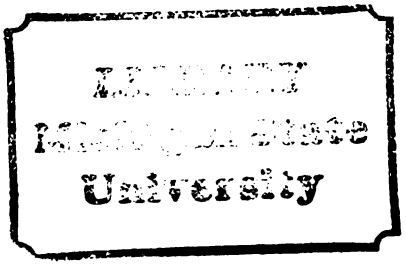

This is to certify that the

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IN THE FIFTH PROFESSION

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AN INQUIRY INTO UNCERTAINTY IN THE FIFTH PROFESSION

By

Sheila Bienenfeld

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ABSTRACT

AN INQUIRY INTO UNCERTAINTY
IN THE FIFTH PROFESSION

By

Sheila Bienenfeld

The relationship between uncertainty in psychotherapy and clinical psychologists' concerns about their work was the primary emphasis of this study. Uncertainty in outcome, theory, and technique of psychotherapy were discussed. The ambiguous findings of psychotherapy research were suggested as an additional source of uncertainty. The literature touching on these areas and on the occupational stresses associated with psychotherapy was reviewed.

Eight questions were posed. These concerned aspects of uncertainty, clinical psychologists' concerns or problems as therapists, psychologists' orientations to psychotherapy, and therapists' attitudes toward research in their professional lives.

Interviews were conducted with thirty-five licensed clinical psychologists. Likert scales covering dimensions of therapists' concerns about psychotherapy, and attitudes

toward research were created, as was a Q-Sort deck referring to therapist's approaches to psychotherapy. Demographic data on such areas as gender, age, experience level, work-load, research activity, and publication records was collected.

Cluster analysis of the Likert scales yielded six dimensions of therapists' concerns about psychotherapy. These were: concerns about the separation between personal and professional life; whether their fees were really earned; uncertainties in psychotherapeutic technique; therapist self-disclosure; ethical issues involving sexual and aggressive feelings toward patients; and the lack of theory and guidelines in psychotherapy.

Cluster analysis of the Q-Sorts yielded six dimensions related to therapists' approaches to therapy. These were: a psychodynamic vs. an eclectic approach; therapist uncertainty and self-doubt; a personalized view of therapy; research-mindedness; perceived patient demands; and a view of therapy as guided by inspiration.

Psychologists' attitudes and approaches toward uncertainty were also investigated. In general these therapists were tolerant of uncertainty and tended to endorse supervision, further training, greater experience, and tolerance for ambiguity as ways of dealing with uncertainty.

Psychologists' attitudes toward the role of research in their professional lives were also investigated. In general, these psychologists tended to value their research related skills and the usefulness of their research backgrounds. They tended to see research as of limited relevance in their current professional lives.

Similarities and differences between these and previous findings were discussed along with this study's broader implications. Directions for future research were suggested.

I will try

to fasten into order enlarging grasps of disorder,
widening scope, but enjoying the freedom that
Scope eludes my grasp, that there is no finality of vision,
that I have perceived nothing completely,

that tomorrow a new walk is a new walk

A.R. Ammons (from Corsons Inlet)

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INTRODUCTION

Despite its European origins, psychotherapy is a peculiarly American phenomenon. Relying upon notions of almost unlimited human potential, it has flourished in a country and in a time where opportunites for external expansion and growth, once the hallmark of the American ethos, have diminished. Psychotherapy charts the unexplored internal territory that for many has replaced the uncharted geographic terrain of earlier explorations.

Psychotherapists are themselves latter day pioneers or the children of pioneers. The overwhelming majority are first or second generation Americans; immigrants or the children of immigrants. Well described as people with a "marginal perspective," an astonishingly large percentage share Eastern European roots and a history of religious and social persecution. They are from predominantly urban backgounds, tend to be of liberal political temperament, and are often upwardly mobile both socially and economically. Seventy percent of them describe themselves as "psychodynamically oriented" in their approach to therapy (Henry, Sims, and Spray, 1971, 1973).

Although psychotherapists are drawn from at least four professions; psychiatry, psychoanalysis, clinical

psychologists and psychiatric social work, they are so similiar in background and practice that they have been called a "fifth profession" (Henry, Sims, and Spray, 1971, 1973). They are people who espouse a traditionally liberal ideology of growth and who value science as a partner in advancing their therapeutic goals. Yet they seem to be shockingly ineffectual by most objective standards in translating their ideals into real-world results. One Nobel Prize winner has described psychotherapy as "...the most stupendous intellectual confidence trick of the Twentieth Century..." (Medawar, 1975). Furthermore, numerous outcome studies have failed to demonstrate the efficacy of psychotherapy. One might reasonably suspect that the good-faith practice of so highly touted and idealistic, yet empirically dubious and uncertain a profession may arouse some conflict in its practitioners.

This study is intended as an exploration of whether such conflicts do appear and if so, in what ways they are manifested in the attitudes of therapists and in the practice of psychotherapy. An additional area to be explored will be the role of research in addressing uncertainty in psychotherapy. This study will focus on clinical psychologists, the researcher-clinicians among psychotherapists.

The following chapter presents both a review and a synthesis of the literature that touches on uncertainty in psychotherapy and its ramifications in the lives and practices of psychotherapists. The discussion is organized by the elements of my own critique and draws upon literature from the fields of psychology, psychiatry, psychoanalysis, social work, and the sociology of professions. In the present discussion psychiatrists, clinical psychologists, social workers, and psychoanalysts are all described as "psychotherapists." This study will focus only upon clinical psychologists however.

It should be noted at the outset that finding literature relevant to the present topic was in one sense easy and in another sense difficult. The identification of uncertainty as an almost definitive aspect of psychotherapy is almost universal. Many authors from a variety of disciplines point to its importance, however in virtually every case they go on to address other issues more germane to their own disciplines. So while uncertainty is widely acknowledged as ubiquitous and essential for understanding the practice of psychotherapy, it is almost never addressed as an issue that is in itself in need of examination. In a sense then, it can be said that vey little directly relevant literature exists; a fact that complicates a literature review but does not

preclude one. In fact, a review of the massive, albeit not directly relevant literature that touches upon uncertainty in psychotherapy only highlights the potential value of a more detailed investigation of this topic.

Not surprisingly, a similar problem is found with regard to the conduct and design of research in psychotherapy. The problems that arise in the conduct of psychotherapy research are well known and commonly acknowledged. But again, the relationship between difficulties of research in psychotherapy and difficulties in the practice of psychotherapy have only occasionally been mentioned in the literature and never to my knowledge have they been specifically examined. The review contained in Chapter I may therefore be misleading. Numerous references to publications may leave the reader with the impression that the uncertainty of psychotherapy is both well documented and extensively discussed. The former is true the latter is untrue. It is partially out of that state of affairs that the present effort grows.

CHAPTER I

PART I - UNCERTAINTY IN PSYCHOTHERAPY

Psychotherapy provides, and some would say requires of its practitioners a level of psychological accessibility, vulnerability, and honesty unparalleled among professions and indeed rare in all areas of social life. As one author has pointed out, "... like few other professional groups, they (psychotherapists) seek to heal by being made whole themselves." (Stern, 1981). But the depth of commitment and the potential for growth that are inherent in the work may be a mixed blessing. On the one hand, the gratifications possible are many. The psychotherapist has opportunities for intellectual stimulation and interpersonal intimacy, the challenge of self-awareness, and the pleasures of seeing and sharing in mutual growth and development. Psychotherapy is also a fairly prestigious and lucrative profession.

The difficulties in psychotherapy are many however. The therapist faces ambiguity in technique and discourse, often extreme duration of treatment, uncertainty of outcome, and isolation in practice. These combine to complicate the life and professional practice of the psychotherapist and to distinguish psychotherapy as one of the most "impossible" of

professions (Freud, 1937; Malcolm, 1980).

For the patient therapy may be a uniquely meaningful and gratifying experience; nonetheless the patient's life is lived primarily in other realms. This is not the case for the therapist, whose working life is prevaded by the comings and going of patients. In addition to this is the continually renewed demand for a high degree of openness and integrity despite the ups and downs of personal and professional life.

Three types of uncertainty inherent in all professions have been identified (Fox, 1957). The first and second types are quite straightforward. There is uncertainty that arises from gaps in the knowledge base itself, i.e., any practitioner is bound to be uncertain in some instances because the knowledge required to resolve that uncertainty does not yet exist. The second type of uncertainty arises from gaps in the practitioner's mastery of his or her discipline; i.e., a more throughly prepared colleague would not under the same circumstances be uncertain.

The third type of uncertainty, one that goes to the heart of the matter regarding psychotherapy, arises from uncertainty about the source of uncertainty itself. Practitioners do not know whether their subjective experience of uncertainty arises from within themselves; from the quality of the interaction with patients; or from within gaps

in the knowledge base of the discipline itself.

With regard to such complex types of professional uncertainty, it has been pointed out that among those gaps that remain unfilled in the professional knowledge base there are some that cannot be filled because of "inherent limitations in the scientific enterprise." Because of this, as Thomas Kuhn has also pointed out, "Phenomena anomalous to the profession's paradigm may be misclassified or ignored entirely." (Nilson, 1979). There may be in other words, uncertainties which cannot be labeled or resolved given the current state of knowledge in the discipline. In such cases the practitioner is continually subject to a type of uncertainty whose source cannot be identified and which in any event cannot be resolved within the existing epistemological paradigm of the profession.

Psychotherapy is an unusually uncertain and complex profession. As such it imposes on the practitioner burdens and responsibilities that are rarely recognized. The present study explores the ways in which psychotherapists talk about the uncertainties and complexities of their work.

The examination of the uncertainties that psychotherapists must cope with and the ways in which they cope is interesting on two levels. On one level, there is the opportunity to examine the effects of professional uncertainty on members of one occupation. This study therefore

contributes to the growing literature concerned with the interaction between occupational characteristics and life stress (Maccoby, 1976). On another level, the examination of such issues becomes particularly interesting with regard to psychotherapists, people whose professional lives are often devoted to helping others deal with problems that are increasingly recognized as significantly socially produced.

The next four sections describe some of the critical areas of uncertainty in psychotherapy. These areas include uncertainty with regard to outcome, theory, technique, and research. Each will be discussed separately. Taken together they clarify some of those aspects of psychotherapy that may impinge on therapists' sense of professional well being.

A. The Problems of Outcome in Psychotherapy

> "... he's not a 'doctor' doctor -- he don't cure nobody. He's a psychiatrist." (Edith Bunker, Archie Bunker's Place, Sept. 30, 1979)

> Even following hundreds of hours, the patient is quite recognizably the same person, perhaps still living in essentially the same circumstances, with his usual relatives and vocation, and with similar recurrent difficulties. Now and then his old symptoms return, though he may pull through such relapses more quickly than before. Yes, he is steadier since therapy, with fewer illusions, but existence for him continues to be a sometime predicament. All told, is he happier? That is hard to decide. Does he still have problems? Of course. Is he better off than the next person who did not have treatment?
> A real question. (Fisher, 1967, p. 86)

Psychotherapy has no proven techniques of assured effectiveness. It uses no apparatus and has no language which all qualified practitioners can be assumed to accept. It is a field in which virtually nothing can be known with certainty save that two or more people participate, generally through verbal interaction. Generally at least one person is defined as being in distress (most often thought to be non-organic in origin), and at least one other person is defined as being an expert at helping people in distress.

We know that after some time, one or both participants may sense that the distress has beem ameliorated although their accounts of how and why this occurs may differ (Maluccio, 1979). We don't know for certain why any improvement happens or how long it will take, or how long it will last. The uncertainty of psychotherapy exceeds the uncertainty inherent in other professions that have clearer "patterns and practices" and more predictable ways of determining outcome.

The work of a sociologist, Marianne Paget, is illuminating in this regard. Her work has centered around the phenomenological study of medicine, particularly regarding the issue of medical mistakes (Paget, 1978). In her examination of medical mistakes she concluded that

medicine by its very nature, is an "error ridden" activity, because errors in medicine are knowable only by unexpected results of medical action. In other words, a physician only knows a mistake has been made when a clinical act produces undesirable or "wrong" results over time. Every medical act initiated thus contains within it a potential mistakenness that can only emerge through time. Paget describes a condition of such work as a "complex sorrow", a sorrow that attends action wherein mistakes are inevitable and potentially irreparable. Her emphasis on the inescapable ambiguity of clinical (medical) action with its attendant condition of "complex sorrow" is relevant to psychotherapy as well. While the sorrow of medical work, and indeed the sorrow of many professions is understandable, the sorrow of psychotherapeutic work may be especially complex and poignant. As another author has pointed out:

> Uncertainty and certainty in medicine are not dichotomies. They are two ends of a continuum with psychiatry at one end and surgery close to (though not entirely at) the other end ... in every specialty the practitioner learns to act in the face of some degree of uncertainty; in psychiatry, the uncertainty is hardly to be ignored. (Coser, 1979, p. 8)

While the both errors and the successful efforts of the surgeon emerge within what Paget calls a "compressed" time frame, their equivalents in psychotherapeutic work generally emerge in a greatly expanded time frame. The surgeon or

medical practitioner of any variety can hope to understand within seconds, minutes, hours, days, weeks or even months, whether a particular treatment effort was successful or mistaken or even the best possible compromise. The psychotherapist, working with less tangible material and methods cannot ever know with a comparable degree of certainty whether, or for how long, or to what degree therapeutic efforts have achieved their desired goals.

The problem for the therapist is not only what leads to successful outcome, but also how to define successful outcome. Clearly the behaviorist and the psychoanalyst have quite different ideas about what constitutes the appropriate diagnosis, conduct, and outcome of psychotherapy. The behaviorist might applaud the psychoanalyst's "cure" of a snake phobia while deploring the years and thousands of dollars that cure might have required. So too might the analyst acknowledge the behaviorist's "cure" of the same problem while at the same time decrying the "shallow", symptomatic emphasis of the behaviorist and while raising the specter of "symptom substitution" or posing questions about the durability of such a symptomatic cure. Even among analysts a "cure" by one of their own number might be labelled a "transference cure" or a "misalliance cure" (Langs, 1976, 1977), particularly if the results were not durable, and even perhaps if they were. Take for example the

following:

> I have heard therapists claim that should even symptom relief achieved without insight prove to last the lifetime of the patient, they would still regard it as a transference cure and something less than desirable. (Fisch, 1977, p. 268)

The process of psychotherapy is generally lengthy; cases in which psychotherapy continues uninterrupted for decades are not unheard of (although such cases are rare, or rarely reported), and it is quite common for therapy to continue for several years. To the practitioner, the absence of a way of knowing when and how psychotherapy will terminate and in what status it will terminate (successful or unsuccessful, sooner or later, permanent or temporary) creates a framework of uncertainty. It is within this framework that the therapist and the patient must labor hour by hour with little theoretical guidance and with landmarks detectable most often retrospectively and only rarely prospectively.

The issue of durability in psychotherapeutic treatment adds to the uncertainty about outcome in a particularly difficult way. One can never know in even the most "successful" cases, how the ex-patient will weather future crises and developments both internal and external. To be sure, neither external events nor internal changes can be effectively predicted, and it would be fatuous to insist that they could or should be. However, the impossibility and

undesirability of making such predictions does not mitigate the "sorrow" of uncertainty that the practitioner must cope with as a condition of the work. Not only do inescapable "real life" uncertainties not mitigate that sorrow, but they form the condition out of which it exists.

The therapist labors painstakingly at an intense and time-consuming task, without demonstrably efficient technology. Any estimate with regard to time can only be made by excluding from consideration the forces of nature and by assuming unflagging strength and patience in both the therapist and the patient. Despite these problems the task can be and frequently is accomplished. Any confidence in success however, is of necessity based upon suspended attention to uncontrollable factors that may render both persons' efforts seemingly or in fact for naught.

Students of psychotherapy have long been aware of the difficulties that arise in a field in which there is little consensus as to the definition of successful outcome, few ways to predict outcome, and little or no replicable technology (Frank, 1972). Indeed, Freud was one of the first to suggest that psychoanalysis was one of three "impossible professions". Along with raising children and governing nations, Freud considered psychoanalysis a profession "in which one can be quite sure of unsatisfying results" (Freud, 1937).

Robert Coles has eloquently summarized these problems in an essay about one of psychotherapy's failures, Michael Wechsler. Michael Wechsler was Young, Attractive, Verbal, Intelligent, and Successful (YAVIS) (Schofield, 1965), in other words, he was the very picture of an optimal psychotherapy patient. Furthermore, he was the son of upper middle-class, sophisticated parents who were willing and able to subsidize his years of psychotherapy with eight esteemed and experienced therapists. Despite all this, he was a suicide at age twenty-six. Along with the parents of Michael Wechsler, Coles struggles to understand what led to so tragic an outcome. In doing so he touches upon the pervasive uncertainty that is endemic to all psychotherapy. As he says:

> Psychiatric terms, apparently so clear-cut and emphatic have extraordinarily versatile lives: they come and go, blend into one another, are used by one doctor, scorned by another. More dangerously, they can have subtle and not so subtle moral or pejorative implications. "Good" patients, liked by their doctors, are described one way, "bad" patients, whose mannerisms (maybe just plain manners) or "attitude" or deeds are found to be unattractive, are described differently. The difference is one of tone, emphasis, and always, choice of words, many of them as portentous as they are slippery. This youth is "obsessive," but much of his behavior is "egosyntonic", and his primary struggle is "oedipal", even if his "defenses" are by no means

adequate, and sometimes shaky indeed. Another youth is also "obsessive", but underneath are serious "pre-oedipal" conflicts. Furthermore, his defenses are "primitive" and he may well be a "borderline case". With additional exploration we might even discover an "underlying psychotic process".

Needless to say, the very same youth can be seen by one psychiatrist, then another, and on and on, with divergence of opinion. X-rays do not affect the diagnosis. Blood tests cannot establish without doubt what has to be done. We are in a world of feeling, the doctor's as much as the patient's, so no amount of training or credentials or reputation can remove the hazards of such a world: inclinations of various kinds, outright biases, blind spots. I do not deny the enormous value that a personal psychoanalysis has for a future psychiatrist, or the effect years of supervision can also have. By the time most psychiatrists have finished their long apprenticeship they do indeed tend to know what kind of patient they ought to avoid,and most important, what their vulnerabilities are.

Still, such awareness isn't always translated into wise clinical decisions. Patients are accepted who ought to be referred. Patients are treated one way, when perhaps another tack might make things a lot easier for both them and their doctors. And even when in a particular case things do begin to work well, "life" is always to be reckoned with. Not everyone can keep at therapy or analysis for those months that have a way of becoming years... There are unavoidable accidents or emergencies...(Coles, 1975, p. 73) (emphasis added)

And finally as another clinician has stated,

> In the end one understands nothing: the therapeutic effect may be real and intended, real and accidental, or chimeric. But all therapists are familiar with this dilemma. How they resolve it depends on where they locate the therapeutic process. (Levenson, 1972, p. 15)

B. The Problem of Theory in Psychotherapy

As Coles makes clear, the problem of outcome is inextricably tied to the problems of language and theory in psychotherapy. It is a field that has no commonly accepted language with which to describe its tasks or the phenomena upon which it works. As such, it can hardly be expected to have a language with which to credibly pass on and evaluate in meaningful ways what has been learned. The language of psychotherapy and discourse about psychotherapy often take on an autistic quality. This is so because the discourse is so often idiosyncratic, and consequently dialogue between members of competing schools may be difficult or nearly impossible.

Leston Havens, like Coles and Levenson, addresses both the inherent ambiguity of outcome and the related issues of ambiguous discourse and theory.

> The question is asked, "Does psychotherapy help, and,if so, with what?" No two therapists agree

> on how HEALTH should be measured; even its definition is disputed. Acute psychoses seem to existential psychiatrists an improvement over many premorbid adaptations; but not so to community psychiatrists. Psychoanalysts may increase symptoms while they struggle to change underlying personality problems; behaviorists reduce symptoms but then are accused of ignoring what lies behind them. There is a great babble of voices but little talking back and forth. (Havens, 1973, p. 2) (emphasis added)

The lack of a common language about psychotherapy both obscures issues of outcome and impedes dialogue between colleagues. Language is the primary tool of psychotherapy, but in talking about therapy, it is a double edged one. It can be used to lay claim to one's own otherwise undetectable success, and to discredit the concrete achievements of ideological competitors. The interpretive stance within psychotherapy also complicates linguistic confusion because language that is in itself vague is used to represent even more ambiguous constructs. Thus, as one critic writes;

> ....the patient's balking at interpretive hints that may be misguided or even silly is taken as a sign of resurgent conflict with parents and siblings. The dissolving of this allegedly atavistic uncooperativeness--a recalcitrance which may in fact attest to the patient's unsurrendered common sense--is considered to be the analyst's infinitely painstaking task. (Crews, 1980, p. 27)

Or as another, less outraged scholar noted:

> In ward meetings, the patients often complained about the stark facilities for living; for example, the women's dormitory had no curtains so that the sun woke them early in the morning. (They also had to hide from the window when dressing.) Residents, by example of the chief, learned to respond to such complaints by psychologizing them. In this instance: "It seems to

me, Mrs. _____ is saying it's hard to wake up and face that we're still here." (Light, 1980, p. 99)

As the quotation suggests, the vagueness of psychotherapeutic concepts and the consequent vagueness of psychotherapeutic language, allow therapists the freedom to define reality in accordance with their own predispositions. They have a license to "prove" the most ridiculous notions, ignore or explain away the most obvious events, and justify a sense of success in an evidential vacuum.

Donald Light tells of staff reaction to a suicide in an esteemed New England psychiatric facility. The patient had left a suicide note in which he mentioned the names of several staff members who had worked with him. He mentioned all the relevant names except that of his therapist. From this, the staff concluded that the therapist was so important to the patient that he could not bring himself to write the therapist's name in his suicide note. As the author points out, "The opposite inference could be made, but the overall conclusion was that the therapist had not made a mistake. He had failed (to keep the patient alive) but he had not erred." (Light, 1980, p. 214)

The point here is not that the therapist did or did not err, or that the absence of the therapist's name from the suicide note necessarily meant anything other than what the staff took it to mean. The point is that the ambiguity of

therapeutic language offers ample room for what has been called "retrospective reorganization;" any result can be made to fit a prior theoretical mold and thus enable the practitioner to avoid cognitive dissonance (Nible, 1978; Festinger, 1957).

Kahn-Hut (1974) suggests that it is the very vagueness of psychiatric concepts that allows therapists to avoid feelings of alienation in a field as uncertain and as conducive to alienation as psychotherapy. The very vagueness about outcome and language that Kahn-Hut predicted would lead to feelings of futility, instead allowed psychiatrists to see their work in a favorable and meaningful light. In another study, the ambiguity of psychotherapy had the opposite effect on practitioners. Former psychotherapy patients and the social workers who had served as their therapists were interviewed. About twice as many patients described their psychotherapy experience as having been beneficial than did the therapists. In other words, ".....most clients were satisfied with the outcome, whereas most workers were either dissatisfied or ambivalent." (Maluccio, 1977, p. 107). The author linked such findings to the emphasis in psychotherapy on the goals of altering psychopathology and developmental arrest. As he notes, these are tasks that are difficult to define and even more difficult to perceive as having been accomplished. The patients on the other hand,

tended to use changes in their external life situations as their criteria in evaluating change. Because of this they were more likely to believe that therapy had been successful. The reactions of the therapists derive from what has been called the "Utopia Syndrome" in psychotherapy (Watzlawick, 1977). According to Watzlawick, vaguely defined but highly utopian goals prolong treatment and obscure more prosaic forms of real-life success and failure. One result of such vagueness is that gaps in psychotherapeutic knowledge are filled in with politically defined goals (Nilson, 1979), or with the personal preferences of the therapist. Therapists may respond to uncertainty by becoming the agents of conventional social more's or by striving to impose their own Utopian or political values upon the therapy. Often therapists are unconscious of such biases and may deny having them. As another author has written,

> Value-laden psychotherapy is possible because the imprecision of psychiatric theory, especially the ambiguity concerning "normality," permits the psychiatrist's moral preferences to be enunciated "in the disguise of scientific descriptions of fact." (Bart, 1974, p. 15)

In summary then, the language, i.e., the theoretical concepts of psychotherapy, are so easy to manipulate but so difficult to define that dialogue is often difficult. Outcome becomes divorced from the circumstances that bring patients into therapy, and therapists are able to see success

where no one else might, and failure where success might be seen. Furthermore, the political aspects of therapy may be obscured and thus denied. This puts psychotherapy at risk of becoming a tool of social control and a servant of repressive conventionality.

C. The Problem of Technique in Psychotherapy

> Well, you know that all hypotheses go. She may be angry at her mother, too, but I can deal directly with her anger at me. The point is that if you guess she is angry at you, and she gives clear signs that she is, then your hypothesis is right. But had you suggested she is angry at her mother, that would be right, too. They're all right. (psychiatric resident, in Light, 1980, p. 94)

Obviously, when outcome is difficult to predict or even define, and when theory and language are ambiguous, technique too must be problematic. The reverse is true as well, when technique is problematic and language is ambiguous, then outcome is difficult to predict. These three elements, theory, technique, and outcome, are interrelated, indeed inseparable. In each area there are problems of uncertainty, and this is what most distinguishes psychotherapy from other professions.

There may be no agreed upon theory as to why or how aspirin works, yet it can be prescribed for certain problems and relief can be reliably predicted. In physics, theory may predict the existence of some subatomic particle or other; the technique for finding such a particle need only be

developed and the predicted outcome, i.e. positive identification of the particle, is likely to follow. In law, theory follows outcome generated by technique. And so on. In psychotherapy neither theory, technique, nor outcome can be reliably agreed upon. There are elegant theories; the most elegant of course is psychoanalytic theory; it is elegant in scope and economy, but in matters of technique it is often crude and virtually impossible to standardize in practice. Not suprisingly, outcome data are often inauspicious. Even distinguished psychoanalysts have been moved to comment on "this remarkable and progressively hardening insistence upon the validity of a theoretical structure even in the face of its failure when applied in therapeutic context....." (Singer, 1965, p. 377). Indeed the problems of uncertainty in technique are such that,

> A psychotherapist may do anything within the law and be immune from the charge that he is incompetent, negligent, or malicious. All he needs do is claim that his activities are for his patient's benefit. He may sit silently, mumble inanities, give advice, moralize, dispense drugs, issue threats, administer electric shocks, or give his patients affection and support. Almost anything that takes place between a psychiatrist and his patient has been labeled as psychotherapy....."
> (Leifer, 1969, p. 156)

Added to the uncertainties of outcome, theory, and technique is the problem of research. It is, of course, to research, the process of investigating and discovering, that

therapists turn in their efforts to resolve uncertainties of theory, technique, and outcome.

In the same essay in which he declared psychoanalysis an impossible profession, Freud expressed the belief that eventually research would help resolve the inherent difficulties in psychotherapy (Freud, 1937). More than four decades of research have done little to bring Freud's hopes to fruition.

D. The Problem of Research in Psychotherapy

There are two levels at which research in psychotherapy is problematic. One is tied directly to the results of the research that has been done. The other is tied to the conflicting methods of discovery used in psychotherapeutic practice and in conventional (quantitatively oriented) psychotherapy research. Both compound the uncertainty of psychotherapy.

One researcher has expressed an aspect of the problem of research in psychotherapy in this way:

> .....despite many years of experience with various psychotherapeutic theories and practices, many psychiatrists, psychologists, and social and behavioral scientists question the effectiveness of conventional psychotherapy. They recognize that there is no objective evidence that shows that a particular theory and practice of psychotherapy is more helpful than any other (since all report about two-thirds "success") or than an individual's life experiences.
> (Hurvitz, 1974, p. 84-85)

This disappointing aspect of psychotherapy research is very well known. Numerous major studies have failed to provide guidance to practitioners concerned with finding out what works in therapy when, on whom, by whom, with whom, and in how long a time (Luborsky, 1972). Many, like Carl Rogers, have given up formal research or have advocated major changes in the way psychotherapy research is done (Bergen and Strupp, 1972; Allport, 1962). The journals however, continue to be filled with studies of psychotherapy process and outcome that many believe contribute nothing to progress in the field (Wachtel, 1980; Levine, 1974; Goffman, 1978).

In coming to terms with the lack of fit between research and practice, psychotherapists have several options. They may, on the basis of the research evidence, doubt the effectiveness of psychotherapy, or they may doubt the design or theoretical basis of the research. Another alternative, altering practice on the basis of research findings, is theoretically possible but tends not to occur (see Frank, 1972). Finally, the therapist may just go about his or her business and in the main ignore the research. The latter is the most frequent approach.

One really has to wonder however, how easy it is to ignore such disquieting research results. Even for those who neither conduct so-called "empirical" research nor generally read the research literature, the issue may not be

easily resolved. Otto Will may speak for many when he confesses that:

> As we cannot demonstrate with precision the causes of the disorders which we treat, or show exactly how what we do works or does not work, we may at times be troubled by the idea that through a more tough and realistic research will be discovered a truth of etiology and treatment and prevention that will reveal our humanistic endeavors as some sort of soft-headed nonsense. (Will, 1979, p. 565)

The research in psychotherapy not only engenders doubts about therapeutic effectiveness, but as Will points out, it may tend to induce in therapists a sort of guilty anxiety. An example of this is the reaction of a former president of the District of Columbia Psychological Association, to NIMH's newly begun five-year study of psychotherapeutic effectiveness. He suggested with mixed anxiety and resignation, that "Psychotherapy will be dead in six years, and we're all invited to the funeral." (Borriello, 1980).

It is surely not all that bad for therapists to feel troubled about the ambiguous findings of the research. But the potentially beneficial effects of appropriate self doubt must be tied to the stimulus for such self examination. If such doubts arise from the application of inappropriate types of research methodology then a cycle of futility is set in motion. In such a case the uncertainty is of the third type described by Fox, ie., there is uncertainty about the source of the uncertainty itself (Fox, 1957). This type

of "game without end" allows no exit. The system cannot generate the rules necessary to generate new rules.

As scientist-essayist Lewis Thomas has pointed out,

> Science gets most of its information by the process of reductionism, exploring the details, then the details of the details, until the smallest bits of the structure, or the smallest parts of the mechanisms, are laid out for counting and scrutiny. Only when this is done can the investigation be extended to encompass the whole organism or the entire system. So we say.
>
> Sometimes it seems that we take a loss, working this way. Much of today's public anxiety about science is the apprehension that we may forever be overlooking the whole by an endless, obsessive preoccupation with the parts. (Thomas, 1979, p. 7)

Here Thomas questions not the scientific method, but certain canons of scientific technique. The accepted rules of practice in research which lead one social scientist to conclude that:

> The 'objectivity' of the social sciences is not the expression of a dispassionate and detached view of the social world; it is, rather, an ambivalent effort to accomodate to alienation and to express a muted resentment of it.... (Gouldner, 1970, p. 53)

Richard Mann echoes such thoughts, and highlights their applicability to the clinical psychologist in particular;

> When a graduate student finally blurts out his pained awareness that what he most wants to do is utterly deprived of legitimacy, the instructor of the methods course says, "Oh, but you know how much we value exploratory, clinical, impressionistic studies as a first step before the really solid research gets underway."

> And so all of us learn, all of our lives, that what we call our work is trivial in their eyes, that it is nowhere near as serious and valid as what they do, and try so hard to make us do. The very things we most want to do become, in their eyes and gradually in our own as well, some kind of vague sloppy self-indulgence which they hope we will transcend as quickly as possible.
> (Mann, 1974, p. 15)

When one of the clearest outcomes of conventional training and practice of psychotherapy research is that therapists learn to suspect that their work is "soft-headed nonesense" (Will, 1979) or "some kind of vague sloppy self indulgence" (Mann, 1974), research becomes a problem in its own right. Instead of fulfilling the need for investigation, it contributes to uncertainty by adding another and irresolvable source of alienation and doubt.

Not only are issues of outcome, theory, and technique highly uncertain; the conventional ways of resolving such uncertainty may be of little help. Research remains a highly valued way of clarifying uncertainty in practice. But the research must not be fundamentally incompatible with the phenomenon under investigation. When it is, additional uncertainty about the appropriateness of the research itself is added to an already uncertain and ambiguous situation. By "denaturing" the phenomenon of psychotherapy, by defining the self, i.e., the therapist's major guide, as a source of error rather than a tool needing refinement, both research as a pursuit with its own pleasures, and psychotherapy, the

phenomenon under investigation, are all too often (albeit unintentionally) discredited. The result may be aptly described as an "anesthetization of the intellect." (Sennet, 1977). The effect of this may be a deadening of curiosity and imagination rather than an enhancement of the spirit of investigation.

One notion to be explored in the present study is that therapists are not trained in a methodology of investigation that effectively puts their natural curiosity to work on their professional uncertainties. Instead they are often trained to employ "methodology" as a substitute for creative thought. The effect of such an alienating approach to investigation may be a genuine turn toward "vague, sloppy, self-indulgence."

A vicious cycle may therefore result. Increased "scientific" rigor, in the most conventionally mechanical sense, is seen as a counterweight for the vagueness of clinical work. The inappropriateness of this approach however, leads to its essential rejection by clinicians who become detached from systematic investigation. This rejection of an empirical and systematic approach may lead to an approach that really is vague and sloppy; and this vagueness is then seen as justification for a more stringently scientific approach. This sets the cycle in motion again, and so it continues. The result is a kind of

warm-fuzzy, touchy-feely, caricature of intellectual and spiritual sloth. Therapists walk a more dangerous tight-rope than is commonly realized, and this must have an effect.

PART II - MANAGING UNCERTAINTY IN PSYCHOTHERAPY

There has been a growing trend in the social sciences toward studying the impact of the work environment on the emotional health of workers. The expanding literature on "burn-out" is one example of the recognition that the characteristics of the work place and of occupations themselves, are important in understanding both individual behavior and the social conventions of occupational groups. It has been pointed out elsewhere that if psychotherapists are to be helpful in dealing with occupatinal stress in clients' lives, the occupational stresses in therapist's lives should also be recognized (Edelwich and Brodsky, 1980). Psychotherapists believe that a problem that is denied is one that is likely to grow and have negative consequences elsewhere in an individual's life. Clearly then, the occupational problems that psychotherapists encounter are a worthy topic for investigation. The following section will explore some of the literature dealing with therapists' subjective experience of their work.

It is important to distinguish here, between this area and the growing interest in "burn-out". As was mentioned above, there has been an expansion of interest in "burn-out" among therapists, and among members of many other occupations as well (Edelwich and Brodsky, 1980). One major finding when the issue of burn-out is examined among

therapists is that "Constant giving without the compensation of success apparently produces burnout." (Farber and Heifetz, 1982). The present study is partially concerned with this issue. The major emphasis of this study however, is not what causes burnout among therapists; but rather, given the overwhelming number of "burn-out producing" aspects of psychotherapy how do therapists avoid burn-out? Consequently the following discussion focuses on the more global question of how do therapists manage the uncertainties and stresses inherent in their work.

A. Therapists' Subjective Reactions to Their Work

In reviewing the psychodynamically oriented literature one can find ample recognition of the problematic nature of uncertainty in psychotherapeutic practice. Psychodynamcially oriented authors, true to their calling, tend to view the occupational difficulties of psychotherapists as deriving from the history and character of the patient in interaction with the history and character of the therapist. Uncertainty in psychotherapy is thus viewed primarily as a transference - countertransference phenomenon. As such, it is to be dealt with, not surprisingly, through supervision, personal therapy, and psychodynamically informed reflection and consultation with colleagues. The focus is on therapeutic resolution of situational or characterological uncertainty,

rather than on the uncertainty-inducing generic features of the work itself.

Within the sociologically oriented literature, most authors have examined the effect of the training situation on psychotherapy trainees (most frequently, psychiatric residents). While their findings are useful and will also be reviewed, they are limited to training in psychiatry rather than its practice by experienced therapists of varying backgrounds. Any conclusions suggested by this research must therefore be viewed with some caution.

To my knowledge the number of studies that examine the reactions of experienced therapists to their work is extremely small. The few such studies that I have located are also reviewed below. In general it can be said however, that these studies either lack the depth of clinical understanding reflected in the psychodynamically oriented literature or they lack the systems perspective to be found in studies of the training context. Unlike the more clinical literature these studies do focus on the critical interaction between the individual therapist and the social context of psychotherapy - an area generally neglected in the psychodynamically oriented literature.

One especially thorough study (Daniels, 1974) focused on how experienced psychiatrists viewed the problems inherent in their work. The researchers interviewed and

administered a sentence completion task to 152 psychiatrists; 81 were private practitioners; 36 were state hospital employees; and 35 were military psychiatrists. One interesting conclusion was that, "Differences in structural position within the specialty do not affect focus on problems concerning the specialty." (Daniels, 1974, p. 209). In other words, expected differences between psychiatrists practicing in different settings did not emerge to the degree expected.

Instead, the psychiatrists tended with small institution based differences, to bring up very similar issues. The major concerns identified were as follows:

1. Effectiveness of Treatment
    a. Lack of Standards and Techniques: ".....a general uncertainty hovers over the entire field; there is not enough knowledge."
    b. Ambiguity of Results: "There is uncertainty about what effective results should be, how long therapy should take."
    c. Pretending to Possess Expertise: ".....psychiatrists worry about overselling their product."
2. Isolation
    a. Structured Isolation: "The practice is physically isolated or isolating."

b. Isolation From Colleagues: "Psychiatrists also complain that they are too isolated from other medical doctors or from other professionals in related fields."

c. Communication Difficulties: "Psychiatrists see themselves as isolated by lack of opportunity to communicate.....the situation in therapy may appear intimate but actually it is not."

3. Image Trouble - Status Problems

a. Patient Image Trouble: ".....patients do not understand what the limitations of psychiatry are."

b. General Image Trouble: "Psychiatrists feel they are generally seen by both the public or their patients as 'either omnipotent or impotent.'"

c. Status Problems in Medicine: ".....psychiatrists see themselves as terrifically underrated or unappreciated by other physicians....."

d. Psychiatrists Create Image Trouble: "Psychiatrists also criticize their colleagues for not trying hard enough to project an appropriate image.....At the same time, they do oversell the profession."

4. Personal Strains Created by the Work
   a. Work Is Too Hard: "Work is too demanding of the practitioner."
   b. Too Much Pressure: "A psychiatrist should be careful.....it was likely to exacerbate personal weakness."
   c. Not Enough Rewards: ".....you can only make a limited amount of money."
   d. Too Many Temptations: ".....the nature of the work puts temptations in their path to do things they know they ought not to do."
5. Negative Personal Characteristics of Colleagues
   a. Overly Superior; Too Much Social Distance Maintained: ".....psychiatrists are arrogant, unfriendly, and uncommunicative."
   b. Dependent and Overconforming: "They saw their colleagues as "unimaginative, inhibited, lazy and timid."
   c. Mental Illness: "They remarked that their colleagues were "masochistic," "odd," "crazy," "crackpots," "depressed," "senile," "immature"....."

   (Daniels, 1974)

Other authors have written of similar problems psychotherapists face. In his exploration of "Why Psychotherapists Fail," Chessick (1971) identified three

interrelated areas of difficulty that he saw psychotherapists struggling with, they are: (1) the issue of professional identity, i.e., concerns similar to those identified by Daniels related to self-image and status among psychiatrists as compared to other professionals; (2) anxiety over psychological mindedness: i.e., concerns about the therapist's own instinctive and intuitive grasp of psychological processes, and (3) the convinction that psychotherapy is meaningful; i.e., therapists' doubts about the effectiveness of psychotherapy.

Another author has examined the ways in which therapists integrate their work with their own "mid-life crises" (Fisher, 1967). During this developmental crisis, the uncertainties of individual development combine with the uncertainties of psychotherapy. This author identified three types of difficulties therapists may have at the same time, and discussed the ways they sometimes seek to resolve these difficulties. They are: (1) the search for an absolute; i.e., a search for safe certainty in adherence to some theory. (2) the search for self-realization; i.e., a search for means to accomplish personal growth; and (3) a quasi-spiritual quest; i.e., a mystical search for peace of mind. In each of these quests, the therapist is driven by a psychological "critical mass" arrived at by attempting to

do a job full of chronic uncertainty during a time of acute personal uncertainty.

Examining an earlier developmental phase, i.e., psychiatric residency, another author described what he calls the "Moral Career of the Psychiatric Resident." (Light, 1980). During the training period Light saw the resident as going through five stages. He described the first as 'Feeling Different and Being Discredited,' during this phase the psychiatric resident, having achieved a minimal degree of competence as a physician, is required to begin again, learning theories and techniques greatly different from those mastered as a medical student and intern. The result according to Light, is that the resident feels incompetent and uncertain. That uncertainty is heightened by "the vagueness of psychiatric principles". Also there is a tendency for more senior staff (and the residents as well) to apply psychiatric principles "to the residents as well as the patients. In fact, it is not always clear how the two groups differ." (Light, 1980).

The second stage that Light observed is that of 'Moral Confusion.' As he says,

> What constitutes moral conduct is unclear. Is one's first duty to get patients out? Or to sit through their pain and not administer drugs? Many residents are not sure from day to day why they are doing what they do.
> .....Each resident (like each patient) tends to think he alone is so bewildered."
> (Light, 1980, p.249)

The third stage is one of 'Numbness and Exhaustion,' or what has been called "therapeutic nihilism." As Light says, "Nothing seems to work. Everyone is tired.....Everybody says they're sad."

The fourth stage, 'Moral Transition' is marked by "Cynicism, conversion, and (most frequently) working out one's own beliefs within the framework of the program" (Light, 1980, p. 251). One result of this transition is that "trainees increasingly attribute successes to themselves and failures to the patients or to difficulties of the case." Another result of this stage is that residents increasingly value the mastery of technique rather than the achievement of cure. In that way they integrate the frustrations and uncertainties of their work through what Light calls, ".....the narrow morality of technique."

The fifth and final stage that Light describes is 'Self-Affirmation.' During this stage the resident develops a "tendency to reinterpret past traumas and self-doubts by minimizing or even ignoring them."

As in all types of professional socialization, the resident is guided toward an acceptance of the conventions of the profession and an identification with its institutions. In this way, troublesome issues such as generic uncertainty are avoided or explained away. Even raising such isues is discouraged.

Other reactions by therapists to the uncertainty of their work have been described. One such reaction concerns the guilt of the therapist. As Bugental says, ".....each old patient I see again is an accusation; each patient of former years will be in some measure someone who trusted me, and whom I failed by today's standards." And as he goes on to say, ".....I must look at my patients today and know that every one of them is getting less than I hope I will be giving his successor five years hence." (Bugental, 1973, p. 297).

Another writer touches on the issue of guilt by addressing the therapist's inability to transcend (or help the patient transcend) the alienating and oppressive social forces that contribute to the patient's problems. This author points out that the traditional "mechanistic" model of psychopathology may allow therapists to feel that they are ".....not responsible, he has done his best. But what if the therapist treats a Hiroshima maiden for depression. He is no less culpable with the suburban lady. In both instances he is the oppressor." (Levenson, 1972, p. 134). Both Levenson and Bugental see a certain degree of guilt as an inherent consequence of practicing psychotherapy.

Otto Will points to the "daily exposure to madness" (Will, 1979, see also McCarley, 1975) and the transitory nature of therapeutic relationships as occupational hazards

of psychotherapy. He describes the therapist as ".....in a sense a prostitute for the lives of others, a sparring partner, but not a contestant in the 'main event'." And as he points out, "These repeated attachments and losses accent the essential loneliness of our lives." (Will, 1979, p. 571). The loneliness of the therapist has also been noted by others (Daniels, 1974; Kahn-Hut, 1974; McCarley, 1975). In the same paper, Will also discusses stresses imposed by the massive social needs of the public; the relatively small numbers that the therapist can actually treat; the expense of treatment; and the increasingly intrusive pressures of government regulators and insurance carriers.

Eric Fromm saw "unconscious despair" as "the major pitfall of the profession" (Epstein and Feiner, 1979, p. 16), and Bugental too, warns that the therapist who flees from a healthy degree of guilt rather than using it as a spur to growth, may become "despondent or self-punitive." (Bugental, 1973). Kubie too, notes the depression and despair that often leads therapists to "retreat from patients."

> In the present state of knowledge, even the "best" psychiatrist piles up a record of mixed results.....The cumulative score breeds depression and anger rather than complacency. (Kubie, 1972, p. 699)

Searles too, touches upon the problems of isolation, alienation, and emotional remoteness that the practice of

therapy often engenders in therapists. He also discusses the tendency of therapists to hold a rather negative view of their colleagues:

> ".....as we move into being as close to a patient emotionally as we feel the work calls for us to be, I think that we are not able to integrate the most hurtful distancing images which the patient has of us--and which we have of the patient, also. And I think there is a very powerful tendency for those images to get displaced onto the colleagues, and for us to feel those colleagues don't understand us, and feel alienated from them.....in our work with patients we have this simultaneous combination of intimacy and that kind of remoteness, remoteness on our own part toward the patient and remoteness on the patient's part toward us.....
> (Langs and Searles, 1980, p. 87)

B. Managing Uncertainty: Responses of Therapists in the Conduct of Their Work

Therapists find ways to "manage" the problems inherent in their work. Some authors believe stress among therapists is a result of working with difficult patients. Some believe that stress among psychotherapists is a matter of individual psychopathology. Others believe that psychotherapy is stressful because of the very nature and structure of the work itself, over and above the personalities of the participants.

Coser for example, argues that psychiatry is by definition so uncertain a field that psychiatric residents are subject to "structural ambivalence" (Merton and Barber, 1957). This is a condition perhaps similar to the "double bind" (Bateson, et. al., 1954) where people find themselves in situations that require the simultaneous integration of

conflicting sets of expectations and social norms. In the case of the psychiatric resident, one set of conflicting expectations is that (1) the resident knows nothing, (2) the doctor knows best. In other words, as a physician the resident outranks other more expert ward staff who know, as does the resident, that he or she is utterly untrained in making psychiatric judgments or providing expert psychotherapy. Trainees in all fields undergo similar experiences of "learning by doing". With regard to psychiatric residents however, Coser notes the added strain induced by the fact that the resident's high status derives from the relative certainty that comes with medical expertise. This is a type of certainty that the resident cannot make much use of in the more ambiguous climate of the psychiatric hospital.

Another point that Coser makes is that because of a combination of structural forces existing in the training program, residents learn to make use of psychiatric techniques in resolving their uncertainty. These ways of dealing with uncertainty are carried forward into their post-residency professional lives. According to Coser, many of the unquestioned norms of professional conduct have dual purposes. They define the nature of the work while protecting its practioners from doubt. One such social "mechanism of defense" is <u>evasiveness</u>; therapists' tendency

to avoid revealing their own reactions or thoughts. Evasiveness on the part of therapists' is a well accepted principle. It keeps the focus on the patient and nourishes and protects the transference. But as Coser points out,

> One must distinguish between a technique that consists in taking distance from an issue that concerns the self and evasiveness that is used as a structurally induced mechanism of defense against having to deal with an ambiguous issue. (Coser, 1979, p. 107)

Another such mechanism, also a major feature of psychotherapy, is confidentiality. As Coser says,

> The norm of confidentiality legitimizes the insulation from observability and knowledgeability which governs the therapeutic situation, and the therapist is, of course, interested in maintaining this insulation. (Coser, 1979, p. 27)

Yet another structural feature of psychotherapy that functions not only to promote the practice of therapy, but to promote a sense of certainty in the therapist as well, is the private office itself. There the therapist is free from group or organizational demands. Privacy allows therapists to construct reality in accordance with their own notions of what therapy is and how it should be practiced. In other words, the structured isolation of psychotherapy may be subjectively experienced as painful by therapists, but it also allows them to believe whatever they wish to believe about the nature and quality of their work. Privacy may lead to isolation but it allows therapists freedom from observation and disquieting feedback.

Coser is not suggesting that therapists stop being evasive, or stop maintaining confidentiality or practicing in private offices. She is pointing out however, the dual functions of these aspects of therapy and their utility in helping therapists construct reality along less ambiguous lines than psychotherapy provides. Like Kahn-Hut (1974), Light (1980), and Daniels (1974), Coser draws attention to the likelihood that aside from any benefits for the patient, some of the very features of therapy that many therapists complain of, effectively protect therapists' belief in the meaningfulness in their work.

A turn to the "narrow morality of technique" as discussed earlier is another way therapists manage uncertainty. A related way is to turn not only to "microtechniques" (Light, 1980), but to turn to the broader "hidden religions" of dogma that many therapists rely upon." (Wheelis, 1958; Will, 1979; Witenberg, 1977; London, 1964). As Robitscher says of this process:

> At some point in his development he goes through a crisis when he doubts his own therapeutic ability and questions the theories that underly his methods.....The young practitioner reluctantly comes to the conclusion that his discipline "is not what it is represented to be, and he begins to be troubled by a vague sense of fraudulence." From this he can retreat into dogma and abolish his doubts by fiat and eventually he may become a serious defender of orthodoxy.
> (Robitscher, 1980, p. 477) (emphasis added)

Dogmatism is a particularly easy way to manage the uncertainties of psychotherapy. Theoretical and technical ambiguities allow ample space for the generation of theories that are self-sealing. Such theories provide the illusion of certainty in their tautological circularity.

A predictable consequence of the "retreat into dogma" is the protection of the theory against deviance or the posing of difficult questions. Ideological dogmatism explains contradictions between theory and reality by reinterpreting observed events in light of theory. So, for example, ".....a significant number of analysts have dealt with their own protracted failure by calling the patient's efforts incomplete and by represcribing the very medicine that had failed to take effect." (Crews, 1980, p. 28). In this way, the patient, as a witness to the failure of theory or technique, is discredited. The "victim" is blamed (Ryan, 1972).

This danger of so relying upon theoretical orthodoxy that all phenomena must be made to fit within the confines of theory, is well known. As Roy Schafer has pointed out, ".....there is a not uncommon tendency to begin to use technical terminology to derogate analysands who don't work out well. Terms begin to be used really as invectives." (Shafer, 1979, p. 353). Not only patients who "don't work out well," but patients who arouse the anxiety of the

therapist for whatever reason, tend to be held responsible, or are "discredited" when the therapy seems stuck.

> It is an old saw that the more anxious the patient makes the therapist, the more likely he is to label or call names. Clara Thompson once said that whenever a candidate in supervision began referring to an analysed as "schizophrenic" she knew that the therapist was threatened. (Levenson, 1972, p. 201)

Others have noticed the same phenomenon (see Maluccio, 1979; Bart, 1974; Coles, 1975). As Searles has noted,

> Such unconscious scorn for the patient--for the patient's own strength and for his ability to reach out, himself, for help from the therapist, without the therapist's having constantly to keep pushing the help at him seems to me to betray much self-contempt on the part of the therapist. (Searles, 1979, p. 77)

In managing their own feelings of uncertainty and its attendant guilt, depression, loneliness, anxiety, and "self contempt," many therapists turn to reliance upon the privacy of psychotherapy, the adoption of rigid dogmatism, concentration upon technical perfection, and viewing patients with scorn. Daniels (1976) found that most of the therapists she interviewed (79 percent) tended also to be highly critical of their colleagues, a tendency also pointed out by others who have commented on "unwarranted feelings of superiority" (Sharaf and Levinson, 1964) among therapists. Other ways of "managing" the stressful aspects of psychotherapy that have been mentioned are "making and keeping the patient dependent, exaggerating one's power,

handling patients in a grandoise way, or institutionalizing omnipotence....." (Light, 1980, p. 306). Many of these points are extremely well described in Janet Malcolm's recent examination of psychoanalysis through the eyes of one analyist (Malcolm, 1980).

Kubie (1972) speaks of the "flight from patients" as one way young therapists react to the uncertainties of their work. He attributes such a retreat to intrapsychic factors such as "discrepancies between conscious and unconscious goals." (Kubie, 1972, p. 699). He does note however, that the discussion of certain topics in psychotherapy may be discouraged for reasons that are not related to the intrapsychic conflicts of individual therapists but to aspects of the profession itself (Kubie, 1972, p. 704). These prohibited topics are not discussed. But the absence of discussion does not mean that such uncertainties and doubts are not experienced. They are experienced in privacy and reacted to in privacy. This condition, of having reactions that are common but which are felt to be unique has been called "Pluralistic Ignorance" (Merton, 1957). Generic problems are seen as idiosyncratic and are dealt with on the individual level rather than on the level of the profession as a whole. Each therapist feels himself or herself to be the first and only one ever to have experienced such conflict. Clearly, then even

from Kubie's primarily individually oriented point of view, there are problems that arise in the therapist's professional life that are not dealt with effectively within the world of psychotherapy.

Several features of psychotherapy that have already been mentioned contribute to the maintenance of "pluralistic ignorance." Among them are isolation, privacy, and confidentiality. The conventions that govern much of the research in psychotherapy also have the effect of limiting the types of questions that can be asked. When the language of a narrowly defined "science" is the primary language of professional discourse, only those topics amenable to that mode of expression can be raised. As Wittgenstein says, "whereof one cannot speak, thereof one must be silent." (Shapiro, 1979, p. 75). And so the conventions of science, too, contribute to the institutionalization of "pluralistic ignorance." This pluralistic ignorance becomes a part of the structure of psychotherapy and thereby perpetuates itself and the problems that give rise to it.

Another way therapists have been described as managing uncertainty is the tendency of some to become <u>followers of psychotherapeutic "gurus</u>." As Havens says:

> Amid the uncertainties of psychiatry, with its fragmentation and often open conflict, students may fall easy victims to identity diffusion. Confident, attractive, answer giving teachers, therefore, attract enormous followings and may turn out versions of themselves like Fords. If, in addition, the style of

> the teacher fits the temperament of the student, development may stop right there. (Havens, 1973, p. 325)

In his study of a large public mental hospital, Erving Goffman described five "role-redefinitions" that the hospital psychiatrist may adopt (Goffman, 1961). Goffman considers the structure of the hospital, more than the structure of therapy, to be responsible for necessitating such role redefinitions. Nonetheless, his descriptions are relevant in a broader context, particularly considering Daniels' finding that state hospital psychiatrists did not differ greatly from their colleagues in the military or in private practice in the ways they viewed their profession (Daniels, 1974).

The five ways of coping that Goffman observed in hospital based psychiatrists are the following: the wise grandfather - this is the psychiatrist who devotes himself to administration i.e., the "custodial aspects of the institution." Another redefines his role as that of the researcher - i.e., the person who no longer defines his purpose as that of service, but rather sees himself as a scientist. The third role redefinition that Goffman observed is the psychiatrist who retreats into the elitism of paperwork or psychotherapy with staff members and "promising" patients only. Another role is what Goffman calls the "patient's man," or the psychiatrist who is openly critical

of the institution and is seen as "siding" with the patients. The fifth role definition that Goffman describes is the role of cynic; the psychiatrist who primarily expresses dissafection with his position in the hospital, thus seeming to remove any investment in the goals of the system.

Donald Light identified three similar stances among the residents he studied. Some residents became "therapeutic" psychiatrists, i.e., they emerged from the residency having defined their role as therapists above all else. They were less interested in the intellectual and research aspects of psychotherapy, and less interested in managerial activities such as ward administration. Others emerged as psychiatrists whose professional identities centered around patient management; i.e., prescribing medication, ward administration, etc. The third group saw themselves primarily as intellectuals; psychiatrists who practiced in order to further their interest in theory, rather than primarily to help their patients (Light, 1980).

All of the stresses and ways of managing them that have been discussed can be seen as developing (mediated obviously by aspects of personality and character) in response to the practice of psychotherapy. They are all worth studying in psychotherapy perhaps more than in most other professions.

As Robert Coles has said:

> I think that our own lives and problems are part of the therapeutic process. Our feelings, our own disorders and early sorrows are for us in some fashion what the surgeon's skilled hands are for his work.....The psychiatrist's hands are himself, his life. (Coles, 1975, p. 12)

Surgeons know the strains their work imposes on their hands (if not their psyches), and they use that knowledge to protect them. In the case of psychotherapy this tends to be less true. To be sure, therapists study themselves and for many, personal therapy becomes "a way of life." (Henry, Sims and Spray, 1973; Whitaker & Malone, 1953). Therapists often focus great attention on the neurotic needs or maladaptive qualities they carry into professional life. Sometimes in supervision they examine the countertransference reactions that specific patients or categories of patients elicit from them. Less attention is paid however, to the phenomenology of the work itself and its impact on therapists. To the degree that therapists are reluctant or ill-equipped to examine the social and occupational forces that impinge on their lives, they become insensitive to the social and structural forces that impinge their patients' lives as well. Furthermore, they develop and maintain "blind spots" in their own experience and about the interface between the personal world and the social world.

Summary and Conclusions

Part I of this chapter advanced the notion that the practice of psychotherapy is subject to a high degree of uncertainty. The notion that uncertainty is an inherent characteristic of psychotherapy is in itself neither surprising nor particularly interesting. All professions are to some degree ambiguous and uncertain; indeed, the reliance upon informed individual judgment in ambiguous situations is a distinguishing characteristic of all professions. What makes psychotherapy a critical example and what distinguishes it among professions, is the nature and extent of that uncertainty.

The combination of ambiguity in outcome, theory, and technique places the psychotherapist in a situation that may be unusually conducive to particularistic, unintegrated, and therefore ineffective or inconsistant decisionmaking. The potential consequences of such a condition of uncertainty in the realm of everyday practice is clear. To mangle a phrase of Dostoevsky's, "If there is no guide, all things are possible", and accordingly, virtually everything has at one time or another been called psychotherapy.

Part II of this chapter reviewed two aspects of psychotherapy from the point of view of the therapist. One section reviewed some of the literature on the subjective

experiences that therapists associate with their work. The other section examined some of the everyday characteristics of psychotherapeutic work that may be both sources and effects of uncertainty in psychotherapy.

The point of view of the present study is that the multiple areas of uncertainty in psychotherapy call forth responses in both the personal and the professional realms. Personal, i.e., individual responses to the uncertainty of psychotherapy can be found in both the general and unique practices and beliefs of therapists, and in their subjective feelings and attitudes about their work. Responses of psychotherapists to the uncertainty of their work are evident in the settings in which psychotherapy is practiced as well as in the idiosyncratic values of individual therapists.

While they may be looked at separately, the two realms, i.e., the personal and the professional, are more accurately seen as interrelated and dynamically interactive. Indeed, one of the problems in psychotherapy and in the research about where and how psychotherapy is done, has been the tendency of researchers, teachers, and therapists, to see the two realms as separable. It is a central thesis of the present study that both the personal and the professional aspects of psychotherapy must be studied jointly, and one intention of the present study is to do so.

Statement of the Problem

The primary objective of this study is the examination of the ways in which clinical psychologists "manage," or make sense of their work. Of particular interest are the ways therapists manage the ambiguity of psychotherapeutic practice and technique. To focus the problem more closely; (1) clinical work is inherently uncertain and ambiguous; (2) much of what are assumed to be merely the everyday attitudes and practices of psychotherapists may protect them from the experience of uncertainty or may help them resolve it; and (3) much of the research in psychotherapy and the conventional ways of carrying out that research neither reduce uncertainty nor alter practice. In fact this approach to investigation may exacerbate problems of uncertainty for some therapists.

The major purpose of the present study is an investigation of the ways that clinical psychologists build a more certain reality than the objective conditions of their work would seem to allow. An additional sub-purpose, and one not unrelated to the primary purpose, is to examine the "clinician - researcher" aspect of clinical psychology in light of the fact that few clinical psychologists continue as active researchers past the completion of their training. Some causes and possible consequences of this

inactivity will be examined.

With regard to the ways clinical psychologists "manage" the work of psychotherapy, this is to my knowledge, the first study that focuses exclusively on the experiences of psychologists as clinicians. Such a study may not only contribute to a more thorough understanding of clinical psychologists and psychotherapists in general, but may also contribute to the growing literature on the nature of work and the interaction between the worker and the work situation. Such a study can explore those aspects of psychotherapy as it is commonly practiced that may be psychologically costly not only to the therapist and the patient, but to the field in general.

Because much of the work done previously in this area focuses on the socialization process in becoming psychotherapists, little is known about the experience of more mature clinicians. The study examines those practitioners who are the everyday representatives of what clinical psychology is, and who presumably have come to terms with the nature and difficulties of their work.

This study explores the following questions, all of which are suggested in the literature about psychotherapy but rarely explored in depth and never focused specifically on clinical psychologists.

1. What types of dilemmas do clinical psychologists experience in their work as therapists?

2. What tacit principles, predispositions, or "theories in use" (Argyris, 1974) guide clincical psychologists' reactions to the uncertainty of psychotherapy?

3. How do the dilemmas that clinical psychologists experience in their work relate to uncertainty in psychotherapy?

4. What are the explicit principles, or "espoused theories" (Argyris, 1974) that guide clinical psychologists' reactions to the uncertainty of psychotherapy?

5. What role does research play in the professional lives and self images of clinical psychologists who practice psychotherapy?

6. Do clinical psychologists experience the imbalance between their clinical and their research efforts as conflictual? If so, how do they resolve such conflict? If not, how do they understand this disparity?

7. What effect does training in research have on the ways clinical psychologists practice psychotherapy?

8. Are clinical psychologists satisfied with their research training?

    1. If yes, in what ways?

    2. If not, in what ways?

CHAPTER II

METHODS AND PROCEDURES

Respondents

The participants in this study were 35 licensed clinical psychologists from the greater Washington, D.C. metropolitan area. Most of them were full-time private practitioners of psychotherapy; all were involved at least part time in private practice. They were well balanced along the lines of age, sex, and experience level, and are described more fully in Chapter 3.

Selection and Contact Procedure

The participants were drawn from the Washington, D.C. Yellow Pages listing of more than 200 licensed clinical psychologists. A pool of potential respondents was created by listing every fifth psychologist and repeating that process until the list contained 110 names. After this master list was created, were contacted potential respondents by telephone. In the process of securing the participation of 35 subjects, 78 psychologists were contacted - an overall acceptance rate of 45%.

During the initial telephone contact, these psychologists were invited to participate in the research by

consenting to a semi-structured interview. The study was described as an examination of clinical psychologists' ideas and feelings about various aspects of their work (see Appendix A (p. 173) for the standard telephone introduction). Potential respondents were advised that the interview would require up to two hours of their time and could be arranged at their convenience. They were also promised that confidentiality would be maintained, and their names would appear nowhere in the data. All potential respondents were assured that any questions they had about the study would be answered as fully as possible after the interview. All interviews were conducted at the respondents' offices. Interviewing began in July 1981 and was completed in January 1982.

Pilot Work

Prior to the actual collection of data, a series of pilot studies was done to perfect the instruments for this work. The first two pilot studies consisted of brief questionnaires, each filled out in writing by ten therapists associated with a public mental hospital in Washington, D.C. These therapists included psychologists, psychiatrists, and social workers. The questionnaires were designed to elicit differing aspects of therapists' experience of certainty and uncertainty in their work.

The results of these pilot studies indicated that uncertainty was a worthwhile area for more extended exploration. The brevity of the written responses and the limited focus of the questions themselves suggested that a more extended measure was needed and that interviews would allow a more meaningful focus on the issues to be studied.

It was also concluded that a focus on clinical psychologists alone would be a more appropriate vehicle for data gathering. Consequently a third pilot study was devised. This work included a broader range of open-ended questions, a set of incomplete sentences adapted from a previous study (Kahn-Hut, 1974), and a demographic questionnaire. This interview schedule was administered to six clinical psychologists. The interviews were transcribed and on the basis of this study revisions were made on the interview format. A final format was then synthesized.

Interview Schedule

The data consisted of participants' responses to two questionnaires. One questionnaire was a paper and pencil survey of various aspects of their professional careers and typical work weeks. Information obtained included their age, gender, years since earning the Ph.D., licensure, and personal psychotherapy experiences. Information about the number of hours per week spent in various professional

activities was also obtained (see Appendix A, p. 174-176) for a copy of this questionnaire.)

The second questionnaire was administered as a semi-structured interview and consisted of 17 open-ended questions followed by a series of 14 incomplete sentences (see Appendix A, p. 177-179) for a copy of this questionnaire). Incomplete sentence stems were adapted partially from Kahn-Hut (1974) and some were generated for this study. The interview as well as the incomplete sentences addressed respondents' subjects' attitudes and experiences regarding the following areas:

1) Their early expectations about clinical psychology as a profession.
2) Their present attitudes and experiences regarding various aspects of their profession, including:
    a) Clinical psychology as compared to other disci plines within the mental health professions.
    b) Occupational strains or pressures associated with the practice of psychotherapy.
    c) The balance between their personal and professional lives.
    d) Whether their notions of what psychotherapy can accomplish have changed since the early stages of their careers, and how these notions have changed.

e) Their definition of successful therapy illustrated through discussion of specific cases deemed by them to have been "successful". What did they do to facilitate that success?

f) Their definition of unsuccessful therapy through discussion of specific cases deemed by them to have been "unsuccessful". What would they do differently now?

g) Tactical or strategic problems they are presently concerned about in psychotherapy through discussion of current problems with specific cases. How will they go about resolving these problems?

3) Their attitudes toward, and degree of contact with colleagues. Do they see enough of colleagues? What do they discuss when they see their colleagues?

4) Their general theoretical orientation, and works in the professional literature that they admire.

5) Their assessment of their training experiences - particulary those aspects of their training they defined as most and least valuable.

6) Their use of research literature in their present work. Which studies have most influenced their work?

7) The degree to which they are currently active as researchers.

8) Their attitudes toward research as part of the "job description" of the clinical psychologist.

9) Whether they experience uncertainty as a major characteristic of their work. How do they deal with this uncertainty if they do experience it?

Thirty-three of the interviews were tape recorded, all with the subjects' knowledge and consent (2 subjects did not consent to tape recording and these interviews were not recorded). In addition to tape recording, copious, nearly verbatim notes were taken during all of the interviews. The basic data in this report consists of transcripts of the 33 taped interviews, and verbatim notes from the two interviews that were not taped, as well as the paper and pencil demographic questionnaire data collected from all 35 subjects.

Data Reduction and Rating Procedure

Two sets of ratings of the interview transcripts were employed in the process of data reduction. One set

consisted of a series of 74 Likert-type scales designed to address six of the eight research questions described in the statement of the problem. Two advanced graduate students in clinical psychology rated the 35 interview transcripts using the Likert type scales described above. Several meetings were held with the researcher during which the raters were able to clarify their understanding of the scales and apply them to pilot interview transcripts.

When a reliable degree of interrater agreement was reached with the pilot data, raters began rating the 35 interviews. Meetings were held after each 5 of the first 15 interviews were rated. During these meetings interrater reliabilities were calculated and any problems were discussed. Appendix B (p. 180-187) contains a full list of the Likert Scales. Instructions to Raters are contained in Appendix D, p. 195.

The research questions are as follows:

Question I: What types of dilemmas do clinical psychologists experience in their therapeutic work?

Thirty-eight Likert type scales were devised to respond to this question (Scales 1-38). Thirty-eight scales were chosen in order to cover as wide a range of dilemmas as possible. A smaller number of scales would not have covered a wide enough range. A much larger number of scales would have been both unwieldy and too detailed. The scales were created by the researcher and touched upon

areas described as problematic by interview participants, pilot study participants, and the literature on psychotherapists' experiences of their work. Ratings ranged from 1 (very concerned), to 5 (very unconcerned) on a variety of issues regarding:

a) Aspects of psychotherapy; e.g. how to know when therapy is successful; the therapist's own skill level; ethical questions; and errors the therapist is concerned about;

b) Specific problems with patients e.g. anger toward patients; management problems; suicide;

c) The therapist's feelings about his or her work: e.q. stress, anxiety, isolation;

d) The therapist's attitudes toward colleagues: e.g. reliance, rejection, cooperation.

The complete set of scales for this and the remaining ratings along with thir anchoring points are presented in Appendix B, pp. 180-182.

Question 2: What principles, predispositions, or tacit "theories in use" guide clinical psychologists' reactions to therapeutic uncertainty?

The Q-Sort is a method introduced by Stephenson (1953) and developed more fully by Block (1961). This method relies upon ratings done by trained observers. The observers are required to describe subjects through the use

of a series of statements which the raters sort into a normal distribution according to the degree of salience each statement has as a descriptor of the respondent.

The method has the advantage that it can quantify very diverse and imprecise information, and reduce it to a standard metric. This method was chosen in particular as a way of quantifying the respondent data to answer Question 2. In order to do this a relevant Q-deck needed to be generated. Appendix B, p. 188-192 presents the final set of items used here.

The Q-deck of statements was generated in the following manner:

1) A list of 229 statements describing therapists' beliefs and approaches to psychotherapy were generated from:
   a) pilot study data
   b) a reading of the interviews
   c) the literature on therapists' reactions to their work
2) Q-Sorts using all 229 statements were done by the researcher, on 6 transcripts of pilot interviews.

3) The 100 statements that appeared most frequently were selected and revised to clarify their content where that seemed necessary.

4) Q-Sorts using the 100 item deck were then done on 6 additional pilot interviews.

5) To assess the stability of these ratings, and indirectly to test the question of whether a denotable set of characteristics could be rated, this process was repeated after an interval of approximately 10 days and a calculation of the test-retest reliability was done. This was sufficiently acceptable to justify using the deck on the respondent data.

When the deck was in final form two additional raters, 4th year clinical psychology graduate students, one male, one female, were trained to use the deck. During the initial training the nature of the Q-Sort task was explained and pilot-study interviews were rated. After these ratings were completed, the raters met with the author again, and unclear statements were clarified. In some cases the statements were revised along lines suggested by the raters. When an adequate degree of interrater agreement (72%) was achieved on pilot data, rating of the research interviews began. Meetings were held after each 5 of the first fifteen interviews had been

rated. During these meetings initial reliabilities were estimated and any problems that had arisen were discussed.

Q-Sort items are placed in categories ranging from 9 (most characteristic or salient statements) to 1 (least characteristic, or negatively salient statements), with the most neutral items in group 5. The specified number of statements allotted per group was as follows:

Group		Number of Statements
9	extremely characteristic or salient	5
8	quite characteristic or salient	8
7	fairly characteristic or salient	12
6	somewhat characteristic or salient	16
5	relatively neutral or unimportant	18
4	somewhat uncharacteristic or negatively salient	16
3	fairly uncharacteristic or negatively salient	12
2	quite uncharacteristic or negatively salient	8
1	extremely uncharacteristic or negatively salient	5
9 groups		100 Statements

Final Q-Sort scores on each item were determined by adding the two raters' scores together (i.e., a final score on an individual Q-deck item could range from 2 to 18), and a final score on an individual Likert scale could range from 2 to 10).

Question 3: How do the dilemmas or problems that clinical psychologists experience in their work relate to uncertainty in theory, technique, and outcome? There were no scales or ratings specifically addressed to this question. Instead, this question is addressed by examining the relationships between the responses already given to Questions 1 and 2.

Question 4: How do clinical psycholgists explicitly view the uncertainties of their work?

Eleven Likert-type scales were devised to respond to this question (Scales 39-49). Again, the interviews, pilot studies, and review of the literature contributed to the creation of these scales. Ratings ranged from 1 (very characteristic) to 5 (very uncharacteristic) on a variety of attitudes or approaches toward uncertainty. These attitudes ranged from:

a) an acceptance of the presence of uncertainty in psychotherapy
b) ways to deal with uncertainty; ways to minimize uncertainty
c) a rejection of uncertainty as an important aspect of psychotherapy. These scales are shown in Appendix B, p. 183.

Question 5: Do clinical Psychologists experience the imbalance between their clinical and their research efforts as conflictual?

Three Likert-type scales (Scales 50-52): were devised to assess this area. These scales are presented in Appendix B, p. 184.

Question 6 How do clinical psychologists resolve the imbalance between their clinical and their research activity?

Eight scales (Scales 53-60), were devised to respond to this question. Ratings ranged from 1 (very characteristic) to 5 (very uncharacteristic) on a variety of attitudes toward research.

Once again these scales were drawn from the interviews, pilot studies, and a review of the literature. They are shown in Appendix B, p. 185.

Question 7: What effect does training in research have on the way clinical psychologists do psychotherapy?

Nine scales (Scales 61-69), were devised to respond to this question. These scales concerned:

a) The respondents' view of the relevance of their research experiences in graduate school to a variety of present day clinical activities such as testing, therapy, consultation, and research.

b) An overall assessment of their graduate school research experiences.

c) Attitudes toward the role of research in the work-life of psychotherapists.

These scales are shown in Appendix B, pp. 185-186.

Question 8: Are clinical psychologists satisfied with their research training?

Five scales (Scales 70-74), were devised to respond to this question. They were designed to address the degree

to which the respondents viewed their research training as:

a) relevant to their clinical training.

b) satisfactory as training in research methodology.

c) important to their professional identities as psychologists.

These scales are shown in Appendix B, p. 187.

CHAPTER III

RESULTS

I. Descriptive Characteristics of The Study Sample

As was noted in Chapter 2, respondents in the present study are 35 licensed clinical psychologists from the Washington, D.C. metropolitan area. Demographic data concerning aspects of their professional backgrounds and current activities are summarized in Table 1 below.

Insert Table 1 About Here

As Table 1 indicates, the present sample consists largely of a group of experienced male and female psychotherapists who spend the majority (76%) of their working time in the practice of psychotherapy. By far the largest portion of the respondents' professional time is spent in the practice of individual psychotherapy (56%). The percentage of their time that they spend doing group, family, and marital therapy combined adds up to about 20% of their total professional working hours and about 26% of their psychotherapeutic practice.

Table 1

Descriptive Characteristics of the Study Sample

N=35 (17 females; 18 males)

	$\bar{x}$	SD	approx. % of professional time
Age	45	8.8	--
Years since Ph.D.	13.3	7.4	--
Years as a psychotherapist	13.8	7.5	--
Number of publications*	2.9	5.3	--
Number of times in personal therapy (N=34)	2.2	1.4	--
Total number of years in personal therapy	5.7	4.1	--
Satisfaction with personal therapy (1=very unsatisfied, 4=very satisfied)	3.3	.7	--
Average work/week (total hours)	36.2	3.1	--
Hours of psychotherapy (total)	27.6	9.5	76
Individual psychotherapy	20.3	8.7	56
Group psychotherapy	2.9	4.7	8
Family psychotherapy	2.7	3.2	7
Other (marital)	1.7	3.5	5
Hours of teaching	.7	1.4	2
Hours of research (N=9)	.8	1.8	2
Hours of supervision (paid, for self)	.7	.9	2
Hours of supervision of students	.8	1.0	2
Hours of supervision of peers	.8	1.0	2
Hours of diagnostic testing	2.3	5.4	6
Hours of consulting	1.1	3.5	3
Hours of administration (billing, phone calls)	1.4	2.3	4

*for subjects who have published N=18, $\bar{x}$=5.7 S.D.=6.2

Other professional activities, aside from psychotherapy are minimal; these include teaching (2%), research (2%), personal supervision for the therapist (4%), supervision of students (2%), diagnostic testing (6%), consultation (3%) and administrative tasks such as billing, making and returning telephone calls, etc. (4%).

Respondents have had their Ph.D's an average of more than 13 years and have practiced psychotherapy for roughly the same number of years. Half of them have published in the professional literature since completing their Ph.D.'s (N=18) Among those who have published, the average number of publications is 5.7.

All but one of the respondents have been in psychotherapy at least once, and the average number of courses of psychotherapy per person is 2.2. The mean combined number of years spent in therapy is 5.7 years per person. Respondents were asked to rate the degree to which they believed the therapy they had received was successful. This rating was done on a 4 point scale ranging from very unsuccessful (a rating of 1) to very successful (a rating of 4). The average rating was 3.3, indicating that overall, these therapists rate their personal psychotherapy experiences as having been moderately to very successful.

One purpose of the present study was to investigate whether, or to what degree, such characteristics as gender,

experience level, type of therapeutic practice, research involvement and publication history were related to the way therapists viewed their work. Accordingly, more detailed attention was paid to these variables; this information is presented in Table 2 below. Table 2 presents means and standard deviations on these variables for the total sample, and is also broken down into a variety of subcategories. A correlation matrix showing the degree to which these variables are interrelated can be found in Appendix C, p. 194.

Insert Table 2 About Here

As is apparent from an inspection of these data, the present group is generally quite homogeneous. The only variables that are significantly correlated are those related to the males in the sample's somewhat greater average age ($\bar{x}$=47.7 for males, $\bar{x}$=42.1 for females). Gender (i.e., in the present data, being female, since this was scored 2, while being male was scored 1) is negatively correlated with age (r=-.37, $p<.05$); and with experience level (r=-.49, $p<.02$): experience level and age are also significantly related. (r=.54, $p<.02$). As was indicated earlier, both males and females earned their Ph.D's at an

Table 2

Demographic Characteristics of The Total Study Sample: Broken down by gender, experience level, hours per week of psychotherapy, research activity, and publication history.

			Sex		Age		Years Since Ph.D		Hours/Week of Psycho-therapy		Hours/week research		#Publica-tions	
		Total	M	F	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
Total Sample		35	18	17	45	8.8	13.3	7.4	27.6	9.5	.8	1.76	2.9	5.3
sex	male	18	18	-	47.7	8.5	16.2	7.8	29.6	9.6	1.3	2.2	4.4	6.9
	female	17	-	17	42.1	8.3	10.3	5.8	25.6	9.2	.3	1.0	1.4	1.6
years since Ph.D.	>13	16	13	3	50.4	7.4	19.9	5.7	28.8	10.2	1.23	2.2	1.4	1.6
	<12	19	5	14	40.3	7.5	7.8	2.5	26.7	9.0	.4	1.0	4.6	7.0
hours/week psychotherapy	>27	18	8	10	45.7	7.4	12.4	6.3	35.0	5.7	.55	1.2	2.1	4.7
	<27	17	10	7	44.2	10.2	14.4	8.6	19.9	5.7	1.10	2.2	3.8	5.8
research	yes	9	7	2	45.3	12.8	14.4	9.4	25.4	11.3	3.1	2.3	5.1	7.3
	no	26	11	15	44.9	7.3	13.0	6.8	28.4	8.9	-	-	2.2	4.3
publish	yes	18	9	9	43.3	9.7	12.7	7.7	25.6	10.5	1.20	2.1	5.7	6.2
	no	17	9	8	46.8	7.6	14.0	7.3	29.8	7.9	.35	1.2	-	-

an average age of 32. The greater average age of the men is thus also reflected in their having their Ph.D.'s for a longer time.

With regard to the remaining descriptive variables, there were no other significant correlations. Thus, for this group of psychologists, the demographic variables are not interrelated in any substantial way. There are no significant relationships between demographic variables and characteristics such as publishing or not publishing, doing or not doing research, working full-time or part-time as a psychotherapist.

II. Research Questions

As was discussed in Chapter II, the basic data for this study consists of ratings of the 35 interview transcripts on 74 relevant Likert-type scales, and utilization of a Q-Sorted set of statements that also quantified the interview findings. The research questions are listed below in Table 3, along with the measures designed to address each one. Two raters rated each measure (scale, Q-Sort): Ratings were then pooled to obtain a respondent's score. Interrater reliabilities for the scales related to each research question are reported in Table 3 along with the overall interrater reliabilities. Coefficient Alpha was the statistic calculated to indicate reliability (Hunter, 1977, p. 103).

Insert Table 3 About Here

As Table 3 indicates, interrater reliability for the entire set of 74 Likert-type scales was .86 and for the Q-Sort, .77. Interrater reliabilities above .75 were considered acceptable; all but one of the measures exceeded this criterion. Thus, overall reliabilities are quite acceptable.

* * *

This study is in two parts. One part examines the role of uncertainty in the professional lives of the therapists interviewed. The other part examines the role of research in their professional lives. Four questions address each of these parts of the study. Both the Likert scales and the Q- Sort involved in scaling these questions were subjected to confirmatory factor (cluster) analysis (Hunter, 1977), as a way of simplifying and reducing the large number of scales and items that deal with each research question. Two sets of cluster analyses were performed. The first such analysis was of the Likert-scales. The Likert scales designed to address each research question were submitted in the initial analysis.

Table 3

Scale Numbers Corresponding to the Different Research Questions and Mean Inter-rater Reliabilities for These Measures

Research Questions	Scales	Inter-rater Reliability (Alpha)
1. What types of dilemmas (or problems) do clinical psychologists experience in their therapeutic work?	1-38	.84
3. How do the dilemmas that clinical psychologists experience in their work relate to uncertainty in theory, technique, and outcome?	39-49	.75
4. How do clinical psychologists explicitly view the uncertainties in their work?	addressed by relationships between questions 1 and 2	
5. Do clinical psychologists experience the imbalance between their clinical and their research efforts as conflictual?	50-52	.84
6. How do clinical psychologists resolve the imbalance between their clinical and their research activities?	53-60	.85
7. What effect (if any) does training in research have on the way clinical psychologists do psychotherapy?	61-69	.87
8. Are clinical psychologists satisfied with their research training?	70-74	.87
Overall mean reliability of Likert Scales	1-74	.86
2. What tacit principles, predispositions or "theories in use" guide clinical psychologists' reactions to the uncertainty of psychotherapy?	Q-Deck	.77

Scales that failed to meet the criteria for inclusion in the clusters were placed in a residual cluster. The analysis was repeated until clusters were formed that best met internal and external statistical criteria as well as the criterion of homogeneity in content. Cluster analysis was also performed on the entire set of Q-deck ratings (Hunter, 1977). The clusters that were formed in these analyses and their interrelationships form the basis for this discussion. The four questions that address the issue of uncertainty will be discussed first.

Question 1: <u>What types of problems or dilemmas do clinical psychologists experience in their therapeutic work?</u>

The scales originally designed to respond to this question were Likert scales 1-38 (scales 34-38 were added at the suggestion of the raters). Cluster analysis of these scales yielded 6 clusters that summarize the content domain assessed by these scales. The cluster names, along with sample high loaded items, are shown in Table 4. To distinguish these clusters from the later analyses they are identified by Roman numerals.

Insert Table 4 About Here

Table 4

Sample (High Loading) Scales from Likert Problem Clusters I-VI

Scale		loading in cluster
	Cluster I: Personal vs. Professional Life	
30	How to keep occupational stress from spilling over into personal life	.79
31	How to balance the needs of patients against those of family members and/or friends	.79
	Cluster II: Concern about earning fees	
15	Whether the therapist really earns the fees patients pay	.78
33	Saving time for reduced fee patients	.78
	Cluster III: Uncertainty about technique	
17	About specific mistakes the therapist has made or tends to make in therapy	.94
48	The way to deal with uncertainty is to seek supervision	.80
	Cluster IV: Self-Disclosure	
13	How much of the therapist's own history and current life situation to reveal to patients	.97
14	How to answer questions about the therapists' history and current life situation	.97
	Cluster V: Ethical Concerns	
8	How to deal with feelings of dislike or contempt for a patient	.83
34	About the therapist's own ethical standards	.70
	Cluster VI: Concern about lack of therapeutic theory and guidelines	
26	About the absence of a generally accepted theory of psychotherapy	.85
27	About the absence of clear technical guidelines for doing therapy	.85

The clusters form a continuum ranging from those general to all professions on the one end, to those specific to psychotherapy on the other. They are numbered and will be discussed in that order beginning with the clusters that describe problems or dilemmas that are generally characteristic for professionals.

1. (Cluster I) Personal Life vs. Professional Life

This cluster consisted of two scales. One of them referred to the difficulty of balancing the demands of professional life against those of family and friends. The other scale referred to therapist concerns about how to keep occupational stress from spilling over into personal life. These scales belong at the "general" end of the continuum because they are not unique to psychotherapists. They reflect concerns to which anyone in a demanding occupation might be susceptible. The majority of the people studied in this project were rated as somewhat concerned about this issue. These scales, along with their mean ratings and standard deviations are present in Table 5.

Insert Table 5 About Here

Table 5

Cluster I: Likert Scales Related to Therapist Concerns About the Separation Between Personal and Professional Life

Scales	$\bar{x}$	SD	loading
30 About how to keep occupational stress from spilling over into personal life	4.3	1.5	.79
31 About how to balance the needs of patients against those of family members and/or friends	5.3	1.3	.79

scale: 2=very concerned; 10=very unconcerned

2. (Cluster II) Concern about earning fees.

This cluster too consisted of two scales, and it also belongs on the more general end of the continuum. One scale referred to therapists' concern over whether they were earning the fees paid to them by patients. The other scale referred to therapists' concern over whether they had reserved enough time to see patients unable to pay their full fees. These scales, like the ones referring to the separation between personal and professional life, reflect concerns that are not at all unique to psychotherapists. Concerns about earning fees or reserving time for reduced-fee clients exist to some degree in professions that are practiced in a context of greater relative certainty. Lawyers, physicians and other professionals certainly share such concerns at times. This cluster, along with the scale means and standard deviations, is presented in Table 6.

Insert Table 6 About Here

Mean scores on the individual scales indicate that as a group, the psychologists in the present sample tended to be somewhat unconcerned about these issues as applied to them. Female therapists did tend to be less concerned about this issue than male therapists however. This is indicated by

Table 6

Cluster II: Likert Scales Related to Therapist Concerns About Whether Fees Are Really Earned

Scales	$\bar{x}$	SD	load-ing
15 Whether the therapist is really earning the money that patient pays for therapy	5.1	1.3	.78
33 About saving time for reduced-fee patients	5.9	.6	.78

scale: 2=very concerned; 10=very unconcerned

the significant correlation (r =-.38, $p<.05$) between gender and concern about whether fees are earned.

3. (Cluster III) Uncertainty in technique

This cluster consists of four scales. Unlike the two preceeding clusters, this one is somewhat more specific to professional uncertainty as it refers to psychotherapy. The four scales that make up this cluster address two areas of uncertainty (uncertainty about issues of therapeutic technique and uncertainty about the status of psychologists as compared to other mental health professionals) and one method for dealing with uncertainty (i.e. supervision). The issue of clinical psychologists' concern over status is not obviously related to uncertainty. Its correlation with scales more clearly linked to competence issues reflects the concern or lack of concern that psychologists have about their comparative status in the mental health professions. This cluster along with item means and standard deviations is presented in Table 7. Scores generated by the sample generally indicate that these psychologists were somewhat concerned about these issues.

Insert Table 7 About Here

Table 7

Cluster III: Likert Scales Related to Therapist Concern About Uncertainty in Technique

Scales	$\bar{x}$	SD	loading
17 About specific mistakes the therapist has made or tends to make in therapy	4.9	1.3	.94
*48 The way to deal with uncertainty is to seek supervision	3.7	2.1	.80
23 About the status of clinical psychologists as compared to other mental health professionals	4.2	1.6	.68
16 Whether the therapist's technical skills are of adequate range or quality	4.3	1.6	.54

*originally designed to respond to research question 3

Scales: 16, 17, 23 2=very concerned; 10=very unconcerned

48 2=very characteristic;10=very uncharacteristic

4. (Cluster IV) Self-Disclosure

This cluster is made up of 2 scales both of which refer to therapists' concern over how much of their own lives to reveal to patients. One scale refers to the issue of how much information therapists should reveal about their own lives. The other scale refers to how to answer clients' questions about the therapist's own history and current life situation. Because of the content of these scales, the cluster is described as having to do with issues of self- disclosure. This cluster along with item means and standard deviations is presented in Table 8.

Insert Table 8 About Here

An examination of the scale means indicates that these therapists on the whole tended to be slightly unconcerned about this issue.

5. (Cluster V) Ethical Concerns

The eleven scales that comprise this cluster touch upon several different issues of particular salience in psychotherapy. These scales are described as having to do with ethical issues because they touch upon such questions of impulse control as how to deal with sexual, aggressive or disapproving feelings toward patients. In addition to these issues, this cluster touches upon more clearly ethical concerns such as therapists' doubts about their own

Table 8

Cluster IV: Likert Scales Related to Therapist Concerns About Self-Disclosure

Scales	$\bar{x}$	SD	loading
13 How much of the therapist's own history and current life situation to reveal to patients voluntarily	5.7	2.6	.97
14 How to answer questions about the therapist's history and current life situation	5.6	2.5	.97

scale: 2=very concerned; 10=very unconcerned

ethical standards and concerns about the possibility of malpractice suits. Mean ratings on these scales show that this sample was rated as slightly concerned about these issues.

This cluster also included scales that deal with uncertainty about outcome in psychotherapy and the difficulties of working with specific categories of patients. Mean ratings on these scales show that this sample was rated as somewhat concerned about these issues. This cluster is presented along with scale means and standard deviations in Table 9.

Insert Table 9 About Here

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6. (Cluster VI) Concern About Lack of Therapeutic Theory and Guidelines

The final cluster - and the one most specific to psychotherapy - concerns the absence of clear and universally accepted guidelines in theory or technique of psychotherapy. This cluster consists of two scales, one referring to uncertainty in theory; the other referring to uncertainty in technique. Specifically, the scales refer to therapists' concern over the lack of clear guidelines in these areas. Because the therapists' concern in these

Table 9

Cluster V: Likert Scales Related to Therapist Concern About Ethical Issues

Scales	$\bar{x}$	SD	loading
8 How to deal with feelings of dislike or contempt for a patient	5.4	1.2	.83
10 What to do if the therapist disapproves of a relationship a patient is involved in	5.9	.85	.82
6 How to deal with sexual attraction to patients	5.9	.93	.76
9 What to do if the therapist disapproves of a decision the patient has made	5.6	1.2	.74
34 Concerns about the therapist's own ethical standards	5.4	1.0	.70
18 About problems that arise in working with specific categories of patients	4.4	1.2	.69
7 How to deal with a patient's sexual attraction to the therapist	5.8	1.0	.68
1 How to know when therapy should be terminated	5.1	1.4	.66
* 2 How to determine whether therapy has been successful	4.7	1.7	.65
35 About how to deal with anger toward a patient	4.9	1.4	.64
24 About the possibility of malpractice actions	5.6	1.1	.61

*Variables reflected for inclusion in cluster. Means shown are not reflected.

Scale: 2=very concerned;10=very unconcerned

scales is about issues concerning psychotherapy as a profession, this cluster is placed at the extreme "specific" end of the continuum. This cluster, along with scale means and standard deviations is presented in Table 10. Mean scores show that on the whole, the respondents tended to be slightly unconcerned about this issue.

Insert Table 10 About Here

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* * *

The relationships among these problem clusters and between these clusters and the demographic variables were correlated. This matrix is presented in Appendix C, p. 194. Correlations were computed in order to determine the degree to which the problem clusters related to question 1 were inter-related. In addition, correlations between these problem clusters and the demographic variables were done to examine possible demographic differences in degree of concern over these areas. The significant relationships are discussed below and are depicted in Figure 1. The figure is a heuristic device, utilized here to chart the degree of common relationship among the variables.

Table 10

Cluster VI: Likert Scales Related to Therapist Concern About Lack of Therapeutic Theory and Guidelines

Scales	$\bar{x}$	SD	loading
26 About the absence of a generally accepted theory of psychotherapy	6.6	1.4	.85
27 About the absence of clear technical guidelines for doing therapy	6.4	1.8	.85

scale: 2=very concerned;10=very unconcerned

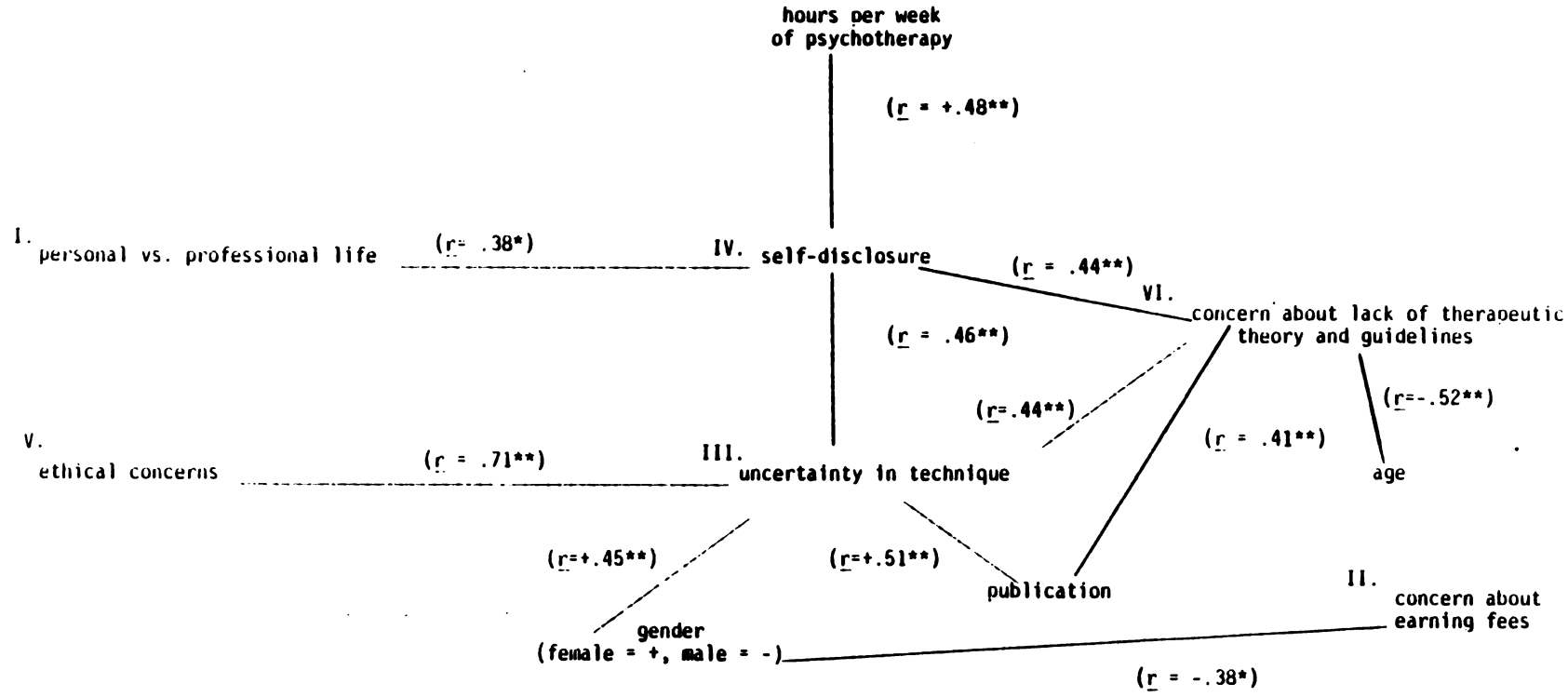
Insert Figure 1 About Here

One way of viewing these overall relationships is to note that they form two interlocking triads. One of these sets of interconnections links concern about issues of boundary maintenance (such as separating personal vs. professional life, and issues of self-disclosure) with concern about the lack of therapeutic theory and guidelines in psychotherapy. The other set of relationships involves a linkage of concerns about technical errors (i.e., uncertainty in technique) ethical concerns, and concern about the lack of therapeutic theory and guidelines in psychotherapy.

Figure 1 shows that high uncertainty in technique is linked to having more ethical concerns, more concerns about self-disclosure and greater concern about the lack of therapeutic theory and guidelines. Uncertainty in technique is also linked to gender (i.e. to femaleness) and to a record of having published. Conversely, low uncertainty in technique is linked to lower ethical concerns, lower concerns about self-disclosure, lower concerns over the lack of therapeutic theory and guidelines, maleness, and the lack of a publication record. This suggests that for this sample of psychologists,

Figure 1

Correlation Linkages Between Demographic Variables and Cluster Measures Having to Do With the Dilemmas That Clinical Psychologists Face in Their Work (Likert Clusters)



*p < .05
** p < .02

females, and respondents who have published may be more concerned than others about issues of uncertainty in therapeutic technique. This also suggests that such issues as ethical concerns and concerns about self-disclosure may be specific examples of uncertainty about technique.

High concern about the lack of therapeutic theory and guidelines was linked to concern about self-disclosure uncertainty in technique, lack of experience (as reflected by age), and having published. Conversely, low concern about the lack of therapeutic theory and guidelines was linked to low concern about self-disclosure, low concern about uncertainty in technique, a higher degree of experience, and the lack of a publication record. These associations indicate more generally that uncertainty, with regard to both specific matters of technique and a general lack of guidelines, are important concerns for subgroups of this sample. Specifically, therapists who are less experienced as might be expected, and therapists who have published. It may be that some therapists are more comitted to publishing as a way of dealing with their uncertainties. Conversely, these therapists may be more aware of areas of uncertainty because of their efforts to clarify in writing, issues of importance to them. By the same token, greater certainty may be associated with

non-publishers because these therapists may be less troubled by uncertainty and therefore less driven to seek clarification. Conversely, therapists who do not publish may refrain from undertaking tasks such as publication that might require them to examine their assumptions more closely. Although these data do not resolve this issue, they do suggest that it would be worth more detailed examination.

High concern about self-disclosure was linked to uncertainty in technique, concern about the lack of therapeutic theory and guidelines, concern about the separation between personal and professional life, and to a heavy case load (as reflected in the number of hours per week spent doing psychotherapy). Conversely, low concern about self-disclosure was linked to less concern about uncertainty in technique, less concern about the lack of therapeutic theory and guidelines, less concern about the separation between personal and professional life, and a lighter case load. These correlations suggest that issues of boundary maintenance are of greater concern to therapists who spend more of their time seeing patients. Conversely, therapists who spend less time seeing patients seem less concerned about maintaining the separation between their personal and professional lives. As was noted earlier, issues of uncertainty, both technical and

more general, were also linked to concerns about boundary maintenance.

Concern about earning fees is associated with being male. Conversely, less concern about earning fees is associated with being female. These associations suggest possible sex-role related differences in concerns about money. The females' lesser concern about whether they were really earning the fees paid them may reflect the point of view of women who, having traditionally been denied access to professions may feel especially competent by virtue of having attained professional status. Conversely, males may be more open to doubts about the worth of their work.

Question 2: <u>What tacit principles, predispositions or "theories in use" guide clinical psychologists' reactions to the uncertainty of psychotherapy?</u>

A form of this question that is more realistically answerable is:

> What principles, predispositions, or tacit "theories in use" guide clinical psychologists' approaches to psychotherapy? Are these predispositions related to uncertainty in psychotherapy?

The Q-Sort method was used to quantify the therapists' responses to this question. The item ratings, pooled over the two raters, were also subjected to cluster analysis.

Six clusters were formed in this analysis. The clusters are summarized and sample statements are presented in Table 11.

Insert Table 11 About Here

To enable these clusters to be more easily differentiated from the Likert clusters discussed above, the Q-Sort clusters are designated by Arabic numberals.
These 6 clusters are described below.

1. Cluster 1: Psychodynamic vs. Eclectic Approach

This cluster consists of 19 items that address the degree to which subjects adhere or do not adhere to views about psychotherapy that can be described as basically psychodynamic as compared to basically eclectic in approach. The reflected items in particular, dealt with a dimension of rejection vs. acceptance of behaviors and ideas inconsistant with a psychodynamic orientation. This cluster, along with item means and standard deviations, is presented in Table 12.

Insert Table 12 About Here

Means ratings of items in this cluster indicate that those reflecting a basically psychodynamic orientation were rated as most salient for this sample of therapists. Items

Table 11

Cluster Names and Sample High Loaded Q-Sort Items
Responding to Question 2

Q-Sort Item Number		loading in cluster
	Cluster 1: Psychodynamic vs. Eclectic	
*18	Psychoanalysis is still the best therapeutic approach	.85
*64	Psychoanalysis is outmoded	.79
	Cluster 2: Uncertainty, Self doubt	
27	Regardles of who the patient is, a good therapist is a good therapist	.78
13	A therapist can never be free from self-doubt	.80
	Cluster 3: Personalization of Therapy	
*83	Therapists should be able to take from their patients as well as give	.82
77	Therapists should be careful to keep their own needs outside of therapy	.79
	Cluster 4: Research Mindedness	
31	Research training helps psychologists to think critically	.95
*32	Alot of therapists don't know what they're doing	.89
	Cluster 5: Perceived Patient Demands	
69	Patients are easy to please	.86
* 8	Therapists have to be very patient people	.69
	Cluster 6: Therapy as inspiration	
*69	Talking to colleagues is helpful, it just helps to have someone to talk to	.78
89	A therapist should always get supervision no matter how experienced he/she is	.73

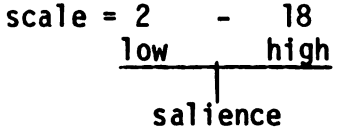
*Item reflected in order to fit cluster

Table 12

Q-Sort Cluster 1: Psychodynamic vs. Eclectic Orientation

Q-deck Items		$\bar{x}$	SD	load-ing
18	Psychoanalysis is still the best therapeutic approach	9.8	4.6	85
*64	Psychoanalysis is outmoded	6.7	3.4	85
*28	Anything you do in psychotherapy is okay as long as you know why you are doing it	8.3	5.4	82
46	Working with the transference is the key to successful therapy	10.3	3.7	79
88	The therapist's best source of information is the patient's resistance	9.9	2.2	76
37	Psychodynamic theory is the most useful theory of psychotherapy	13.2	3.4	72
*81	Psychodynamic theory is not helpful in doing therapy	3.4	2.3	72
*53	Therapy is more like friendship than anything else	6.7	3.7	71
39	The most important training experience for therapists is supervision	12.2	3.3	68
* 7	It is best for therapists to be eclectic	11.1	3.8	68
79	It is important to belong to a philosophical "school" of therapy	7.7	3.5	67
*10	There are as many "therapies" as there are therapists	9.1	2.2	67
84	It is inappropriate for a therapist to give advice to patients	7.5	3.7	67
20	Therapists should stick to the "tried and true" methods of therapy	8.5	4.3	65
*55	Insight is basically irrelevant	5.3	2.3	62
*80	It is important to focus on the patient's behavior outside of therapy	11.2	3.1	59
*92	Talking about their own lives is a way for therapists to "give" to patients	10.8	4.6	57
75	A therapist should have a coherent theoretical framework for doing therapy	10.0	3.7	55
*78	Therapists should always be experimenting with the latest techniques	7.9	3.3	52

*Variables reflected for inclusion in cluster. Means shown are not reflected.



reflecting rejection of a psychodynamic approach were rated as negatively salient for this sample.

2. Cluster 2: Uncertainty, Self-Doubt

This cluster consists of 15 items that refer to feelings of uncertainty or self-doubt, as well as a generally relativistic stance toward psychotherapy. This cluster is more problematic than others because the interrater reliability for the statements in this cluster is only .54. The low reliability indicates that the two raters were in disagreement with each other when assigning values to these statements. Consequently, the cluster is more difficult to interpret: the mean ratings for each statement are skewed toward neutrality by the two sets of ratings cancelling each other out. Even with this effect these statements were rated overall as fairly salient for the present group. This cluster, along with item means and standard deviations is presented in Table 13.

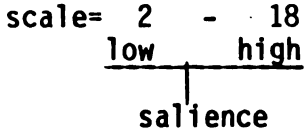
Insert Table 13 About Here

Table 13

Q-Sort Cluster 2: Uncertainty, Self-doubt

Q-deck items		$\bar{x}$	SD	load-ing
*27	Regardless of who the patient is, a good therapist is a good therapist	9.7	3.1	80
13	A therapist can never be free from self-doubt	11.6	4.4	78
*26	A therapist who is uncertain about his/her work is probably a poor therapist	7.0	3.5	77
22	To be a good therapist you have to be able to tolerate a lot of uncertainty	13.3	3.0	75
43	No one really knows how psychotherapy works	10.0	4.0	74
*23	A well trained therapist can work with almost any kind of patient	9.7	2.8	72
96	Therapists expect too much from themselves	9.9	3.2	68
33	A good therapist for one person can be a lousy therapist for someone else	11.0	3.0	66
5	Therapy is an almost magical proces, it defies explanation	9.2	3.8	65
34	Therapy is an art, not a science	12.2	3.5	64
*47	Successful therapy helps people fit in better in society	11.8	1.5	60
*68	Therapists usually feel satisfied with the outcome of therapy	12.0	3.0	59
51	When therapy fails, both patient and therapist are responsible	10.6	2.3	53
* 2	Playfulness is an important part of therapy	8.7	1.2	52
*59	Therapy is a skill that an be explained and taught	9.8	3.6	49

*Variables reflected for inclusion in cluster. Means shown are not reflected.



3. Cluster 3: Personalization of Psychotherapy

Cluster 3 consists of 8 statements that refer to therapists' orientations toward the place of their own needs in psychotherapy. These statements reflect an acceptance of the gratification of the therapists' needs in therapy. They reflect a view of therapy as in many respects akin to friendship. This cluster, along with item means and standard deviations is presented in Table 14. An examination of the item means for this cluster indicate that these items were rated as somewhat negatively salient for this group as a whole.

Insert Table 14 About here

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4. Cluster 4: Research Mindedness.

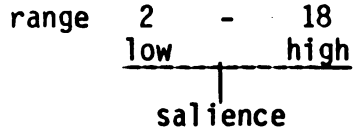
Cluster 4 consists of 6 items that generally reflect a set of values favorable to research as useful in developing the ability to think critically and make use of the professional literature. This is coupled with a positive view of the value of research training and skepticism concerning the skills of colleagues. This cluster, along with item means and standard deviations is presented in Table 15. An examination of the item means indicates that most of these statements were rated as essentially neutral for this sample. The importance of flexibility as a

Table 14

Q-Sort Cluster 3: Personalization of Therapy

Q-deck items		$\bar{x}$	SD	loading
83	Therapists should be able to take from their patients as well as give	7.6	2.3	82
*77	Therapists should be careful to keep their own needs outside of therapy	13.0	3.4	79
85	It is impossible for therapists to keep their own needs outside of therapy	6.7	3.4	77
86	Therapists should feel free to touch or hold their patients	7.4	3.5	70
82	It is important to be honest with patients at all times	7.9	4.0	63
*21	It is important for therapists to accept the fact that they are not omnipotent	12.3	4.7	63
93	Even when they try not to, therapists impose their values on patients	8.5	1.7	58
*19	Psychotherapy is no more ethically difficult than any profession	6.2	2.1	54

*Variables reflected for inclusion in cluster. Means shown are not reflected.



characteristic of therapists was rated as somewhat salient for this sample. A rejection of the research literature as helpful to therapists was rated as negatively salient for this sample. In other words, this sample was rated as finding the research literature useful.

Insert Table 15 About Here

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5. Cluster 5: Perceived Patient Demands

Cluster 5 consists of 5 items that refer to difficulties in meeting the expectations of patients and the general public. This cluster, along with item means and standard deviations is presented in Table 16. An examination of these scores shows that for this sample, the belief that patients are easy to please was negatively salient as was the view that therapy should be terminated when its initial goals have been reached. The view that therapists have to be very patient people was rated as salient for this sample.

Insert Table 16 About Here

Table 15

Q-Sort Cluster 4: Research Mindedness

Q-deck items		$\bar{x}$	SD	loading
31	Research training helps psychologists to think critically	11.1	3.0	95
32	Alot of therapists don't know what they're doing	9.6	3.7	89
*62	Research training is ultimately of little value to therapists	10.3	4.6	88
90	Research training helps psychologists understand their work	8.0	4.3	79
*57	Therapists don't usually find the professional literature very helpful	6.4	2.9	60
30	Flexibility is one of the most important characteristics a therapist can have	12.5	3.2	55

*Variables reflected for inclusion in cluster. Means shown are not reflected.

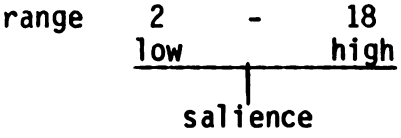
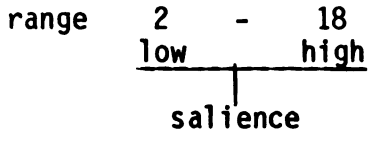


Table 16
Q-Sort Cluster 5: Perceived Patient Demands

Q-deck items	x	SD	load-ing
*69 Patients are easy to please	5.2	1.7	86
8 Therapists have to be very patient people	12.5	2.6	69
24 It is difficult to work with patients when they are angry	10.4	2.9	66
*74 Therapy should be terminated when its initial goals have been reached	6.9	1.5	63
6 People expect too much from therapists	9.5	1.5	57

*Variables reflected for inclusion in cluster. Means shown are not reflected.



6. Cluster 6: Therapy as Inspiration

Cluster 6 consists of 11 items that form a general pattern reflecting a view of psychotherapy as a basically intuitive process without formal guidelines. This cluster also reflects a view of therapy as a difficult and emotionally draining type of work. This cluster, along with item means and standard deviations is presented in Table 17. Means here show that a view of therapy as emotionally draining for the therapist was rated as salient for this sample as a whole. The view that therapy is mostly a matter of inspiration was rated as negatively salient for this sample, as was the view that supervision is no longer necessary after a certain amount of experience.

Insert Table 17 About Here

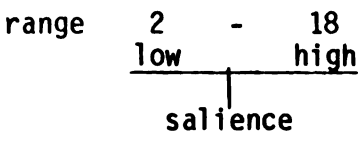
Relationships between Q-Sort clusters

A correlation matrix showing the relationships between the Q-Sort clusters described above is presented in Appendix C, p. 194. These correlations were computed in order to determine the degree to which the Q-Sort clusters related to Question 2 were inter-related. In addition, correlations between these clusters and the demographic variables were computed in order to examine the possibility

Table 17
Cluster 6 - Therapy as Inspiration

items		$\bar{x}$	SD	loading
*61	Talking to colleagues is helpful, it just helps to have someone to talk to	13.9	2.5	78
*89	A Therapist should always get supervision no matter how experienced he/she is	10.8	4.4	73
60	After a certain amount of experience, supervision is no longer really necessary	7.3	3.8	68
9	For therapy to succeed the therapist and the patient must like each other	10.9	3.2	66
*66	Setting boundaries is one of the most important parts of therapy	13.1	3.5	64
100	There's a certain kind of person who's a born therapist	10.5	3.4	62
*15	Psychologists should get as much post-Ph.D. training as possible	10.1	3.7	62
*48	Therapy is emotionally draining for the therapist	15.4	2.4	58
54	Therapy is mostly inspiration and a little hard work	5.7	2.4	53
*70	A good therapist is a skilled craftsman	9.3	3.8	51
91	Therapists often rely on their own life experiences in order to know how to guide their patients	11.2	2.5	50

*Variables reflected for inclusion in cluster. Means shown are not reflected.



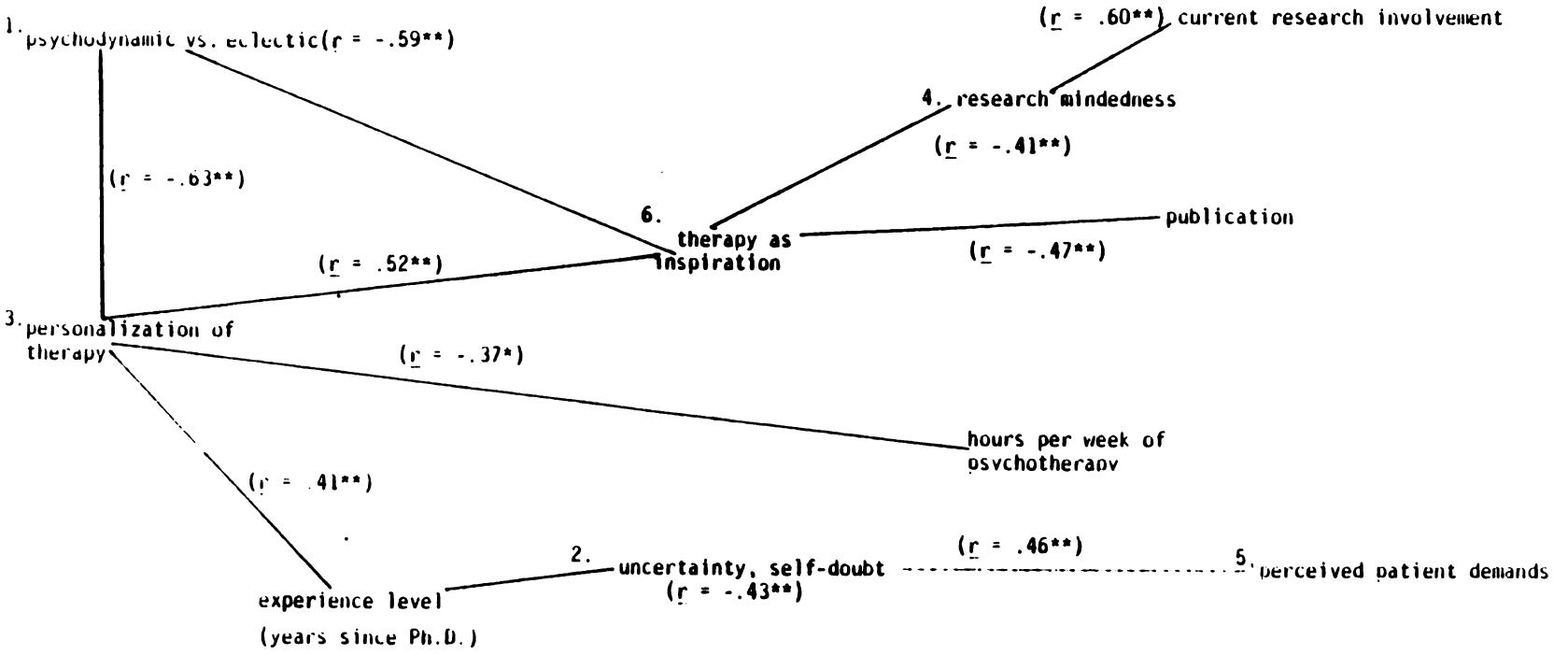
that there might be demographic differences in these areas. The significant relationships are discussed below and are depicted in Figure 2. The figure is again a heuristic device, utilized here to chart the degree of common relationship among the variables that have significant association.

Insert Figure 2 About Here

Figure 2 shows that a view of therapy as guided by inspiration was negatively related to research mindedness, a psychodynamic view of therapy, and a record of publication. It was related to high personalization of therapy. Conversely, rejection of the view that therapy is guided by inspiration was associated with a record of publication, high research mindedness, a more psychodynamic view of therapy, and low personalization of therapy. This points to a general pattern that reflects a highly intuitive (or "tender-minded") approach that rejects the formal constraints of psychodynamic theory or a critical style of thinking associated with research. By the same token, a less intuitive (or "tough-minded") approach is characterized by greater adherence to a more formal

Figure 2

Correlation Linkages Between Demographic Variables and Cluster Measures Having to Do With the Ways Clinical Psychologists Approach Their Work as Therapists



* p < .05
** p < .02

psychodynamic approach or to a style of thinking associated with research.

High personalization of therapy was related to a greater experience level, a greater view of therapy as inspiration and a lighter work load. Conversely, low personalization of therapy was related to less experience, a heavier case load, and low acceptance of the view of therapy as guided by inspiration. This suggests a general pattern not unlike the one described above in most respects. A highly personalized view of therapy in this sample was associated with a greater degree of experience whereas a less personalized view was associated with less experience. It may be that for more experienced therapists their own life's experience plays a greater role in their work, and this may be reflected in a more personalized view. By the same token, less experienced (i.e., younger) therapists may have less of a store of life experience to draw on and thus may rely more heavily on formal theory.

A high degree of uncertainty and self-doubt was related to greater perceived patient demands and less experience. Conversely, a low degree of uncertainty and self-doubt was related to lower perceived patient demands, and a higher degree of experience. This suggests that some therapists (less experienced therapists in this sample) may feel more uncertain about their work when they perceive their

patients as demanding more than they have to give. By the same token, they may perceive their patients as too demanding because of their own uncertainties and inexperience. Conversely, more experienced therapists in this sample seem more sanguine about both their own skills and their patients' demands.

A high degree of research mindedness was related to current research activity. Conversely, a low degree of research mindedness was related to a lack of current research activity. This finding is not surprising, it merely suggests that therapists who do research value research-mindedness, while non-researchers value research-mindedness less.

Question 3 addresses the relationships between the two sets of clusters discussed above:

Question 3: <u>How do the dilemmas that clinical psychologists experience in their work relate to uncertainty in theory, technique and outcome?</u>

This question was addressed by examining inter-relationships between the clusters already identified for Questions 1 and 2. Relationships between therapist concerns (Likert Scales) and approaches to therapy (Q-Sorts) are presented in Table 18.

Insert Table 18 About Here

The significant relationships from this matrix are summarized in Figure 3. This figure is used as a heuristic device to depict the extent of overlap between therapist concerns or dilemmas related to Question 1 and therapists' approaches to therapy related to Question 2. Because these measures were originally scored in opposite directions, relationships between therapist concerns and the other variables have been reflected here to facilitate understanding.

Insert Figure 3 About Here

Figure 3 shows that a psychodynamic approach to therapy was associated with several areas of concern. Specifically, this approach was related to high concerns about the lack of therapeutic theory and guidelines, uncertainty in technique, the separation between personal and professional life, and concern about self disclosure. Conversely, low ratings on this approach were associated with less concern about the lack of theory and guidelines

Table 18
Correlations between Likert Problem Clusters and Approaches to Therapy (Q-Sort Clusters)

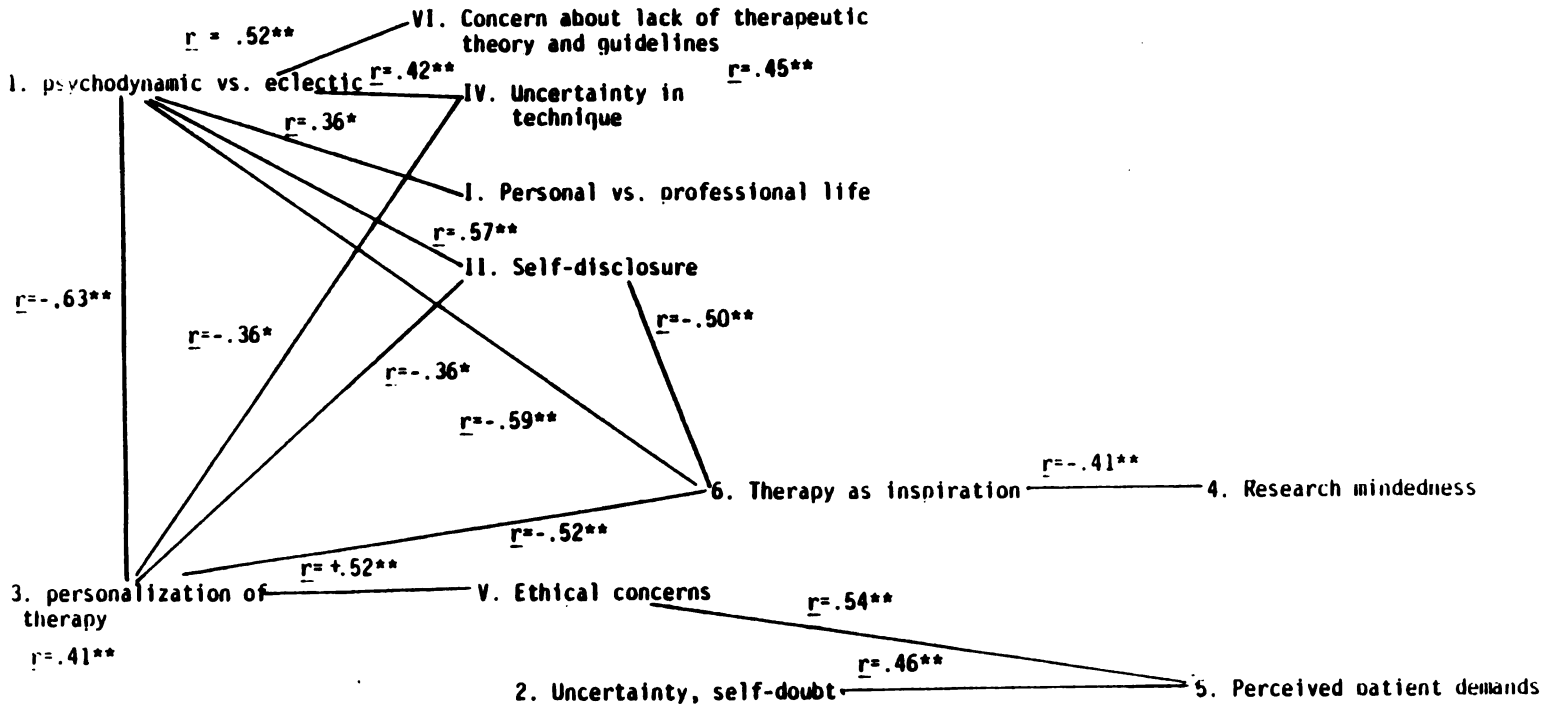
	V. Ethical Concerns	II. Concern About Fees	VI. Concern About Lack of Therapeutic Theory and Guidelines	IV. Self-Disclosure	I. Personal vs. Professional Life	III. Uncertainty in Technique
1. psychodynamic vs. eclectic	-.33	-.02	+.52**	+.57**	+.36*	+.42**
2. uncertainty, self-doubt	-.39*	-.06	-.24	-.08	.17	-.13
3. personalization of therapy	.52**	-.01	.20	-.36*	.29	-.36*
4. research mindedness	-.32	-.02	.08	.10	-.11	-.27
5. perceived patient demands	-.54**	-.10	.02	-.03	-.12	-.30
6. therapy as inspiration	.41**	-.002	.30	-.50**	-.42**	-.55**

*p=<.05 **p=<.02

Note: Clusters I-VIII were scored in the direction opposite to the scoring of clusters 1-6. In order to facilitate understanding, relevant (i.e. significant) correlations have been reflected here.

Figure 3

Correlation Linkages Between Therapists Approaches to Psychotherapy and Therapist Concerns



* p < .05
** p < .02

in therapy, less concern about uncertainty in technique, and less concern about boundary issues such as self-disclosure and the separation between personal and professional life.

These findings suggest that therapists in this sample who were identified as psychodynamic in their approach to therapy may have been more reliant on a theoretically consistent point of view than therapists rated low on this dimension. Consequently, the lack of clear guidelines may be of more conern to them. High concern about boundary maintenance is consistent with a psychodynamic approach which tends to discourage self-disclosure and in general relies heavily on maintaining a strict separation between personal and professional life.

Conversely, a more eclectic, non-psychodynamic approach showed the opposite pattern, with less concern about the lack of theory and guidelines in therapy, less concern about uncertainty in technique, and less conern about issues of boundary maintenance. A non-psychodynamic approach was also associated with a personalized view of therapy, and a view of therapy as a matter of inspiration. In general, the pattern is of therapists who are less reliant upon a formal theory and more reliant on their own intuitions. Consequently there is less concern about

theory or about issues (such as boundary maintenance) that are related to psychodynamic theory.

High personalization of theory was associated with a view of therapy as a matter of inspiration and negatively associated with a psychodynamic approach, concern about uncertainty in technique, concern about self-disclosure, and ethical concern. Conversely, low personalization of therapy was associated with a psychodynamic approach. It was also negatively associated with a view of therapy as inspiration, and with concerns about self-disclosure, uncertainty in technique, and ethical concerns.

These findings suggest a pattern that is almost the mirror image of that associated with a psychodynamic approach. Therapists rated as having a personalized approach to therapy seem to rely more on intuition than on any formal theory. By the same token therapists rated as rejecting a personalized approach tend to be rated as accepting a psychodynamic approach.

The view of therapy as inspiration is associated with high personalization of therapy, low concern about self disclosure, a non-psychodynamic approach and a lack of research-mindedness. Conversely, low ratings on a view of therapy as inspiration were related to lack of concern about self-disclosure, and a low degree of research-mindedness. The rejection of this view was associated with

a psychodynamic approach and with low personalization of therapy.

These findings generally mirror those related to personalization of therapy. Once again the pattern is of reliance on intuition rather than formal theory or research mindedness in approach. By the same token, the rejection of this view is associated with a research-minded view or with adherence to psychodynamic theory.

Perceived patient demands were related to both uncertainty, self-doubt, and a high degree of ethical conerns. Conversely, a low degree of perceived patient demands was associated with low uncertainty, low self-doubt, and with less concern about ethical issues. These linkages suggest that in this sample therapists who perceived their patients as very demanding tended to be highly uncertain and troubled by concerns such as aggressive or sexual feelings toward patients. By the same token, therapists rated as less troubled by patients' demands were also seen as being more certain about their own skills and less troubled by ethical issues. High scores on this triad suggest a generally reactive stance toward therapy in the lack of association with either the basically intuitive or the basically theory-bound approaches discussed earlier. High scores on this triad may suggest a general burn-out or frustration factor, while

low scores on these dimensions may reflect a lack thereof.

Question 4: How do clinical psychologists explicitly view the uncertainties of their work?

The measures designed to scale issues relating to this question were Likert scales 39-49, which are presented in Appendix B, p. 183. These scales failed to form a cluster or, with one exception (scale #48) to constitute part of any other cluster. In other words, conceptually as well as statistically they neither belonged together nor with any other cluster. For this reason, they are all reported separately. These scales, along with their mean ratings and standard deviations, are shown in Table 20.

Insert Table 20 and Figure 4 About Here

Relationships between these scales, therapist dilemma clusters and demographic variables are shown in Table 20. Figure 4 is presented as a heuristic device to summarize the significant relationships between these approaches, therapist concerns, and the demographic variables.

An examination of the means shown in Table 20 indicates that all of these approaches were seen as slightly to somewhat characteristic of this sample. The approach to

Table 19

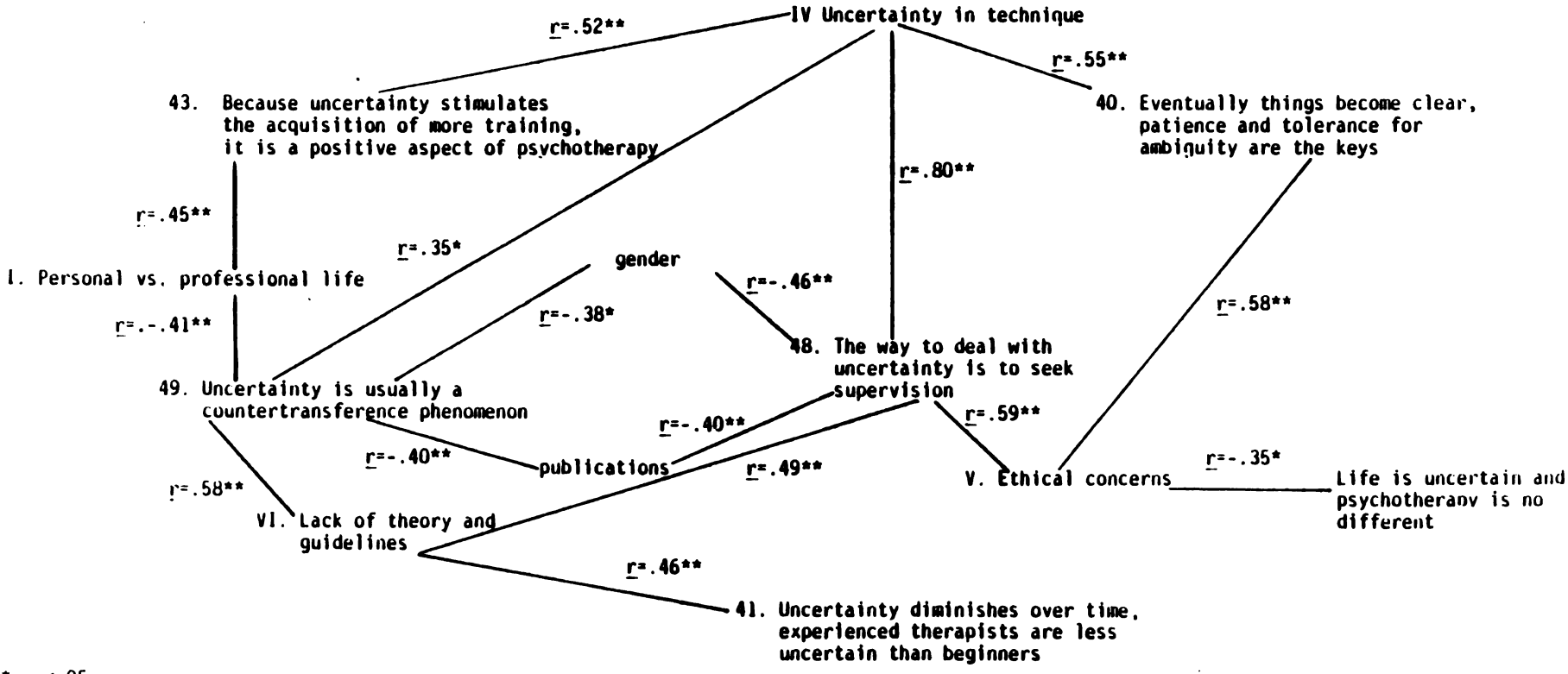
Clinical Psychologists' Explicit Attitudes Toward Uncertainty; Scale Means and Standard Deviations

	$\bar{x}$	SD
39 Life is uncertain and psychotherapy is no different	4.3	1.3
40 Eventually things become clear, Patience and a tolerance for ambiguity are the keys	4.3	1.0
41 Uncertainty diminishes over time, experienced therapists are less uncertain than beginners	4.9	1.3
42 Experienced therapists are no less uncertain than beginners, they just tolerate uncertainty better	5.3	1.2
43 Because uncertainty stimulates the acquisition of more training, it is a positive aspect of psychotherapy	4.8	1.4
44 Uncertainty is a sign of incompetence	5.4	1.4
45 Uncertainty is a sign of burn-out	6.1	1.0
46 The best way of dealing with uncertainty is by being honest with oneself	4.1	1.0
47 Therapists can best deal with uncertainty by having faith in their ability to be helpful	4.3	1.0
48 The way to deal with uncertainty is to seek supervision	3.7	2.0
49 Uncertainty is usually a countertransference phenomenon	5.4	1.2

Range: 2 = very characteristic
10 = very uncharacteristic

Figure 4

Correlation Linkages Between Therapist Approaches to Uncertainty; Therapist Concerns or Dilemmas (Likert Scales);*** and Demographic Variables



* p <.05
**p <.02
***Because these measures were rated on the direction opposite (high-low, vs. low-high) to that of the other variables, these values have been reflected here in order to facilitate understanding.

uncertainty most characteristic of this sample was to seek supervision.

As Figure 4 shows, a high score on this scale was associated with high degrees of conern about uncertainty in technique, ethical issues, and the lack of theory and guidelines in psychotherapy. A high score on this scale was negatively associated with gender (i.e., males scored higher on this scale), and with not having published. Conversely, a low score on this scale was associted with having published, and with being female. A low score on this scale was also associated with less concern about ethical issues, uncertainty in technique, and lack of theory and guidelines.

These findings suggest that supervision is most highly endorsed by therapists who perceive uncertainty as potentially resolvable through greater theoretical and technical sophistication and perhaps attendant clarification of ethical concerns. Conversely, these findings suggest that therapists who do not endorse supervision as a way of resolving uncertainty may not see theoretical and technical sophistication as especially useful. Such therapists also seem less concerned about ethical issues.

The view that uncertainty is usually a counter-transference phenomenon was associated with greater degrees

of concern about uncertainty in technique, and the lack of theory and guidelines in psychotherapy. It was associated with not having published, and with being male. Conversely, this view was negatively associated with having published, and with being female. It was also associated with less concern about uncertainty in technique, the lack of theory and guidelines in therapy, and with concern about the separation between personal and professional life. This pattern of relationships is very similar to the pattern reported above. The only exception being the negative relationship between this approach and concern about the separation between personal and professional life. This finding makes sense in that therapists who tend not to be concerned about maintaining strict boundaries between their personal and professional lives may be more aware of, or sensitive to, issues of countertransference. BY the same token, therapists in this sample who are more concerned about the separation between personal and professional life, may rule out countertransference as a source of uncertainty.

A positive view of uncertainty as a spur to training (scale 43) was associated with concerns about uncertainty in technique, and concern about the separation between personal and professional life. Conversely, low ratings on this scale were associated with less concern about

uncertainty in technique and less concern about the separation between personal and professional life. These findings suggest that therapists who value advanced training also value more clarity in technical guidelines, and may seek more training in order to achieve such clarity. They tend also, to be less concerned about the separation of personal and professional life. By the same token, therapists who do not see uncertainty as a spur to more training may be less troubled by uncertainty in technique. Such therapists also tend to be less concerned about the separation between personal and professional life.

Therapists who were rated as believing more experienced therapists are less uncertain than beginners (scale 41), were also rated as more concerned about the lack of theory and guidelines in therapy. Conversely, therapists rated as rejecting this view were less concerned about the lack of theory and guidelines in therapy. This finding suggests that therapists concerned about the lack of theory and guidelines in therapy may defer some of their uncertainty in expectation that uncertainty is resolved through experience. Conversely, therapists who have less faith in experience as offering resolution to uncertainty may be less troubled by uncertainty in the first place.

The view that life is uncertain and psychotherapy is no different is associated with less concern about ethical issues. Conversely a rejection of this view is associated with more concern about ethical issues. This finding suggests that therapists who are highly concerned about ethical issues view psychotherapy as posing special problems not encountered elsewhere. By the same token, therapists who are less concerned about ethical issues seem more sanguine about the uncertainties of psychotherapy.

The view that eventually things become clear and that patience and a tolerance for ambiguity are the keys to uncertainty in psychotherapy was associated with greater concern about uncertainty in technique and ethical concerns. Conversely rejection of this view was associated with less concern about uncertainty in technique and ethical issues. These findings suggest that some therapists who are concerned about ethical and technical uncertainties, believe that patience and a tolerance for ambiguity are the keys.

In summary, these therapists, with few demographic differences, tended to view uncertainty as resolvable through a combination of patience, tolerance for ambiguity, experience, and supervision. Although some differences between approaches to uncertainty and therapist concerns

were found, these differences form no compellingly consistent pattern. Relationships between these approaches demographic variables, and therapist concerns are shown in a correlation matrix presented on p. 193. Figure 4 is presented as a heuristic device to summarize the significant relationships among these variables.

II. Questions pertaining to the role of research in the respondents' professional lives.

Question 5,6,7 and 8 addressed several aspects of psychologists attitudes toward research. The questions were as follows:

Question 5: Do clinical psychologists experience the imbalance between their clinical and their research efforts as conflictual?

Question 6: How do clinical psychologists resolve the imbalance between their clinical and their research efforts?

Question 7: What effect does training in research have on the way clinical psychologists do psychotherapy?

Question 8: Are clinical psychologists satisfied with their research training?

These questions were addressed by Likert scales 50-74 Appendix B, p. 187. (Interrater reliabilities for these

scales have already been reported in Table 3.) The scales intended to respond to each of these questions were cluster analyzed. When this was completed, the scales designed to address all four of these questions formed one large cluster. This cluster described an overall dimension of (high-low) research relevance in the context of clinical psychologists' professional lives. In addition to this large cluster, a much smaller cluster was formed: this cluster is best described as concerned with clinical psychologists' views about the goals of research training. These two research related clusters along with item means and standard deviations are presented in Table 20.

Insert Table 20 About Here

The questions and the Likert scales related to each will be addressed individually below:

Question 5: Do clinical psychologists experience the imbalance between their clinical and their research efforts as conflictual.

This question was addressed by scales 50 and 51 from the large cluster shown in Table 20.

Scale 50: Does the therapist see his/her work life as well balanced (research vs. therapy)?

Table 20

Cluster VII: Likert Scales Related to Relevance of Research in Clinical Psychologists' Professional Lives, and Cluster VIII

	x	SD	Loading	Rating
CLUSTER VII:				
*68 Research experiences have had little effect on the way s/he does therapy	5.9	2.7	.90	disagree slightly
62 Relevance of past research experiences to present activities as a therapist	6.2	2.7	.89	slightly irrelevant
74 Overall view of research as part of the professional identity of the clinical psychologist	6.4	2.3	.88	slightly important
*53 Views research as irrelevant to psychotherapy	6.6	2.3	.88	slightly uncharacteristic
*63 Relevance of past research experiences to present activities in other professional areas	5.7	1.5	.86	slightly relevant
72 Relevance of research training for learning diagnostic procedures	6.0	1.6	.86	neutral
55 Believes therapy is research	5.8	1.9	.85	slightly characteristic
64 Relevance of past research experiences to present activities in psychological testing	5.7	1.6	.84	slightly relevant
65 Overall view of graduate research experience	6.4	1.9	.82	slightly negative
*67 Research experiences lead to a way of thinking that gets in the way of doing therapy	7.9	1.3	.82	disagree somewhat
69 Views psychotherapy as a science	6.4	2.1	.82	disagree slightly
70 Relevance of research training for completion of graduate school requirements	5.8	1.8	.81	slightly important
61 Relevance of past research experience to present activities as a researcher	5.2	1.5	.80	slightly relevant
66 Research experiences have led to a tendency to think more critically and thus enhance the practice of therapy	5.1	2.0	.77	slightly relevant
71 Relevance of research training for learning to do psychotherapy	6.7	2.3	.77	slightly unimportant
*54 Views research as incompatible with therapy	7.5	1.8	.75	somewhat characteristic
73 Overall satisfaction with research training	6.4	2.3	.72	slightly disatisfied
50 Does the therapist see his/her work life as well balanced(research vs. therapy)	6.8	1.8	.70	slightly unbalanced
*58 Believes that research is an activity for academicians	5.4	1.8	.66	slightly characteristic
51 Does s/he express conflict about a lack of balance between research and therapy	8.4	1.6	.61	somewhat unbalanced
32 Concern about how to make sufficient time available for writing, research, and other professional activities	5.6	1.5	.59	neutral
59 Believes that clinical psychologists have a responsibility to do research	6.9	.87	.59	slightly uncharacteristic
*60 Believes that research requires skills that therapists don't have	6.9	1.0	.50	slightly uncharacteristic

Table 20 (continued)

Cluster VIII. Usefulness of Research Training Outside of Actual Research Activity

CLUSTER VIII:				
56 Believes that the goal of research training is to develop a style of rigorous thinking rather than actual research productivity	5.1	1.8	.94	slightly characteristic
57 Believes the goal of research training is the development of the ability to read and evaluate published research, rather than actual research productivity	5.4	1.5	.92	slightly characteristic

*Variables reflected for inclusion in cluster. Means shown are not reflected.

Scales

variables		
66,67,68,69	2=agree strongly	10=disagree strongly
61,62,65,64	2=very relevant	10=very irrelevant
70,71,72		
74	2=very important	10=very unimportant
53,54,55,58		
59,60	2=very characteristic	10=very uncharacteristic
65	2=very positive	10=very negative
73	2=very satisfied	10=very dissatisfied
50	2=very balanced	10=very unbalanced
51	2=very conflicted	10=very unconflicted
32	2=very concerned	10=very unconcerned

The mean rating for this scale ($\bar{x}$=6.8) indicates that this sample was seen as viewing their professional lives as slightly unbalanced in this regard. Only nine of the respondents were engaged in research however. The effect of these nine therapists on the mean rating for the whole group may obscure the fact that most of the respondents did no research. Regardless of the ratings, the fact remains that 26 of the respondents , roughtly three-fourths, were not engaged in any research or planning to be any time soon.

Scale 51: Does s/he express conflict about a lack of balance between research and therapy?

The mean rating ($\bar{x}$=8.4) for this scale indicates that this sample was seen as very unconflicted in this regard. This rating probably reflects therapists' satisfaction with their research involvement; i.e. both researchers and non-researchers were unconflicted about their degree of research activity or inactivity.

In view of these findings, the answer to Question 5 is no; although most respondents were not engaged in research this sample of therapists did not express conflict about an imbalance between their activities in research and therapy.

Question 6: How do clinical psychologists resolve the imbalance between their clinical and their research efforts?

The eight scales taken from the large research cluster in Table 20 that address this issue are shown in Table 21 below, along with their mean scores standard deviations and corresponding sample ratings.

Insert Table 21 About Here

As Table 21 shows, the ratings for this sample as a whole indicated that the respondents tend to value skills that accompany research training, i.e. the development of a rigorous style of thinking and the ability to evaluate research. They do not tend to view research as incompatible or irrelevant to therapy. They tend to believe that while they may possess research skills and see therapy itself as research in a sense, they have no special responsibility to do formal research. Instead they tend to see research as an activity for academicians.

This pattern suggests that these psychologists may resolve the imbalance between their clinical and research efforts by making use of those research-related skills that can be helpful in other areas of their professional lives. They do not seem to view research activity as a

Table 21

Mean Scores, Standard Deviations, and Overall Rating On Scales Responding to Question 6: How do clinical psychologists resolve the imbalance between their clinical and their research efforts?

Scales	$\bar{x}$	SD	Overall rating for sample
*53 Views research as irrelevant to psychotherapy	6.6	2.3	slighly uncharacteristic
*54 Views research as incompatble with therapy	7.5	1.8	somewhat uncharacteristic
55 Believes therapy is research	5.8	1.9	slightly characteristic
56 Believes that the goal of research training is to develop a style of rigorous thinking rather than actual research productivity	5.1	1.8	slightly characteristic
57 Believes the goal of research training is the development of the ability to read and evaluate published research, rather than actual research productivity	5.4	1.5	slightly characteristic
*58 Believes that research is an activity for academicians	5.4	1.8	slightly characteristic
59 Believes that clinical psychologists have a responsibility to do research	6.9	.87	slightly uncharacteristic
60 Believes that research requires skills that therapists don't have	6.9	1.0	slightly uncharacteristic

*Scale reflected to fit cluster. Mean reported is unreflected.

Range: 2=very characteristic 10=very uncharacteristic

responsibility in their professional lives. They do see research as a relevant activity for therapists however.

Question 7: What effect does training in research have on the way clinical psychologists do psychotherapy? The nine scales included in the large research cluster shown in Table 20 that address this question are shown along with their means, standard deviations, and sample ratings, in Table 22.

Insert Table 22 About Here

As Table 22 shows, these psychologists tend to see their past research experiences as slightly irrelevant to their present activities as therapists. At the same time they seem to believe that their research experiences have had some effect on the way they do therapy. They disagree somewhat with the idea that research experiences may lead to a way of thinking that gets in the way of doing therapy. They also view their past research experiences as slightly relevant to a variety of professional activities other than therapy (such as testing). In sum, the pattern suggests that these therapists tend to value slightly their past research experiences and to view these experiences as slightly relevant to their professional lives. Their

Table 22

Mean Scores, Standard Deviations, and Overall Rating on Scales Responding to Question 7:
What effect does training in research have on the way clinical psychologists do psychotherapy?

Scales	$\bar{x}$	SD	Overall rating for sample
61 Relevance of past research experience to present activities as a researcher	5.2	1.5	slightly relevant
62 Relevance of past research experiences to present activities as a therapist	6.2	2.7	slightly relevant
*63 Relevance of past resarch activities to present activities in other professional areas	5.7	1.5	slightly relevant
64 Relevance of past research experiences to present activities in psychological testing	5.7	1.6	slightly relevant
65 Overall view of graduate school research experience	6.4	1.9	slightly negative
66 Research experiences have led to a tendency to think more critically and thus enhance the practice of therapy	5.1	2.0	slightly relevant
*67 Research experience lead to a way of thinking that gets in the way of doing therapy	7.9	1.3	disagree somewhat
*68 Research experiences have had little effect on the way s/he does therapy	5.9	2.7	disagree somewhat
69 Views psychotherapy as a science	6.4	2.1	disagree slightly

*Scale reflected in order to fit into large research cluster. Means shown are not reflected.

Range: Scales 61,62 63,64,66 2 = very relevant 10 = very irrelevant
Scale 65 2 = very positive 10 = very negative
Scale 67,68,69 2 = agree strongly 10 = disagree strongly

overall view of their graduate school research experiences is slightly negative. It is not clear from the present data whether the majority of the respondents (i.e. the 26 non-researchers) have had additional research experiences since graduate school that they might have viewed more positively than their graduate school experience.

Question 8: Are clincial psychologists satisfied with their research training?

Four of the scales presented in Table 20 address this question. They are the following:

Scale 70: Relevance of research training for completion of graduate school requirements.

An examination of the mean rating ($\bar{x}$=5.8) shown in Table 20 indicates that these psychologists were rated as viewing research training as slightly important for completing graduate school.

Scale 71: Relevance of research training for learning to do psychotherapy.

An examination of the mean rating ($\bar{x}$=6.7) shown in Table 20 indicates that these psychologists were rated as viewing their research training as slightly unimportant in doing psychotherapy.

CHAPTER IV

DISCUSSION

In order to further understand and make use of the findings already presented several questions must be posed. They are as follow:

1. How representative of clinical psychologists in general are the present study's respondents?

2. How are the findings of this study similar to or different from findings reported elsewhere?

3. What are this study's important strengths and weakenesses?

4. What are the broader implications of this work for: a. clinical psychology?
   b. psychotherapy in general?

5. What further research could capitalize on the work's strengths and/or correct its deficiencies?

These questions will be discussed one at a time in the order listed.

I. How representative of clinical psychologists in general are the present study's respondents?

In most respects this sample of psychologists is quite typical of psychologists nationally. According to a recent national study of psychologists' activities (Stapp and Fulcher, 1981), the percentage of their time that these psychologists spend in such activities as research, administration, teaching, psychotherapy, and other professional activities is comparable to that of independent practitioners nationally. The differences in these areas between the present sample and the national sample are minimal. The experience level of the present sample is also comparable to that of the national sample.

There are four areas in which the present sample is different from the national sample. These areas are:

1. The percentage of female respondents in this study is much higher than the percentage of female independent practitioners nationally. Females were just under 50% of the present sample. Nationally females make up only about 21% of independent practitioners.
2. The Washington, D.C. area has the highest concentration of licensed psychologists in the nation. There are 11.6 licensed psychologists for every 10,000 residents of the District of

Columbia. The state with the next highest concentration of licensed psychologists is New York, with only 2.2 licensed psychologists per 10,000 population (Dorken and Webb, 1981).

3. Although the percentage of their time that the therapists in this study spend seeing patients is comparable to the national sample, these therapists tend to see more patients. In other words they tend to work more hours than the national average for psychologists who are independent practitioners. Nationally, only 27.5% of independent practitioners spend more than 30 hours a week seeing patients. In this sample about half of the respondents spend more than 28 hours a week with patients. It is therefore likely that these therapists carry larger case loads than the national average.
4. No Black, Hispanic, or Asian American therapists were interviewed in this study (several minority therapists were interviewed in pilot studies). Nationally 4.1% of therapists are members of minority groups.

The relative over-representation of women in this study, was largely by design. No special efforts were made to recruit female respondents, but had the percentage of

females fallen much below 40% such efforts would have been initiated. The reason for this was the wish to compare the responses of males and females; to do this well, one needs as robust a sample of females as possible.

The question remains as to why females made up so high a percentage when no special efforts were made to recruit them. Although formal data on the relative numbers of males and females in practice in the Washington area are unavailable, my impression is that women make up much more than 21% of independent practitioners there. The high sex-ratio in Washington may account for this. The acceptance rate of females contacted was no higher than for men, and this substantiates that impression.

Washington D.C. has the highest percentage of licensed psychologists in the nation. Many of these psychologists are Federal employees, working in the various branches of the government and not engaged in private practice. Also, most psychologists licensed in nearby Maryland and Virginia are also licensed in the District of Columbia. Both of these factors inflate the numbers of psychologists nominally in Washington. Until recently, Federal employee's insurance benefits were very generous and therapy was quite accessible to many in the Washington area. Furthermore, Washington is full of the young, attractive, verbal, intelligent, and successful individuals

who are traditionally considered "good" patients. Because of this, Washington has been a very attractive setting for psychologists.

If this high density makes the present sample somewhat atypical, it is because these respondents have more access to resources than many psychologists do. They also have more potential competition.

In addition to their greater numerical density, psychologists in this sample tended to see a larger number of patients than the national average for independent practitioners. Again, this may be due to the greater demand for psychotherapists in Washington. It may also be due to the high cost of living in that area. In any event, the present sample is representative of therapists who are very much involved in their practices.

The present data were not compared to that from therapists practicing in other locales and with other client loads. Such a study would be useful. Also no minorities were present in this study. Such a comparison would also be of interest.

In summary then, in all most important respects this sample is comparable to national ones investigated by both Stapp and Fulcher (1981), and Dorken and Webb (1981).

II. How are the present findings similar to or different from findings reported elsewhere?

A. Psychologists' reactions to the uncertainty of their work.

As was noted in the introduction, the importance and ubiquity of uncertainty in psychotherapy is very well documented but very little explored. No previous studies that specifically addressed this issue were located in a review of the literature. Documentation of its importance has come mostly from the writings of psychoanalysts and sociologists. These writings have been based on the observations of the authors, either in their clinical and professional activities or, in the case of sociologists, from their observations in the field. Additionally, both the psychoanalysts and the sociologists have observed samples very different from the present one. The analysts write mostly of other analysts - the majority of them psychiatrists. Sociologists have written mostly about psychiatric residents. Psychologists as a distinct group have not generally been studied.

Only one study was found that focused on psychologists, and on issues similar to those addressed in the present work (Coan, 1979). That report examined the relationship between the "personal and theoretical" pathways of the psychologists studied. Interesting as that

study was, it's relevance in the present context is limited because of the diverse specialities of the psychologists. Coan found two basic factors, the objectivist - subjectivist split described in so much of the literature. Clinicians, as one would predict, tend to be found on the "subjectivist" side of the fence. Coan did not examine different personal and theoretical pathways among clinicians separately and in that sense his work contributes little in the present context.

In addition, there have been no studies of psychologists alone, nor have there been studies of how experienced therapists respond to the uncertainty of their work.

There is, however, one study that speaks to the current topic: Daniels, (1976) in a study of the complaints psychiatrists have about their work found five basic areas of concern. These were:

1. Concerns about the effectiveness of treatment.
2. Concerns about the isolation involved in psychotherapy.
3. Concerns about the image of psychiatrists among colleagues, patients, and the general public.
4. Concerns about the personal strains imposed by work that is too hard; too pressured; lacking

adequate financial rewards; and fraught with too many temptations.

5. Concerns about the negative personal characteristics of many colleagues.

The present research identified six areas of concern among clinical psychologists. They were:

1. Concerns about maintaining the boundaries between personal and professional life.
2. Concerns about self-disclosure.
3. Concerns about whether the therapist was really earning the fees patients paid.
4. Uncertainty in matters of technique.
5. Concerns about ethical issues.
6. Concerns about lack of theory and guidelines in psychotherapy.

A comparison of these two lists of problems shows that they overlap in some areas but not in others. One large area of overlap is the concern about the effectiveness of treatment. In the present sample, this concern was expressed in several of the problem areas described above. Specifically, concerns about whether fees are really earned; concerns about specific matters of technique; and concerns about the lack of theory and guidelines in psychotherapy, all seem to be related to concern about effectiveness.

The concern about personal strains of the work, that Daniels identified, is comparable to two of the dimensions of therapist concern identified in this work. One of these was the concern about the separation between personal and professional life. The other was the concern about self-disclosure found in the present research. Therapists who were rated high on either of these dimensions were concerned about making sure that the pressures of psychotherapy didn't spill over into their personal lives. Other therapists, those rated low on one or the other of these dimensions, were not concerned about these issues. High concern about the separation between personal life and professional life was one type of personal strain identified in this research. High concern about self-disclosure is another personal strain identified in this work.

Concern about the temptations available to psychiatrists, as reported by Daniels, is similar to the dimension of concern about ethical issues found in the present sample. A high degree of concern about ethical issues seems to overlap with concern about the temptations of the work. A low degree of concern about ethical issues would, of course, not overlap conceptually with the concern about temptations that Daniels identified.

Two areas of concern identified by Daniels that were not identified in the present work were concern about isolation and rejection of colleagues. Perhaps Daniels' respondents felt isolated because they didn't respect their colleagues. When asked about whether they saw enough of, and benefited from seeing colleagues, most respondents in the present study reported that they were generally pleased with their relationships with colleagues.

Although Daniels' study came closest to an examination of therapists' personal responses to therapy it is limited in its applicability in the present context for three reasons:

1. She studied only psychiatrists.
2. Uncertainty was not a specific focus of her study.
3. She did not attempt to differentiate between the theoretical orientations of the therapists she studied.

Another study was also somewhat similar to the present study (Kahn-Hut, 1974). Kahn-Hut studied experienced psychiatrists, most of them psychoanalysts affiliated with a private hospital in the Boston area. Her primary focus was on how these analysts managed to avoid alienation given the many characteristics of psychotherapy that might produce alienation. Probably her most important finding

was that the analysts tended to attribute "successful" outcomes to their own efforts, and "unsuccessful" outcomes to their patients' unreadiness for change.

One of the dimensions of approach to therapy identified in this study had to do with therapists' perception that patients and the general public were too demanding. Therapists who scored high on this dimension were rated as viewing patients and lay-persons as too demanding of psychotherapists. Conversely, the opposite was true of therapists rated low on this dimension. On the surface, this dimension seems conceptually similar to the tendency to blame failures on patients that Kahn-Hut identified.

As part of the interview for the present study therapists were asked to describe a successful case and an unsuccessful one, and to say what factors they thought contributed to those outcomes. A reading of the interview transcripts shows that a few of the therapists did tend to fit the pattern Kahn-Hut described. These therapists were in the minority however. Both the Q-Sort statements about therapists' approaches to therapy, and the Likert Scales referring to therapists' dilemmas or concerns included items that could have confirmed Kahn-Hut's findings. None of these statements emerged as prominent descriptors of the present sample. It therefore seems that the psychologists

interviewed were not as likely as Kahn-Hut's respondents to believe that the responsibility for failure lay more with patients than therapists.

How can this difference be explained? Assuming for the moment that the differences are real, to what might they be attributed? Kahn-Hut's sample differs from the present one in several important respects. Her respondents were all psychiatrists, psychoanalysts, and all were affiliated with the same hospital. Any one of those factors may be critical in influencing the attitudes she observed. Light (1980), found similar notions among the psychiatric residents he studied - but again, his sample was of psychiatric residents, and his study took place in the same area where Kahn-Hut's sample was based. Light's respondents were different from Kahn-Hut's only in their relative lack of experience. Therefore his findings do little explain the differences.

Possible explanations of these differences include:

(1.) That present respondents were more ideologically diverse than the analysts interviewed by Kahn-Hut. Because of this they did not have a particular "party-line" to rely on or to defend when discussing cases that had not worked out well.

(2.) That present respondents were not affiliated with any single institution. They shared neither a common peer group nor the need to uphold the status of a particular hospital.

(3.) That present respondents were not physicians by training. Consequently these psychologists may have felt less of a professional expectation about "cure" than physicians. Therefore they may have been less defensive about the image of themselves as "healers".

B. <u>The role of research in the professional lives of clinical psychologists</u>

The results indicated, not at all surprisingly, that the respondents had somewhat mixed attitudes about research. This is not earth-shaking, given that three-fourths of the respondents were not engaged in research and were not planning to be anytime soon.

What lay behind the interest in this topic was the notion that there was something not quite right about the way clinical psychologists often approach research. It was felt that a profound distrust of self underlay conventional styles of research. That apparent distrust seemed at least alienating if not potentially worse. Especially in a field as uncertain as psychotherapy, it seemed that better ways of translating subjective perceptions into testable

hypotheses were necessary. It also seemed that given the realities of a declining economy and a declining student population, most recently trained clinical psychologists have little likelihood of working in academic settings. Without access to grant offices, sophisticated computer systems and university libraries, the conduct of research as it is generally taught seems a difficult proposition indeed. In sum, the approach to research that prevails seemed inappropriate as well as nearly impossible for the non-academician. Furthermore, other styles of investigation more useful in non-academic settings do exist but tend not to be taught or to be published in the psychological literature. The issue was not the abandonment of intellectual rigor, but a broader methodology. Rigid adherence to inappropriate methodology was seen as potentially leading to an atrophy of curiosity with consequences extending into clinical practice.

The situation seemd analogous to the person searching for a lost car key in a brightly lit part of a parking lot. As the story goes, the searcher is joined by a passerby who helps him search. Finally the passerby asks the searcher "Are you sure you dropped the key here?" to which the searcher replies, pointing to a darkened area at a distant part of the lot, "No I dropped it over there." When the passerby asks "Why then, are you searching here?" The

searcher replies "Because this is where the light is." Clearly the key will not be found and in that sense the search becomes a waste of time.

There was, therefore, a proto-hypothesis underlying the interest in exploring clinical psychologists' views about research. The hypothesis was that: without more appropriate models of investigation psychologists are left with an unconstructive distrust of self. They are also left without better ways to investigate the issues that interest them or trouble them. This hypothesis was not confirmed in the present study. The psychologists interviewed did not seem troubled by the nature of research in the field. Most of them rejected conventional research as a component of their own professional lives, but for the most part the results show that they were content with the model.

There are several possible reasons why these ideas were not confirmed. One of them is that they were wrong. To some degree I believe they were. It was clear from many of the interviews that the respondents simply ignored the issue of research. Instead they found other ways to solve the dilemmas their practices engendered. Many attended workshops or enrolled in advanced training programs. Most had peer groups with whom they met to discuss their work. Most also tried to keep up with the clinical literature.

These activities constituted the respondents' research involvement in a meaningful though broadly defined way. Furthermore, the results indicate that the respondents valued the skills associated with their research training.

It may also be that the socialization process involved in completing graduate school creates a situation of cognitive dissonance (Festinger, 1957). The institutions of clinical psychology as it is conventionally taught and practiced may be internalized simply because they are commonly accepted and are the source of valuable status and group membership.

Another possibility is that the tools to properly investigate this issue were lacking in the present study. One way to approach this issue would be through a longitudinal experiment. For example, therapists could be trained in the methodology of hermeneutics - (i.e. the analysis of texts - a method analogous to biblical or literary criticism, and one the present author views as potentially of great use to therapists (Bauman, 1978)). These therapists could be monitored over time and their approaches to therapy could be compared to those of a control group. Differences in their development over time would be of interest. One possible hypothesis would be that the experimental group would tend to publish more than the control group. What lies behind this hypothesis is the

possibility that therapists trained in a research methodology more compatible with both clinical work and with non-academic life, would have research tools that they could more realistically and effectively apply to their everyday professional lives. Consequently they might beel empowered in matters of investigation in ways they may not presently feel. Although it must be recalled that the present sample of psychologists do, on the whole, value their research skills, they do not tend to do research, nor do they tend to publish their work.

Another hypothesis would be that such a group would do better on measures of therapy process and outcome than a control group. What lies behind this notion is the hypothesis that a methodology such as hermeneutics incorporates skills that are synergistic with therapeutic skills, i.e., the ongoing analysis of a text of which both participants (patient and therapist) are co-constituents and co-authors.

The foregoing discussion leads naturally to a discussion of the strengths and weaknesses of the present study. It also leads to a discussion of the broader implications of these findings for both clinical psychology and psychotherapy in general.

In my view, this study has two major strengths, one substantive and the other methodological, but also personal. On the substantive level this work attempted to establish that a linkage exists between uncertainty in psychotherapy and therapists' approaches to psychotherapy. It established some linkages between the concerns - or lack thereof, that therapists experience in their work and aspects of their approaches to psychotherapy. Three areas of concern were especially linked to uncertainty. These were uncertainty in technique, concern about ethical issues, and concern about the lack of theory and guidelines in psychotherapy. These areas of concern were linked to differing approaches to psychotherapy.

In addition, therapists' attitudes toward uncertainty in their work and the ways they dealt with uncertainty were also studied. On the whole, these therapists recognized uncertainty as an aspect of their work and were generally rated as more tolerant than intolerant of uncertainty. The two ways of dealing with uncertainty most characteristic of this sample were seeking supervision and personal honesty. Relationships between attitudes toward uncertainty, ways of dealing with uncertainty, therapists' concerns, and demographic characteristics were reported and discussed. On the whole, patience, a tolerance for ambiguity, further training and a high value set on honesty summarizes the

approaches of this group to resolving uncertainty in their work. Although some relationships were found between these approaches to uncertainty and therapists' concerns about their work, no other compelling patterns were identified.

Taken together, all of these findings add some support to a broadening of interest from the level of individual differences to the levels of group socialization processes and the structure of institutions -- especially with regard to professions. These findings emphasize the importance of studying the interaction between issues inherent in the profession and individual consciousness. Specifically, this study emphasizes the context of psychotherapy rather than the personalities of therapists. The influence of training and conventional practice is recognized as being more important than has often been assumed, and consequently they are seen as worthy of more in-depth study.

The biggest strength of this work then, is the expansion of interest to include these areas. It supports a systems oriented view of the profession of psychotherapy. Studying the context of practice in psychotherapy may help psychologists anticipate, avoid, or cope better with the problems inherent in their work.

On the level of methodology this study has several strengths. Interviews were conducted by the researcher.

Original measures were derived from pilot data and from interview transcripts, and raters were trained. In each phase attention was paid to making this research compatible if not synergistic with clinical work itself.

These combined factors are considered a "strength" of the work for two reasons. They involved varied and mutually enhancing tasks, and enhanced interviewing and conceptual skills useful in clinical work. This author believes strongly that the integration in meaningful ways, of clinical and research skills is an important task for clinical psychologists. Consequently, the subjective experiences of the researcher should be attended to where relevant just as they are in psychotherapy.

* * *

In summary, it can be concluded that uncertainty is an issue therapists deal with; that therapists have fairly distinct orientations; and that the two areas are linked in some cases. It cannot be concluded from this study that conventional approaches to research are inappropriate or generally viewed as problematic. They were viewed as irrelevant in many respects, however.

One flaw in this study was the absence of personality measures. This absence was deliberate because the major area of interest was psychotherapy itself rather than the personalities of practitioners. Nonetheless, it would

be interesting to have some sense of how the findings of this study relate to personality variables.

The present sample was small for the somewhat sophisticated statistical analyses to which the data were subjected. A larger sample would have been preferable. Thus, the size of the sample is another shortcoming of this study.

The broadening of concern to include generic aspects of the profession in studying therapists has potentially important benefits. Therapists should not only know themselves as they come already formed to psychotherapy. They should also be conscious of the forces at work on them that derive from the nature of the profession. They should be enabled to systematically examine those features of the profession that influence both ideology and personality. Whitaker and Malone noted long ago that psychotherapy often becomes a "way of life" for its practitioners (Whitaker and Malone, 1953). This way of life with all its ramifications bears examining if therapists are to become better observers of the world around them and of their patients.

CHAPTER V

SUMMARY AND CONCLUSIONS

This dissertation concerns several aspects of uncertainty in psychotherapy. The literature review presented the notion that uncertainty is pervasive in psychotherapy. Drawing upon relevant discussions from the fields of clinical psychology, psychiatry, psychoanalysis, social work, and the sociology of professions, findings from these diverse areas were synthesized and analyzed to document the relevance of uncertainty as an aspect of psychotherapy.

The broad topic of uncertainty in psychotherapy was divided into three subcategories, namely uncertainty in outcome, theory, and technique. It was suggested that although all professions are characterized by some types of uncertainty, psychotherapy is distinguished by uncertainty in all areas. It was therefore suggested that all therapists must find ways of coping with the uncertainty of their work if they are to continue working with conviction. The literature touching upon therapists' responses to the strains of their work was also reviewed, with particular emphasis on uncertainty as a source of stress.

Another area of uncertainty was also discussed. This area concerned the uncertainty of research in psychotherapy. Much of the conventional psychological research on psychotherapy has been unsuccessful in providing guidance for practitioners. It was therefore suggested that these research findings may add to the uncertainty of psychotherapy. Such findings, by their very lack of clarity, may become part of the problem rather than part of the solution. In effect, the practitioner is left in doubt as to whether the ambiguous research findings are due to poor research or to psychotherapy itself. This situation therefore increases rather than resolves uncertainty.

Eight questions were posed to investigate these areas. These questions were as follow:

1. What types of dilemmas do clinical psychologists experience in their therapeutic work?
2. What principles, predispositions, or tacit "theories in use" guide clinical psychologists' reactions to therapeutic uncertainty?
3. Are these dilemmas and their resolution related to uncertainty in theory, technique, and outcome?
4. How do clinical psychologists view the uncertainty of their work?

5. Do clinical psychologists experience the imbalance between their clinical and their research efforts as conflictual?
6. How do clinical psychologists resolve the imbalance between their clinical and research efforts?
7. What effect does training in research have on the ways clinical psychologists do psychotherapy?
8. Are clinical psychologists satisfied with their research training?

Clinical psychologists were to be studied exclusively in this project because of the absence of such examination in the earlier literature. Seventeen questions and fourteen incomplete sentences were devised to respond to these questions. Using an interview format, these instruments were given to thirty-five clinical psychologists in the Washington, D.C. area. Two scaling measures were then created and applied to the interview transcripts. One measure consisted of 74 Likert-type scales touching on psychologists' concerns about aspects of their therapeutic work. These scales also addressed psychologists' attitudes toward research in their training and in their current professional lives. The other measures was a 100 item Q-Sort deck generated from pilot studies, the literature, and the interviews, and then used by raters

to scale therapists' approaches to psychotherapy. Demographic data concerning age, gender, full vs. part time practice, research involvement, and publication history were also collected. Correlational and cluster analytic techniques were used to analyze these findings.

Six areas of concern about doing therapy were identified from cluster analysis of the Likert scales. Ranging from the general (relevant to all professions) to the specific (specific only to psychotherapy), these problems were the following:

1. Concern about maintaining the boundary between personal and professional life.
2. Concern about how much of their own experiences therapists should disclose to patients.
3. Concern about whether therapists were really earning the fees they were paid.
4. Concern about uncertainty in technique.
5. Concern about ethical dilemmas such as sexual or aggressive feelings toward patients.
6. Concern about the lack of therapeutic theory and guidelines.

Six basic points of view about psychotherapy were identified from the cluster analysis of the Q-Sort

ratings of therapists' approaches to psychotherapy. These were the following:

1. Psychodynamic vs. eclectic approach to therapy, i.e, an approach to psychotherapy that was highly theory-bound in a psychodynamic sense, vs. an approach that rejected psychodynamic theory in favor of a more eclectic approach.

2. Therapist uncertainty and self-doubt in psychotherapy, i.e. a point of view about psychotherapy that focused heavily on therapist concerns about personal inadequacies and technical uncertainties.

3. Personalization of psychotherapy, i.e., a point of view about therapy that approached psychotherapy as not unlike friendship in the gratification of the therapist's own needs within the context of therapy.

4. Perceived patient demands, i.e., a point of view about psychotherapy that focused heavily on the difficulties in meeting the needs and expectations of both patients and the lay-public.

5. Research mindedness, i.e., a point of view about therapy that emphasized the role of cognitive and research oriented or "tough-minded" empiricis in practicing psychotherapy.

6. View of therapy as a matter of inspiration, i.e., a point of view about therapy that focused heavily on

the role of the therapist's intuition as a guide to therapy.

Correlations between therapists' concerns about their work and therapists' "tacit" approaches to psychotherapy were done. Several basic approaches were found. One approach was characterized by a basically psychodynamic vs. an eclectic point of view. This basic orientation was reflected in a series of relationships all of which tended to be consistent with an approach to therapy heavily influenced by and consistent with a psychoanalytically oriented point of view. A non-psychodynamic point of view, called "eclectic" in this work, was characterized by a series of relationships the converse of those characteristic of a psychodynamic point of view.

A psychodynamically oriented point of view was characterized by a high degree of concern about such issues as uncertainty in technique, the lack of theory and guidelines in psychotherapy, the separation between personal and professional life, and self-disclosure. These concerns were negatively associated with the basically ecletic point of view that was the obverse of the psychodynamic approach. This point of view was highly relativistic, forsaking formal theory in favor of a more case-by case approach, and showing less concern about the lack of theory and guidelines in therapy, uncertainty in

technique, self-disclosure, and the separation between personal and professional life.

Another basic approach to therapy was similar to the eclectic point of view in that it shows a pattern of relationships almost the mirror image of the psychdynamic approach. This approach was best characterized by the pattern of relationships associated with a highly personalized view of therapy. This pattern was related to lack of concern about uncertainty in technique, self disclosure, and ethical concerns, as well as a negative association with a psychodynamic point of view and a positive association with a view of therapy as largely a matter of inspiration. In general, this pattern was consistent with a view of therapy as an intuitive process not unlike friendship. Conversely, a rejection of this point of view was associated with a pattern of relationships very similar to that associated with a psychodynamic point of view.

A third constellation of relationships linked perceived patient demands with both therapist uncertainty and self-doubt and concerns about ethical issues. This pattern was not linked with either a personalized, an eclectic, or a psychodynamic point of view. Instead these relationships linked the presence or absence of a perception that patients or the lay-public were too demanding with the

presence or absence of concerns about ethical issues and therapist self-doubt. High ratings on this approach were described as generally reactive because of the lack of association with specific approaches to therapy. Low ratings on this approach indicate an approach of greater certainty and sanguinity with regard to ethical concerns.

In addition, therapists' views about uncertainty in psychotherapy and ways to resolve it were discussed. In general, these therapists tended to view uncertainty as an important aspect of psychotherapy. The most characteristic approaches to uncertainty included seeking supervision, endorsing patience and a tolerance for ambiguity, and seeking more training and experience.

Therapists' attitudes toward the relevance of research in their professional lives were also studied. In general, these psychologists tended to value their competence in research, and to recognize the value of their research experiences and related skills. At the same time they tended to consider research irrelevant to their present professional lives.

Demographic characteristics of this sample were compared with characteristics of psychologists reported in a recent national survey. It was concluded that these respondents were similar in most important respects to the national sample. Disproportionately high numbers of

females and low numbers of minorities in the present sample were reported and their implications were discussed.

The overall findings of this research were summarized and compared with findings reported in the literature. Similarities and differences between the present findings and those of other research were also discussed. Primary among these differences was the fact that this sample was composed entirely of psychologists. Another major difference was the fact that therapists' approaches to psychotherapy were discussed along with the problems that the therapists experienced in their work. Neither of these two issues as they relate to clinical psychologists had been studied previously.

Areas for future research were suggested. Among these were the inclusion of personality measures in a study like the present one; a comparison between groups trained in different research methodologies; a comparison of minority therapists to white therapists; and comparisons with therapists practicing in other geographical areas.

Strengths and weaknesses of this research were also discussed. The primary strength discussed was in the interface between the personal and the professional aspects of psychotherapy. The primary weaknesses discussed were the small sample size and the absence of any personality measures.

The broader implications of these findings were also discussed.

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APPENDIX A

Telephone Request For Subjects

Hello, my name is Sheila Bienenfeld. I am working on my dissertation in clinical psychology from Michigan State, and I've called you because I would like to interview you, at your convenience, as part of my data collection.

My dissertation is called An Inquiry Into Uncertainty In The Fifth Profession, and it has to do with how clinical psychologists feel about psychotherapy, and in general about being clinical psychologists.

The interview is semi-structured, and it involves your answering about twenty-five questions and filling in a brief questionnaire. Of course I promise to maintain the strictest confidentiality, and your name will not appear anywhere in the data.

The interview will probably take about an hour and a half, certainly not more than two hours.

I think it is an interesting interview, and other psychologists I've interviewed have found it very interesting as well.

I would be very grateful if you would participate. Perhaps we can set a time when it would be convenient for you.

If you have any questions, I'll be happy to answer them when we meet, as I'm sure you understand I would rather wait until after the interview to get into any detail about the specific questions I'm looking at in this dissertation.

Interview # _____ Date _____

Questionnaire I

Please complete the following survey. If you have any questions, please feel free to inquire. Please answer all of the questions. Do not write your name anywhere on the questionnaire.

1. Sex _____ 2. Age _____

3. Are you licensed as a psychologist? _____

4. In what State? _____

5. When did you receive your Ph.D.? _____

6. For how many years (not including your training) have you been practicing psychotherapy? _____

7. How many hours a week do you typically spend in the following activities:

   a. psychotherapy _____

      1. individual therapy _____

      2. group therapy _____

      3. family therapy _____

      4. other _____

   b. teaching _____

      1. what do you teach _____
         _____

   c. research _____

      1. what activities does that entail? _____
         _____
         _____

   d. psychotherapy supervision of your own work _____

   e. psychotherapy supervision of others' work _____

      1. students _____

      2. peers _____

Interview # _____ Date _____

f. testing _____

1. what type of testing? _____

2. with what population? _____

g. consultation _____

1. what types of consultation? _____

h. administration _____

1. what activities does that entail? _____

8. Have you had any publications in the professional literature? _____

a. if yes, how many? _____

b. how would you describe them?

1. research reports _____

2. clinical reports _____

3. theoretical ideas _____

4. other _____

9. Have you had psychotherapy yourself? _____ how many times ___

a. For how long were you in therapy in the past (list each therapy if more than once) _____

b. If you are currently in therapy, for how long? _____

Interview # _____ Date _____

10. For each time that you have been in psychotherapy yourself, indicate whether you consider that therapy to have been: very successful (VS); moderately successful (MS); moderately unsuccessful (MU); very unsuccessful (VU).

personal psychotherapy	VS	MS	MU	VU
first time				
second time				
third time				
fourth time				
fifth time				

Questionnaire II

1. What was your image of the practice of psychotherapy when you decided to make it your profession, e.g. How did you think you would be spending your day?

   a. What did you think would be the satisfaction of this work?

   b. Dissatisfaction?

2. Has your idea of the profession changed in any way since you first came into it?

   a. Since you became a psychologist has your idea of what kind of practice you wanted to have changed at all?

   b. In what way - time, type of patients, other activities, satisfactions, dissatisfactions?

   c. Would you advise someone contemplating clinical psychology to come into this field? What would you tell them about the problems and satisfactions of the work?

3. Are there any strains or pressures which you experience that seem inherent in the work of doing psychotherapy?

4. Do you ever feel restricted by the requirements which practicing therapy places on you, e.g. like to say or do something? How often? How do you feel at such times?

5. How do you feel about revealing your own feelings or talking about yourself if a patient asks you to do so?

6. Have your expectations about what can be accomplished in therapy changed since you entered the field?

7. Tell me about one of your most successful cases, why do you think it turned out this way?

8. Tell me about a case which was not successful? Why do you think that it turned out this way?

9. Can you give me an example of a problem which you recently had with a patient? Did you discuss it with anyone?

10. What sorts of things do you discuss with colleagues? Under what conditions do you see them? Would you like to see them more often?

11. If you were asked to recommend one book that has most influenced your work, what would it be?

12. What was the most valuable part of your training?

    How so?

13. What was the least valuable part of your training?

    How so?

14. Are you presently involved in any research projects? If yes, describe. If not, do you plan to be anytime soon? How do you feel about that?

15. Which research studies have had the most influence on your thinking? How?

16. Does your research training influence the way you do therapy? If yes, how? If not, do you have any thoughts about why?

17. During the course of your work you must encounter much uncertainty and perhaps doubt. Has this been a problem for you at any time? How have you dealt with it?

Sentence Completion

1. I know I am doing good work when.....
2. Some of the warning signals that a therapy case is going badly are.....
3. Some of the lessons my patients have taught me are.....
4. I admire my colleagues who.....
5. The thing I most dislike about research is.....
6. One thing about psychotherapy that I feel certain about.....
7. My biggest problem in relating to some of my colleagues has been....
8. A big influence on the way I do therapy has been.....
9. Some predictable milestones in the course of therapy are.....
10. An incident in therapy that was difficult for me to handle was when.....
11. The thing I most like about research is.....
12. I have learned the most from patients who.....
13. One of my biggest conflicts about my work has been.....
14. In my work I feel most uncertain about.....

APPENDIX B

Likert Scales

Question I: What types of dilemmas do clinical psychologists experience in their therapeutic work?

Scale: 1 = very concerned
2 = somewhat concerned
3 = neither concerned nor unconcerned. Can't tell from interview
4 = somewhat unconcerned
5 = very unconcerned

1. How to know when therapy should be terminated.

2. How to determine whether therapy has been successful.

3. The durability of changes that patients make in therapy.

4. How to behave upon meeting a patient outside of the therapy setting (e.g. a party or a bar).

5. What to do if a friend requests treatment for a friend or relative (of the friend).

6. How to deal with sexual attraction to patients.

7. How to deal with patients' sexual attraction to the therapist.

8. How to deal with feelings of dislike or contempt for a patient.

9. What to do if the therapist disapproves of a decision a patient has made.

10. What to do if the therapist disapproves of a relationship a patient is involved in.

11. What to do if a patient fails to pay bills on time.

12. What to do if a patient makes frequent phone calls between sessions to the therapist.

13. How much of the therapist's own history and current life situation to reveal to patients voluntarily.

14. How to answer patient's questions about the therapist's history and current life situation.

15. Whether the therapist is really earning the money that patients pay for therapy.

16. Whether the therapist's technical skills are of adequate range or quality.

Question 1 (continued)

Scale: 1 = very concerned
2 = somewhat concerned
3 = neither concerned nor unconcerned. Can't tell from interview
4 = somewhat unconcerned
5 = very unconcerned

17. About specific mistakes the therapist has made or tends to make, in therapy.

18. About special problems that arise in working with specific categories of patients.

19. About feeling isolated from colleagues.

20. About the danger of becoming isolated from colleagues.

21. About the competence of other therapists.

22. About the ethical standards of other therapists.

23. About the status of clinical psychologists as compared to other mental health professionals.

24. About the possibility of malpractice actions.

25. About the possibility of suicide by a patient.

26. About the absence of a generally accepted theory of psychotherapy.

27. About the absence of clear technical guidelines for doing therapy.

28. About how to accurately diagnose new patients.

29. About the stresses that are part of doing therapy.

30. About how to keep occupational stress from spilling over into personal life.

31. About how to balance the needs of patients against those of family members and/or friends.

32. About how to make sufficient time available for writing, research, or other professional activities.

Question 1 (continued)

Scale: 1 = very concerned
2 = somewhat concerned
3 = neither concerned nor unconcerned. Can't tell from interview
4 = somewhat unconcerned
5 = very unconcerned

33. About saving time for reduced-fee patients

34. About one's own ethical standards.

35. About dealing with feelings of anger toward a patient.

36. About limit setting with clients in therapy.

37. About being in therapy in order to deal with one's own issues.

38. About having sufficient time for clients.

Question 4: How do clinical psychologists explicitly view the uncertainties in their work?

Scale: 1 = very characteristic
2 = somewhat characteristic
3 = neither characteristic nor uncharacteristic. Can't tell from interview
4 = somewhat uncharacteristic
5 = very uncharacteristic

39. Life in general is uncertain and psychotherapy is no different.

40. Eventually things become clear, patience and a tolerance for ambiguity are the keys.

41. Uncertainty diminishes over time, experienced therapists are less uncertain than beginners.

42. Experienced therapists are no less uncertain than beginners, they just tolerate uncertainty better.

43. Because uncertainty stimulates the acquisition of more training, it is a necessary and positive aspect of psychotherapy.

44. Uncertainty is a sign of incompetence.

45. Uncertainty is a sign of burn-out.

46. The only way to deal with uncertainty is by being honest with oneself.

47. The therapist can best deal with uncertainty by having faith in his/her ability to be helpful.

48. The way to deal with uncertainty is to seek supervision.

49. Uncertainty is usually a countertransference phenomenon.

Question 5: Do clinical psychologists experience the imbalance between their clinical and their research efforts as conflictual?

50. Does the therapist see his/her work life as well balanced in terms of psychological research vs. psychotherapeutic practice?

    1 = very balanced
    2 = somewhat balanced
    3 = neither balanced nor unbalanced. Can't tell from interview
    4 = somewhat unbalanced
    5 = very unbalanced

51. If the therapist does not view his/her work life as well balanced in terms of research vs. clinical work, does s/he express conflict about this lack of balance?

    1 = very conflicted
    2 = somewhat conflicted
    3 = neither conflicted nor unconflicted. Can't tell from interview
    4 = somewhat unconflicted
    5 = very unconflicted

52. If the therapist does not view his/her work life as well balanced in terms of research vs. clinical activity, does s/he express satisfaction with the ways s/he spends his/her work time?

    1 = very dissatisfied
    2 = somewhat dissatisfied
    3 = neither satisfied nor dissatisfied. Can't tell from interview
    4 = somewhat satisfied
    5 = very satisfied

Question 6: How do clinical psychologists resolve the imbalance between their clinical and their research activities?

Scale: 1 = very characteristic
2 = somewhat characteristic
3 = neither characteristic nor uncharacteristic. Can't tell from interview
4 = somewhat uncharacteristic
5 = very uncharacteristic

53. Views research as irrelevant to psychotherapy.

54. Views research as incompatible with therapy.

55. Believes therapy <u>is</u> research.

56. Believes that the goal of research training is to develop a style of rigorous thinking rather than actual research productivity.

57. Believes the goal of research training is the development of the ability to read and evaluate published research, rather than actual research productivity.

58. Believes that research is an activity for academicians, and that practitioners have no special obligation to do research in a formal sense.

59. Believes that clinical psychologists have a special responsibility to do research.

60. Believes that research requires special skills that most therapists don't have.

Question 7: What effect does training in research have on the way clinical psychologists do psychotherapy?

Scale: 1 = very relevant
2 = somewhat relevant
3 = neither relevant nor irrelevant
4 = somewhat irrelevant
5 = very irrelevant

<u>Relevance of past research experiencese to present activities</u>

61. as a reseacher.

62. as a therapist.

63. in other professional activities.

64. in psychological testing.

Question 7 (continued)

65. Overall view of graduate school research experience

_____ 1 = very positive 4 = somewhat negative _____

_____ 2 = somewhat positive 5 = very negative _____

_____ 3 = neither positive nor negative, can't tell from interview

66. Research experiences have led to a tendency to think more critically and thus enhance the practice of therapy.

1 = strongly agree
2 = agree somewhat
3 = neither agree nor disagree. Can't tell from interview
4 = disagree somewhat
5 = strongly disagree

67. Research experiences lead to a way of thinking that gets in the way of doing therapy.

1 = strongly agree
2 = agree somewhat
3 = neither agree nor disagree. Can't tell from interview.
4 = disagree somewhat
5 = disagree strongly

68. Research experiences have had little effect on the way s/he does therapy.

1 = strongly agree
2 = agree somewhat
3 = neither agree nor disagree. Can't tell from interview.
4 = disagree somewhat
5 = strongly disagree

69. Views psychotherapy as a science.

1 = strongly agree
2 = agree somewhat
3 = neither agree nor disagree. Can't tell from interview.
4 = disagree somewhat
5 = strongly disagree

Question 8: Are clinical psychologists satisfied with their research training?

Scale: 1 = very relevant
2 = somewhat relevant
3 = neither relevant nor irrelevant, can't tell from interview
4 = somewhat irrelevant
5 = very irrelevant

70. Relevance of research training for completion of graduate school requirements.

71. Relevance of research training for learning to do psychotherapy.

72. Relevance of research training for learning diagnostic procedures.

73. Overall satisfaction with research training.

1 = very satisfied
2 = somewhat satisfied
3 = neither satisfied nor dissatisfied, can't tell from interview
4 = somewhat dissatisfied
5 = very satisfied

74. Overall view of research as part of the professional identity of the clinical psychologist.

1 = very important
2 = somewhat important
3 = neither important nor unimportant, can't tell from interview
4 = somewhat unimportant
5 = very unimportant

Q-Sort Deck

Question 2: What principles, predispositions, or tacit "theories in use" guide clinical psychologists' reactions to therapeutic uncertainty?

1. Therapists who work in institutions burn-out faster.
2. Playfulness is an important part of therapy.
3. The needs of the patient should determine the therapist's approach.
4. People don't really understand what therapists do.
5. Therapy is an almost magical process, it defies explanation.
6. People expect too much from therapists.
7. It is best to be an eclectic therapist.
8. Therapists have to be very patient people.
9. For therapy to succeed, the therapist and the patient must like each other.
10. There are as many "therapies" as there are therapists.
11. There's really no way to predict whether a patient will get better or not.
12. Therapists should be content to see small changes in their patients' lives.
13. A therapist can never be free from self-doubt.
14. Psychologists are at a disadvantage because they don't have the power that psychiatrists have.
15. Psychologists should get as much post-Ph.D. training as possible.
16. The ambiguity of psychotherapy is one of the things that makes it frustrating.
17. If therapy is to succeed, the therapist has to be on the patient's side.
18. Psychoanalysis is still the best therapeutic approach.
19. Psychotherapy is no more ethically difficult than any other profession.
20. Therapists should stick to the "tried and true" methods of psychotherapy.

Q-Sort Deck (continued)

21. It is important for therapists to give up their omnipotent strivings.

22. To be a good therapist you have to be able to tolerate alot of uncertainty.

23. A well trained therapist can work with almost any kind of patient.

24. It is difficult to work with patients when they are angry.

25. The main goal of therapy is to help patients relate better to others.

26. A therapist who is uncertain about his/her work is probably a poor therapist.

27. Regardless of who the patient is, a good therapist is a good therapist.

28. Anything you do in psychotherapy is OK as long as you know why you're doing it.

29. "Process" is more important than "content" in psychotherapy.

30. Flexibility is one of the most important characteristics a therapist can have.

31. Research training helps psychologists to think critically.

32. Alot of therapists don't know what they're doing.

33. A good therapist for one person can be a lousy therapist for someone else.

34. Therapy is an art, not a science.

35. Therapists should feel more guilty about their failures than they do.

36. Psychotherapy requires risk-taking on the patient's part.

37. Psychodynamic theory is the most useful theory of therapy.

38. For therapy to succeed, the patient has to feel heard and understood by the therapist.

39. The most important training experience for therapists is supervision.

40. Psychotherapy works best with patients who are already doing well.

Q-Sort Deck (continued)

41. A therapist just has to have confidence in his/her ability to be helpful.

42. The most important training experience for therapists is practice.

43. No one really knows how or when psychotherapy works.

44. When therapy becomes emotionally draining for the therapist it is a sign that something is going wrong.

45. It is difficult for therapists not to take their patients' problems home with them.

46. Working with the transference is the key to successful therapy.

47. Successful therapy helps people fit in better in society.

48. Therapy is emotionally draining for the therapist.

49. The goals of therapy should be allowed to change over time.

50. When it is going well, therapy is an emotionally enriching experience for the therapist.

51. When therapy fails, both patient and therapist are responsible.

52. People are all basically alike, no matter what their socio-economic background.

53. Therapy is more like friendship than anything else.

54. Therapy is mostly inspiration and a little hard work.

55. Insight is basically irrelevant.

56. It is important for therapists to take the patient's economic and social situation seriously.

57. Therapists don't usually find the professional literature very helpful.

58. Therapists don't change people, they are just catalysts for change.

59. Therapy is a skill that can be explained and taught.

60. After a certain amount of experience, supervision is no longer really necessary.

Q-Sort Deck (continued)

61. Talking to colleagues is good because it just helps to have someone to talk to.

62. Research training is ultimately of little value to therapists.

63. Intuition is one of the therapist's major tools.

64. Psychoanalysis is outmoded.

65. Humor is an important therapeutic tool.

66. Setting boundaries is one of the most important parts of therapy.

67. Life experience is one of the therapist's major tools.

68. Therapists usually feel satisfied with the outcome of therapy.

69. Patients are easy to please.

70. A good therapist is a skilled craftsman.

71. The therapist's own feelings about the patient are the best data about how therapy is progressing.

72. It is the therapist's responsibility if therapy fails.

73. Therapy is an intrinsically slow process.

74. Therapy should be terminated when its initial goals have been reached.

75. A therapist should have a coherent theoretical framework for doing therapy.

76. Patients are rarely healthier than their therapists.

77. Therapists should be careful to keep their own needs outside therapy.

78. Therapists should always be experimenting with the latest techniques.

79. It is important to belong to a philosophical "school" of psychotherapy.

80. It is important to focus on the patient's behavior outside of therapy.

81. Psychodynamic theory is not helpful in doing therapy.

Q-Sort Deck (continued)

82. It is important to be honest with patients at all times.

83. Therapists should be able to take from their patients as well as give.

84. It is inappropriate for a therapist to give advice to patients.

85. It is impossible for a therapist to keep his/her own needs outside of therapy.

86. Therapists should feel free to touch or hold their patients.

87. The therapist's job is to build up the patient's self-esteem.

88. The therapist's best source of information is the patient's resistance.

89. A therapist should always get supervision no matter how experienced s/he is.

90. Research training helps psychologists understand their work.

91. Therapists often rely on their own life experiences in order to know how to guide their patients.

92. Talking about their own lives is the way some therapists give to their patients.

93. Even when they try not to, therapists impose their values on patients.

94. Most therapists feel guilty about their failures.

95. Patients are therapists' best teachers.

96. Therapists expect too much from themselves.

97. Insight is the most important outcome of therapy.

98. Miracles don't happen in psychotherapy.

99. Ineffective therapists think their colleagues are ineffective too.

100. There's a certain kind of person who's a born therapist.

APPENDIX C

Table C-1

Psychologists' Explicit Attitudes Toward Uncertainty: Relationships Between These Attitudes and Demographic Characteristics and Between These Attitudes and Therapist Concerns (Likert Scales)

	sex	age	hours/week of psychotherapy	publication	current research activity	I. Personal vs. Professional Life	II. Concern about self-disclosure	III. Concern about whether fees are earned	IV. Uncertainty in technique	V. Ethical concerns	VI. Concern about lack of therapeutic and guidelines
39 Life is uncertain and psychotherapy is no different	-.09	.03	.21	.03	.23	-.10	-.05	-.13	-.25	-.39*	.01
40 Eventually things become clear. Patience and a tolerance for ambiguity are the keys	-.29	-.18	-.09	-.15	.07	-.07	.25	-.16	.59**	.59**	.13
41 Uncertainty diminishes over time, experienced therapists are less uncertain than beginners	-.30	.02	-.29	-.15	.01	-.18	.21	-.14	-.03	-.07	.49**
42 Experienced therapists are no less uncertain than beginners, they just tolerate uncertainty better	.01	-.04	.18	-.19	-.24	.16	.05	-.18	.03	.13	-.02
43 Because uncertainty stimulates the acquisition of more training, it is a positive aspect of psychotherapy	.02	-.12	-.05	-.11	-.32	.49**	.25	-.19	.52**	.25	.10
44 Uncertainty is a sign of incompetence	.03	.27	-.19	.09	-.25	-.03	.02	.35	-.07	.07	.19
45 Uncertainty is a sign of burn-out	-.23	.08	.08	.08	.03	-.05	-.15	.20	.08	.05	-.03
46 The best way of dealing with uncertainty is by being honest honest with oneself	-.09	.03	.21	.03	.23	.12	.02	-.16	.09	-.24	-.14
47 Therapists can best deal with uncertainty by having faith in their ability to be helpful	.01	-.11	.11	-.07	-.17	-.21	-.02	-.39*	-.05	.02	-.05
48 The way to deal with uncertainty is to seek supervision	-.49**	.29	-.12	-.49**	-.02	.24	.42**	-.16	.59**	.59**	.49**
49 Uncertainty is usually a countertransference phenomenon	-.39*	-.01	-.08	-.49**	.24	-.41**	.29	-.13	.39*	-.01	.59**

*p <.05 ** p <.02
**sex is scored high for females
low for males

Table C-2

Master Correlation Matrix Showing Relationshps Between Therapist Concerns (I-VIII), Approaches to Psychotherapy (1-6), and Demographic Characteristics

	sex***	age	years since Ph.D.	hours/week, therapy	publications	research	VII. relevance of research training in professional life	V. ethical concerns	II. concern about fees	VI. concern about lack of therapeutic theory and guidelines	IV. self-disclosure	I. personal vs. professional life	VIII. usefulness of research training outside of actuale research activity	III. uncertainty in technique	1. psychodynamic-eclectic	2. umcertaintv. self-doubt	3. personalization of therapy	4. research mindedness	5. perceived patient demands	6. therapy as inspiration
sex***	100																			
age	-.37*	100																		
years since Ph.D.	-.49**	.54**	100																	
hours/week, therapy	.14	-.08	-.20	100																
publications	.03	-.08	.03	-.14	100															
research	-.31	.08	.08	-.08	.31	100														
VII. relevance of research training in professional in professional life	.15	-.09	-.16	.28	-.14	+.70**	100													
V. ethical concerns	-.16	-.17	.11	-.06	-.31	-.16	-.02	100												
II. concern about fees	-.38*	.00	-.06	-.18	-.14	-.09	-.04	.19	100											
VI. concern about lack of therapeutic theory and guidelines	-.33	-.52**	.32	-.12	+.41**	.01	-.15	.03	-.21	100										
IV. self-disclosure	-.18	.16	.16	+.48**	-.09	.27	-.24	.27	.06	.44**	100									
I. personal vs. professional life	.12	.18	.15	-.29	.16	-.15	.03	.27	.23	.01	.38*	100								
VIII. usefulness of research training outside of actual research activity	-.01	-.01	-.28	.00	-.05	.15	.12	.02	-.23	-.19	.01	.07	100							
III. uncertainty in technique	+.45**	.18	.31	-.02	+.51**	-.09	.06	.71**	-.17	.44**	.46**	.24	.05	100						
1. psychodynamic-electic	.33	-.12	-.33	.18	.11	-.17	.15	-.33	-.02	+.52**	+.57**	+.36**	.06	+.42**	100					
2. uncertainty, self-doubt	.31	-.41**	-.43**	-.04	.18	-.13	.29	+.39*	-.06	-.24	-.08	.17	.01	-.13	.15	100				
3. personalization of therapy	-.23	.06	.41**	-.37*	-.18	-.02	-.10	-.52**	-.01	.20	-.36*	.29	-.01	-.36*	-.63**	-.28	100			
4. research mindedness	-.13	.20	.14	-.26	.13	.60**	+.78**	-.32	-.02	.08	.10	-.11	-.13	-.27	.02	-.19	-.19	100		
5. perceived patient demands	.23	.10	-.18	-.16	.04	-.10	.04	+.54**	-.10	.02	-.03	-.12	-.06	-.30	.10	.46**	-.25	.24	100	
6. therapy as inspiration	-.12	.10	.25	-.02	-.47**	-.12	.26	-.41**	-.002	.30	-.50**	-.42**	.22	-.55**	-.59**	.08	+.52**	-.41**	-.27	100

Note: Clusters I-VIII were scored in the direction opposite to that of the demographic variables and Clusters 1-6. In order to facilitate understanding, relevant correlations (i.e., significant) have been reflected here.

*p<.05 **p<.02
***+=female
-=male

APPENDIX D

General Instructions To Raters

Before you begin rating an interview, read the entire transcript. Once you have read the transcript through you can begin. Although you should base your ratings on the entire transcript there are certain portions of it that should be especially relevant for different groups of scales. These are as follow:

For scales 1-38 pay special attention to interview questions 3;6;9; and 17; and incomplete sentences 6; 10; and 14.

For scales 39-49 pay special attention to interview questions 3;6;9; and 17; and incomplete sentences 6; 10; and 14.

For scales 50-60 pay special attention to interview questions 11;14;15; and 16; and incomplete sentences 5 and 11.

For scales 61-74 pay special attention to interview questions 1;2;12;13;15; and 16; and incomplete sentences 5;8; and 11.

As a general rule, a rating of 1 (very concerned) should be given when the therapist is either strongly concerned or conflicted about an issue or the issue is clearly one of considerable concern.

A rating of 2 (somewhat concerned) shouldbe given when the therapist expresses some conflict, distress, or concern, but the issue does not seem very important to him or her.

A rating of 3 (neither concerned nor unconcerned, can't tell from the interview) should be given when the issue does not appear at all in the interview, or when the therapist takes a relativistic or case by case stance toward the issue.

A rating of 4 (somewhat unconcerned) should be given when the therapist recognizes the issue as potentially important but only for others rather than for him/herself.

A rating of 5 (very unconcerned) should be given when the therapist either views the issue as trivial or has a fixed stance of one sort or another toward the issue that allows for virtually no conflict.

APPENDIX E

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.

T.S. Eliot (Little Giddings)