PERSPECTIVES ON PSYCHOTHERAPY: DRIVE EXPRESSIONS AND SELF-ESTEEM AS RELATED TO OUTCOME

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ABSTRACT

PERSPECTIVES ON PSYCHOTHERAPY: DRIVE EXPRESSION AND SELF-ESTEEM AS RELATED TO OUTCOME

By

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This study investigated the differences in change scores between Successful (S) and Partially Successful (PS) therapy groups. Change scores were based on differences from pre to post therapy testing. Specifically, changes in self esteem as measured by the Tennessee Self Concept Scale and drive expression (amount, level of socialization, and degree of integration) as measured by the Pine Rating System for Thematic Appreciation Test protocols were examined.

Successful and Partially Successful groups were formed on the basis of client and therapist evaluation of outcome of therapy and pre therapy ego strength as measured by Barron's Ego Strength Scale, a scale derived from the MMPI. Nine clients were classified as Successful and 11 as Partially Successful.

The following hypotheses were examined.

Hypothesis I: Amount and level of drive content as expressed in TAT protocols will change more from pre to post testing in those cases rated successful as opposed to those cases rated partially successful.

Specific predictions are:

Hypothesis I-a: Total amount of drive expressed as measured by the Total Drive Content (TDC) will increase more in those cases rated successful as opposed to those rated partially successful.

Hypothesis I-b: The amount of drive which is expressed in socially acceptable ways as measured by Direct-Socialized (D-S) Drive Content will increase more in those cases rated successful as opposed to those rated partially successful.

Hypothesis I-c: The amount of drive which is expressed in highly constricted ways as measured by the Disguised-Indirect (D-I) score will decrease more in those cases rated successful as opposed to those rated partially successful.

Hypothesis I-d: The amount of drive expressed in unsocialized ways as measured by the Direct-Unsocialized (D-U) score will decrease more in those cases rated successful as opposed to those rated partially successful.

Hypothesis I-e: The degree of drive integration as measured by the weighted proportion of thematic, incidental, and nonappropriate drive ratings will increase more in those cases rated successful as opposed to those rated partially successful.

Hypothesis II: Self esteem as measured by the Total P score on the Tennessee Self Concept Scale will increase more in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis III: There is a positive relationship between pre therapy ego strength as measured by Barron's Ego-Strength Scale and post therapy measures of Total Drive Content, Direct-Socialized drive, degree of integration, and self esteem.

Neither Hypotheses I nor II were supported by the data. That is, there were no differences in change scores between groups. It was suggested that clients designated as S and PS are so similar that differences in the potential effects of therapy may not be great enough to be measurable.

In a post hoc analysis, within group changes from pre to post therapy were examined. Although there were no changes in *manner* of expressing drive, *amount* of drive significantly decreased and self esteem significantly increased within both groups. It was suggested that the Pine Rating System, although capable of assessing gross changes, such as amount of drive content, may lack the needed sensitivity to reflect subtle changes, such as manner of expressing drive. The increase of self esteem from pre to post therapy testing is similar to the findings of other researchers. It was speculated that the decrease in Total Drive Content from pre to post therapy testing reflected a movement toward average, adaptive amounts of drive expression.

Hypothesis III was partially confirmed. Although all of the correlations were in the predicted direction, the majority was small and non-significant with the exception of post therapy self esteem which was significantly correlated with pre therapy ego-strength. It was suggested that Barron's Ego-Strength Scale and the Tennessee Self Concept Scale assessed similar aspects of personality in contrast to those assessed by the Pine Rating System.

As a sidelight to this study, it was noted that experienced therapists saw clients who as a group had lower ego strength scores. Clients with lower ego strength scores were rated as being less successful in terms of therapy outcome. It was further noted that clients in the two

groups (Successful vs. Partially Successful) differed at a statistically significant level on pre therapy measures of self-esteem as well as post therapy measures of self-esteem.

Approved Norma Abels
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INTRODUCTION: THE PROBLEM

One of the most important areas within the domain of psychotherapy is the issue of outcome. The relative merit of various approaches to psychotherapy, the effectiveness of psychotherapy, process research, as well as the assessment of therapists' skills are a few issues of import in which outcome is a central variable.

In spite of the magnitude of import attributed to outcome, there has been a dearth of research in this area. This relative lack of attention seems to be due, at least in part, to the difficulties associated with assessing outcome. An overriding issue is the criterion problem, that is, dimensions along which therapeutic outcome has and can be measured and the theoretical and measurement problems associated with these dimensions. In short, it is very difficult to adequately define and measure therapeutic outcome.

In the past, various methods have been utilized in an attempt to assess outcome. While it may be obvious that a therapist's knowledge of a client is second to none, it is also obvious that a therapist's judgment is vulnerable on a number of grounds. His personal involvement as well as a necessarily sequential view of the client's life are both factors which tend to contribute toward a biased evaluation.

A concerted effort has been made in recent years to objectify the therapist's observations, by developing measures of the patient's intratherapy behavior. Thus, one approach quantifies aspects of the patient's verbal behavior, another approach asks the patient to

evaluate his own status, while a third method has dealt with assessment by means of psychological tests.

Gottschalk and Auerbach (1966) have delineated 3 major types of psychological test instruments in assessing outcome. Included in the major types are the self-report test, the projective test, and the behavioral rating scale. Each has its specific advantages and disadvantages. Self-report forms are easy to administer, require little skill on the part of the examiner and lend themselves readily to statistical analysis. However, all self-report type tests present a situation in which the subject may attempt to present a distorted picture of himself. That is, in contrast to other types, self-report tests lend themselves more easily to faking or distortion.

In contrast, subjects find it much more difficult to anticipate which personality traits are being assessed by a projective test. Among the attributes of projective tests are their ambiguous character and an indirectness reminiscent of the psychoanalytic emphasis on the importance of memories, thoughts, and feelings that are less available to consciousness, i.e., they cannot be communicated in response to direct questions. This characteristic of indirectness is reflected in the subject's relative inability to assess the significance of his responses as well as a lack of awareness as to the purpose of the task. This characteristic, coupled with the ambiguity of projective stimuli, serves to facilitate the communications of associations that might be avoided in a direct verbal exchange. Although the above characteristics are definite advantages, there are certain disadvantages associated with projective tests. Because the aim of tests of this type is to assess a broad range of personality variables as well as uncovering psychodynamic relationships and unconscious psychological drives and conflicts,

the resulting constructs are necessarily complex. As a result, projective tests require a highly skilled examiner and to date, the precision with which these complex constructs can be assessed has been highly variable. However, some researchers feel the projective test's lack of precision is compensated for by its breadth.

The third major category, behavioral rating scales, is also beset with positive and negative aspects. The major problem associated with this type of measurement is that one is forced to make inferences if the subject's psychological experience is of import. Another major problem is in determining whether the behavior observed is typical of the individual and occurs rather regularly or whether the behavior is specifically bound to a particular situation. On the other hand, many theorists, particularly those associated with behavioristic leanings, have little interest in a subject's psychological experience, and view behavioral changes as the ultimate criteria.

To summarize, it has been established that the issue of criterion as related to outcome in therapy is of considerable import. In addition, there is the difficulty of adequately defining therapeutic outcome. Lastly, the various problems associated with measuring therapeutic outcome with established measuring tools which are laden with drawbacks have been presented.

Various positions have been taken by theorists in regard to the above issues. Strupp (1963) has come to the conclusion that outcome studies must be held in abeyance, that ". . .more pressing matters must be dealt with first before we can address ourselves meaningfully to the question of the effectiveness of psychotherapy." In contrast, Astin (1961) emphasizes social responsibility and the ethical implications of offering a service in the absence of solid evidence of its effectiveness.

The present author takes a position more akin to Astin's, a position which recognizes the social responsibility and the ethical implications, as well as the difficulties inherent in outcome research. One of the real issues seems to revolve around difficulty and uncertainty. If an area is fraught with difficulties and perplexities, is it to be avoided? Or is this an indication that the issue is even more viable and demanding of greater attention? The present author subscribes to the latter statement and in the present study will attempt to clarify some of the issues.

Granted that the present methods of assessing outcome are far from perfect, there still remains the position that perhaps each type makes a unique contribution in terms of defining and measuring criterion. Meehl (1955) states that

> there is no single test, observation, rating procedure, behavior sample, or other criterion that is sufficient to stand alone as a determiner of the level of mental health (or illness) of an individual, or of the amount of significant change which occurred over time.

In addition, Schofield (in Gottschalk and Auerbach, 1966) states that

> the best measures of therapeutic effort must entail the application of the same, standard method of observation at not less than two points of time, pre- and post therapy. The effectiveness of therapy cannot be reasonably inferred from a patient's scores on a rating scale (e.g. of ego strength) which is applied only at the termination of therapy.

It appears reasonable that a test designed for diagnostic purposes should also reflect changes in the personality of the individual as he deteriorates or improves with the passage of time or the effects of therapy. Although there is a multitude of diagnostic tests which could be utilized in assessing outcome, the present study will utilize both pre- and post therapy scores utilizing the TAT and the Tennessee Self-

Concept Scale as well as therapist evaluation in assessing outcome. In recognition of the need for multiple criteria, additional variables will be included. Client rating as to outcome of therapy as well as a measure of ego strength will be utilized. It is felt that the combination of a self-rating test, a projective test, therapist rating, client rating, and a measure of ego strength will constitute a balanced composite of the various methods of assessing outcome.

REVIEW OF THE LITERATURE

Although a multitude of diagnostic tests, self-report scales, and various behavioral scales have been utilized in assessing outcome, a primary concern will be with that literature which emphasizes the self-concept and/or utilizes the TAT.

The Self-Concept

In recent years a variety of definitions of the self concept have been generated. As a rule these definitions do not differ greatly from one another. This is particularly true of those theorists such as Rogers, Snygg and Combs, and Allport, who are in the mainstream of contemporary non-philosophical psychology. Rogers (1951) defines the self-concept as follows:

> The self-concept, or self-structure, may be thought of as an organized configuration of perceptions of the self which are admissible to awareness. It is composed of such elements as the perception of one's characteristics and abilities; the percepts and concepts of the self in relation to others and to the environment; the value qualities which are perceived as associated with experiences and objects; and goals and ideals which are perceived as having positive or negative valence.

Allport (1955) uses the term "Self Image," to refer to the self concept: "The image has two aspects: the way the patient regards his present abilities, status, and roles and what he would like to become." Allport sees it as one of several "propriate" functions of the self. Yet the self-concept is something more than a bare self-image. As Fitts (1954) defines it, the self-concept is "the phenomenological

configuration of self-reflexive, affective-cognitive structure." It is also, as Taylor (1953) states, an affective structure--the individual's perception of himself and his feelings and evaluation of those perceptions.

Self-Concept and Adjustment

It has also been proposed that self-concept has an important relation to adjustment. Cameron (1947) states that

> the basis of much frustration and many conflicts is in this universal circumstance, that no man ever fuses all his self-reactions together into a single unambiguous, coherent whole.

Similarly, Rogers (1947) states:

> It would appear that when all of the ways in which the individual perceives himself--all perceptions of the qualities, abilities, impulses, and attitudes of the person, and all perceptions of himself in relation to others--are accepted into the organized conscious concept of the self, then this achievement is accompanied by feelings of comfort and freedom from tension which are experienced as psychological adjustment. . .

This inner stability characteristic of the normal individual appears to be lacking in schizophrenics (Snygg and Comb, 1949). It appears that they feel so threatened in many aspects of self that they cannot accept any consistent evaluation of themselves. Lecky (1945) postulated a drive toward self-consistency, a drive to maintain the unity and integrity of the organization of the self. It might be postulated that the less successful this impulse is, the more inner disturbance will be experienced by the individual. In addition, it seems likely that an effort to keep incompatible elements of the self-concept separate will be costly to the individual.

Similarly, Snygg and Combs (1949) state that an integrated individual is accepting of his interpretations of reality. In contrast, the self-concept of the disintegrated individual maintains "enduring

contradictions" which result in distorted interpretations of reality. Consequently, one outcome of successful therapy might be the individual perceiving himself as more integrated.

The above theoretical formulations gave impetus to the development of a measure of the self-concept. Although a variety of self pictures have been explored, the most commonly used measure has been based upon the degree of similarity between perceived ideal self and perceived real self. Furthermore, Butler and Haigh (in Rogers and Dymond, 1954) state that the discrepancy between the placements of a given characteristic on the self scale and the ideal scale yield an indication of self-esteem. It follows that certain life experiences might have consequences for the way in which a person views himself. A positive experience such as psychotherapy would be expected to enhance the self-concept with a resultant rise in self-esteem.

Self Esteem and Adjustment

Various theorists such as Fromm, Sullivan, Horney, and Frieda Fromm-Reichman have greatly emphasized the concept of self-esteem. The primary source of self-esteem accures from the mother-child relationship. Adequate amounts of self-esteem will enhance the individual's capacity to accept and love others, to successfully relate interpersonally, and will reduce the possibility of the development of a neurosis or psychosis. In other words, it appears that realistic self-esteem is a prerequisite for adjustment. Adequate and realistic levels of self-esteem result in a productive orientation towards the world (Fromm) and adequacy in interpersonal relations (Sullivan), whereas low levels of self-esteem lead to a non-productive orientation towards the world and unsuccessful interpersonal relations.

Since "better adjustment" is one generally accepted goal of psychotherapy, it appears pertinent to examine the effects of psychotherapy on self-concept and self-esteem.

Self-Concept, Self-Esteem, and Psychotherapy

Rogers (1951) sees the self-concept as the criterion determining the "repression" or awareness of experiences and as exerting a regulatory effect upon behavior. Thus, the self-concept's relevance to any study of psychotherapy is clear. Butler and Haigh (in Rogers and Dymond, 1954) hypothesized that client-centered counseling results in an increase in congruence between the self and the self-ideal concepts in the client and that this reduction would be particularly marked in those cases judged independently as exhibiting improvement. Pre-therapy Q sorts indicated a large discrepancy between self and ideal, with the relationship approximating a zero correlation. By the end of therapy the discrepancy between self and ideal self had decreased and the mean correlation was .34, which is a statistically significant change. In contrast, the control group exhibited a small discrepancy between self and real self at the outset and there was no significant change in this discrepancy over time. Furthermore, the reduction in self-ideal discrepancy from pre- to post therapy was even more marked in a "definitely improved" group.

Dymond (in Rogers & Dymond, 1954) also found clients coming into therapy with low self-esteem and low adjustment as compared to controls, leaving therapy with significant increases in both, and these improvements were confirmed by therapist ratings. Rudikoff's (in Rogers & Dymond, 1954) findings were essentially the same.

The Tennessee Self Concept Scale has also been utilized in assessing adjustment and psychotherapeutic changes. Instead of measuring the

discrepancy between self and ideal self, the Tennessee Self Concept Scale consists of self-descriptive statements which the S uses to portray his own picture of himself. Thus, an overall level of self-esteem is obtained. Fitts (1965) states that an individual's concept of himself is:

> . . .highly influential in much of his behavior and also to be directly related to his general personality and state of mental health. Those people who see themselves as undesirable, worthless, or "bad" tend to act accordingly. Those who have a highly unrealistic concept of self tend to approach life and other people in unrealistic ways. Those who have very deviant self concepts tend to behave in deviant ways. Thus, a knowledge of how an individual perceives himself is useful in attempting to help that individual, or in making evaluations of him.

Ashcraft and Fitts (1964) utilized the Tennessee Self Concept Scale in an assessment of psychotherapeutic change. The design included an experimental group consisting of 30 patients who had been in therapy for an average of six months and a no-therapy control group of 24 patients who had been waiting for therapy for an average of 6.7 months. All subjects were measured on a test-retest basis with the Scale. The therapy group changed significantly and in the expected direction of 18 of the 22 variables studied while the control group changed in 2 variables.

In summary, an individual's self-concept appears to be highly related to adjustment, and consequently can be valuable as a criterion of change due to successful therapy.

Ego Functioning and Adjustment

Because there is a certain degree of overlap, it seems helpful at this point to distinguish between the constructs of ego and self-concept. Ausubel (1958) defines the self-concept as

> an abstraction of the essential and distinguishing characteristics of the self that differentiate an individual's 'selfhood' from the environment and from other selves. In the course of development, various evaluative attitudes, values, aspirations, motives and obligations become associated with the self-concept. This organized system of interrelated self-attitudes, self-motives, and self-values that results may be called the ego.

Although Freud's conceptualization of the ego underwent several revisions, his latest definition (Freud, 1949) is as follows:

> The principal characteristics of the ego are these. In consequence of the relation which was already established between sensory perception and muscular action, the ego is in control of voluntary movement. It has the task of self-preservation. As regards external events, it performs that task by becoming aware of the stimuli from without, by storing up experiences of them (in the memory), by avoiding excessive stimuli (through flight), by dealing with moderate stimuli (through adaptation) and finally, by learning to bring about appropriate modifications in the external world to its own advantage (through activity). As regards internal events, in relation to the id, it performs that task by gaining control over the demands of the instincts, by deciding whether they shall be allowed to obtain satisfaction, by postponing that satisfaction to times and circumstances favorable in the external world or by suppressing their excitations completely.

Briefly stated, Freud describes the ego as a problem-solving agent. Similarly, Hilgard (1962) states that

> the ego represents our ordinary social self, going about the work of the world, being realistic and as rational as possible, being in general congenial with other people, and accepting the social roles that are prescribed.

Thus, the self-concept is seen as part of the ego, and the above conceptualizations of the ego and its functions make the relationship of ego functioning to adjustment clear.

Barron's Ego Strength Scale

Barron's Ego Strength (Es) Scale consists of 68 items from the MMPI which reflect the various aspects of effective personal functioning which are usually subsumed under the term "ego-strength." Barron (1953) arranged the 68 items into several groups according to item content: physical functioning; psychastenia and seclusiveness; attitudes toward religion, moral posture, sense of reality; personal adequacy and ability to cope, phobias; and a final miscellaneous group. Originally the scale was designed to predict the response of psychoneurotic patients to psychotherapy. However, a later consideration of the scale content and its correlates indicated that the Es scale had broader psychological implications and could also be utilized in assessing ego strength.

Initially, the 68 items were selected from the total pool of 550 MMPI items on the basis of significant correlation with rated improvement in 33 psychoneurotic patients who had been treated for six months in a psychiatric clinic. Because the scores were obtained before patients began therapy, the scale, so far as logic of construction is concerned, is designed to predict whether or not after approximately six months of therapy the patient will have improved.

The original sample of 33 patients was divided into two groups: 1) a group of 17 patients who were judged to have clearly improved, and 2) a group of 16 patients who were judged to be unimproved. Barron (*Ibid.*) states that

> although the sample is small, the cases were intensively studied, and two skilled judges who had thoroughly acquainted themselves with the course of the therapy (although not themselves involved in it otherwise) were in considerable agreement (r of .91 in their independent ratings of degree of improvement).

While one would not ordinarily base scale development on a sample of this

size, it was reasoned here that a small number of well-studied cases who were classified with high realiabilty and with high accuracy as well, would serve better than the practical alternative, which was to get a large sample in which the therapist's rating was accepted uncritically. The mean of the improved group on the 68 item scale was 52.7, whereas the mean of the unimproved group was 29.18, a difference significant at greater than the .01 level. In addition, Barron reports an odd-even reliability of .76 in a clinic population of 126 patients and a test-retest reliability of .72 in a sample of 30 cases after three months.

As assessed by the Es scale, the pre-therapy group which later improved could be characterized in the following manner: good physical functioning, spontaneity, ability to share emotional experience, conventional church membership but not fundamental or dogmatic, permissive morality, good reality contact, feeling of personal adequacy, physical courage and lack of fear.

In contrast, the unimproved group was characterized by chronic physical ailments, broodiness, inhibition, intense religious experience, repressive and punitive morality, dissociation and egoalienation, confusion, phobias and infantile anxieties. As Barron (*Ibid.*) states, "From an inspection of these differences, one might easily be led to envy the mental salubrity of psychoneurotic patients who are about to improve." However, Barron is quick to add that their actual mental distress is quite evident and suggests that what the group comparison reveals is the dimension on which the improved and unimproved groups differ. It is further suggested that had the improved patients been compared with an exceptionally healthy group of subjects, the same items might well have emerged as descriptive of the difference between the groups, but with the characteristic responses of the improved patients

being exactly opposite to those listed above. That is, the nature of the criterion behavior determines the nature of the dimension which the item analysis will reveal, but the question of the strength of that variable in the criterion groups must be answered separately.

In an attempt to cross-validate the scale as a predictive instrument, Barron (*Ibid.*) conducted several other studies. In a sample with 53 patients the Es scale's correlation with terminal rating was .42. In another study with 46 patients, therapists' ratings of outcomes correlated .38 with the pre-therapy Es scale. Lastly, 50 patients were classified as having made exceptional improvement, complete lack of improvement, and moderate improvement during therapy. The degree of relationship between pre-therapy Es scores and the ratings was .54. The means were as follows: Unimproved, 32.75; improved, 43.07; exceptional improvement, 49.66. Thus, the Es scale appears to be a fairly accurate predictor of response to therapy.

The TAT and Assessment of Ego Functioning

Although the TAT appears to possess an inherent quality of eliciting extremely complex and rich responses, there seem to be about as many ways of analyzing the TAT as there are clinical psychologists who use the method. The most popular method among clinicians seems to be a subjective, intuitive approach in which the entire protocol is perused a number of times by the analyst and such things are noted as repetitive themes, the sequence of stores, peculiar verbalization, perceptual distortion, slips of the tongue, the differential degree of emotion invested in the stories, the outcome, and unusual interpretations. They are then usually checked against a subjective kind of norm which the psychologist has built up from his experience. Then, on the basis of the total

impression which remains with him, an interpretation of S's personality is given. It is difficult, if not impossible, however, to pin down the basis on which specific statments about S are generally made--what there is specifically in the stories which leads the analyst to a particular conclusion. It is for this reason that such methods of TAT analysis are generally uncommunicable and cannot be duplicated.

In addition, when an impressionistic analysis of a protocol is utilized, there is the ever present danger of selective perception on the part of the analyst. In an attempt to eliminate or reduce some of the above-mentioned problems, there have been efforts to devise methods whereby the available evidence in a protocol may be noted and summarized consistently and objectively. A majority of the methods devised for semi-objective analysis of the raw TAT protocol seem designed primarily to facilitate intra-individual analysis. Pine (1960) addressed himself to the problem and set out to devise a scoring manual for the TAT which described significant variables that have broad enough relevance to permit meaningful comparisons among individuals. Psychoanalytic theory suggested the significant variables associated with processes of impulse expression, with ego control operations, and with the coordination between these two.

The Pine Manual for Rating Drive Content in the TAT

Recent developments in psychoanalytic ego psychology gave Pine (1960) a rational basis for utilizing drive content in TAT stories. Ego psychology theory suggests that the absence of drive content indicates a pervasive, generally rigid, and often fragile system of ego defenses. On the other hand, a high level of drive content has at least two implications depending upon how the drive is expressed: 1) that there is poor

ego control of impulses and that these impulses are expressed in ego alien and/or maladaptive ways, or 2) that drive energies have been sufficiently "neutralized" (Hartmann, 1955) in order to be used in productive activity rather than solely in the satisfaction of libidinal and aggressive drives. As a result of these theoretical formulations, the Pine manual outlines a procedure for rating amount of drive content (drive content as used by Pine refers to the expression of instinctual drives and their derivatives, including aggressive and libidinal drives and partial drives--oral, anal, phallic, genital, exhibitionistic, voyeuristic, sadistic, masochistic, homosexual, and narcissistic) as well as the degree and kind of ego control over expressed drive content; that is, ego control may also be reflected in the level of drive expression, i.e., in the moderation of drive intensity and the socialization of its aims.

Three main types of ratings are included in the Manual. The first represents the total number of reasonably direct derivatives of sexual and aggressive drives which appear in ideational form in the manifest content of the TAT stories (i.e., the total drive content [TDC] score). The second two ratings reflect 1) the degree to which drive content is integrated into the stories, and 2) the degree of drive socialization (Pine, 1960, p. 45).

1) Drive Integration Ratings: S's task on the TAT is to tell a story about a picture. Drive content which is used to develop the main theme of the story (*thematic* ratings) and that which is used to enrich the story (*incidental* ratings) is interpreted as *task-appropriate*, whereas side comments, verbal slips involving drive derivatives, and other unrelated expressions of drive which are not in accord with the TAT task are given a *non-appropriate* rating.

2) Level of drive expression: The second index of ego control assesses the degree of drive socialization.

(A) Direct-Socialized (D-S) ratings: D-S ratings include those expressions of drive content where libidinal or aggressive impulses are expressed directly but in socialized ways. Anger expressed without physical violences, arguments, sexual rivalries and jealousies, kissing, eating, social drinking, intercourse between marriage partners and childbirth are all rated here.

(B) Direct-Unsocialized (D-U) ratings: D-U ratings include those expressions of drive content where libidinal or aggressive impulses are directly expressed in a way contrary to conventional social values. Murder, robbery, rape, prostitution, alcoholism, etc., are all rated here. In addition, a second criterion is applied to physical expression. Anger is rated D-U only when it involves physical violence.

(C) Disguised-Indirect (D-I) ratings: D-I ratings include those expressions where a drive is an issue for the person but, although some reflection of the drive appears in the manifest story, the drive itself is not expressed.

Because of the Manual's relatively recent development there is a scarcity of validation studies. However, those which have been undertaken do generally support the Manual and the scoring categories mentioned above. Pine (1960), with a sample of 14 males, obtained TAT and Rorschach protocols, Wechsler-Bellevue scores, and a written autobiography as well as extensively interviewing each S. All of this data was utilized by two raters, first independently and then by consensus, to rate each S on six Q-sorts (Effect and Inner states, Though processes, Motives, Defensives, Interpersonal behavior, Identity, and Self-attitudes). The following favorable results were reported: S's with high TDC scores

tend towards emotionality, expressiveness, and flux. Their thinking, communication, and relationships are characterized by an expressive quality. This expressiveness has a distinctly positive and adaptive character and is associated with spontaneous effect, insightfulness, and meaningful relationships. In marked contrast, S's with low TDC scores appear to reflect a pattern of inhibition, overcontrol and rigidity. They appear to be out of touch with inner resources; thinking is blocked and control operations seem both excessive and shaky (*Ibid.*, p. 42).

A general picture of smooth functioning is given by those S's with well-integrated use of drive (high thematic ratings). Expressive needs find their outlet through relatively controlled channels, thinking is efficient and proceeds without disruption by anxiety, and a basis for steady and adequate personality functioning appears well established. On the other hand, S's with poorly integrated use of drive material (lower thematic ratings) are characterized by anxiety and disruption of adaptive functions (*Ibid.*, p. 43).

There is a relatively balanced relationship between expressive and control processes in those S's who express drives in direct-socialized ways. They are characterized by a relatively free intellectual and esthetic expressive style, a flexible identity, and adequate controls over impulses. However, S's rated high on direct-unsocialized expression of drive are characterized by impulsive discharge, loose thinking, and a fear of loss of control (*Ibid.*, p. 45).

In a very recent study, Dietzel (1970) found that individuals with high self-esteem produce TAT stories with higher levels of sexual and aggressive drive content and also displayed higher levels of drive integration and drive socialization in their thematic productions. In

contrast, individuals with low self-esteem produce TAT stories with lower levels of sexual and aggressive drive content. Stories told by these S's tended to be of two types: 1) highly descriptive, banal stories with little direct drive expression, or 2) stories with higher levels of poorly-integrated, blatantly unsocialized drive expression.

In short, S's with high self-esteem produced stories with higher drive content, drive integration, and drive socialization as compared to low self-esteem S's who produced stories with little direct drive expression or high levels of poorly integrated, unsocialized drive expression. Because a shift from expressing drive in an indirect, weak and/or unsocialized manner to expressing drive directly and in a socialized manner would be evaluated by a majority of therapists as a positive move, it seems possible to make the inference that ways of expressing drive can be related to outcome of therapy.

The TAT and Outcome in Therapy

Although the Pine Manual has not been utilized in assessing outcome, and a number of studies have failed to find pre- and post therapy differences on the TAT, a few studies have reported favorable findings. Dymond (in Rogers & Dymond, 1954) utilized blind ratings of the TAT with a sample of 25 experimental subjects who had therapy and 10 controls who did not. The TAT ratings agreed with the counselor's estimation of the success of the therapy, with the adjustment scoring of their self-descriptive Q-sorts in terms both of score and of degree of change in adjustment, and with the change in the correlation of their self and ideal sortings.

However, in a similar study, Grummon and John (in Rogers & Dymond, 1954) computed the correlations between the TAT and the Willoughby

Emotional-Maturity Scale, the Self-Other Attitude Scale, the Q adjustment index, and counselor judgments. After computing 19 different correlations, only one was large enough to be significant and this could be expected by chance alone. The authors point to the obvious conclusion that there was no relationship between mental health status as measured by the TAT and the other measures utilized. To complicate matters, most of the other measures indicated that therapeutic progress had occurred.

Finally, Ullman (1957) found two highly related measures--clinical judgment of TAT protocols and a social perceptions test--to be correlated significantly with two criteria of improvement: the Palo Alto Group Therapy Scale and hospital status after six months (hospitalized vs. discharged).

In conclusion, results relating the TAT and outcome in therapy have been more than somewhat equivocal. However, a closer examination of the studies indicates that part of the lack of agreement between studies may be related to the very different patient populations. That is, the above studies' patients vary from college students seen at counseling centers to hospitalized VA patients. It is very likely that these differences are contributing to the lack of agreement.

Therapist Judgment and Outcome

A third variable to be utilized in the present study is the therapist judgment concerning therapeutic outcome. The therapist's judgment is probably one of the most frequently used criteria of therapeutic outcome. The validity of counselor judgments has frequently been questioned and a number of studies have addressed themselves to this question. Previous studies of counselor judgment fall into two main groups: those which compare counselor judgment with internal measures of therapeutic

process and those which compare counselor judgment with other measures of therapeutic outcome. The process measures show a fairly consistent positive relationship with counselor judgment. Raimy (1948) found a significant correspondence between counselor rating of success and a rising ratio of positive attitudes as therapy progressed. Similarly, Raskin (1949) summarized the results of five therapy process studies and found a composite correlation of .70 between counselor ratings and extent of change in this measure.

Studies which assess correspondence between counselor judgment and independent measures of therapeutic outcome have revealed more equivocal results. Mosak (1950) found significant correlation between MMPI changes and case rating, and Muench (1947) found the correlation of Rorschach change with case rating was significant at the 10 per cent level. However, Rorschach studies by Mosak (1950) and Carr (1949) showed no relationship between case rating and extent of change. Thus, although results are somewhat equivocal there does seem to be a somewhat promising indication of correspondence between therapist judgment and extent of change. Recognizing that therapist judgments of therapy outcome in and of themselves are often questioned, two other criteria will be utilized in order to validate and justify the existence of two groups, i.e., Satisfactory and Partially Satisfactory outcome in therapy. In addition to the therapist rating of outcome, client evaluation of therapy will be utilized as well as Barron's Ego Strength scale which has been established as a valid predictor of response to therapy.

In light of the above discussion, an attempt will be made to assess the effects of therapeutic intervention on drive level and self concept. To this end the following hypotheses were generated.

EXPERIMENTAL HYPOTHESES

Pre- and post therapy scores of Thematic Apperception Test protocols and the Tennessee Self Concept Scale will be examined and are the basis for generating the following hypotheses. Three major hypotheses, with the first major hypothesis having severalsub-hypotheses, were generated.

Hypothesis I: Amount and level of drive content as expressed in TAT protocols will change more from pre- to post testing in those cases rated successful as opposed to those cases rated partially successful.

Specific predictions are:

Hypothesis Ia: Total amount of drive expressed as measured by the Total Drive Content (TDC) will increase more in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis Ib: The amount of drive which is expressed in socially acceptable ways as measured by Direct-Socialized (D-S) Drive content will increase more in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis Ic: The amount of drive which is expressed in highly constricted ways as measured by the Disguised-Indirect (D-I) Score will decrease more in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis Id: The amount of drive expressed in unsocialized ways as measured by the Direct-Unsocialized (D-U) Score will decrease more in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis Ie: The degree of drive integration as measured by the weighted proportion of thematic, incidental, and non-appropriate drive ratings will increase more in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis II: Self-esteem as measured by the Total P Score on the Tennessee Self Concept Scale will increase more in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis III: There is a positive relationship between pre-therapy Ego Strength as measured by Barron's Ego Strength Scale and post therapy measures of Total Drive Content, Direct-Socialized drive, degree of integration and self-esteem.

METHOD

Source of Data

The cases utilized in the present study are part of the library of tape-recorded psychotherapeutic sessions developed at the Michigan State University Counseling Center. All clients were late adolescents, self-referred, and university undergraduate students. Their problems were of a personal and/or social nature.

Initially, the prospective client was given an intake interview during which it was determined whether the client would be seen for psychotherapy at the Counseling Center. If the intake counselor and the prospective client determined that he would be seen, and if the client had not previously been involved in therapy, the client was asked to participate in the research project.

The majority of the clients were assigned therapists on the basis of available time and special competencies of the therapists. Intake notes as well as personal impressions of the intake counselor were available for the therapist to utilize in deciding final acceptance of a client. Additional selection of cases occurred due to the fact that not all therapists at the Counseling Center participated in the study.

Two groups make up the psychotherapists. The staff group included 10 Ph.D. clinical and counseling psychologists with two to twenty years of psychotherapy experience. The intern counselors included 10 advanced candidates in counseling or clinical psychology. All interns had

completed their practicum experience and had an average of two years of supervision during their practicum experience.

The 10 staff psychotherapists saw 10 clients, while the 10 interns saw the remaining 10 clients. Fourteen therapists were male, the remaining six being female. Fifteen clients were female and five male. See Table 1 for a summary description of client and therapist variables.

Table 1--Descriptive Summary of Client and Therapist Characteristics

Therapists	N	Sex Male	Female	Mean Years Experience in Therapy
Staff	10	8	2	7.5
Interns	10	6	4	2.0

Clients	N	Sex Male	Female	Mean Number of Interviews
Clients seen by staff	10	3	7	14.4
Clients seen by interns	10	2	8	10.5

The usual policy at the Counseling Center is for clients and therapists to meet one hour a week. Relatively short term therapy, 10-20 interviews, is encouraged, although therapy sometimes is longer. See Table 2 for a summary of therapist experience level and durations of treatment.

Table 2--Experience Level and Duration of Treatment

	Number of Interviews				
	5-8	9-12	13-16	17-20	21+
Staff	2	3	2	1	2
Interns	4	2	4	0	0
Total	6	5	6	1	2

After a client was terminated, each therapist was asked to rate the outcome of therapy as successful, partially successful, partially unsuccessful, or unsuccessful. Of the 20 cases, nine cases were rated as successful, and eleven rated as partially successful. See Table 3 for a summary of therapist experience level and therapist rating of outcome.

Table 3--Experience Level and Therapist Rating of Outcome

	Rating of Outcome	
	S	PS
Staff	3	7
Interns	6	4
Total	9	11

Selection of Cases

The selection of cases was based on a number of criteria: 1) at least five therapy sessions were involved; 2) the client had been administered the TAT, the MMPI, and the Tennessee Self Concept Scale prior to

beginning therapy; 3) therapy had been terminated; 4) the client had been administered the TAT and the Tennessee Self Concept Scale after termination; 5) therapists had rated the outcome of therapy as either successful or partially successful; 6) clients had rated the outcome of therapy. Fifteen female and five male clients met these criteria with the exception of one client who lacked the Es score (MMPI) and two clients who had failed to rate outcome.

Clients were asked to rate outcome along a seven point scale which consisted of describing the S's feeling about whether counseling helped to solve his problems. The seven levels were: 1) was extremely harmful, 2) harmed me quite a lot, 3) harmed me somewhat, 4) indifferent--neither helped nor harmed, 5) helped me somewhat, 6) helped me quite a lot, 7) was extremely helpful. Since only the latter three levels were checked by the present sample, only that portion of the scale was utilized and a rating of 1 was given to "helped me somewhat," 2 to "helped me quite a lot," and a rating of 3 given to "was extremely helpful." See Table 4 for a summary of client and therapist rating of outcome. Appendix A contains the scale with which clients rated outcome of therapy.

Table 4--Client's Rating of Outcome as Related to Therapist's Rating

	Therapist Rating	
	PS	S
Helped somewhat (1)	3	0
Helped quite a lot (2)	5	4
Extremely helpful (3)	1	5

t = 3.57 sign. at .01 level

As mentioned previously, the Es subscale of the MMPI will be utilized to validate the therapist judgment of outcome. The successful group has a pretherapy mean Es score of 47.0 while the partially successful group has a pretherapy mean Es score of 40.2. This difference is significant at the .05 level. In light of Barron's (1953) findings in which the Improved group's pretherapy mean Es score was 52.7 and the unimproved group 29.1, it appears that the present study's successful group is similar to Barron's improved, while the partially successful falls between Barron's improved and unimproved group and might be predicted to improve somewhat. Even more similar, is Barron's tridimensional rating of outcome mentioned previously in which the means were as follows: Unimproved, 32.75; improved, 43.07; exceptional improvement, 49.66. See Table 5 for a summary of the relation of therapist rating of outcome to pretherapy Ego Strength Scores and Appendix B for examples of items utilized in the Es scale.

Table 5--Pretherapy Ego Strength as Related to Therapist Rating of Outcome

	Therapist Rating	
	PS	S
Mean raw score on Es scale (MMPI)	40.2	47.0

t = 2.42 difference significant at .05 level

The Instruments

Selected cards of the Thematic Apperception Test (TAT) and the Tennessee Self Concept Scale (TSCS) were utilized in deriving the experimental variables. The TAT and the TSCS were administered on two separate occasions, pre- and post therapy.

The Tennessee Self Concept Scale. The Counseling and Research (C&R) Form of the TSCS is a 100 item inventory of self descriptive statements designed to assess the individual's self-concept and level of self-esteem. S's rate statements on a five point Likert scale, from "completely false" (+1) to "completely true" (+5). In order to control for response set, half of the Scale items are stated negatively. Appendix C contains the TSCS booklet.

Fitts (1965) reports that the Total P Score is the most important single score and that it reflects the overall level of self-esteem. Persons with high scores tend to like themselves, feel that they are persons of value and worth, have confidence in themselves, and act accordingly. People with low scores see themselves as undesirable; are doubtful of their own worth; often feel anxious, depressed, and unhappy; and have little faith or confidence in themselves. The Self-Criticism (SC) Score is also used in interpreting the Total P Score. If the SC score is low, high P scores are suspect and may be the result of defensive distortion. Thus, the SC score serves as a validity index.

Development of the Scale. Initially, a large pool of self-descriptive items was compiled. Fitts (1965) reports that the original pool of items was derived from a number of other self-concept measures including those developed by Balester (1956), Engel (1956), and Taylor (1953). Additional items came from written self-descriptions of patients and non-patients. Next, a phenomenological system, which later evolved into a 2-dimensional, 3x5 scheme, was developed for classifying items on the basis of what the S's themselves were saying. Seven independent judges classified the items according to the 3x5 scheme and also rated each item as to being either negative or positive in content. There was

perfect agreement by the judges on the final 90 items, which are equally divided in positive and negative content. The remaining 10 items make up the Self Criticism Scale.

Reliability. Fitts (1965) reports a test retest reliability coefficient of .92 for the Total P Score. In addition, there is reported a remarkable similarity of patterns found in profiles during repeated measures of the same individuals over long periods of time . . . "the distinctive features of individual profiles are still present for most persons a year or more later (*Ibid.*, p. 15)." Finally, Congdon (1958) used a shortened version of the Scale and obtained a reliability coefficient of .88 for the Total P Score.

Validity. Procedures to establish four types of validity have been utilized: 1) content validity; 2) discrimination between groups; 3) correlation with other personality measures; 4) personality changes under particular conditions.

1) Content Validity. Because only those items on which there was unanimous agreement among the judges as to classification were retained, it appears that the categories in the Scale are logically meaningful and publicly communicable.

2) Discrimination between Groups. Fitts (1965, p. 15) reports significant differences between a group of 369 psychiatric patients and 626 non-patients. Differences were highly significant (mostly at the .001 level) and were found on almost every score of the Scale. Similarly, Congdon (1958), Piety (1958), Havener (1961), and Wayne (1963) found significant differences between patients and non-patients. In addition, the Scale had been utilized to discriminate within patient

groups. Huffman (1964) found marked differences between an Emotionally Unstable Personality group, Paranoid Schizophrenics, and a Depressive Reaction group.

3) Correlations with other Measures. Fitts (1965) reports that most of the scores of the Scale correlate with MMPI scores in ways one would expect from the nature of the scale. Correlations with the Edwards Personal Preference were rather low, but Fitts (*Ibid.*, p. 24) points out that the nature of the two scales is such as to contraindicate very many high linear correlations.

4) Personality Changes under Particular Conditions. As reported earlier, Ashcraft and Fitts (1964) utilized the Scale with a therapy and non-therapy group. The therapy group changed significantly on 18 of the 22 variables while the control group changed on only 2 variables.

In conclusion, there appears to be a solid basis of experimental evidence which establishes the validity of the Scale.

The Thematic Apperception Test: Each client told stores about 4 TAT cards. Three cards (4, 6BM, 13mf) were utilized with all clients. The remaining card differed for males and females, with Card 18GF being utilized with female S's while card 18BM was utilized with male S's. These particular cards were utilized because normative studies (Eron, 1941) and other researchers (Dietzel, 1970) have indicated that these particular cards possess considerable "stimulus pull" in respect to sexual and aggressive themes and thus seem to be particularly appropriate for eliciting the desired data. The TAT protocols became the basis for assessing ego functioning by rating the stories for drive expression according to procedures in the Pine Drive Content Manual (1960).

Appendix D contains the manual along with operational definitions of terms and examples.

Scoring Procedure: Scoring of the TAT protocols consisted of a content analysis of the typewritten transcripts of S's written stories. Initially, the entire protocol was read and each unit of drive content was underlined. Usually drive content is expressed several and sometimes many times in one story. In order to aid raters, four additional rules are given for selecting the unit to be rated in each instance: 1) Expressions of derivatives of different drives are rated as separate instances of drive expression, e.g., oral content followed by aggressive content; 2) Expressions of drive with differing degrees of integration into the story (*thematic*, *incidental*, or *non-appropriate*) are always rated separately, even if the drive expressed is identical; 3) A drive expressed at more than one level (Direct-Socialized, Direct-Unsocialized, Disguised-Indirect) is rated only once . . . the rating of the more extreme content; 4) A drive expressed at the same level or same degree of integration is given a second separate rating if new behavior sequences are described or if the expressed impulse has a new aim (Pine, 1960).

After determining the actual number of drive units in a protocol, each unit is rated for level of drive expression (Direct-Socialized, Direct-Unsocialized, or Disguised-Indirect) and degree of drive integration (*thematic*, *incidental*, or *non-appropriate*).

Thus, complete scoring results in seven pre-therapy and seven post-therapy scores for each client. The pre- and post-therapy scores represent identical variables. The seven scores include a score representing the total number of drive content (TDC) ratings in the four thematic

productions, one score each for the total number of D-S, D-U, and D-I ratings, and one score each for the number of thematic, incidental, and non-appropriate ratings.

Mathematical Procedures

Several mathematical procedures were utilized in order to statistically assess the data. Theoretically, the range in TDC Scores is from 0 to an infinitely large number. The total of the three levels' scores is equal to the TDC. Thus, because the sub-scores are not independent of the total number of drive content ratings, it was necessary to hold total drive content constant for the statistical analysis of the sub-scores. Therefore, to make inter-individual comparisons of level of drive expression, the D-S, D-U, and D-I scores were converted to proportions and multiplied by 100. As a result, the theoretical range in scores for these three variables is from 0 to 100.

To test the hypotheses concerning drive integration, a weighted composite score was utilized. Weighting the instances of drive integration (three times the number of *thematic* ratings plus two times the number of *incidental* ratings plus the number of *non-appropriate* ratings), dividing by the total number of ratings, and multiplying by a constant K=100, gives a score which represents a trend toward well-integrated drive content at the one extreme (higher scores) and poorly integrated drive at the other extreme (lower scores) with a theoretical range of 0 to 300 (Pine, 1960, p. 36).

Scoring Reliability

Two reliability scorers were utilized in the present study (the present author and a third-year graduate student). The actual scoring consisted of visual inspection of the typewritten transcripts taken

from tape recordings of the TAT stories. As a preliminary step, each scorer studied the manual. The judges then scored together a series of protocols from another source.* This was followed by the establishment of a practice pool containing protocols from the same other source. These protocols were scored independently by the judges and then discussed unit by unit. When consistency between the judges was reached, the reliability sample was created.

Forty percent of the entire sample of TAT protocols was utilized in creating the reliability sample. Twenty clients were given pre and post TATs, in effect there being 40 protocols. Because comparisons of changes over therapy are the focus of the present study, it was necessary to prevent knowledge of whether a particular protocol was pre or post therapy. To this end, the protocols were coded by a non-judge. Then, a random sample of 16 protocols (40% of 40) was selected from the entire sample of 40, and all 4 cards of each of those protocols were scored, resulting in a sample of 64 separate stories. In order to avoid "halo effects," all card 4 stories were scored, then all Card 6BM, etc. The same precautions were utilized in scoring the remaining protocols. See Table 6 for reliability sample results.

Of the 160 stories rated, there were 396 rated units of drive content. The raters agreed in 361 instances or 91.1% of the time. Since agreement by chance alone would be near 0 percent, the results seem more than adequate. The percent of agreement for the various levels of drive expression and the degrees of integration was also generally high. Although agreement by chance alone would be 33% in each category, only

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*Protocols from clients who did not meet the study's criteria were utilized, e.g., less than 5 therapy sessions, lacking post TAT, etc.

the percent of agreement for non-appropriate use of drive (60%) falls below the 81% level.

Table 6

Inter-rater Agreement for Total Drive Content, Drive Level, and Drive Integration Ratings
(N 16)

Drive Ratings	Number Units	Number** Agreed	Percent*** Agreed
Total Drive Content	396	361*	91.1
Direct-Unsocialized	108	88	81.4
Direct-Socialized	124	108	87.1
Disguised-Indirect	128	119	92.8
Total for Levels	360	315	87.5
Thematic	302	251	83.1
Incidental	51	46	90.1
Non-appropriate	10	6	60.0
Total for Integration	363	303	83.4

*Of the 361 agreements there were 11 unrated stories, i.e., both raters agreed that 11 stories had no ratable drive content.

**Number of Units where there was agreement on drive present initially.

***Based on the degree to which rater II (CD) agreed with rater I (BF).

RESULTS

General Findings

Table 7 is a summary of the basic statistics for each of the relevant variables. Table 8 summarizes the mean differences between pre and post scores for each group.

Table 7--Means and Standard Deviations for Major Variables (N=20)

Variable	Pre Mean	Pre SE	Post Mean	Post SE	Mean Difference
Successful group					
1. Total P (level of self esteem)	320.88	24.16	346.44	27.64	25.56
2. Total Drive Content	38.22	20.73	22.88	9.12	-15.34
3. D-S Score (Level 2) socialized drive	42.00	12.00	49.00	12.00	7.00
4. D-U Score (Level 1) unsocialized drive	17.00	7.00	19.00	6.00	2.00
5. D-I Score (Level 3) disguised-indirect	41.00	11.00	31.00	14.00	-10.00
6. Degree of Integration	264.66	17.80	279.33	13.32	14.67
Partially successful group					
1. Total P (level of self esteem)	286.54	27.91	315.36	31.67	28.82

Table 7--cont'd.

Variable	Pre Mean	Pre SE	Post Mean	Post SE	Mean Difference
2. Total Drive Content	21.72	11.91	14.63	7.43	-7.09
3. D-S Score (Level 2) socialized drive	27.00	11.00	36.00	11.00	9.00
4. D-U Score (Level 1) unsocialized drive	27.00	14.00	29.00	22.00	2.00
5. D-I Score (Level 3) disguised-indirect	46.00	20.00	34.00	16.00	-12.00
6. Degree of Integration	265.81	17.13	281.90	18.14	16.09

Table 8

Mean Difference of Pre and Post Scores for Successful and Partially Successful Groups

Variable	Mean Differences Successful	Partially Successful
1. Total P (level of self esteem)	25.56	28.82
2. Total Drive Content	-15.34	-7.09
3. D-U Score (Level 1)	2.00	2.00
4. D-S Score (Level 2)	7.00	9.00
5. D-I Score (Level 3)	-10.00	-12.00
6. Degree of Integration	14.67	16.09

Differences in Change Scores between Groups

In order to assess differences between the successful and partially successful groups in change scores, a multivariante and univariante analysis of covariance was utilized in testing Hypotheses I and II.

Hypothesis I: Amount and level of drive content as expressed in TAT protocols will change more from pre to post testing in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis I-a: Total amount of drive expressed as measured by the Total Drive Content (TDC) will increase more in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis I-b: The amount of drive which is expressed in socially acceptable ways as measured by Direct-Socialized (D-S) Drive Content will increase more in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis I-c: The amount of drive which is expressed in highly constricted ways as measured by the Disguised-Indirect (D-I) Score will decrease more in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis I-d: The amount of drive expressed in unsocialized ways as measured by the Direct-Unsocialized (D-U) Score will decrease more in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis I-e: The degree of drive integration as measured by the weighted proportion of thematic, incidental, and non-appropriate drive ratings will increase more in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis II: Self-Esteem as measured by the Total P Score on the Tennessee Self-Concept Scale will increase more in those cases rated successful as opposed to those cases rated partially successful.

Tables 9 through 14 are a summary of the univariante analysis. Because three of the variables (Level 1, 2, and 3) summed to a constant (1), all six of the variables could not be examinated simultaneously with a multivariante analysis of covariance. Therefore, five variables were examined simultaneously with one of the levels being dropped. This

was done three times with a different level being eliminated each time, so that all levels were examined in relation to the other variables. The three multivariante F's were identical, F=.0340, P=.9992. Although theoretically not appropriate, in the interest of understanding, the univariante F's were examined. As indicated by the multivariante F's and the univariante F's which are summarized in Tables 9 through 14, Hypotheses I and II were not supported. There are no significant differences in amount of change between the two groups for any of the variables (i.e., self-esteem, Total Drive Content, level of socialization or degree of integration).

Table 9

Analysis of Covariance on Post Self-Esteem Using Pre Self-Esteem as the Covariante

Source	SS	MS	df	F	P
Groups	995.76	995.76	1	1.19	.29
Error	142.25	836.77			
Total	1138.01	1832.53			

Table 10

Analysis of Covariance on Post Level 1 (Direct-Unsocialized) of Socialization Using Pre Level 1 as the Covariante

Source	SS	MS	df	F	P
Groups	.0149	.0149	1	.50	.49
Error	.5066	.0298	17		
Total	.5215	.0447			

Table 11

Analysis of Covariance on Post Level 3 (Disguised-Indirect) of socialization using Pre Level 3 as the Covariante

Source	SS	MS	df	F	P
Groups	.0026	.0026	1	.1089	.75
Error	.4199	.0247	17		
Total	.4225	.0273			

Table 12

Analysis of Covariance on Post Level 2 (Direct-Socialized) of socialization using Pre Level 2 as the Covariante

Source	SS	MS	df	F	P
Groups	.0286	.0286	1	2.07	.17
Error	.2346	.0138	17		
Total	.2632	.0424			

Table 13

Analysis of Covariance on Degree of Post Integration using Pre Integration as the Covariante

Source	SS	MS	df	F	P
Groups	39.95	39.95	1	.15	.70
Error	4372.77	257.81	17		
Total	4412.72	297.76			

Table 14

Analysis of Covariance on Post Total Drive Content using Pre Total Drive Content as the Covariante

Source	SS	MS	df	F	P
Groups	29.04	29.04	1	.73	.40
Error	676.26	39.78	17		
Total	705.30	68.82			

Hypothesis III: There is a positive relationship between pre- ego strength as measured by Barron's Ego Strength Scale and post therapy measures of Total Drive Content, Direct-Socialized level of drive, degree of integration and self-esteem.

As Table 15 indicates, only self-esteem is significantly correlated with pre ego-strength. Pre ego-strength is not significantly correlated with TDC, D-S, or Integration, although there is a trend in the hypothesized direction. Hypothesis III was, therefore, partially confirmed by the data.

Table 15

Correlation of Pre Ego Strength with Post Self-Esteem, D-S, TDC, and Degree of Integration

Variable	Pre Therapy Ego Strength r	t	P
Self-esteem	.52	2.588	.01
D-S (Level 2)	.22	.909	n.s.
Integration	.21	.879	n.s.
TDC	.07	.025	n.s.

Differences in Change Scores Within Groups

Although statistical analysis indicated that there were no differences in change scores between groups, it was of some interest to ascertain if there were within group changes. That is, do pre- and post scores for a particular variable change within groups? Since the hypotheses were based on change differences, it is of import to ascertain whether any change at all occurred. Although it is not possible to attribute change, if any, to therapy, in the spirit of exploration the within group changes were examined. Table 16 is a summary of changes within groups and indicates that self-esteem significantly increased and Total Drive Content significantly decreased. There were no significant changes in level of Socialization or degree of Integration.

Table 16

Pre and Post Scores of Self Esteem, Total Drive Content, Level of Socialization, and Degree of Integration

Variable	Mean Pre	Post	t	P
Successful group				
Self esteem	320.98	346.44	2.71	.05
Level 1 (D-U)	17.00	19.00	1.30	n.s.
Level 2 (D-S)	42.00	49.00	1.20	n.s.
Level 3 (D-I)	41.00	31.00	1.73	n.s.
Integration	264.66	279.33	1.45	n.s.
TDC	38.22	22.88	2.98	.05
Partially Successful group				
Self esteem	286.54	315.46	3.020	.01
Level 1 (D-U)	27.00	29.00	.003	n.s.
Level 2 (D-S)	27.00	36.00	2.180	n.s.
Level 3 (D-I)	46.00	34.00	.085	n.s.
Integration	265.81	281.90	2.190	n.s.
TDC	21.72	14.63	3.000	.05

DISCUSSION

An inspection of the results section of the present study indicates that hypotheses I and II were not supported by the data. Furthermore, there were not even trends in the hypothesized directions. Obviously this is a troublesome event, as the present author had anticipated some differences in change scores which did not occur.

Before exploring possible reasons for the lack of support for the hypotheses, the reader may be interested that the original dissertation proposal included hypotheses related to differences within groups as well as differences between groups. However, one of the committee members quite accurately pointed out that since there was no control group and since the groups (successful vs. partially successful) might be different from the beginning (e.g., ego strength) changes in the groups might simply reflect the fact that the groups differed in psychological status at the beginning, that they differed at the end and that within group changes during that period might be the result of factors other than changes due to psychotherapy (e.g., changes due to time passing, instrumental variables, developmental processes, etc.). Therefore, since there was question regarding the validity of hypothesizing within group changes, it was decided to handle this on a post-hoc basis and those changes will be discussed separately.

Differences Between Groups

A major reason suggested here for the fact that there were no differences in change scores is related to the similarity of the groups. That is, differences in change scores might be more evident in two extreme groups such as Successful as opposed to Unsuccessful. It may be that differences in the potential effects of therapy evaluated as success vs. partial success are not great enough to be measurable.

Another interesting possibility is suggested by the relationship of therapist experience level to whether outcome was evaluated as successful or partially successful. As reported earlier, a greater number of interns evaluated outcome as successful. Several things may be occurring here. Interns may have a lower set of criteria than staff. Or interns, with a shakier sense of competence, may be less inclined to rate outcome as less than successful. Another possibility is that staff saw clients who were more "disturbed" and therefore less likely to be evaluated as successful, particularly in view of the fact that therapy was relatively brief (M=12.4 one hour sessions) and the mean number of interviews was very similar for both experience levels (staff M=14.4; intern M=10.5). An examination of pre-ego strength indicated that at least in terms of ego-strength, staff saw more "disturbed" clients than did interns. The mean pre therapy ego-strength scale score of clients seen by staff was 40.7 in contrast to the mean of 46.4 for clients seen by interns, a difference significant at the .05 level (t=1.972).

Although all of the above factors may be operating, it seems reasonable to hypothesize that clients seen by staff were more "disturbed" and thus less likely to be evaluated as successful. This suggests an interesting possibility in terms of the interaction between

therapist experience level and therapeutic outcome. It may be that this interaction operated in such a way as to wash out any differences in change scores between groups. That is, more experienced therapists saw more "disturbed" clients and less experienced therapists saw less "disturbed" clients. Thus, differences in change scores may have appeared if either experience level or degree of "disturbance" was equated. Specifically, if either all clients were seen by staff or all seen by interns, differences may have occurred. Similarly, differences may have occurred if pre-therapy ego-strength was similar for both experience levels.

In addition, although the Pine Rating System for the TAT has been used fairly extensively in studies concerning wit, creativity, vocational choice, etc., a review of the literature indicates that the Pine system has not been previously utilized in assessing change. Thus, one can argue that the Pine System is not sensitive enough, particularly in terms of assessing changes in *manner* of expressing drive . . . though this does not explain the significant decrease in amount of drive content within groups. This will be further discussed in the section on within group changes.

Lastly, failure to find change difference between groups may be a function of sample size. That is, groups of 9 and 11 respectively may be too small to reflect differences in change scores.

Differences Within Groups

One reasonable question to raise when failing to find differences in change scores, is whether or not there were any changes. That is, if there were no changes from pre to post within the Successful and Partially Successful groups, it is impossible for there to be differences

in change scores between groups. As reported earlier, there were no significant changes within either the Successful or Partially Successful group in either the manner of expressing drive or in degree of integration. Thus, differences in change scores between groups for these variables were impossible.

However, the post hoc analysis of the data did reveal a significant increase in self esteem within both groups. Since the increase for both groups was very similar, there was no difference between groups in amount of change. This finding of an increase of self esteem from pre to post therapy is essentially a replication. Rogers (1954), Butler and Haigh (in Rogers & Dymond, 1954), Dymond (in Rogers & Dymond, 1954), and Ashcraft and Fitts (1964) have all reported significant increases of self esteem from pre- to post therapy testing.

In addition, a closer examination of the pre- and post self-esteem scores reveals an interesting finding. The Successful and Partially Successful groups differed significantly at pre-testing (S group, M=320.9; PS group, M=286.5; t=3.018, sign. greater than .01 level) and though they both increased, they remained different at post testing (S group, M=347.2; PS group, M=315.4; t=2.429, sign. greater than .05 level). Also, both groups increased similarly, 25.6 for the S group and 28.9 for the PS group. Fitts (1965), in his normative data for the Tennessee Self Concept Scale, reports a mean score of 345 for total P. Thus, it appears that both groups gained a similar amount of self-esteem from pre- to post therapy testing and that the S group's self-esteem (347.2) is very similar to normative findings (345), another finding which indicates more successful outcome for the S group as opposed to the PS group.

Contrary to the predicted direction in Hypothesis 1-a, Total Drive Content significantly decreased within both groups. There are several possible explanations for this decrease. Examiner effects may be present. That is, one examiner administered 10 cards to approximately 40 clients before therapy and 30 after therapy. Fatigue and boredom on the part of the examiner may have influenced the clients to give shorter and less rich post stories, thus reducing Total Drive Content.

Similarly, it is possible that clients' test taking motivation may differ before therapy as opposed to after therapy. That is, before therapy, clients are generally uncomfortable and seeking aid as opposed to successful post therapy clients. It is possible that the pre-therapy uncomfortableness contributes to a greater sense of cooperation on the client's part and thus leads to longer, rich and greater Total Drive Content in pre protocols as compared to post protocols. Or if the sense of cooperativeness persists, a decrease in Total Drive Content may be a reflection of the client's desire to please the therapist (i.e., get well) and lead to the client's attempting to give "well" protocols, thus resulting in decreased Total Drive Content.

Another consideration is that the decrease in Total Drive Content may reflect a resolution of conflict concerning sexual and aggressive drives and/or a change in behavior which leads to sexual and aggressive needs being met, thus reducing the need to express these impulses.

An additional explanation of the decrease in Total Drive Content is related to the meaning of drive content in TAT protocols. Ego psychology suggests that there may be a dual significance in the use of drive content. Extremely low amounts of drive content indicate a generally constricted, rigid, and frequently fragile system of ego defenses. While extremely high amounts of drive content may indicate

that there is a weakening of ego controls over impulses, such that these impulses break through. Thus, within this theoretical framework, there is some point between extremely low or high drive expression, which represents adequate ego controls over impulses without resorting to constrictive, rigid, or inhibitive modes of control.

Dietzel's (1970) recent findings were examined with the above hypothesis in mind. Dietzel's sample was taken from a college student population and consisted of 91 students enrolled in an advanced undergraduate psychology course at Michigan State University. The S's tended to express drive primarily in ego-syntonic, socialized ways and were able to appropriately integrate impulses in respect to the stimulus as well as the situation. Thus, there were several indications that the sample represented a relatively normal, adaptive group of college students and therefore generated norms in regard to Total Drive Content. From 4 TAT protocols, Dietzel's S's gave a mean of 8.40 units of drive content. The S's of the present study were also administered 4 cards, but their pre therapy means were significantly higher, with the Successful group having a pre therapy mean of 38.2 ($t=4.447$; $P > .005$) and the Partially Successful group having a mean of 21.7 ($t=2.710$; $P > .005$). However, there were several design features which may be contributing to these differences. Dietzel's protocols were administered in a group and were written by the S's. In contrast, the present sample's S's were administered the TAT individually and stories were tape recorded verbatim. In addition, although 2 of the TAT cards were identical (4 and 13MF) for both studies, the other 2 cards differed (Dietzel utilizing Cards 1 and 2; the present study utilizing 6BM and 18). These design differences are undoubtedly contributing somewhat to the differences. However, the pre differences are so great, it seems

reasonable to interpret them at least in part, as true differences. Thus, a significant decrease from pre to post therapy in Total Drive Content can be interpreted as a movement toward average, adaptive amounts of drive expression.

Although amount of drive content decreased from pre to post therapy testing, there was no significant change in the manner the drive was expressed. That is, proportions of drive expressed in Direct-Socialized, Direct-Unsocialized, and Disguised-Indirect ways, and degree of integration remained the same. There are several possible explanations for this finding. One explanation has been mentioned previously and is related to the sensitivity of the Pine Rating System. It may be that the System reflects gross changes, such as amount of drive expressed, but lacks the needed sensitivity to assess more subtle changes, such as manner of expressing drive.

Another explanation is related to the significance of level of socialization of drive. That is, ways and modes of expressing drive may be of long term standing and may represent a fairly solidified part of the underlying personality structure. The S's of the present study participated in relatively short term therapy (M=12.4 one hour sessions). Thus, it may be that relatively brief therapy has little or no effect on the underlying structure of personality whereas it is able to affect an S's evaluation of self . . . a possible explanation of no change in level of socialization but significant changes in self esteem.

Correlations

Finally, Hypothesis III predicted a positive relationship between pre ego strength and post Total Drive Content, self-esteem, degree of integration, and Direct-Socialized level of socialization. Although all

of the correlations were in the predicted direction, the majority of them were small and non-significant with the exception of self-esteem, which has a correlation of .52. Thus, it appears that Barron's Ego Strength Scale and the Tennessee Self Concept Scale are assessing similar aspects of personality in contrast to the aspects assessed by the Pine System. In addition, this may represent differences in paper and pencil tests as opposed to projective tests.

SUMMARY

This study investigated the differences in change scores between Successful (S) and Partially Successful (PS) therapy groups. Change scores were based on differences from pre to post therapy testing. Specifically, changes in self esteem as measured by the Tennessee Self Concept Scale and drive expression (amount, level of socialization and degree of integration) as measured by the Pine Rating System for Thematic Apperception Test protocols were examined.

Successful and Partially Successful groups were formed on the basis of client and therapist evaluation of outcome of therapy and pre therapy ego strength as measured by Barron's Ego Strength Scale, a scale derived from the MMPI. Nine clients were classified as Successful and 11 as Partially Successful.

The following hypotheses were examined.

Hypothesis I: Amount and level of drive content as expressed in TAT protocols will change more from pre to post testing in those cases rated successful as opposed to those cases rated partially successful.

Specific predictions are:

Hypothesis I-a: Total amount of drive expressed as measured by the Total Drive Content (TDC) will increase more in those cases rated successful as opposed to those rated partially successful.

Hypothesis I-b: The amount of drive which is expressed in socially acceptable ways as measured by Direct-Socialized (D-S) Drive

Content will increase more in those cases rated successful as opposed to those rated partially successful.

Hypothesis I-c: The amount of drive which is expressed in highly constricted ways as measured by the Disguised-Indirect (D-I) score will decrease more in those cases rated successful as opposed to those rated partially successful.

Hypothesis I-d: The amount of drive expressed in unsocialized ways as measured by the Direct-Unsocialized (D-U) score will decrease more in those cases rated successful as opposed to those rated partially successful.

Hypothesis I-e: The degree of drive integration as measured by the weighted proportion of thematic, incidental, and non-appropriate drive ratings will increase more in those cases rated successful as opposed to those rated partially successful.

Hypothesis II: Self esteem as measured by the Total P score on the Tennessee Self Concept Scale will increase more in those cases rated successful as opposed to those cases rated partially successful.

Hypothesis III: There is a positive relationship between pre therapy ego-strength as measured by Barron's Ego-Strength Scale and post therapy measures of Total Drive Content, Direct-Socialized drive, degree of integration, and self esteem.

Neither Hypotheses I nor II were supported by the data. That is, there were no differences in change scores between groups. It was suggested that clients designated as S and PS are so similar that differences in the potential effects of therapy may not be great enough to be measurable.

In a post hoc analysis, within group changes from pre to post therapy were examined. Although there were no changes in *manner* of

expressing drive, *amount* of drive significantly decreased and self esteem significantly increased within both groups. It was suggested that the Pine Rating System, although capable of assessing gross changes, such as amount of drive content, may lack the needed sensitivity to reflect subtle changes, such as manner of expressing drive. The increase of self esteem from pre to post therapy testing is similar to the findings of other researchers. It was speculated that the decrease in Total Drive Content from pre to post therapy testing reflected a movement toward average, adaptive amounts of drive expression.

Hypothesis III was partially confirmed. Although all of the correlations were in the predicted direction, the majority was small and non-significant with the exception of post therapy self esteem, which was significantly correlated with pre therapy ego-strength. It appears that Barron's Ego Strength Scale and the Tennessee Self Concept Scale assessed similar aspects of personality in contrast to those assessed by the Pine Rating System.

As a sidelight to this study, it was noted that experienced therapists saw clients who as a group had lower ego strength scores. Clients with lower ego strength scores were rated as being less successful in terms of therapy outcome. It was further noted that clients in the two groups (Successful vs. Partially Successful) differed at a statistically significant level on pre-therapy measures of self-esteem as well as post therapy measures of self-esteem.

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APPENDIX A

STUDENT EVALUATION OF COUNSELING

APPENDIX A

STUDENT EVALUATION OF COUNSELING

Your response to this questionnaire as with all the material you've completed are completely confidential.

1. Place an (X) at the point on the scale that *best describes your feelings* about whether counseling helped you to solve your problems.

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was extremely harmful	harmed me quite a lot	harmed me somewhat	indifferent - neither helped nor harmed me	helped me somewhat	helped me quite a lot	very much was extremely helpful

APPENDIX B

SOME EXAMPLES OF ITEMS FROM THE BARRON'S EGO-STRENGTH SCALE, DERIVED FROM THE MMPI

APPENDIX B

SOME EXAMPLES OF ITEMS FROM THE BARRON'S EGO-STRENGTH SCALE, DERIVED FROM THE MMPI

I have a good appetite.

One or more members of my family is very nervous.

Much of the time my head seems to hurt all over.

I cannot keep my mind on one thing.

In my home we have always had the ordinary necessities (such as enough food, clothing, etc.).

I have had very peculiar and strange experiences.

I feel unable to tell anyone all about myself.

I very much like horseback riding.

I am made nervous by certain animals.

I pray several times every week.

APPENDIX C

THE TENNESSEE SELF CONCEPT SCALE TEST BOOKLET

APPENDIX C

THE TENNESSEE SELF CONCEPT SCALE TEST BOOKLET*

INSTRUCTIONS

On the top line of the separate answer sheet, please fill in your age, sex, and educational status. Write only on the answer sheet. Do not put any marks in this booklet.

The statements in this booklet are to help you describe yourself as you see yourself. Please respond to them as if you were describing yourself *to yourself*. *Do not omit any items*. Read each statement carefully; then select one of the five responses listed below. On your answer sheet, put a *circle* around the response you chose. If you want to change an answer after you have circled it, do not erase it but put an *X* mark through the response and then circle the response you want.

As you start, be sure that your answer sheet and this booklet are lined up evenly so that the item numbers match each other.

Remember, put a *circle* around the response number you have chosen for each statement.

Responses -	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

You will find these response numbers repeated at the bottom of each page to help you remember them.

*William H. Fitts, 1964.

	Page 1	Item No.
1.	I have a healthy body	1
3.	I am an attractive person	3
5.	I consider myself a sloppy person	5
19.	I am a decent sort of person	19
21.	I am an honest person	21
23.	I am a bad person	23
37.	I am a cheerful person	37
39.	I am a calm and easy going person	39
41.	I am a nobody	41
55.	I have a family that would always help me in any kind of trouble	55
57.	I am a member of a happy family	57
59.	My friends have no confidence in me	59
73.	I am a friendly person	73
75.	I am popular with men	75
77.	I am not interested in what other people do	77
91.	I do not always tell the truth	91
93.	I get angry sometimes	93

Responses -	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

Page 2

		Item No.
2.	I like to look nice and neat all the time.....	2
4.	I am full of aches and pains.....	4
6.	I am a sick person.....	6
20.	I am a religious person.....	20
22.	I am a moral failure.....	22
24.	I am a morally weak person.....	24
38.	I have a lot of self-control.....	38
40.	I am a hateful person.....	40
42.	I am losing my mind.....	42
56.	I am an important person to my friends and family.....	56
58.	I am not loved by my family.....	58
60.	I feel that my family doesn't trust me.....	60
74.	I am popular with women.....	74
76.	I am mad at the whole world.....	76
78.	I am hard to be friendly with.....	78
92.	Once in a while I think of things too bad to talk about.....	92
94.	Sometimes, when I am not feeling well, I am cross.....	94

Responses -	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

	Page 3	Item No.
7.	I am neither too fat nor too thin	7
9.	I like my looks just the way they are	9
11.	I would like to change some parts of my body	11
25.	I am satisfied with my moral behavior	25
27.	I am satisfied with my relationship to God	27
29.	I ought to go to church more	29
43.	I am satisfied to be just what I am	43
45.	I am just as nice as I should be	45
47.	I despise myself	47
61.	I am satisfied with my family relationships	61
63.	I understand my family as well as I should	63
65.	I should trust my family more	65
79.	I am as sociable as I want to be	79
81.	I try to please others, but I don't overdo it	81
83.	I am no good at all from a social standpoint	83
95.	I do not like everyone I know	95
97.	Once in a while, I laugh at a dirty joke	97

Responses -	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

	Page 4	Item No.
8.	I am neither too tall nor too short.....	8
10.	I don't feel as well as I should.....	10
12.	I should have more sex appeal.....	12
26.	I am as religious as I want to be.....	26
28.	I wish I could be more trustworthy.....	28
30.	I shouldn't tell so many lies.....	30
44.	I am as smart as I want to be.....	44
46.	I am not the person I would like to be.....	46
48.	I wish I didn't give up as easily as I do.....	48
62.	I treat my parents as well as I should (Use past tense if parents are not living).....	62
64.	I am too sensitive to things my family say.....	64
66.	I should love my family more.....	66
80.	I am satisfied with the way I treat other people.....	80
82.	I should be more polite to others.....	82
84.	I ought to get along better with other people.....	84
96.	I gossip a little at times.....	96
98.	At times I feel like swearing.....	98

Responses -	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

Page 5

		Item No.
13.	I take good care of myself physically.....	13
15.	I try to be careful about my appearance.....	15
17.	I often act like I am "all thumbs".....	17
31.	I am true to my religion in my everyday life.....	31
33.	I try to change when I know I'm doing things that are wrong...	33
35.	I sometimes do very bad things.....	35
49.	I can always take care of myself in any situation.....	49
51.	I take the blame for things without getting mad.....	51
53.	I do things without thinking about them first.....	53
67.	I try to play fair with my friends and family.....	67
69.	I take a real interest in my family.....	69
71.	I give in to my parents. (Use past tense if parents are not living).....	71
85.	I try to understand the other fellow's point of view.....	85
87.	I get along well with other people.....	87
89.	I do not forgive others easily.....	89
99.	I would rather win than lose in a game.....	99

Responses -	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

	Page 6	Item No.
14.	I feel good most of the time	14
16.	I do poorly in sports and games	16
18.	I am a poor sleeper	18
32.	I do what is right most of the time	32
34.	I sometimes use unfair means to get ahead	34
36.	I have trouble doing the things that are right	36
50.	I solve my problems quite easily	50
52.	I change my mind a lot	52
54.	I try to run away from my problems	54
68.	I do my share of work at home	68
70.	I quarrel with my family	70
72.	I do not act like my family thinks I should	72
86.	I see good points in all the people I meet	86
88.	I do not feel at ease with other people	88
90.	I find it hard to talk with strangers	90
100.	Once in a while I put off until tomorrow what I ought to do today	100

Responses -	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

APPENDIX D

A MANUAL FOR RATING DRIVE CONTENT IN THE THEMATIC APPERCEPTION TEST

APPENDIX D

A MANUAL FOR RATING DRIVE CONTENT IN THE THEMATIC APPERCEPTION TEST*

Fred Pine

The Scoring Manual

Presence of drive content

Throughout the manual, the term "drive" is used in the psychoanalytic sense to refer to instinctual drives and their derivatives. This includes aggressive and libidinal drives and partial drives (oral, anal, phallic, genital, exhibitionistic, voyeuristic, sadistic, masochistic, homosexual, narcissistic) (cf., Freud, 1905). The term "drive content" refers to observable ideational derivatives of the inferred aggressive and libidinal drives. These derivatives appear in the TAT story content.

Drive content is rated only if it is stated explicitly in the story; thus, for example, implied motives and symbolic expressions of drives are not rated. The decision to rate only the manifest story content was made for two reasons: first, in the belief that individual differences would be erased somewhat in speculations about more universally present drives which are latent (in the story) relate the ratings closely to the psychology of ego functioning. The manual is not intended to be an all-purpose one; both its usefulness and its limitations are tied to its commitments to psychoanalytic theory (reflected here in the selection of aggressive and libidinal drives for rating) and its more specific commitment to psychoanalytic ego psychology (reflected here in the emphasis on control operations with regard to expressed drive content).

Drive content is rated if it appears at any point in S's response to a TAT card except in response to a direct inquiry question. Thus, "how did he feel? - "angry" would not be rated although responses to inquiries such as "tell me more" or "how did it all turn out" are rated. Drive content is rated without regard to its extent; passing mention or full thematic development of, say, an aggressive incident would each be rated. On the other hand, drive content which is too far removed from aggressive or libidinal connections is not rated (for example, friendship, achievement motives, gazing at scenery); it was found necessary to establish some such cutting point, albeit an arbitrary one, in order to avoid a tendency to rate almost everything S says. The ratings of drive level, described below, represent an attempt

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*Journal of Projective Techniques, 1960, 24, 32-45.

to cope with this entire issue. Finally, affective experiences which are directly linked to particular drives (anger, love) are rated, although affective states in general are not (shame, guilt, sadness, elation, etc.). These and all other ratings are illustrated below.

Integration of drive content

S's task on the TAT is to tell a story about a picture. To the degree that drive content is given in accord with this task requirement, some ego control is indicated. The degree to which drive content is integrated into S's response to a card (the response ordinarily being a story, but on occasion an essay-like production or an elaborated description) was taken to be an index of appropriateness of drive expression and adequacy of ego control.

Of the appropriately used drive content, two types were distinguished. Drive content which is part of the central them or character portrayal of the story is rated *thematic*, in contrast to drive content which is *incidental* to the main them (but still part of the story). Drive content can be rated thematic even if it is given only briefly; its links to the main story rather than its extent is at issue here. Even if the rater feels a story could get along without an item of drive content, if S gave it as part of the central story theme it is rated thematic. Incidental drive content, while integrated into the story, is generally expendable even in S's presentation of the material. For example, drive content is generally incidental when it is given in analogy which is intended tangentially to enrich the story.

In contrast to both thematic and incidental ratings, a rating of *nonappropriate* is given to those expressions of drive which are not in accord with the TAT task (telling a story about a picture) or which were not intended by S. These include: 1. Exclamations and side comments before, during, or after the story (for example, "Wow, this is a sexy one" or "That murder last week gives me an idea for this story"). 2. Drive content given in card descriptions when it does not then get included in the story (for example, mention of the gun on card 3BM followed by a story about fatigue rather than, say, suicide). 3. Misperceptions or doubts about the identity of persons or objects when drive content is involved (for example, calling the violin on card 1 a machine gun or misperceiving the sex of a character; the figure on 3BM and the lower figure on 18GF were unrated whether seen as male or female). 4. Verbal slips where drive content is evident in the slip itself (including the sexual ambiguity suggested by use of wrong-sex pronouns --"he" instead of "she" for example). Slips that are made in a broader drive content context are rated separately while the story context gets its own rating.

Directness of expression of drive content

TAT stories vary in the degree to which their expressed drive content is primitive, value-violating, and direct on the one hand, or socialized, value-syntonic, and/or disguised on the other. The present manual distinguishes three levels of expression of drive content, the levels partially modelled after Holt and Havel's (1959) distinction between two levels of drive content in Rorschach responses.

Level I (direct-unsocialized) includes those expressions of drive content where libidinal or aggressive impulses are directly expressed in a way contrary to conventional social values. Murder, robbery, rape, prostitution, homosexuality, alcoholism, and extramarital sexual relationships, for example, are all rated here. In addition to the criterion "violation of conventional values," a second criterion is applied for aggression derivatives, i.e., physical expression. Anger is rated level I only when it involves physical violence. In all cases, it is only the unsocialized and direct drive expression in the *manifest* story content which gets rated.

Level II (direct-socialized) includes those expressions of drive content where libidinal or aggressive impulses are expressed direclty but in socialized ways. Anger expressed without physical violence, arguments among family members, sexual rivalries and jealousies, kissing, eating, social drinking, intercourse between marriage partners, and childbirth are all rated here.

Level III (indirect-disguised; weak) actually includes two kinds of drive content. The first, indirect and disguised drive expression, includes those instances that are associated with (often relatively strong) drives, but where the underlying impulse is neither explicitly thought nor acted upon in the story. Mention of police, soldiers, rulers, restaurants, saloons, illness, accidents, natural or accidental deaths are all included here. All of these permit the inference that a particular drive is an issue for the person but, although some reflection of the drive appears in the manifest story, the drive itself is not expressed. If the context alters this, e.g., "he *ate* in a restaurant" or "the soldier *fought*," level II or I would be rated. The second type of content rated level III includes drive expressions which are weak and highly derived. For example, social expressions of aggression derivatives such as strikes and militant unions are rated here as hihgly formalized drive expressions such as familial affection. An arbitrary cutoff point must be established here so that material which is too weak does not get rated. Reference to surgeons, microscopes, struggles to get ahead in life are not rated although inferences can readily be made to impulses from which they derive.

Three additional points on drive level ratings: (1) Negation of drive expression is rated identically with positive expression. "He wanted to kiss her but he didn't" is rated level II. (Such negated expressions are often given in such a manner as to make them "incidental"; for example, "let's see...it's not that he wanted to kiss her, I'd say he just liked her.") (2) Thoughts and wishes are rated equally with actions in most cases. "He wanted to kill him" is rated level I whether or not the act is carried out. On occasion, such content is given as a way of communicating intensity rather than true intent; in those instances a more controlled level may be rated. (3) Context is always considered in rating drive level. For example, kissing as part of an attempted seduction of a married person is level I rather than II. Similarly, criminal execution and war are the two major examples of killing that may be rated level II rather than level I; for war stories, the level II rating is given when the emphasis is patriotism, duty, and the normal course of events in war rather than on aggressive acts and violations of rules of warfare.

Units of analysis

Drive material may be rated many times in any one story, and considerations of the extent of the expressed content were independent of the rating unit. Several rules were established to guide raters in selecting the unit to be rated in each instance: (1) Expressions of derivatives of different drives are rated as separate instances of drive expression. For example, "he was angry but a couple of drinks helped him to settle down" would be rated once for the aggressive content and once for the oral content. (2) Expressions of drive with differing degrees of integration into the story (thematic, incidental, or nonappropriate) are always rated separately, even if the drive expressed is identical. Thus, an incidental and a thematic aggressive phrase would receive two ratings. (3) In contrast, a new level of an already expressed drive would not get a separate rating. "He went into a bar (level III) and got dead drunk" (level I) would be rated only once, the rating of the more extreme content. This stepwise expression of drive material appears so often and generally with such an inevitability in the sequence that to rate them independently would artificially raise the total number of ratings given. (4) Within the same general type of drive content and the same degree of integration separate ratings are given if new behavior sequences are described or if the expressed impulse has a new aim.

Some illustrative stories and ratings

Four illustrative TAT stories are given below. Stories particularly rich in rating issues were selected. In each, certain material is lettered and italicized; comments on the lettered material are given immediately following each story, using the letters for cross reference. Ratings are given in parentheses. The first symbol indicates the drive level (I, II, or III); the second symbol indicates the degree of integration ("T" for thematic, "In" for incidental, and "N" for nonappropriate).

1. (Card 3BM) (a) *Well, I take it that is a pistol on the floor.* This young man is in a Balkan country. He was young and (b) *inclined to melancholy.* (c) *The Germans had overrun the country. His father had been captured and killed by the Germans.* His fortune was lost and *all his friends died.* Oh, I forgot to say he was Jewish. He's been making feverish attempts (d) *to release his father,* but without success. Now he has returned from an exploit where he went to German headquarters, (e) *shot the man who was there,* and ran through the streets to his home. He knows what will happen when he's caught, so he (f) *puts a bullet through his own head.* (g) *I guess that's a pistol. It certainly isn't a very realistic representation of one though.*

a. (Not rated) Although this is card description, it is later used in the story. Had the gun been mentioned and then omitted from the story it would have been rated III-N (level III because it is associated with an aggressive impulse which, however, would not have been expressed in the story). As is, the rating is included with (f), below.

b. (Not rated) Affects are rated only if drive content is specifically stated.

c. (I-T) All of this is rated as one unit. The emphasis on the atrocities of war requires the level I rating. It is all central to the story theme.

d. (I-N) The phrase "release his father" contradicts the earlier "his father had been captured and killed." There is a slip here somewhere, and since it involves the killing of the father, it is rated level I, nonappropriate.

e. (I-T) Though still aggression, this is a new behavior sequence (in relation to the actions of the German invaders) and is rated separately. Although one may sympathize with the actions of the hero, the murder in a revenge context is best rated as level I.

f. (I-T) This aggression too is sufficiently different from the former instances to be rated separately. Suicide is level I. Although the suicide is only briefly mentioned, it is still part of the central theme of the story and is rated thematic.

g. (I-N) This is a nonappropriate extraneous comment; it has nothing to do with the story. Since context is considered in rating drive level, and since the gun has already been established in the story as a murder and suicide weapon, the reference to the gun here is level I rather than level III.

2. (Card 10) (a) *A soldier going off to fight in the war*, and the woman with whom he is supposedly (b) *in love* is crying *and kisses him goodbye.* Much later, he returns to France and finds that his young lady has (c) *married someone else* in order to keep herself in (d) *food* and clothing. And he does nothing probably. Looks for (e) *food* and clothing for himself. No action. Well, of course the marriage--I could clear that. He could find her, and she, not having married for love, (f) *could give herself to him as well as to the person she married.*

a. (II-T) In the context of duty, war is rated level II.

b. (II-T) This is a direct expression of a libidinal impulse in a socialized way and in line with the main story theme.

c. (III-T) The later references to marriage in the story add nothing new to this first reference and are included in this rating. Marriage, when given in such a stylized way, is rated level III since only a very watered down expression of drive comes through into the story.

d. (II-T) Oral (food) content is different from the earlier rated libidinal content (kissing and marriage) and is rated as a separate unit. The reference to food provides motivation for the marriage under wartime conditions and, as such, is essential to the main theme of the given story. It is a direct expression of an oral need.

e. (II-In) Once again the reference to food is a direct oral expression in a socialized way. Here, however, it seems to be presented by S as a momentary pause in the story, before S gets on with the main theme; as such it is rated incidental. Incidental presentation by S in the story, rather than the rater's decision that a story could do without an item of drive content, is what requires an item of drive content to be rated incidental. Although the "food" content here is identical with the previously rated item, it is rated as a separate unit because it is a different degree of integration (incidental rather than thematic) and because it is a new behavior sequence carried out by another person; either of these reasons alone would be sufficient to require a separate rating for this unit.

f. (I-T) Using the conventional values of society as the yardstick for deciding between level I and level II ratings, this is unsocialized drive expression and is rated level I.

3. (Card 13MF) This boy had (a) *time to kill* and stopped in a (b) *bar for a few drinks*. He kept (c) *noticing a girl* who was not pretty but *whose dress showed off her body well*. She came up to him after a while and suggested they go to her apartment. She was (d) *not what might be considered an actual prostitute* but she was lonely and wanted to do something to change her mood. After they had (e) *three or four drinks* at her place, she suddenly suggested (f) *they go to bed together*. The boy was naive and was taken aback, but felt his (g) *manly pride* required him to do so--so he did. As he's leaving the room now, he feels that sexual relations are not all that they are made out to be and that he can take it or leave it. But what he doesn't realize is that (h) *sex should never be an end in itself but only a means to an end with someone you love*.

a. (Not rated) Figurative expressions like this one are not rated.

b. (II-T) This is an instance where two similar instances of drive content are rated as one unit even though they would individually be rated at different levels (bar as level III and drinks as level II). The two form a consistent unit and are rated at the level of the strongest expression.

c. (II-T) Although "noticing" alone would be considered too distant from voyeuristic impulses to be rated, the total context provides a ratable voyeuristic-exhibitionistic theme. The expression is direct, socialized, and thematic.

d. (I-In) The denial here makes this incidental to the main theme. Although prostitution is negated, it is still level I.

e. (II-T) This is a new behavior sequence and is rated separately from the earlier oral content. The drinking here is still sufficiently socialized to get a level II rating.

f. (I-T) This rating includes the various references to intercourse in the story. Premarital intercourse, certainly in this non-love context, is rated level I.

g. (III-T) This is a thematic and highly derived expression of narcissistic libido.

h. (II-In) This is extraneous comment, but it manages to retain enough of a link to the story (as a "moral" of sorts) so that it cannot be rated nonappropriate. Hence, the incidental rating.

4. (Card 4) (a) *These people resemble Clark Gable and Gene Tierney*. The curtains give the impression this takes place in a house, but (b) *the pin-up picture* in the back seems to negate this. So I conclude that it's (c) *in a bar or a roadside stand or someplace like that*, and (d) this waitress is trying to prevent this truck driver from leaving. He's (e) *not too well liked* by the other drives on the route, so one of them started a rumor that his (f) *girlfriend here was cheating on him*. The eyes of the girl make it clear that she'll convince him of the falseness of the rumors. (How does he feel?) He has a tinge of doubt, but he believes (g) him...her... basically, but he has doubt. The doubt makes him have a not very convincing (h) *fit of anger* but then they forget it.

a. (Not rated) Although this is relevant commentary, it has no drive content and is not rated.

b. (II-In) This is card description which gets into the story only peripherally, through providing a kind of atmosphere and backdrop; as such it is incidental. The voyeuristic implications of the pin-up picture seem direct enough to require a level II rating.

c. (III-In) All of this oral content is level III; no one is actually eating. Although this is part of the story, the way in which S presents it ("it could be X or Y or Z") indicates that it is incidental even to S himself.

d. (III-T) "Waitress" is rated separately from "bar or restaurant" since it is given as part of the main story theme and is thus a new level of integration.

e. (II-T) The rating is level II. In spite of the euphemistic and negative mode of expression, this is still a direct expression of hostility.

f. (II-T) Applying conventional standards of morality: since the first man and the woman are unmarried, and since intercourse is not explicit here, the reference to "cheating" seems better described as level II than level I.

g. (III-N) This slip, involving a sexual confusion, gets rated although a slip in which the drive content is not evident in the slip itself would not be rated. The him-her ambiguity does not involve any direct drive expression and is rated level III.

h. (II-T) Although this is part of the inquiry, it is rated because it was not evoked directly by an inquiry question. (If the sequence had been, "how does he feel?," "angry," there would be no rating.) No physical violence is made explicit in the story, so the "fit of anger" remains level II.