occurrence over diverse periods of time during psychotherapy.

Clay (1968) observed that therapists commonly note changes in the quality of a patient's free associations over the course of a therapy session and at different stages over the course of treatment. He suggested that a patient's associations typically reflect greater openness and awareness as treatment progresses—changes which indicate that resistances are being weakened, and that the patient is in the process of discovering more than he "knew" at the beginning of the session or of the treatment. Clay defined openness as "the capacity to experience one's subjective states fully and freely—to have concrete images, emotions, and impulses without constraint or inhibition". He defined awareness as "the capacity to verbalize and conceptualize observations about the self". Awareness of one's own emotions and motives may vary in degree from absence of self-reflection to dynamically accurate awareness of emotions and motives which were unrecognized before therapy began; from perceiving oneself as a victim of events to perceiving oneself as a perpetrator of events; and from denial of responsibility for one's distress to recognition of one's own responsibility for it. The present study is based on an acceptance of Clay's observation as an hypothesis to be tested, and is conducted to provide empirical support for this widely-held notion concerning two
important patient variables in the therapeutic process.

The study was prompted in part by the results of some research on client "experiencing" in client-centered therapy (cf., Gendlin, Beebe, Cassens, Klein, & Oberlander, 1968). To provide perspective for the study, these results will be described, and theoretical considerations regarding psychoanalytic therapy will be elaborated in some detail. Finally, some supportive evidence for the psychoanalytic conception of psychotherapy will be offered before the hypotheses and methodology of the present study are described.

Gendlin's Concept of "Experiencing" as a Mediator of Therapeutic Progress

According to Gendlin et al. (1968), practitioners of psychotherapy have long observed that an effective treatment process requires something more than a patient's cognitive reports, explanations, and descriptions of external situations. They noted that "intellectualizing" and "externalizing" modes of patient behaviour are widely considered to be insufficient, and claimed that an "experiential" patient interview manner is essential for progress in client-centered therapy. By the use of the term "experiential" the authors drew attention to the importance of "feeling" as a mechanism of personality and behaviour change. They cautioned that they were not attributing effectiveness to simply talking about "feeling", but rather to an ongoing process in which the client focuses on emotions being aroused in him at the moment by the subject matter of the interview.

It should be noted that the term "feeling" as used by Gendlin et al. (1968) included not only emotions ("I feel angry") but also thoughts ("I feel that I shouldn't put up with the situation since it causes me to become angry, yet I don't seem able to get myself out of it"). "Feeling"
was thus used by these investigators in an equivocal sense to refer to both emotional and cognitive modes of patient communication—an observation that will be returned to later in this chapter.

The process described by Gendlin et al. (1968) begins as a client attends to a concrete feeling within himself. As he does so, he may find that it becomes more elaborate and specific with the passing moments. If the feeling experience continues to be refined and explored by the client, applications of it may suddenly occur to him with reference to other situations. As he attends to the anger initially experienced in regard to a particular event or person, for example, a client may come to see the emotion more clearly as resentment based on feelings of shame and powerlessness in certain types of relationships, and may suddenly realize how this feeling determines his behaviour in other similar situations. This sudden realization of the role of the feelings of shame and resentment in various situations is a process of becoming aware of feelings which existed in the past and influenced the client's behaviour, but which were previously in a preconceptual state, and so were not recognized or experienced consciously.

Gendlin and his associates consistently worked within a client-centered framework, but they postulated that all schools of psychotherapy recognize this "experiential" mode of patient behaviour as effective. They claimed that the process of "attending to and carrying forward concretely felt preconceptual experience" is what therapists of all theoretical persuasions seek to respond to and facilitate in order to help their patients see the implicit feelings and motives underlying their behaviour.

Gendlin et al. (1968) described several studies carried out to gather information on the role of the "experiential" mode of patient behaviour
in client-centered therapy. Gendlin and Tomlinson (1960) constructed a scale to measure a client's "experiencing" in which seven levels of experiential client interview manner were described sufficiently clearly that judges, listening to taped excerpts of therapy interviews, were able to reliably rate the client's experiential behavior levels. This scale, derived from Rogers' Process Scale (Rogers, 1959), was designed to reduce the degree of clinical inference its predecessor had required of judges concerning the degree to which a client's words "refer to, or freshly phrase his ongoing felt experience", by providing objective examples of the different levels of the scale.

In a series of studies examining the role of "experiencing" over the course of client-centered treatment, an experiential manner was consistently found to characterize the interview behavior of clients who eventually succeeded in psychotherapy, while it was found not to be typical of clients who failed to improve (Tomlinson & Hart, 1962, Walker, Rablen, & Rogers, 1959). Moreover, data from these and similar studies (cf., Kiesler, Klein, & Mathieu, 1965) indicated that clients who began therapy in a very intellectualized or externalized manner did not develop a more experiential mode of behavior during the course of treatment. This finding suggested that success or failure in client-centered therapy might be predicted from the first few sessions, and further implied that such psychotherapy does not teach an individual to attend to his ongoing experiential or feeling processes. Effective client-centered therapy appeared to be associated with a constant level of experiential involvement rather than a trend to increasing involvement over the course of treatment.

Kiesler, Klein and Mathieu (1965) obtained Experiencing ratings for
five successive eight-minute segments of one therapy session for each of 24 patients. Half the interview recordings selected were sampled from sessions early in therapy (the first five sessions), and half were drawn from the latter portion of therapy (the last five sessions). In order to sample comprehensively across individual sessions, the investigators excerpted eight-minute segments from five nearly consecutive portions of each recorded session. The resulting 120 eight-minute segments were presented in a standard random order to each of four judges trained in the use of the Experiencing Scale. The judges had no information concerning the cases, or the interview location of the segments. Analysis of the judges’ ratings indicated that there was no significant difference in the level of patient experiencing between early and late therapy sessions. Neurotic subjects showed a steady progression in the level of experiencing over the course of individual interview sessions, however.

In a more recent study, (Kiesler, 1971), the first 30 recorded sessions of 38 patients were sampled, and a single four-minute segment was randomly excerpted from each of the resulting 1,140 individual sessions. The patients were divided into successful and unsuccessful groups for analysis of the data in terms of therapy outcome. Results indicated that, as observed in previous findings, more-successful patients showed higher overall levels of experiencing than did their less-successful counterparts. In this study, all patients changed in their levels of experiencing over the course of 30 sessions of treatment. The actual amount of change on the seven-point Experiencing Scale was not great, and the degree of change did not differ between more and less successful patients. The changes that occurred were nonmonotonic, (the slope of the change curve was U-shaped over the first 20 sessions, with a subsequent
drop in experiencing from the twentieth to the thirtieth interviews—an inverted cubic function over the first 30 sessions), and there was no overall increase in experiencing scores for either group.

The results of research utilizing the Gendlin Experiencing Scale raise the issue of what "experiencing" means and how adequately it is measured by the scale. In particular, the equivocal findings in the research referred to above do not allow a definite conclusion to be drawn between the possibilities that the scale ratings measure a change or improvement dimension in psychotherapy characterizing successful outcome (a state construct), or a trait dimension which remains consistent over therapy, and which is related to successful outcome (a readiness, or constant ability to experience).

Kiesler (1971) suggested that different sampling methods than the random approach usually employed in studies of the experiencing construct might shed light on this issue. He suggested that the sequence of experiencing over some specific topic, problem, or thematic area might be tapped by prior editing of the taped sessions. He acknowledged, however, that random sampling is consistent with Rogers' theory that change in psychotherapy is general, cumulative and pervasive at every stage of the interaction, regardless of the interview content.

Gendlin and his associates reported that the ability to "focus" on "concrete felt experiencing" did not correlate with an external measure of "psychological adjustment". The investigators (Gendlin et al., 1968, p.231) developed a self-administered set of instructions and used it to "teach" high school students to attend to their immediate feelings. Their success in doing so was measured by a set of open-ended questions to each subject after he had carried out the process outlined in the
instructions. To arrive at an index of the degree to which a subject succeeded in focusing on his feeling experience, judges rated his answers to the open-ended questions on a four-point scale of "focusing".

Gendlin and his associates hypothesized that this "focusing" process, developed in experimental rather than therapeutic surroundings, corresponds to the experiential manner of patient behaviour during psychotherapy. Assuming such a correspondence, the authors correlated the above subjects' "focusing ability" scores with personality descriptions as measured by Cattell's High School Personality Questionnaire. The "focusing" scores did not correlate with Cattell's measure of "psychological adjustment".

The authors were surprised by this because they believed that client-centered theory would predict a high level of experiential behaviour in adequately-functioning persons. But perhaps the theory does not predict such a correlation in persons who are functioning in a merely adequate manner (which is what objective tests define as "adjustment"), but rather implies that high levels of "experiencing" would characterize the "peak experiences" of which these persons are capable.

Gendlin et al. (1968) took some consolation that a similar finding has been reported regarding psychoanalytic theory. Bordin (1966b) found that the ability to associate freely, which psychoanalytic theory might be expected to predict as characteristic of well-adjusted individuals, did not correlate highly with external measures of adjustment. Bordin used a different set of personality measures and a different experimental task, however, making direct comparison of results questionable. The experimental task given to Bordin's student Ss was to "free associate" for 30 minutes. Adequacy of a S's free associations was assessed by judges' ratings. These ratings were correlated with a wide-ranging
battery of personality measures, including the Rorschach, MMPI, and MPI.

Even allowing the correspondence alleged by Gendlin between ability to focus on affective experience and ability to associate freely, and their common lack of correlation with external measures of personal adjustment, it is not clear that this similarity in research findings implies the further conclusion that a patient's experiential level should not be expected to increase during psychoanalytic therapy, as Gendlin et al. implied. Bordin's paper (1966b) recalls the psychoanalytic hypothesis that the very pathological states which bring a patient to therapy will make it difficult or even impossible for him to comply with the rule of free association. In therapy, attention is focused on points where this difficulty occurs, and on the modes of avoidance adopted by the patient. Analysis of resistances to free association, primarily via transference, directs a patient's attention to his motives and feelings. Bordin stated that to the extent that one subscribes to the notion that a goal of psychotherapy is to make even the most primitive impulses available for constructive use ("regression in the service of the ego"), an improved ability to associate freely remains one of the important end states of successful psychoanalytic therapy.¹

Theoretical Overview

According to psychoanalytic theory, the neurotic is burdened by pathogenic defences or "repressions" which prevent drive discharge and

¹ Bordin also discussed methodological and theoretical difficulties in testing such a prediction. He cautioned that ambiguities in concepts and propositions, the consequent uncertainties in the ratings designed to represent them, and the crudity of the present state of personality measurement, all combine to produce complex problems in research on psychotherapy, and a lack of clear answers in the results of such research.
limit the ego's functioning. Repression is characterized by lack of awareness of and inability to experience certain emotions and impulses. The dammed-up energy escapes in the form of symptoms, which are emergency discharges containing elements of repressed impulses, anxiety, and manifestations of defences. The patient does not understand the meaning of his symptoms, and cannot express openly the motives underlying them, but appears compelled to repeat them in spite of attempts or wishes not to do so.

The psychoanalytic view of therapy is that the therapist's interpretation of unconscious defensive tendencies enables the patient to overcome barriers to the experience and awareness of emotions or impulses that he had not been conscious of in himself. At the same time, or closely following, the patient may suddenly grasp the relationship of these warded-off emotions or impulses to situations in his life in which he had not been able to account for his (symptomatic) behaviour; that is, he may suddenly see that they also occurred in similar situations in his past. This process is referred to as the acquisition of insight, and is considered a core component of therapeutic effectiveness.

More specifically, psychoanalytic theory postulates that a patient's behaviour in psychotherapy is determined by a balance of internal defensive and impulsive forces. The immediate goal of therapy is to abolish the defence against awareness of the wish-defence conflicts, so that the patient may become aware of his defences, the motives for the defences, and ultimately the impulses and feelings against which the defences were instituted. The effectiveness of the therapist's interpretations depends on his accurately labelling defensive tendencies in the patient and the motivations for these defences. Such a label, in the form of an inter-
pretation, must be offered at the right time, and in an optimal manner, to be effective. That is, the therapist must judge the unrecognized defensive tendency to be sufficiently close to awareness that the suggestion of it as a possibility to be considered will enable the patient to recognize the tendency within his own experience. The therapist recognizes the degree to which the patient's defences are amenable to interpretation by the fact that they are expressed implicitly in what the patient is saying even though he does not verbalize them explicitly and does not seem to be aware of them in himself. The therapist assumes that the patient almost, but not quite, recognizes what is implied in what he says.

To achieve adequate psychological functioning, the patient must come to recognize and actually experience the defences and the underlying motives that are in conflict within him, as they become manifest in the psychoanalytic situation itself, especially in the form of neurotic feelings toward the therapist. These unwarranted reactions toward the therapist ("transference resistances") are analyzed, and the patient is confronted with his defensive operations. Both the patient's experiencing and observing ego functions are essential in this analysis, particularly in his response to interpretations. "The interpretation splits the ego into an observing and experiencing part so that the former can judge the irrational character of the latter" (Fenichel, 1945).

The assumptions are made that a patient seeks therapy to relieve subjective distress which he has been unable to control, and that relief from distress is gained as a function of the insight he acquires during the therapeutic process. Acquisition of insight depends on the release and re-experiencing of repressed emotions and impulses within the therapy situation itself, but is equally dependent on the secondary-process
functions of judgment and intelligence for the attainment of understanding of how emotions and impulses influence behaviour. The patient must repeatedly experience and observe the elements of his conflicts, in order to achieve adequate discharge of his drives, and freedom from symptoms.

This process requires something of the patient. He cannot remain a passive recipient of the therapist's healing ministrations. If progress is to occur, he must have the capacity to express whatever comes to mind without selection, and to objectively reflect on the significance of his own associations. Such a task is not an easy one for the patient. It may be easier for him to talk in a general intellectualized way about his feelings, or to experience them concretely without expressing reflective awareness of them in words, but it is often most anxiety-arousing for a patient to experience and reflect simultaneously upon a dynamically significant feeling. Strong resistances are often directed against recognition, acknowledgement and reflective observation of affective and motivational reactions experienced during therapy, especially toward the therapist. The patient is motivated to avoid the co-occurrence of reflecting on and concrete experiencing of painful affects, by acting out or defensive avoidance. Such evasive behaviours are reinforced because they reduce the anxiety that the conjunction of such events would cause (Auld, 1968).

The Role of the Experiencing and Observing Ego Functions in Psychotherapy

Psychoanalytic theory postulates that the extent to which the patient is able both to experience and reflectively attend to his feelings and motives underlies movement toward the therapeutic goals of reduction of resistances and the acquisition of insight (Bellak, 1961; Greenson, 1967). While a high degree of openness of communication is
considered essential for therapeutic progress, psychoanalytic theory postulates that it is not sufficient. It must occur in conjunction with a capacity to reflect on one's ongoing experience. Intense emotionality in the absence of such a self-reflective capacity cannot be productive of psychological insight. At the same time, the theory suggests that a high degree of awareness cannot be characteristic of communication in which openness is not discerned, for the patient who clings to obsessive intellectualization is not aware of his own emotions and impulses.

Bellak (1961) has pointed out that the therapist's instruction to say whatever comes to mind without selection is an invitation to relax the perceiving, reasoning, delaying, planning and controlling ego functions that the patient usually employs in his interactions with the environment. It is an invitation to regress to a primary mode of experiencing. The patient must be able to allow himself to relax everyday controls so as to actually experience the emotions and motives evoked by his unguarded associations—feelings which inevitably come to be experienced in a regressive manner toward the therapist in the transference neurosis.

As suggested above, psychoanalytic therapy also requires the patient to maintain the capacity to take a detached and reflective stance toward himself, to ally himself with the therapist from time to time in examining how his emotions and motives determine his behaviour. The patient's dissatisfaction with himself, and his commitment to change (acknowledged by seeking treatment), are important aspects of his rational ego to which the therapist's interpretations appeal. Bellak (1961) stated that the successful patient is able to adopt a reflective stance toward his own experiencing through a process of identifying with the therapist's analytic approach, and through the encouragement of the therapist to do so.
Ideally, the patient will oscillate between the two ego functions, first regressively experiencing his emotions and motives concerning some area of his life, then joining with the therapist in an objective attempt to gain an understanding of these dynamic factors. The patient is required to oscillate between reduced and increased adaptive ego functioning, and by exercising synthesizing ego functions he is expected to arrive at new insights. Although the patient is expected to regress, the regressive experiencing is ideally "in the service of the ego" (ibid).

Greenson (1967) stated that the split in the patient's ego between a reasonable, observing, analyzing ego, and an experiencing, subjective, irrational ego can be seen in free association: "when the patient permits himself to be carried away by a painful memory or fantasy, the experiencing ego is in the foreground, and there is no awareness of the meaning or appropriateness of the emotions at the time. If the analyst were to intervene at this point, the patient's reasonable ego would come back to the fore and the patient would now be able to recognize that the affects in question came from the past; there would be less anxiety, and perhaps eventually less distorted derivatives would come up" (p. 47). Greenson also pointed out that the emergence of this "therapeutic alliance" may be noted when the patient spontaneously becomes silent and then ventures an opinion that he has been avoiding something in his preceding associations.

Further Theoretical Considerations Relevant to the Formation of the Hypotheses

The psychoanalyst employs certain techniques that will facilitate the development of intense emotions in the patient. These techniques are designed to facilitate the patient's tendency to react to him as he
does to other significant persons in his life—to stir up painful feel-
ings which, although they originated in past relationships, distort and
interfere with the development and maintenance of satisfying, mature
interpersonal relationships and impulse gratifications in the patient's
current life situation. These techniques are predicated upon a consist-
ent attitude and approach to therapy—the relationship is a professional
one in which the therapist's sole task is to help the patient gain open-
ness to and understanding of his emotions, motives, and defences. To
this end, the therapist maintains personal anonymity, pays complete and
free-floating attention to the verbal productions of the patient, main-
tains a deprivational posture toward neurotic emotional demands by the
patient, and makes effective use of interpretations designed to lessen
and remove resistances which the patient develops toward recognizing
some of the feelings he experiences in this highly unusual relationship.
He uses restraint as part of his therapeutic strategy to frustrate the
patient's neurotic emotional demands in order to strengthen them and
provide an opportunity for interpretation. The patient's experiencing
of the demands for what they are—a tendency to see others in a certain
manner, and to react to others in habitual and unrealistic ways—is
believed to provide the corrective emotional power of analytic therapy.
And it is not until the therapist directly confronts the patient at the
very moment he is exhibiting evidence of overgeneralizing his perceptions
of others without sufficient evidence that the patient can truly experi-
ence the strength of this tendency, and the extent to which it is unreal-
istic and maladaptive. At this moment of heightened and immediate
patient affect, the analyst requests the patient to follow the fundamental
analytic requirement that he retain the capacity to explore objectively
with the therapist the operation and origin of the feeling patterns he is experiencing.

The therapist's aim is to overcome the exclusion of the patient's defensive tendencies from awareness. If these processes are already close to awareness, correct labelling of them is usually sufficient to result in the patient's concrete emotional experience of them, and acknowledgement of the congruence between his experience and the label provided by the therapist. Ideally, he will experience a relaxation of his resistances, an increasing range and depth of subjective feeling and observation about himself, and some degree of conceptualization of insight into the motives for the defence and the underlying impulse against which it was mobilized (Colby, 1951). If the interpretation is appropriate, and stated in such a way as to be effective, it will cause the patient to have the "carrying forward" type of affective experience Gendlin et al. (1968) referred to—a sudden shift in reference of an intense feeling to other situations or relationships, followed by increased understanding of those situations or relationships. "Insight" is the psychoanalytic label for that point in therapy which Gendlin was describing—a point at which affective and cognitive processes converge to produce personality and behaviour change.

Psychoanalytic theory is generally assumed to predict a reduction of defensive resistances during an individual therapy session. Such a prediction is based on the theoretical notion that the patient defines the theme of a session in the first several minutes, and that during the remainder of the session, therapeutic techniques are directed toward the reduction of resistances which are maintained against openness to and awareness of conflicting forces underlying that theme (Saul, 1958, Pp. 90-103).
But although psychoanalytic theory postulates that appropriate interpretations increase the patient's awareness of and access to his experience, it does not postulate that the course of psychotherapy is characterized by a smoothly continuous and cumulative process of reduction in defences and resistances. Freud (1914) stated that interpretations successfully made frequently have to be made again, as if the patient had forgotten the work of a previous session. Fenichel (1939) referred to the process of therapy as being analogous to the work of mourning. In the process of mourning, memories of a lost one continue to appear in different thought constellations and in association with various life situations, and must be systematically excised from each locus of their evocation. In a similar manner, a long-repressed conflict may underlie more than one set of ideas in a patient's life, any one of which may be the next topic of his associations in psychotherapy. Although a successful interpretation might reduce the force of repression in one instance of a conflict, thus allowing the patient a measure of insight into his needs and defences, the conflict will be found to have relevance to other topics which he will introduce later, and the resistant forces, like the memory of a lost friend in the varied recollections of a person in mourning, will be found not to have diminished in these different contexts. "Working through" the various contexts in which a conflict interferes with a patient's openness and awareness is an important part of the psychoanalytic process. Each time a resistance to self-awareness and access to experience is met, it must be weakened by appropriate interpretations.

It has been hypothesized (Fenichel, 1939; Dollard, Auld, & White, 1953) that as the process of working through continues, the instances in
which a given wish-defence conflict are observed become more and more central to the original conflict of the developing personality. A corollary of this hypothesis is that the intensity of anxiety aroused by the recurring derivatives of the core conflict, and thus the strength of repressive forces pitted against openness to and awareness of one's own experience, may actually increase as therapy progresses, depending on the topic at the moment of observation.

The entire process is considered to be cumulative, however, in that insight into the core conflict would not be possible before its more external, more "distorted" derivatives are first worked through. In the long run, therapy should result in a decrease in the strength of resistances in a wish-defence conflict, as a point is eventually reached when subsequent interpretations, building upon past interpretations and made possible by the repeated undermining of defences, reverse the general tendency of the patient to regress in his associations and defensive operations (Menninger, 1958). Eventually, it is postulated, the defensive forces guarding against drive expression become sufficiently weakened that the patient is able to withstand levels of anxiety which previously were avoided, and to explore ways of obtaining expression of his impulses. At this stage in the resolution of a conflict, the patient is more open to and more aware of the experience of his drives and feelings than he had been before embarking upon a course of psychotherapy.

This stage may not appear in marked contrast to the preceding analytic work, however, for patients typically deal with more than one conflict in therapy, and although one conflict is being resolved, others, which are operative during the same sessions, may not have reached a comparable stage of resolution. Thus even near the end of treatment, the
patient's communication might still be characterized as more or less resistant, depending on the topic of his associations at the moment of observation. The nature and extent of changes in the strength of resistance to free communication over the course of treatment remains to be empirically demonstrated.

**Evidence supporting the Psychoanalytic Hypothesis of Reduction of Resistance during Treatment**

As noted earlier, Clay (1968) postulated that the qualitative differences in the nature of a patient's free associations during a typical therapy session and at different stages over the course of therapeutic treatment reflect "reduction in resistances". These changes consist of shifts away from the narrative or explanatory behaviour typical of patients in the initial stages of therapy, toward increased self-reference and more intense emotional experiences of an immediate, concrete nature.

In order to study such shifts in a patient's associations, Clay constructed a scale of degree of shift in "freedom of patient communication" which he used as a measure of shifts in a patient's self-awareness and openness to subjective states of affect. Clay accepted the assumption (Auld, 1968) that--given that communication in a therapeutic relationship takes place under conditions of permissiveness, privacy, and instructions to the patient to communicate fully everything he is experiencing in thought and feeling--repression and resistance can be considered equivalent for research purposes. He pointed out that therapists generally accept this assumed correspondence between a patient's capacity for self-observation and his openness to affective experience on the one hand, and his ability to communicate these matters
freely and explicitly in psychotherapy on the other, in order to determine how freely their patients are communicating. The therapist compares his observations of a patient and inferences about his emotional state with the patient's own explicit verbalizations about himself. If there is a discrepancy between the therapist's inferences based on "objective" external observations of the patient and the patient's "subjective" self-report, the therapist infers a lack of freedom to communicate, and a corresponding lack of intrapsychic openness to and awareness of affective experience.\(^2\)

It follows that the degree to which the patient is able to oscillate between the two ego functions of experiencing and observing will be reflected in his communication to the therapist. In fact, an analyst must constantly assess the degree to which each ego function is reflected in his patient's communication in order to judge his amenability to interpretations, for if either the observing or experiencing ego functions are absent, the patient is not likely to gain any understanding or control of the cause of his distress.

Clay (1968) examined the incidences of patient shift toward greater openness and awareness following three types of therapist intervention in psychoanalytic therapy. Using Dollard and Auld's (1959) content analysis categories for the classification of verbal interventions by the therapist, he compared taped segments of patient verbalization immediately before and after therapist interventions categorized as Interpretation (labelling of unconscious forces), Reward (interventions thought to reduce tension, such as reassurance, advice, answering questions, and

---

\(^2\) The term "objective" refers to the assumption that if other therapists were asked to make similar judgments about the patient, we would obtain reasonable inter-judge reliability.
giving information) and Drive (interventions thought to increase patient tension, such as questions, and verbalizations intended to motivate the patient to continue verbalizing).

Judges listened to taped segments of psychotherapy, each consisting of patient statements that immediately preceded and followed the three different types of therapist interventions. The therapist interventions were erased, so that the judges heard only the patient's initial comments, then 15 seconds of silence, followed by the patient's reply to the therapist's intervention. The judges rated the degree of shift in freedom of communication between the two patient utterances in each taped segment.

Clay compared the relationship between the three types of therapist intervention and the degree of shift in the level of patient openness and awareness. His results showed the predicted effects of therapist interpretations on patient openness and awareness, supporting the psychoanalytic hypothesis that interpretation is effective in weakening resistances.³

Development of Hypotheses and Methodology

In view of Gendlin's and Kiesler's findings regarding the experiential mode of patient behaviour in client-centered therapy, in view of Clay's observation that qualitative differences in the nature of free

---

³ The psychoanalytic proposition that therapist interpretations are uniquely effective in reducing resistances did not receive unequivocal support. An approximately equal shift in freedom of patient communication followed Rewarding and Interpretative therapist interventions. Clay suggested that the context in which Rewarding therapist interventions occur in psychoanalytic therapy (in the midst of generally deprivational therapist behaviour) might account for the relationship between Reward interventions and the degree of shift in freedom of patient communication found in his study. In any case, generalization of Clay's findings to other forms of therapy must be tempered by the fact that only cases of psychoanalytically-oriented treatment were involved in his observations.
associations are typically noted both within individual sessions and at
different stages over the course of psychoanalytic treatment, and finally,
in view of his finding of a relationship between therapist interpretations
and shifts in freedom of patient communication in psychoanalytic therapy,
it is of interest to examine systematically what changes occur in the
level of patient openness-to-experience and self-awareness during psycho-
analytic treatment.

To the extent that psychoanalytic techniques are directed towards
eliciting heightened emotional responses toward the psychoanalyst and the
therapy situation themselves, and to the extent that the therapist's
interpretations direct the patient's attention to these phenomena, we
might hypothesize that psychoanalytic procedures "teach" patients to
attend to their ongoing experience. This study will examine whether
these techniques also produce changes in a patient's openness and aware-
ness during the therapeutic process.

As is true of every form of human behaviour, individual differences
can be assumed to characterize the degree to which patients are able to
oscillate between the two ego functions of experiencing and observing.
The existence of such individual differences should be reflected in
ratings of openness and awareness of communication during psychotherapy.

The psychoanalytic proposition that interpretation decreases the
strength of resistances suggests that a patient's level of openness and
awareness will increase during psychoanalytic psychotherapy. Such
increases can be predicted to occur within individual therapy sessions
as a function of the ongoing interaction between the patient and thera-
pist. Within individual sessions, improvement in a patient's function-
ing should be reflected in monotonic increases in measures of openness
and awareness of communication. In view of theoretical considerations regarding the process of "working through", however, a monotonic increase in such measures cannot be firmly predicted over sessions. But it is of theoretical interest to examine any changes which do occur in the openness and awareness with which a patient communicates over the course of treatment, since the theory suggests that some improvement in a patient's functioning in this regard will occur (Bordin, 1966b).

As mentioned earlier, Gendlin's Experiencing Scale, which has been used in previous research studying the communication of patients in psychotherapy, appears to collapse the distinction between a patient's emotional and self-reflective functioning—what analytic theory labels the experiencing and observing ego functions—into the "experiencing" construct. The distinction between these two modes of patient functioning will be clearly maintained in this study, in accord with the psychoanalytic theory of optimal patient functioning during psychotherapy. It is expected that a major contribution of the study will be methodological, insofar as the development of separate scales to measure openness to emotional experience and the degree of discernible self-observation represents an innovation in the study of patient communication.

In summary, scales will be constructed with which to measure changes during psychotherapy in a patient's access to his own emotional experience, and in his degree of self-observation. Stated in terms of the null hypotheses, the predictions are made that the results of the study will: 1) disprove the absence of significant overall differences between the ratings of openness and awareness assigned to the communication of different patients; 2) disprove the absence of a monotonic increase in the ratings of openness and awareness of patient communication over
successive segments within sessions; and, for the sake of speculation, 3) disprove the absence of a similar increase in the ratings of openness and awareness of patient communication over sessions ranging from the initiation of psychotherapy to its approximate termination.
Chapter 11

Method

General Procedure

The investigator constructed two scales, one to measure the openness of a patient's communication, the other to measure the degree of awareness of his own functioning shown in his communication. A reliability study was then carried out, utilizing psychotherapy material that had not been used in the construction of the scales. Finally, the investigator systematically sampled recorded therapy sessions from five patients treated by psychoanalytically-oriented psychotherapy, in order to test the major hypotheses of this study. Five sessions from each case were sampled, ranging over the entire sequence of therapy. From each sampled session (50 minutes), a five-minute segment was excerpted in each successive ten-minute interval of time, for a total of five segments from each session. The resulting 125 segments were listed and numbered, then rearranged in a random sequence. These segments were rated by judges who worked independently of each other, one of whom rated the openness of patient communication, the other of whom rated the degree of awareness discernible within each segment. The judges were naive with regard to the specific hypotheses being investigated, and with regard to the cases they were asked to rate. Each judge was trained in the use of one of the two scales. The investigator himself also rated the segments on both scales, using one scale at a time, in order to carry out a reliability check.

The details of the procedures, including the development of the
scales, the method of determining their reliability, the method of obtaining patient excerpts, the training of the judges, and the analysis of the data will be described in the following sections of this chapter.

Construction of the Openness and Awareness Scales

The research plan called for the communication of psychotherapy patients to be rated for its openness and awareness. To construct scales for this purpose, the investigator selected at random recorded therapy sessions from six neurotic patients. From each of these therapy sessions he excerpted a five-minute segment from each ten-minute time block in the session. In this way a large group of segments was selected from the total. These segments, which included patient communications that seemed to cover a wide range of degrees of openness and awareness, were then used in the construction of the scales.

An attempt was made to construct two five-point scales: a scale of openness and a scale of awareness. These qualities are believed to be separate dimensions of patient communication in psychoanalytic psychotherapy. The investigator and his dissertation supervisor listened to segments and attempted to locate natural groupings of the variables. They also considered criteria and dimensions which would serve to define the five points in each scale.

The scale of openness that emerged from this work turned out to be very similar to a scale published by Bordin (1966a). Bordin's General Scale of Free Association had been constructed as part of the experimental analogue study referred to in Chapter I in which student subjects were required to "say whatever comes to mind" for thirty minutes. The scale used by the present investigator makes three modifications to Bordin's scale. In Bordin's study some subjects' verbalizations consisted of
naming various objects in the room or reciting names of objects or general events, and a separate scale point was required for such uninvolved listing. In view of the differing motivations of therapy patients and student subjects, and the resulting unlikelihood of such communication in actual psychotherapy, this category was simply omitted from the investigator's scale of openness. The second modification consisted of the inclusion at the upper end of the scale of specification of the degree of concreteness of imagery contained in a patient's associations. Bordin's scale lacked any consideration of this dimension, but the present investigator believes it to be an important component of primary-process functioning which should not be overlooked in any assessment of openness of communication in psychotherapy. Thirdly, the descriptive titles of the scale-points have been omitted because one of them was found to be misleading.

No scale of awareness was available for consideration; therefore the investigator was completely on his own in constructing a scale of awareness designed to specify the degree to which a patient's associations reveal a capacity to reflect on his own experiencing.

The five points on each scale were each assigned a scale number and a verbal description (see Appendix A). The investigator and his dissertation supervisor achieved satisfactory agreement in rating further trial segments with these scales, and it appeared that the two scales could be used to test the hypotheses of the study. A tape recording containing 24 segments was compiled from the material of the six patients whose sessions had been used in the construction of the scales. This recording was employed as a "demonstration tape" included in the training of judges in the use of the scales. The segments on this tape were arranged in ascending order (the early segments on the tape were examples of low
scale-points on the rating scales, the later segments were examples of high ratings). Finally, instructions were formulated for the rating scales (see Appendix B), and short explanatory notes were written to accompany the demonstration tape and to explain how and why particular scores had been assigned to the sample segments (see Appendix C).

The Unit of Analysis for Patient Verbalization

While the investigator recognized that the choice of a unit of time for the segments to be sampled was somewhat arbitrary (units ranging from 1½ to 8 minutes have typically been reported in studies similar to the present research), it seemed desirable to choose a unit which would be directly comparable to that used in other investigations that are most similar to the present study (cf., Gendlin et al., 1968). For this reason, segments of five minutes' duration were used throughout. It was decided that periods of silence would not be excluded in counting the time, since the patient was assumed to have the opportunity during silence to speak and report his thoughts and feelings of the moment.

Preliminary Reliability Study

In order to determine whether the scales were reliable measures of patient communication, they were tried out on material excerpted from cases other than those on whom the construction of the scales had been based. Two therapy sessions were selected from each of the five cases that would later be used in the hypothesis-testing phase of the project. As the design of the research was such that the sessions selected for later hypothesis-testing were pre-determined, the selection of sessions to be sampled for the preliminary reliability study was arbitrarily made from the remaining sessions of recorded therapy of these five patients.
Three segments from each session were excerpted, and the total of 30 segments was randomized and presented to two judges, each an experienced psychotherapist, who were asked to rate each segment with the openness and awareness scales. Each judge was trained by means of the written instructions for the scales and the demonstration tape with its accompanying explanatory notes. Each judge rated the segments with both scales as he went along. In addition, the investigator made independent ratings of the same 30 segments. The inter-rater reliability coefficients derived from the ratings of these judges were used to determine the reliability of the scales, and to assess their adequacy as measures for the purpose of this study.

Both judges who took part in this reliability study agreed that the concepts of openness and awareness could easily be confused by judges. They suggested that individual judges be asked to rate segments on only one scale, in order to minimize the confusion between the two scales. This suggestion was adopted.

**Description of Patients and Therapists**

The particular psychotherapy cases included in this investigation were chosen because tape recordings of their therapy happened to be available, and to be more or less complete. In addition, the therapists in every case had utilized a psychoanalytic approach. All recordings were made prior to the design of the present study.

The five cases studied in the hypothesis-testing phase of this research comprised five different patients and four different therapists. Table 1 identifies the patient-therapist combinations and shows the number of sessions of therapy which occurred in each case. The numbers indicated as the number of sessions in the sampling pool are the number
Table 1  
Description of Patients and Therapists

<table>
<thead>
<tr>
<th>Case</th>
<th>Therapist</th>
<th>Number of Sessions in Sampling Pool</th>
<th>Complete or Incomplete*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs. A</td>
<td>#1</td>
<td>33</td>
<td>Incomplete</td>
</tr>
<tr>
<td>Mr. B</td>
<td>#2</td>
<td>96</td>
<td>Complete</td>
</tr>
<tr>
<td>Mrs. C</td>
<td>#3</td>
<td>23</td>
<td>Complete</td>
</tr>
<tr>
<td>Mrs. D</td>
<td>#4</td>
<td>50</td>
<td>Complete</td>
</tr>
<tr>
<td>Mrs. E</td>
<td>#2</td>
<td>405</td>
<td>Incomplete</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Sessions</th>
<th>Total Cases</th>
<th>2 Incomplete</th>
<th>3 Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>607</td>
<td>300</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Complete or Incomplete refers to whether the entire case was available on recording*
of sessions over which therapy was actually conducted. In some cases, not every session was preserved.

The patients were four adult women and one man, all with neurotic difficulties. None was suspected of having psychotic tendencies or personality disturbance of organic origin. They entered psychotherapy because of typical neurotic problems--difficulties in inter-personal relationships, anxiety, and sexual or marital problems.

The four therapists had in common a generally psychoanalytic orientation. They viewed the patients in terms of psychoanalytic theory, and used techniques based on the psychoanalytic approach. All therapists were male. Therapists #1, #3 and #4 were graduate students who were being trained and supervised in psychoanalytic therapy. Therapist #2 was a psychologist experienced in psychoanalytic therapy.

**Sampling Method**

The sampling procedure to obtain the psychotherapy excerpts was designed to be similar for each case studied, in spite of the fact that the total number of therapy sessions differed for each patient. The aim was to ensure a sampling from a broad cross-section of therapy sessions.

For each case, the total number of sessions was listed, and five sessions were selected ranging over the entire sequence of therapy according to the following scheme: in each case the sessions selected were the third, the middle session, the third-from-final session and two intervening sessions at about the first the third quartiles of the therapy sequence.

From each of the five sessions thus selected for each patient, a five-minute segment was excerpted from each successive ten-minute time interval. The first segment was excerpted beginning at the 3-minute
mark, the second at 13 minutes, the third at 23 minutes, the fourth at 33 minutes, and the fifth at 43 minutes.

Table 2 indicates the specific sessions that were sampled from each case in both the hypothesis-testing and preliminary reliability-testing phases of the study. Session #25 was substituted for the pre-selected session #24 in the case of Mrs. A, because the tape containing session #24 was found to have been erased half-way through the session. Similarly, session #4 was substituted for session #3 in the case of Mrs. E, because the tape containing the third session could not be located. Other exceptions to the predetermined method of sampling from the recordings of these five patients should be mentioned. In the third session of Mrs. A's therapy, the therapist appropriated the final ten or twelve minutes of the session to summarize what had preceded. For this reason five segments were excerpted from the session beginning at three minutes, but with three-minute intervals between the remaining four segments. A similar situation occurred in session #21 in the case of Mrs. C. This modification in sampling was carried out in an attempt to select segments in which the therapist's proportion of speech was less than 40%, or two of the five minutes in a segment. Throughout the sampling procedure, if a therapist spoke for more than two minutes of a segment, the next five minutes within the ten-minute interval of therapy was substituted in its place. Similarly, if the patient said something which clearly indicated that the segment was sampled from the beginning or the end of either a session or the course of treatment, the following five-minute period was used. This was done to avoid giving raters cues as to the place of the segment within the therapy. Six changes of segment sampling were made because of such therapist or patient factors.
<table>
<thead>
<tr>
<th>Case</th>
<th>Hypothesis-testing Phase</th>
<th>Preliminary Reliability Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs. A</td>
<td>3, 10, 17, 25, 31</td>
<td>7, 27</td>
</tr>
<tr>
<td>Mr. B</td>
<td>3, 25, 48, 71, 94</td>
<td>11, 87</td>
</tr>
<tr>
<td>Mrs. C</td>
<td>3, 7, 12, 16, 21</td>
<td>5, 17</td>
</tr>
<tr>
<td>Mrs. D</td>
<td>3, 14, 25, 36, 48</td>
<td>12, 43</td>
</tr>
<tr>
<td>Mrs. E</td>
<td>4, 103, 203, 303, 403</td>
<td>36, 323</td>
</tr>
</tbody>
</table>
The 25 segments from each of five cases which were obtained by the above method were listed and numbered, and were arranged in a random order to be rated independently by trained judges. The investigator did not carry out the randomization, in order to be able to make relatively unbiased ratings himself.

**Training Procedures for Judges**

The two judges who rated the 125 segments were naive with respect to the hypotheses under investigation. They were graduate students in psychology who had completed a graduate course in psychoanalytically-oriented psychotherapy and had concurrently been provided with supervised experience as psychotherapists. They each received a copy of one scale, a set of appropriate instructions, the demonstration tape and the accompanying explanatory notes. In addition, each rater received a "practice tape" which contained 21 of the 30 segments used in the preliminary reliability study. Each judge was asked to rate these segments before proceeding further. An important part of the training procedure consisted of a discussion between the investigator and each judge of how and why he assigned particular scores on these 21 segments. This discussion provided an opportunity to clarify misunderstandings or misconceptions about the various scale-points.

**Analysis of the Data**

The reliability of the scales was assessed by the calculation of Pearson product-moment correlation coefficients between the ratings of the judges in the preliminary reliability study. As an additional check on the reliability of the scales, the first 60 ratings of the student judges who took part in the hypothesis-testing phase of this dissertation
were correlated with the ratings of the same material done by the investigator.

In order to test the hypotheses of the study, the ratings of the two student judges were analyzed by an analysis of variance, with patients, segments within sessions, and sessions over the course of treatment as the independent variables, and the judges' ratings as the dependent variable.
Chapter III

Results

Preliminary Reliability Study and Reliability Data on the Final Ratings

In the preliminary reliability study, as described in the previous chapter, 30 segments were arbitrarily excerpted from recorded therapy hours of the five cases used in the hypothesis-testing phase of this investigation. For each scale, inter-judge Pearson product-moment correlation coefficients were calculated between the ratings of two independent judges, and between the ratings of each of the judges and ratings made by the investigator.

In view of the limited number of segments rated in the preliminary reliability study, and the observation that the range of obtained scores was restricted—few of the ratings were as low as one or as high as four on either of the five-point scales—the reliability of the scales was considered sufficiently high to warrant their use in the hypothesis-testing phase of the dissertation, with the provision that the reliability of the first 60 of the 125 ratings made by each of the student judges was at least comparable. In order to demonstrate this, the first 60 ratings of each student judge were correlated with ratings of the same segments made by the investigator. Table 3 shows the inter-judge correlation coefficients obtained from both calculations of the reliability of the openness and awareness scales.

Results of the Final Ratings

It was not until the data analysis was under way that the investigator discovered that the number of available recorded sessions of one of the
Table 3  
Total Reliability Data

### Reliability of the Openness Scale

<table>
<thead>
<tr>
<th>Judges</th>
<th>Sample</th>
<th>n</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 &amp; 2</td>
<td>Preliminary</td>
<td>30</td>
<td>.496</td>
</tr>
<tr>
<td>1 &amp; 3*</td>
<td>Preliminary</td>
<td>30</td>
<td>.556</td>
</tr>
<tr>
<td>2 &amp; 3*</td>
<td>Preliminary</td>
<td>30</td>
<td>.645</td>
</tr>
<tr>
<td>3* &amp; 4</td>
<td>Final</td>
<td>60</td>
<td>.620</td>
</tr>
</tbody>
</table>

### Reliability of the Awareness Scale

<table>
<thead>
<tr>
<th>Judges</th>
<th>Sample</th>
<th>n</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 &amp; 2</td>
<td>Preliminary</td>
<td>30</td>
<td>.510</td>
</tr>
<tr>
<td>1 &amp; 3*</td>
<td>Preliminary</td>
<td>30</td>
<td>.618</td>
</tr>
<tr>
<td>2 &amp; 3*</td>
<td>Preliminary</td>
<td>30</td>
<td>.726</td>
</tr>
<tr>
<td>3* &amp; 5</td>
<td>Final</td>
<td>60</td>
<td>.679</td>
</tr>
</tbody>
</table>

* Investigator
five therapy cases selected for the study, case C, was far from the total number of sessions over which the therapy had been conducted. Previously, it had been supposed that most of the sessions were available on tape. For this reason, case C had to be omitted from the analyses of the data which follow.

The final data consisted of the student judges' ratings on the openness and awareness scales of the 100 segments excerpted from the four remaining cases. One student judge (Judge #4) rated the segments with the openness scale, and the second student judge (Judge #5) rated the same segments with the awareness scale.

Results on openness. Means of the final ratings of openness of communication are presented for subjects, segments, and sessions in Table 4 and Table 5. The numbers in the cells of the tables are each the mean of five observations, the scores at each level of one factor (segments or sessions) being summed across the other factor (segments or sessions) for each case. Overall openness means for cases and segments are given in the right column and bottom row of Table 4, and for cases and sessions in the right column and bottom row of Table 5.

Table 6 summarizes the results of a three-factor analysis of variance for Judge #4's ratings with the openness scale, with cases, segments and sessions as the independent variables. As the design of this study provided no within-cell variance estimate, the highest-order interaction was used as an estimate of experimental error, and this ABC interaction mean square was used as the denominator of the F ratio to test for significance of the double interaction and main effects (Kirk, 1968, p. 227; Winer, 1962, p. 273).

The mean ratings of openness between different cases varied signifi-
Table 4
Means of the Openness Ratings of Segments within Sessions

<table>
<thead>
<tr>
<th>Case</th>
<th>Segments</th>
<th>Case Means over Segments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>A</td>
<td>3.00</td>
<td>3.20</td>
</tr>
<tr>
<td>B</td>
<td>2.60</td>
<td>2.20</td>
</tr>
<tr>
<td>D</td>
<td>2.40</td>
<td>2.20</td>
</tr>
<tr>
<td>E</td>
<td>2.40</td>
<td>3.00</td>
</tr>
</tbody>
</table>

Segment Means | 2.60 | 2.65 | 2.70 | 2.95 | 2.95 | Grand Mean 2.77
Table 5
Means of the Openness Ratings of Sessions over the Course of Therapy

<table>
<thead>
<tr>
<th>Case</th>
<th>Sessions 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Case Means over Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>3.80</td>
<td>3.00</td>
<td>2.60</td>
<td>3.60</td>
<td>3.60</td>
<td>3.32</td>
</tr>
<tr>
<td>B</td>
<td>2.20</td>
<td>2.80</td>
<td>2.80</td>
<td>2.00</td>
<td>2.40</td>
<td>2.44</td>
</tr>
<tr>
<td>D</td>
<td>2.60</td>
<td>2.20</td>
<td>2.60</td>
<td>2.60</td>
<td>2.80</td>
<td>2.56</td>
</tr>
<tr>
<td>E</td>
<td>3.00</td>
<td>2.80</td>
<td>2.80</td>
<td>2.80</td>
<td>2.40</td>
<td>2.76</td>
</tr>
</tbody>
</table>

| Session Means | 2.90 | 2.70 | 2.70 | 2.75 | 2.80 | Grand Mean 2.77 |


Table 6

Analysis of Variance of the Openness Scale
for Cases, Segments and Sessions

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Between Ss</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A (Cases)</td>
<td>11.3900</td>
<td>3</td>
<td>3.7966</td>
<td>12.45***</td>
</tr>
<tr>
<td><strong>Within Ss</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B (Segments)</td>
<td>2.2600</td>
<td>4</td>
<td>.5650</td>
<td>1.85</td>
</tr>
<tr>
<td>AB</td>
<td>3.2600</td>
<td>12</td>
<td>.2717</td>
<td></td>
</tr>
<tr>
<td>C (Sessions)</td>
<td>.5600</td>
<td>4</td>
<td>.1400</td>
<td></td>
</tr>
<tr>
<td>AC</td>
<td>8.9600</td>
<td>12</td>
<td>.7467</td>
<td>2.45*</td>
</tr>
<tr>
<td>BC</td>
<td>4.6400</td>
<td>16</td>
<td>.2900</td>
<td>.95</td>
</tr>
<tr>
<td>ABC</td>
<td>14.6400</td>
<td>48</td>
<td>.3050</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>45.7100</td>
<td>99</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*** p < .001  
* p < .05
cantly more than would be expected on the basis of the null hypothesis of no difference between the means of different cases, indicating that some patients were more open in their communication during psychotherapy than were others. The significance of differences between case means was tested by the post-hoc Newman-Keuls procedure (Kirk, 1968, p. 91). As seen in Table 7, the mean of the openness ratings assigned to case B did not differ from the mean of case D, but did differ significantly from the means of cases A and E. The mean of case D also differed significantly from the means of cases A and E. Finally, the mean of the ratings assigned to case E differed significantly from the mean of the ratings assigned to case A.

The variance among the segment means was not great enough to reach significance, and the variance due to interaction between cases and segments was not significant. This indicates that the variation in openness from one segment to another during the course of individual sessions for any patient is not significantly greater than a random variation.

The mean ratings of openness over different therapy sessions did not vary significantly, but the variation due to the interaction between cases and sessions was significant, indicating that there were differences from one case to another in the relation between sessions and openness of communication. The interaction between segments and sessions was not significant.

In order to explore the meaning of the interaction between cases and sessions, the mean scores of each patient for each session were plotted in Figure 1. It can be seen that patients began therapy at different levels of openness of communication and tended to converge toward a
Table 7
Newman-Keuls Post-Hoc Analysis of the Differences between Case Means on the Openness Scale

<table>
<thead>
<tr>
<th></th>
<th>$\bar{x}_1$</th>
<th>$\bar{x}_2$</th>
<th>$\bar{x}_3$</th>
<th>$\bar{x}_4$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.44</td>
<td>2.56</td>
<td>2.76</td>
<td>3.32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pair</th>
<th>$t$ Value</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>$\bar{x}_1$ vs $\bar{x}_2$</td>
<td>.12</td>
<td>.32**</td>
</tr>
<tr>
<td>$\bar{x}_2$ vs $\bar{x}_3$</td>
<td>.20*</td>
<td>.76**</td>
</tr>
<tr>
<td>$\bar{x}_3$ vs $\bar{x}_4$</td>
<td></td>
<td>.56**</td>
</tr>
</tbody>
</table>

$\bar{x}_1$ = Case B
$\bar{x}_2$ = Case D
$\bar{x}_3$ = Case E
$\bar{x}_4$ = Case A

** p < .01
* p < .05
FIG. 1. Mean Openness Scores of Each Patient in Each Session.
(Each mean score represents the combination of five segment scores during a session).
medium level of openness at the mid-point of treatment, then to fan out again as treatment continued toward termination. Towards the end of treatment, the patients tended to have returned to their approximate initial levels of openness.

Results on awareness. Means of the final ratings of awareness are presented for subjects, segments, and sessions in Table 8 and Table 9. The numbers in the cells of the tables are each the mean of five observations, the scores at each level of one factor (segments or sessions) being summed across the other factor (segments or sessions) for each case. Overall awareness means for cases and segments are given in the right column and bottom row of Table 8, and for cases and sessions in the right column and bottom row of Table 9.

Table 10 summarizes the analysis of variance for Judge #5's ratings with the awareness scale. Again the ABC interaction mean square was used as an estimate of error variance to test for significance throughout the analysis. The mean ratings of awareness between different cases varied significantly, indicating that the communication of at least some patients was characterized by different levels of self-reflection than was the communication of others. The significance of differences between the case means was tested by the Newman-Keuls procedure. As can be seen in Table 11, the mean of awareness ratings assigned to case B differed significantly from the means of cases D, E and A. The mean of case D did not differ significantly from the mean of case E, but did differ from the mean of case A. Case E differed significantly from case A as well.

The variation among the segment means on the awareness scale was not sufficient to reach significance in this analysis, and the variance
Table 8

Means of the Awareness Ratings of Segments within Sessions

<table>
<thead>
<tr>
<th>Case</th>
<th>Segments</th>
<th>Case Means over Segments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>A</td>
<td>2.80</td>
<td>3.00</td>
</tr>
<tr>
<td>B</td>
<td>1.80</td>
<td>2.40</td>
</tr>
<tr>
<td>D</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>E</td>
<td>2.20</td>
<td>2.20</td>
</tr>
</tbody>
</table>

Segment Means: 2.20 2.40 2.45 2.60 2.55

Grand Mean: 2.44
Table 9
Means of the Awareness Ratings of Sessions
over the Course of Therapy

<table>
<thead>
<tr>
<th>Case</th>
<th>Sessions</th>
<th>Case Means over Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>A</td>
<td>3.40</td>
<td>2.00</td>
</tr>
<tr>
<td>B</td>
<td>2.00</td>
<td>2.20</td>
</tr>
<tr>
<td>D</td>
<td>2.00</td>
<td>2.40</td>
</tr>
<tr>
<td>E</td>
<td>2.40</td>
<td>1.80</td>
</tr>
</tbody>
</table>

| Session Means | 2.45 | 2.10 | 2.55 | 2.45 | 2.65 | Grand Mean 2.44 |
Table 10
Analysis of Variance of the Awareness Scale
for Cases, Segments and Sessions

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Ss</td>
<td>5.3600</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A (Cases)</td>
<td>5.3600</td>
<td>3</td>
<td>1.7866</td>
<td>4.83**</td>
</tr>
<tr>
<td>Within Ss</td>
<td>45.2800</td>
<td>96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B (Segments)</td>
<td>1.9400</td>
<td>4</td>
<td>.4850</td>
<td>1.31</td>
</tr>
<tr>
<td>AB</td>
<td>6.5400</td>
<td>12</td>
<td>.5450</td>
<td>1.47</td>
</tr>
<tr>
<td>C (Sessions)</td>
<td>3.4400</td>
<td>4</td>
<td>.8600</td>
<td>2.32</td>
</tr>
<tr>
<td>AC</td>
<td>7.8400</td>
<td>12</td>
<td>.6533</td>
<td>1.77</td>
</tr>
<tr>
<td>BC</td>
<td>7.7600</td>
<td>16</td>
<td>.4850</td>
<td>1.31</td>
</tr>
<tr>
<td>ABC</td>
<td>17.7600</td>
<td>48</td>
<td>.3700</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>50.6400</td>
<td>99</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** p < .01
Table 11

Newman-Keuls Post-Hoc Analysis of the Differences
between Case Means on the Awareness Scale

<table>
<thead>
<tr>
<th></th>
<th>( \bar{X}_1 )</th>
<th>( \bar{X}_2 )</th>
<th>( \bar{X}_3 )</th>
<th>( \bar{X}_4 )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.16</td>
<td>2.36</td>
<td>2.44</td>
<td>2.80</td>
</tr>
<tr>
<td>( \bar{X}_1 )</td>
<td>2.16</td>
<td>.20*</td>
<td>.28**</td>
<td>.64**</td>
</tr>
<tr>
<td>( \bar{X}_2 )</td>
<td>2.36</td>
<td>.08</td>
<td>.44**</td>
<td></td>
</tr>
<tr>
<td>( \bar{X}_3 )</td>
<td>2.44</td>
<td></td>
<td>.36**</td>
<td></td>
</tr>
<tr>
<td>( \bar{X}_4 )</td>
<td>2.80</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\( \bar{X}_1 \) = Case B
\( \bar{X}_2 \) = Case D
\( \bar{X}_3 \) = Case E
\( \bar{X}_4 \) = Case A

** p < .01
* p < .05
due to interaction between cases and segments was not significant. As in
the results of the openness scale, the implication of the analysis of
variance is that awareness did not vary significantly during individual
therapy sessions for any patient.

The variance of awareness ratings due to sessions was not greater
than that expected on the basis of the null hypothesis, indicating that
the level of self-reflective communication at different points over the
course of psychotherapy did not change significantly for the mean scores
of the whole sample of patients. The interaction effects between cases
and sessions, and between sessions and segments, were both insignificant.

Order of segment means. Although the variance of mean ratings of
segments over the course of individual therapy sessions was not great
enough to be significant for either scale, the means of both sets of
ratings were observed to fall in approximately the monotonically-increas-
ing rank order predicted by psychoanalytic theory (see Tables 4 and 8).
This apparent trend was tested by the calculation of Spearman rank order
correlation coefficients for the segment means of the openness and aware-
ness ratings. This statistic was used to compare the order of the
obtained ranking of segment means with the monotonic increase in ranks
which is predicted theoretically. The rank correlation of the order of
the segment means of the openness ratings with the theoretically-predicted
order was .975, and the correlation of the order of the segment means of
the awareness ratings with the theoretically-predicted order was .900.
Both these rank correlation coefficients were significant at the 5% level.
Chapter IV

Discussion

The finding that levels of openness and awareness discerned in the communication of patients to their therapists varied significantly between patients is consistent with the finding (Gendlin et al., 1968) that some patients in client-centered therapy tend to be rated higher than others on a similar rating scale based on the construct of "experiencing". Patients whose course of client-centered therapy was reported to be successful were consistently rated higher on the Experiencing Scale than were patients considered unsuccessful in therapy.

Three of the five patients whose communication during therapy was rated in this study had been labelled previously as successful in therapy, and the remaining two patients had been considered unsuccessful. These judgments were made by the therapist or supervisor in each case. (Case C, whose data were omitted from the analysis, had been considered a success.) It is of interest to note that, as indicated in Tables 5 and 9, the patients whose therapy had been labelled successful, cases A and E, received higher mean ratings in this study on both the openness and awareness scales than did their less-successful counterparts, cases B and D. The mean ratings assigned to these patients are thus in the order we might expect on the basis of theoretical considerations regarding successful psychotherapy, and on the basis of the empirical evidence reported by researchers who used the Experiencing Scale.

As a matter of interest, the investigator calculated t tests between the combined overall means of cases A and E on the one hand, and cases B
and D on the other, for both the openness and awareness ratings. The difference between the openness means of successful versus unsuccessful patients was significant at the 1% level (t = 3.18), and the corresponding difference between means of awareness ratings was significant at the 5% level (t = 2.12).

The difference between the mean ratings of cases divided on the basis of outcome into successful and unsuccessful groups corresponds rather directly to the findings based on the Experiencing Scale. In order to determine if the two cases labelled "successful" in this study began treatment at a higher level of openness and awareness than did the two "unsuccessful" cases, (corresponding to the findings reported with the Experiencing Scale), t tests were calculated between the combined means of cases A and E on the one hand, and cases B and D on the other, for the ratings of the third session with both the openness and awareness scales. Both ts were significant at the 1% level (openness ratings, t = 3.62; awareness ratings, t = 3.61), indicating that the two patients who went on to complete successful courses of psychotherapy began treatment with higher levels of openness and awareness in their communication than did the two patients considered unsuccessful.

The implication of the finding is the same one that surprised Gendlin and his associates—that prospective patients who communicate in a manner which does not demonstrate access to concrete emotional experience and the ability to reflect on that experience might be ruled out as suitable candidates for a course of psychotherapy. Although Gendlin et al. (1968) expressed surprise at this discovery, it has long been recognized by psychoanalytic practitioners, who typically accept prospective patients for a brief period in order to discover whether both experiencing
and observing ego functions can be discerned in their communication. Of course the present result cannot be considered conclusive or even generally true of psychoanalytic therapy on the basis of this study's limited sampling, but it is a provocative finding which should prompt further study.

The obtained mean ratings of sessions over the course of therapy did not increase in the predicted manner on either the openness or awareness scales. The obtained interaction between mean openness ratings of sessions and cases appeared to be due to the fluctuation in ratings assigned to individual cases over the course of treatment. The meaning of this interaction effect is that individual differences in changes from session to session in openness of communication were so great that we cannot generalize about the nature of such changes over the course of psychotherapy. The most that we can safely conclude is that non-monotonic changes occur in the level of openness of the communication of some patients during psychotherapy, and that these changes do not occur in any clear pattern.

The differences between ratings of awareness over sessions was not significant. The obtained means appeared to fall in a saw-toothed pattern, suggesting that the level of self-observation reflected in a patient's communication varies in a non-monotonic fashion during the course of therapy, and that it is not necessarily higher at the end of treatment than it was at the beginning.

The failure of the data to confirm the predictions that ratings of openness and awareness would increase over the course of treatment indicates that it is not, in general, true that such changes occur in an orderly, continuous and cumulative fashion during the psychotherapeutic
process. Empirically, any such notion about the nature of the therapeutic process was not supported.

What are the implications of the present findings? It appears that the proposition that a patient becomes more open and aware over the course of psychotherapy might have to be discarded, or at least revised. Because of the variety of conflicts dealt with in therapy, and the various levels of derivatives of any single conflict which must be worked through, any attempt to show an overall increase in how openly and with what degree of self-awareness a patient communicates during psychotherapy may be doomed to meet with failure. This is a legitimate and important finding, in that it bears upon a widely-held assumption about the nature of the therapeutic process (Clay, 1968).

The suggestion put forward by Kiesler (1971) that sampling of therapy material should be preceded by ratings of the subject matter by qualified judges is relevant here. In view of his lack of success in demonstrating an increase in the level of experiencing over the course of client-centered treatment, Kiesler proposed that as an alternative to random sampling of material to be rated, the entire sequence of a recorded therapy case should first be edited and arranged according to instances of a particular conflict or theme, or of a particular phase of the patient-therapist relationship. By sampling from therapy material arranged in this manner, he suggested, it would be possible to determine if ongoing therapeutic attention to a particular conflict or theme results in increased patient experiencing in the relevant areas, without the interfering influence of other aspects of the therapeutic process masking such changes.

Although Kiesler acknowledged that such sampling procedures would
not be consistent with the theory of non-directive therapy, they can be shown to have considerable appeal for future research within the psychoanalytic framework. As described in the first chapter, psychoanalytic theory postulates that the process of "working through" involves the weakening of resistances which might already have been removed from another (related) layer of the same conflict. For instance, a woman incapable of satisfying sexual relations with her husband might come to experience and reflect upon the unconscious hostility she directs toward him as a function of the therapist's interpretations of the anger and fear she experiences toward the therapist himself, but she might not be able to consciously experience similar feelings toward her father until the therapist again interprets how she is behaving towards him in the immediate therapy situation. Although the same defensive blocks to openness and awareness recur, they are postulated to become weaker eventually as a function of each successful episode of insight.

The point of the example is that these two instances of the same basic conflict might not occur in temporal conjunction with each other during therapy, and the material which intervenes might spring from other conflicts which are in more or less advanced stages of resolution. Therefore, in order to test the theoretical prediction that the therapeutic process consists of a gradual or eventual reduction in the level of resistances surrounding a particular conflict, instances of that conflict could be isolated before the sampling of material to be rated is carried out. Sampling would then be restricted to material which is thematically or dynamically relevant to the test of the specific hypothesis.

The fact that no gradual increase was found to characterize the levels of openness and awareness in a patient's communication during the
course of treatment is perhaps not as theoretically significant as is the absence of any overall increase in the data by the time therapy was terminated. For although the theoretical considerations concerning the process of 'working through' suggest that changes in the openness and awareness of a patient's communication during therapy might vary in a non-monotonic fashion, the theory does seem to predict that eventually, at least toward the end of a successful course of treatment, the patient should be able to experience his affective impulses reasonably openly, and with a considerable degree of self-awareness (cf., Bordin, 1966b). The finding that no such overall increase in the levels of patient openness and awareness occurred tends to disconfirm such a theoretical prediction.

Perhaps the theory can be interpreted not to predict such overall changes in a patient's communication, if it is assumed that new conflicts or new derivatives of old conflicts could continue to arise in a patient's associations even in the last session. But the manner in which a patient communicates is often taken as a major criterion of success by therapists, and as an indication of when therapy should be terminated. Surely a therapist would not feel satisfied in discharging a patient whose communication did not reflect an openness to and awareness of the emotional and motivational forces which determine his sense of well-being.

The theoretical prediction that the openness and awareness of a patient's communication would increase during a typical therapy session was not unequivocally supported. Neither of the student judges' ratings showed significant changes in scores assigned to segments within sessions according to the analyses of variance, although it can be seen in Tables 4 and 8 that the mean scores of successive segments within sessions fell
in the predicted order on both scales. (The analysis of variance, unfortunately, tests whether any variations from segment to segment are occurring; it does not specifically test whether monotonic increases occur).

It might be speculated that such differences would be found to be statistically significant with larger Ns. This speculation was supported by the significant Spearman rank order correlation coefficients between the rank order of segment means on both the openness and awareness scales on the one hand, and the monotonically-increasing order of these measures predicted by psychoanalytic theory on the other. In order to ascertain whether this finding regarding the rank ordering of segment means could be generalized over cases, Kendall’s coefficient of concordance was calculated on the segment means for each set of ratings. The results were not significant for either scale, indicating that we cannot generalize the rank order effect of segment means to all cases.

The results of the analyses of changes in segment means within psychotherapy sessions are at once tantalizing and inconclusive. The Spearman rank order correlation coefficients between the rank order of obtained and theoretically-predicted segment means provide evidence for a trend towards a monotonic increase in ratings over the course of a therapy session. This evidence must be considered weak, however, in view of the lack of generalizability of the rank order effect to all cases, and in view of the lack of significant variation in segment means found in the analyses of variance.

The results of the analyses of variance and the Kendall coefficient of concordance might be interpreted to suggest that whatever ebb and flow takes place in psychotherapy does not occur according to the structure of sessions. (Some evidence for this can be found by examining the
segment means of individual cases in Tables 4 and 8). This interpretation of the results suggests the possibility that a patient might become aware of a conflict at the beginning or mid-point of a session, and then move to a different topic within the same session. His discourse might then represent another level of the same basic conflict (Fenichel, 1939), or it might relate to another conflict entirely; but in either case, the degree to which his associations are characterized by openness and awareness would not necessarily increase over the course of the session. Such a possibility does not fit with the notion that the patient develops a single theme during the individual session, or that he moves toward greater openness or awareness as the session progresses. It may be that the notion that each therapy session has a single unifying theme is not an empirically-supportable proposition. If not, the proposition is of course weakened. Further research on patient communication during sessions pre-judged to concern a single basic conflict would cast light on this issue.

The present results suggest that the conception of psychotherapy referred to by Clay (1968) has been too much influenced by those dramatic sessions in which a patient does move in a cathartic manner from the tentative introduction of a topic to the intense and insightful experience characterized by Hollywood as marking the close of every therapy session. This research does not support such a stereotyped expectation of the therapeutic process. Psychotherapy involves a lot of difficult and frustrating work in which strong resistive forces are continually operating in the patient to prevent change of any sort, including the development of openness to and awareness of anxiety-producing impulses and defences. Episodes of genuine insight are not frequent in the average
course of psychoanalytic therapy, and the present results support the theoretical proposition that whatever gains may be made are not maintained in a continuous and cumulative manner. Further research is needed which, following Kiesler's procedural suggestions, measures therapy material relevant to the working-through of specific conflicts and transference manifestations, in order to test the hypothesis that the therapeutic process is characterized by increasing levels of patient openness and awareness as a function of the resolution of specific conflicts.

Of course, such research as that suggested above, and the present study itself, is purely correlational in nature. No independent variables are manipulated, and no cause-and-effect relationships are unequivocally demonstrated. Such studies as this are undertaken as exploratory efforts to delineate parameters of the therapeutic process. When this has been accomplished, experimental research in which some aspect of the therapy situation is manipulated will have a basis for the evaluation of results in the effects of the manipulations on known parameters of the therapeutic process.

The use of separate scales in this study to measure the openness to emotional experience and the degree of self-observation discernible in a patient's communication during psychotherapy was a methodological innovation. The construction and use of separate scales was based on the theoretical distinction between the two types of ego function required of patients in psychoanalytic therapy. It is, of course, of theoretical interest to examine whether the two scales can be demonstrated to function independently. It might be argued that if the scales measure two separate ego functions, ratings of the same therapy material made with the two scales by separate judges should not correlate as highly as ratings of
identical material made by two independent judges with the same scale.

On this premise, the first 60 ratings of the two student judges were correlated, and the size of the correlation coefficient (.562) between these two sets of ratings was compared to the size of the reliability coefficients obtained for each of the individual scales (.620 for the openness scale; .679 for the awareness scale) based on the ratings of each of the student judges and those of the investigator, who rated the first 60 segments with each scale, using one scale at a time. The significance of the differences between the correlation coefficient of the two scales on the one hand, and the reliability coefficients of each of the individual scales on the other, were calculated according to the procedure outlined in McNemar (1962, Pp. 139-140). Neither reliability coefficient of the individual scales was significantly greater than the correlation coefficient of the two scales, based on the ratings of the two independent student judges.

Since the investigator had carried out the ratings of the 60 segments with both scales, using one scale at a time, a similar analysis of his ratings was carried out. His ratings on the two scales were first correlated ($r = .314$), and this correlation coefficient was compared to the reliability coefficient based on the ratings of the investigator and student judges for each scale. The correlation coefficient between the two sets of ratings made with the separate scales by the investigator was significantly smaller than either of the reliability coefficients of the individual scales. The difference was significant at the 5% level.

This result prompted a return to the data of the preliminary reliability study, since one of the two judges who rated therapy segments in that phase of the dissertation had reported difficulty maintaining the
notion that the openness and awareness discernible in a patient's communication might not be highly correlated. His ratings with the two scales correlated highly \( (r = .752) \). On the other hand, the second judge had reported no such theoretical difficulty. His ratings with the two scales correlated much less \( (r = .374) \). As reported earlier, these judges agreed that in order to avoid possible confusion on the part of future raters, each judge should be asked to rate material on only one scale.

The discrepancy between the degree to which the two student judges' ratings with the individual scales were correlated on the one hand, and the much less substantial correlation between the ratings made with the two scales by the investigator on the other hand, was consistent with the discrepancy between the correlations of the two sets of ratings made by the judges who took part in the preliminary reliability study. In view of the fact that the investigator was thoroughly familiar with and accepted the theoretical distinction between the concepts of openness and awareness; in view of the fact that the two judges who took part in the preliminary reliability study contrasted sharply in this regard; and in view of the fact that no explicit theoretical rationale was given the two student judges who made the final ratings, it is believed that each rating scale, if properly used, will measure different things. That is, it is assumed that, given instruction in and acceptance of the theoretical distinction between the two types of ego functioning by raters, each scale will account for variance in the obtained ratings that is independent of the variance accounted for by the other scale.

Although significant differences between the correlation coefficients of ratings made with the two scales on the one hand and the reliability coefficients of the individual scales on the other might be interpreted
to support the theoretical distinction between the experiencing and observing ego functions as separate aspects of a patient's communication, the investigator realizes that this expectation cannot be held to constitute a definitive test of the analytic theory of patient functioning during psychotherapy. It is certainly possible that the scales in their present form do not fully define the theoretical constructs they represent. Secondly, it is not clear whether the theoretically-predicted oscillation between ego functions is sufficiently infrequent that both would not typically occur within a five-minute period. The oscillation between ego functions might be so rapid and frequent that both functions would almost certainly occur in the communication of an adequately-functioning patient within such an interval. No clear theoretical specification could be found in this regard. It does seem clear, at any rate, that future training procedures in the use of such scales should include a theoretical exposition of the differences between the two ego functions which the individual scales are meant to measure. The ratings of the student judges in this study might well have been confounded by a lack of a clear distinction between the two aspects of patient functioning that psychoanalytic theory regards as separate and essential.

Some limitations of the present study should be acknowledged. The investigator noted that although all therapists could fairly be described as using an analytic approach, some student therapists did not employ psychoanalytic techniques consistently or in a fully effective manner, with the result that intense communication and a focus on the immediate moment tended not to occur in their therapy. Such an observation is not surprising, nor should it be. It does suggest, however, that cases of student therapists should be carefully evaluated before being included in
tests of psychoanalytic hypotheses.

Although inter-judge reliability for the two scales was not as high as had been anticipated, it was considered adequate for the purpose of this study. The inter-judge correlations obtained were comparable to reliability figures published in similar research in the past (cf., Garduk & Haggard, 1972). Apart from whatever degree of inter-judge unreliability was due to the inherent difficulty in measuring such complex variables as the degree of openness and awareness in a patient's communication (i.e., such factors as lack of clear theoretical orientation towards the two concepts, ambiguity of scale items, or differences in amount of clinical facility and experience of judges), another source of unreliability was probably the variability in intra-judge ratings over time. Optimally, such ratings should be completed in as short a time as possible to control for shifts in frame of reference, but the exigencies of everyday professional life made such a stipulation difficult to insist upon, and impossible to enforce. Future researchers should be aware of the practical difficulties in this regard, as the likelihood of fulfilling the oft-recommended ideal conditions for valid and reliable ratings (well-qualified and equally-experienced judges who are willing and able to devote a large block of time to the rating task) is probably remote in most settings. Nonetheless, efforts should be made to satisfy such requirements of good research technique whenever possible.

The present study provided results which correspond to several findings reported by investigators who used Gendlin's Experiencing Scale to assess changes in the mode of patient functioning during client-centered therapy: significant overall differences between patients judged to have succeeded in treatment and patients deemed to have failed to
improve; non-monotonic changes in scale ratings during the course of
treatment but no overall increase in the level of the ratings; and finally,
an indication of a trend of such ratings to increase in a monotonic
fashion within individual therapy sessions. Such parallels in results
are impressive in view of the theoretical differences between client-
centered and psychoanalytic therapy techniques. It is hoped that the
present results will be considered provocative enough to stimulate further
research in the area of psychotherapeutic process.
Appendix A

Scale of Openness of Free Association

1. Many, many pauses. Long silences in a context of blocking or defensiveness, perhaps with remarks about nothing coming to mind, or complaints or questions about the task. Patient may be obviously upset by/about the task, but otherwise, no significant affect is discerned. Silences or intellectual argument and/or query about task predominates.

2. Coherent discourse with no notable spontaneity, fairly standard pacing, deliberate sentences. Emphasis on conversational narrative quality, although the impression might be one of marking time in a cool and avoidant fashion. On the impersonal side.

3. Dealing with emotionally significant matters with at least medium involvement. Little concern with connected, related-topic, organized narrative. But secondary process--with no or only occasional breakthrough of sudden, tangential transitions and ruptured sentence structure. At least some emotional expressiveness; may be relaxed animated conversation, or affective communication with some censoring discernible.

4. Spontaneous, unprepared, little-selected, strongly involved and meaningful, primarily conversational in nature, but permitting significant fragmentation of sentences and overtly "incoherent", unusual transitions. Imagery in the patient's associations is somewhat concrete.
5. Irregularly paced, spontaneous, highly involved and meaningful, fragmented non-conversational form with "illogical" transitions, unprepared and not studied or deliberate. Imagery primarily concrete throughout.
Scale of Self-Awareness

1. Discourse about external phenomena, abstract ideas, or the therapeutic task, with no mention of own emotional reactions or motives in other than an indifferent voice tone. The patient is not acknowledging the distress which led him to seek psychotherapy. The only affect likely to be present is tension evoked by the therapeutic situation itself rather than by the patient's associations. Examples:
   --description of events, places or persons, without significant reference to his own involvement;
   --or a discourse about abstract ideas, which could be an abstract discourse on emotions or motives in which his own are used as hypothetical examples; his references to his own emotions or motives are so intellectualized that he appears to be telling a story;
   --or an intellectual argument about the therapeutic task, or attempts to engage the therapist in discussion about psychotherapy.

2. Non-reflective associations about the self, or strongly-defended references to the self. Although the patient's associations contain references to his emotions or motives, defensive operations are discerned which prevent the patient's acknowledgement of emotions or motives which a therapist would infer from his associations. Examples:
   --by the use of rationalization he cites reasons for behaviour which seem non-essential, self-justifying, and dynamically insufficient to account for it;
   --or by the use of reaction-formation he "protests too much" an emotion or motive that appears dynamically unlikely;
--or the patient portrays himself as a helpless victim: by the use of projective defences he states or implies that his suffering is due to the actions of other persons. If interpersonal relations are at issue the patient does not entertain the possibility that he is responsible for them.

3. The patient demonstrates at least the beginning of an accurate appreciation of significant defensive operations, emotional reactions or motives. Although considerable defensiveness toward the acknowledgment of these variables is discerned, the impression is gained that the patient reflects, however tentatively or questioningly, on dynamically significant defences, emotions or motives. If interpersonal relations are at issue, the patient at least minimally entertains the possibility of his own initiative, participation or provocativeness in causing events.

The patient may be prevented from reflecting on the emotions or motives he is experiencing by the obvious intensity of his experiencing. Any mention of accurate (therapist- or rater-inferred) dynamics is considered to be properly scored at this level, however, since the ability to refer to them is assumed to involve some minimal reflective capacity.

4. In describing events or interpersonal relations, the patient reflects on his defences, emotional reactions or motives. Appropriate affect is discerned in the voice tone. The impression is gained that the patient is reflecting on dynamically significant defences, emotional reactions, or motives, and that defensive operations are not preventing this, although some resistant interference might be discerned.
If interpersonal difficulties are at issue, the patient reflects on his own role or responsibility for events.

5. The patient's primary focus throughout the segment is on self-reflective scrutiny of his own defences, emotions or motives rather than on a description of events. The patient appears to be exploring his own emotional reactions and/or examining his own responsibility for his distress. He is able to explore the extent to which he is a perpetrator of his distress. He verbalizes his emotional reactions or his own role in relationships with appropriate affect, and is able to state significant generalizations or discriminations about himself.
Appendix B

Instructions for the Use of the Openness Scale

1. Study the scale and the taped examples of scale points on the demonstration tape. Listen to the tape all the way through as a "warm-up," by listening to a segment, then reading the description of how it was scored before listening to the next segment.

2. Rate the excerpts on the remaining tapes as you go along. First, listen to an excerpt as a whole and decide the main aspect of what the patient is communicating and how he is doing it. The purpose should be to gain an understanding of the axis along which the segment moves. This understanding should be used as a framework from which the material in the segment may then be judged. Listen to the excerpt a second time and assign a rating for it. Avoid re-listening a third time and changing your ratings.

3. Ratings of openness should be based on an evaluation of a) the degree of affective intensity and appropriateness of the patient's associations, b) the degree of spontaneity or lack of conscious editing, and c) the degree of concreteness of the imagery contained in the patient's communication.

4. The variables in the scale of openness are expected to be correlated. Therefore, a particular level of emotional expression should be accompanied by a comparable degree of spontaneity. This expectation is reflected in the verbal definitions of the scale points. At times, however, this may not be the case, and the rater will have to
make a judgment based on his evaluation of the significance of the particular aspects of the patient's communications within the segment. The samples on the demonstration tape include segments where this consideration is illustrated.

5. The occurrence of a dream report or a report of fantasy material does not automatically constitute scrutiny of one's own role in events or examination of one's own emotional responses or motives. A dream or fantasy report should be rated just as any other report of events, i.e., according to the degree to which the patient's associations about the dream reflect openness.

6. Always make a judgment, even if you are uncertain. The number assigned should reflect only the judge's rating, and not his degree of confidence in the rating.

7. The most extreme scores are expected to occur relatively infrequently, reflecting the assumption that resistant forces are not often either completely dominant or quiescent. Do not avoid extreme scores because of uncertainty, however.

8. Rate the segments in the order in which they occur. Attempt to judge each segment independently of every other segment, i.e., without regard to the same patient's behaviour in other excerpts. The rating should be absolute rather than relative to the particular patient.

9. When you resume rating after an interruption, listen to the demonstration tape to regain your frame of reference.

10. Rate the excerpts in as concentrated a time period as possible.
Instructions for the Use of the Awareness Scale

1. Study the scale and the taped samples of scale points on the demonstration tape. Listen to the tape all the way through as a "warm-up", by listening to a segment, then reading the description of how it was scored before listening to the next segment.

2. Rate the excerpts on the remaining tapes as you go along. First, listen to an excerpt as a whole and decide the main aspect of what the patient is communicating and how he is doing it. The purpose should be to gain an understanding of the axis along which the segment moves. This understanding should be used as a framework from which the material in the segment may then be judged. Listen to the excerpt a second time and assign a rating for it. Avoid re-listening a third time and changing your ratings.

3. Ratings of awareness should be based on an evaluation of the degree to which the patient is able to verbalize and conceptualize observations about himself. Any attempt to do so should be scored higher than a segment containing no self-reflection. Similarly, self-reflection judged to be accurate should be scored above self-reflection distorted by defensive operations.

4. Ratings of awareness should be made on the current flow of material only, on the feelings and motives that are explicitly or implicitly communicated by the patient along the central axis of the segment. Implicit communication is defined as occurring when a patient's defensive operations communicate more to the therapist than the patient "knows" (i.e., more than he is consciously aware of). Apart
from the occurrence of obvious defensive operations related to the axis along which the segment moves, no inference of unconscious motives (which may be theoretically postulated) should be allowed to influence the rating of a segment. For example, although analytic theory postulates that Oedipal conflicts lie at the core of neurotic complaints, a patient's associations may reflect more or less awareness regardless of the degree to which they represent a derivative of such central core conflicts. Thus the degree of awareness reflected in a female patient's associations does not depend on the extent to which she verbalizes feelings of envy towards her husband or father, or the extent to which she reflects upon feelings of inferiority to men in general, unless such dynamics can be inferred from the context of the segment. The rating depends instead on the extent to which she scrutinizes her own motives or emotions, or her own initiative in causing the events or relationships involved in her current associations, whatever their topic.

5. Sometimes a level of awareness seems to be reached in a segment, only to be followed by associations that are more defensive in nature. Sometimes a shift in topic may occur which involves a shift in the degree of self-observation as well. In such a segment, awareness should be scored in accord with the higher level reached, under most circumstances. It is assumed that the anxiety aroused by accurate self-reflection may cause the patient to regress to a more defensive level of functioning. But credit is given for the accurate self-reflection if the impression is gained that the patient is backing off, rather than repudiating, the awareness that was attained.
6. The occurrence of a dream report or a report of fantasy material
does not automatically constitute scrutiny of one's own role in
events or examination of one's own emotional responses or motives.
A dream or fantasy report should be rated just as any other report
or events, i.e., according to the degree to which the patient's
associations about the dream reflect awareness.

7. Always make a judgment, even if you are uncertain. The number
assigned should reflect only the judge's rating, and not his degree
of confidence in the rating.

8. The most extreme scores are expected to occur relatively infrequently,
reflecting the assumption that resistant forces are not often either
completely dominant or quiescent. Do not avoid extreme scores
because of uncertainty, however.

9. Rate the segments in the order in which they occur. Attempt to judge
each segment independently of every other segment, i.e., without
regard to the same patient's behaviour in other excerpts. The rating
should be absolute rather than relative to the particular patient.

10. When you resume rating after an interruption, listen to the demon-
stration tape to regain your frame of reference.

11. Rate the excerpts in as concentrated a time period as possible.
Appendix C

Explanatory Notes for the Openness Ratings
of Segments on the Demonstration Tape

Segment #1 - 2 The patient carries on a coherent discourse with fairly standard pacing, and deliberate sentence formation, and the overall impression is one of marking time in a cool and avoidant fashion. The lack of emotional tone gives the segment an impersonal quality. This segment is properly scored 2 rather than 1, in spite of the fact that the subject matter of the patient's associations concern a technical consideration about psychotherapy, because he carries on a discourse without silent periods, which indicates that defensive blocking does not occur.

Segment #2 - 1 The long silences occur in a context of defensive blocking. The patient is obviously upset about the task and tells us in so many words that she does not want to remember and report her memories.

Segment #3 - 2 Although the patient's discourse contains fairly concrete imagery, the overall impression is one of little spontaneity, a somewhat avoidant emotional tone, and an emphasis on maintaining a narrative character to her discourse.

Segment #4 - 3 The patient's associations take the form of a relaxed, animated conversation with the therapist, in which some emotional expression is clearly present.

Segment #5 - 3 The patient's discourse contains some blocking, is largely narrative in form, with moderate emotional involvement.

Segment #6 - 3 The patient's communication is too affect-laden to be scored less than 3, and too controlled to be scored higher.

Segment #7 - 3 The patient is talking about emotionally significant matters, with some emotional expressiveness.

Segment #8 - 3 The degree of affect in the patient's communication merits a score of 3, since the affect is related to ongoing associations rather than to the therapeutic task itself. The degree of defensive control present in the segment is too great to allow a rating of 4.

Segment #9 - 3 The patient talks about emotionally significant matters with at least some affect, however strangled it sounds. His description of his resentment towards his parents
does not sound cool, avoidant or indifferent, and the segment is therefore not scored 2.

Segment #10 - 3 The patient's discourse is narrative in quality, with minimal emotional expressiveness. But it is not impersonal or avoidant, and spontaneity is clearly present in her sudden transition to the topic of her defensive tendency to fill up space with words.

Segment #11 - 3 The patient is talking about emotionally significant matters, and some emotional expressiveness is present in her voice tone.

Segment #12 - 3 The segment contains emotionally significant material, with affective expression in the voice tone. But there are significant defensive controls.

Segment #13 - 3 Although the patient's communication is characterized by obvious affective tone, the segment is not spontaneous enough or concrete enough to be scored 4.

Segment #14 - 4 The patient's associations are spontaneous, strongly involved, and imagery is somewhat concrete.

Segment #15 - 1 Long silences occur in the context of defensive blocking, and her anxiety is related to the task itself rather than to any ongoing associations.

Segment #16 - 4 The patient's communication is meaningful and involved and her imagery is concrete. Some fragmentation of sentences occurs.

Segment #17 - 4 The patient's associations appear spontaneous, and highly meaningful. Her voice tone indicates strong emotional involvement. Some fragmentation of sentences occurs. But transitions are not sufficiently unusual, sentences are not sufficiently fragmented, and imagery is not concrete enough to be scored 5.

Segment #18 - 3 The patient is dealing with emotionally significant matters with at least some emotional expressiveness.

Segment #19 - 4 The segment is highly involved and meaningful and imagery is primarily concrete. But the patient's associations are too conversational to be scored 5.

Segment #20 - 3 The patient speaks with moderate emotional expressiveness in her voice tone, but secondary process controls are maintained, and little or no sudden, tangential transitions or ruptured sentence structure occurs. Imagery is primarily concrete, but the presence of defensive blocking, and the lack of both intense affect and fragmented sentences make 3 the appropriate score.
Segment #21 - 3 The defensive blocking indicates a lack of the degree of spontaneity characteristic of a segment scored 4.

Segment #22 - 3 The patient deals with emotionally significant matters with concrete imagery and moderate emotional expressiveness. But the narrative quality and lack of spontaneous verbalization or strong affect make 3 an appropriate score.

Segment #23 - 4 The segment is spontaneous, strongly involved and meaningful, with considerable fragmentation of sentences.

Segment #24 - 5 The patient's imagery is concrete, and her language is very evocative. Affect is intense throughout, and conscious editing is not obvious. The initial silence does not detract from the scoring as the context is that of strong affect related to her associations within the segment rather than to the therapeutic task.
Explanatory Notes for the Awareness Ratings of Segments on the Demonstration Tape

Segment #1 - 1 The axis of this segment is a consideration by the patient of the question of how one can be said to need therapy. How does one evaluate such a need? He is not aware of the defensive purpose being served by his raising the question. What he is aware of is a problem in his conceptualization of what psychotherapy is, and who can benefit from it, and he attempts to draw the therapist into a discussion of this topic. Such a concern in a man who has presented himself for treatment in order to relieve his subjective distress is evidence of strong resistance to even acknowledging that distress, let alone examining it.

Segment #2 - 2 The patient is saying that it is upsetting to talk about what has happened in the last fourteen years. She is presently experiencing the same upset about the task, but it does not lead to any effective communication, and the intensity of her experiencing seems to be blocking even minimal self-reflection. In essence, she is saying that it does no good to talk, and she is not going to. She does not describe feelings or inner conflicts which could account for the upset. The segment is scored 2 because she refers to herself rather than to external events, abstract ideas, or the task itself, nor is her self-reference intellectualized.

Segment #3 - 2 The patient is talking about some early sexual behaviour. She projects all responsibility onto others, and rationalizes not telling her parents because they would not have believed or understood her.

Segment #4 - 2 The patient is describing a friend's behaviour as a contrast to her own. But there are strong clues that the behaviour being described does not contrast with her own impulses—the obvious delight with which she describes her friend's behaviour, and her admission that if she were to carry on in a similar manner she might want a few friends to know. It is assumed that she is externalizing and denying her own motives.

Segment #5 - 2 The patient is talking about her current relationship with her husband. She is blaming him for the problems they are experiencing.

Segment #6 - 2 The axis of the segment is the manner in which the patient handles her hostility towards her husband. She claims that she does not dare to be hostile towards him because he could not deal with it. Besides, she wonders if part of her sense of frustration may be caused by her own
Inability to be what he would like her to be. She is not able to accept the therapist's remark that to express hostile feelings in therapy is not the same as expressing them to her husband. Thus the segment is best characterized by her denial of her own hostile impulses via rationalization. She is not able to say that she wants to hurt him.

Segment #7 - 2 After the therapist connects the patient's feelings about her mother's sexual activities to her current distress, the patient begins to speak about the tension she experiences when her sexual needs are aroused. She does not recognize her fear of her own sexual impulses, or that in trying to resist these impulses she is drawn into obsessive sexual rumination.

Segment #8 - 2 Although the patient probably accepts the therapist's labelling of her fear, she does not seem to reflect on it as a common response to both the therapist and her husband, nor does she recognize it as a defensive response. Her experience of the moment is too intense to allow her such perspective. She simply is not able to reflect on what her fear might be related to, and the entire segment is characterized by strong resistance to free association and self-exploration.

Segment #9 - 3 The patient talks about his feelings of resentment toward his parents for not having taken enough interest in him to guide him in his educational and vocational pursuits. He also describes how he reacts with exasperation toward people who cannot match his performance although, as he imagines, they suffered no such parental "stumbling-blocks". In spite of the strength of his projective defences he is able to reflect that the agitation he feels towards others is perhaps out of all proportion, and that the resentment he feels towards his wife provokes guilt because he realizes that she did have parental problems. He is not able to explore the significance of this observation with regard to his own dependency needs, and at the end of the segment he is trying to elicit support from the therapist, just as he probably does from everyone else.

Segment #10 - 3 The patient is avoiding something in this segment, and recognizes her defensive tendency to fill in with words in order to lessen the anxiety that silence would create. She is unable to elaborate on this self-reflection, however, and cannot recall what she was talking about in her conversation with her husband. She changes topic.

Segment #11 - 3 The axis of this segment is the patient's description of her feelings of depression. She tries to account for her feelings by describing her physical condition and her husband's insensitivity, but she also reflects on
her own contribution to her distress a) by observing that her attitude to her physical complaints is a component of her not wanting to do things, and b) by noting that her anger towards her husband arose "as if he had really done something terrible". This self-observation is not maintained, and throughout the segment one senses a self-justifying quality in her communication, and a projective defense against self-exploration.

Segment #12 - 3 The axis of the segment concerns the patient's attitudes to her own impulses, and her relationship with her husband. We can assume that the conjunction of these topics is no accident. She reflects on the possibility that her fear of sexual impulses is related causally to the tension she is currently experiencing. She also begins to recognize that her relationship with her husband is a function of her being nice to him, although she does not reflect on the sexual aspect of this, and probably has not recognized that her anxiety about her own sexual impulses motivates her to provoke antagonistic responses from him.

Segment #13 - 2 The patient reports that she is not able to meet people or to do even the things she wants to do, without the support of her husband. She does not clearly blame him for this state of affairs, and describes examples of a long-standing lack of perseverance and self-discipline. But the responsibility for her current state is left on his shoulders. Defensive operations are strong enough to prevent her from exploring her motives or emotions. An impression is created that she is portraying herself as helpless rather than looking at the way in which she handles her passive needs, and that she is portraying herself in this way in order to elicit support from the therapist. An underlying conflict may be postulated between a wish to be cared for, and a fear of that wish within herself.

Segment #14 - 2 The axis of this segment is the patient's complaint that her husband treats her unfairly by showing no initiative or responsibility regarding what should be joint decisions, although she wants him to make such decisions. She shows no glimmer that what she says of his mother is also true of her, and she is not able to reflect on the proposition that she provokes his passivity as a defensive operation against her own fear of initiative on his part. We can predict that her response to the therapist's interpretation in the final moments of the segment (i.e., that she chose a weak person to marry) would be "yes, but......". During the segment, she is behaving in such a way as to prevent initiative by the therapist.

Segment #15 - 3 The patient's observation that she is trying to avoid something is confirmed during the rest of the segment.
She is not able to explore what she might be avoiding, or why, but instead experiences mounting anxiety because she has nothing to say—nothing comes to mind.

Segment #16 - 3 The patient is describing her feelings of anger towards her husband, and her jealous resentment of his ability to make a fool out of her. She is minimally able to reflect on her own role in provoking his aggravating behaviour, although one senses that she does not yet appreciate the significance of her observation—that her childish provocation of her husband is a way of insuring that he will continue to aggravate her. Her bitchy, rasping tone is a clue to her provocativeness in the relationship.

Segment #17 - 3 The axis of the segment is the patient's feelings of anxiety and distaste regarding sexual relationships. She recognizes some degree of ambivalence in her feelings during the first moments of the segment, but appears to back off from this reflective scrutiny of her positive interest because of the anxiety aroused by the fact that her interest was directed toward her own father. The remainder of the segment confirms her interest in being stimulated by men, however. The slip "asexually" is considered significant in this regard. Although she is somewhat concrete at the beginning of the segment, she backs off and tends to generalize as the segment continues.

Segment #18 - 3 The patient is talking about her relationship with her husband, with no observation of her own role in the interaction after her initial comment that if she praises and does not nag, he may feel better about her and try harder to please her. The remainder of the segment is made up of projection of blame for her loneliness, and attempts to account for her tension by citing dislike of arguments.

Segment #19 - 4 The patient is comparing her feeling reactions of the other night with her feelings of the moment. She reflects on the tense, tight feelings she experienced when her friend moved closer to her at the front of his desk, and reports that she is experiencing that reaction now. She is able to report that her defensive impulse is to run when she experiences such emotions. Her focus throughout the segment is on her own feeling reactions to physical proximity with the two men. But she does not make any general observation about herself.

Segment #20 - 4 The patient explores her emotional reactions toward the therapist. She is able to reflect on her hostile fantasy towards him, and then go beyond that to the underlying anxiety she experiences in response to her own sexual stirrings. She recalls that she used to
feel such stirrings towards her husband, but rationalizes that it is not that important to her now. She does not generalize about her own emotional reactions, and employs some defensive ambivalence in her report of her fantasy.

Segment #21 - 4 The patient is talking about her lack of responsiveness to her husband. She observes that perhaps she married him in the first place because he was not sexually demanding and offered the companionship she sought. Now that he is demanding more responsiveness she is able to consider the possibility that she bears some responsibility for her current distress. Her ability to explore this self-observation is spoiled by her rationalization about his dependence and lack of confidence, and the reaction-formation against her own anger towards him for not stimulating her and allowing her to be dependent on him. She reflects more than minimally upon her role in the marriage, but some defensive operations are discerned in the segment.

Segment #22 - 4 The patient is talking about her sexual relationship with her husband, and reflects on her own responsibility for its unsatisfactoriness and her own lack of involvement. She goes on to observe the difficulty she experienced in describing a typical sexual episode to the therapist, and wonders if the difficulty could have something to do with how she feels about the therapist. She explores her feelings toward the therapist in the last moments of the segment.

Segment #23 - 5 The patient is reflecting on her responsibility for her unsatisfactory sexual relationship with her husband. Her observation that she tries to protect herself from being used by him by withdrawing her own emotional reactions, and her recognition that this constitutes punishment of her husband seems significant, considering the hostility which a rater might infer. She reflects further on her fear of letting anyone (including her husband) know that she has negative thoughts, and the frustration that such a pose has created for her in the past. Her self-observations have a conclusive quality, and defensive operations are not discernible within the segment.

Segment #24 - 4 The patient is telling about her relationship with her father, and exploring her developing independence and its concomitant loss of intimacy with him. Her primary focus is on herself rather than the relationship, with some recognition of her own responsibility for the distress she experiences at finding "no warmth, no softness, no understanding, no love". The self-observation in this segment sounds more descriptive than conclusive or general, and is therefore not scored 5.
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