THE USE OF MULTIPLE THERAPY IN GROUP COUNSELING AND PSYCHOTHERAPY

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This is to certify that the

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ABSTRACT

THE USE OF MULTIPLE THERAPY
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AND PSYCHOTHERAPY

By

Kenneth Guy Nunnelly

The purpose of the study was to evaluate the effectiveness of multiple therapy, using male and female therapists, in group therapy with university counseling center clients. It was hypothesized that after therapy clients in a group led by two therapists would be more improved than clients in groups led by one therapist on the following outcomes: (1) perceptions of father acceptance; (2) perceptions of mother acceptance; (3) increase in ego strength; (4) increase in self-acceptance; and, (5) decrease in social introversion.

In a consideration of the history and theory of multiple therapy it was pointed out that the therapeutic configuration of multiple therapy represented a family situation with both parents present. The resulting therapy was regarded as a process of personal maturation. It was stated that in the early stages of therapy conflicts pertaining to clients' problems with one or both parents

would be brought into sharp focus. Once trusting relationships with the therapists were established clients would be secure in regressing to deep levels of feeling. They would subsequently be supported in strengthening their feelings of adequacy in coping with their emotions and with environmental problems. As the therapy process continued clients' individualization and self-acceptance would be helped by their experiences of the two therapists' sometimes similar and sometimes contrasting perceptions of them. The terminating phase of therapy for the clients would be the establishing of healthy relationships to persons outside of the therapy setting.

In a review of experimental studies no research evidence was found which supported the use of multiple therapists in group therapy. However, authors of descriptive reports indicated that in their experiences multiple therapy was an approach that appeared to be consistently effective with both individual and group clients.

The design of the study was a pretest-posttest design in which the multiple therapy group was compared with a group led by a male therapist and a group led by a female therapist on five outcome variables: (1) perceptions of father acceptance; (2) perceptions of mother acceptance; (3) ego strength; (4) self-acceptance; and, (5) social introversion. Scales from three objective instruments were used as operational statements of the variables. The scales were: the Father Acceptance and Mother Acceptance scales of the Family Relations Inventory, the Total Positive scale of the Tennessee Self

Concept Scale, and the Ego Strength and Social Introversion scales of the Minnesota Multiphasic Personality Inventory.

The clients were single, male and female undergraduate students who were selected for participation in the study according to the following three criteria: (1) there were expressed needs for help in resolving conflicts with one or both parents; (2) there were feelings of self-depreciation; and (3) there was dissatisfaction with relationships to peers. Clients were assigned to groups on the basis of their time availability. Each group met for thirteen sessions, for twenty-six hours of therapy. There were six clients in each group.

The male therapist was a counseling center intern who was completing his doctoral degree in Counseling Psychology. The female therapist had just completed her counseling center internship and had received her doctoral degree in Clinical Psychology. Both therapists had similar training experiences, and had worked together as a multiple therapy team prior to the study.

An analysis of covariance statistic was used to analyze data obtained before and after therapy. Where results were statistically significant, post hoc comparisons were used to test differences between adjusted mean scores. On the basis of the results, the following conclusions were formulated:

1. Clients in the multiple therapy group perceived their fathers as being more accepting than did clients in the male therapist group, which partially supported the contention that multiple therapy helped

clients resolve conflicts with one or both parents. No differences were found on comparisons between the female therapist group and the multiple therapy group on perceptions of father acceptance.

2. There was no statistical support provided for hypotheses that the use of multiple therapists would be more effective than the use of one therapist in group therapy for increasing clients' perceptions of mother acceptance, feelings of ego strength, feelings of self-acceptance, and social adjustment.

3. There was no indication that one-therapist groups showed more pretest to posttest improvement than the multiple therapy group on any of the five variables which were measured. The implication was that the use of multiple therapists did not prove to be less effective than the use of one therapist in group therapy.

4. The multiple therapy group did not deteriorate on any of the measures used to assess therapeutic progress, which contradicted claims of some practitioners who stated that the use of more than one therapist would be detrimental to clients' improvement.

The results were discussed and suggestions for revision of theory and design were made. Following a speculative examination of the data in which several tentative conclusions were formulated, it was suggested there was slight but consistent enough evidence in support of the use of multiple therapists that further investigation would be warranted.

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to nona, my very favorite person

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CHAPTER I: INTRODUCTION

There are many techniques which are employed to help clients achieve therapeutic health. Traditionally therapists have used the one-to-one relationship, which began in the intense, long-term doctor-patient arrangement of the psychoanalytic approach. When demands for therapist time increased, and the values of socializations were made known, the practice of group therapy was established. Researchers in the fields of counseling and psychotherapy have investigated process and outcome variables present in the traditional methods. They varied the length of therapy, they experimented with different numbers of clients working with one therapist, they changed the types of client populations, and they used a variety of therapeutic procedures.

A recent and somewhat unique procedure of therapy has been to vary the number of therapists who relate to a client or a group of clients. Seldom has more than one therapist been used, because the presence of additional therapists has been regarded as non-traditional and inefficient. There have been indications, however, that the use of two or more therapists in either individual or group therapy would make it possible to obtain results which not only included those of traditional one-therapist approaches, but would enhance them.

Where two or more therapists are used it is believed that clients are helped to intensely experience and resolve conflicts specifically elicited by a particular configuration which is represented by the therapists' relationship. In the special case of the therapists being of opposite sexes, the configuration is that of a symbolic family. In group therapy it is that of a symbolic family with parents and siblings present. The family-like setting leads clients to experience, express and resolve conflicts which may be traced to incomplete, fixated or distorted processes in emotional maturation. When there are male and female therapists present, clients are given an opportunity to use them as models for sex and role identification, and for help in establishing healthy interpersonal relationships.

A related advantage of using two or more therapists is that it benefits the therapists perhaps as much as it does their clients. Therapists who work together find that it increases their therapeutic effectiveness, it helps them in their professional and personal growth, and it facilitates their personal compatibility.

The relatively new technique of using two or more therapists has been called "multiple therapy," or "cotherapy," the two terms being somewhat interchangeable. The term multiple therapy is used in the study to represent the configuration of the relationship of two therapists to each other and to their clients. It is not to be confused with the term "multiple counseling," which has been used to mean

counseling with more than one client, nor does it refer to situations in which role playing is used.

The use of multiple therapists presents an intriguing subject for research and discussion. Client outcomes unique to the process need to be examined. The therapists' relationship needs to be studied to find what kinds of personal compatabilities and divergency are required for good therapy. Multiple interactions between persons and the relationships they establish present a new problem for students of therapeutic processes. Doubts may be raised about the advisability of using two therapists where one has usually sufficed, but the indications are that therapeutic outcomes are augmented by means of the multiple therapy approach. For that reason multiple therapy should be studied with the view that it may prove to be of worth at least to the client's growth, if not to considerations of efficiency and tradition.

Need for the Study

A study which indicates whether or not multiple therapy has value equal to or beyond that of traditional therapeutic approaches would be useful to a wide range of practitioners who work in a variety of settings. Research would give a preliminary indication of the worth of the theoretical formulations which claim that multiple therapy has an effect that other forms of therapy do not, being that of creating a milieu resembling that of a family.

The present study is designed to contribute theoretical and research knowledge to the subject of the use of multiple therapists in group counseling and psychotherapy. Hopefully it will be of use to college counselors and psychotherapists, to practitioners in individual and group counseling, and to students who would like to participate in the experience of multiple therapy.

Definition of Counseling and Psychotherapy

As used in the study counseling and psychotherapy is defined as a growth-facilitating process which takes place in the context of interpersonal relationships between therapists and clients, and which encompasses the personal and situational concerns which are expressed by clients. The therapists have been trained in skills pertaining to both of the disciplines of Counseling Psychology and Clinical Psychology. The term "therapy" will be used to denote "counseling and psychotherapy."

Definition of Multiple Therapy

Multiple therapy is an approach to therapy in which two or more therapists are simultaneously present with one or more clients. Therapists are free to interact with clients at whichever levels of depth and intensity therapist and client personalities permit. The interactions present in one-therapist situations are also present in multiple therapy, but in multiple therapy there is the added dimension of there being several possible therapist-client

relationships instead of just one. Therapist-client interactions lose their dyadic nature and give way to what Kell and Burow describe as a multiplicity of relationships:

> There are at least four dynamically distinct possible relationships when two therapists work with one client, and when a second client is involved the number of relationships increases considerably. These relationships are, namely, (1) and (2) that between the client and each of the therapists separately, (3) that between the two therapists and (4) the client's interaction with the relationship between the two therapists. These four recapitulate the client's relationship to his parents in the simplest form, but we add to it two more, which are each therapist's interaction with the relationships between the client and the other therapist. It is the addition of interrelationships between two people when a third or fourth person is present that we see the opportunity for both conflict generation and resolution not so available in dyadic therapy.[1]

The addition of a second therapist, then, multiplies the number of relationships with which clients and therapists must contend. It expands the boundaries of conflicts which are perceived and experienced by clients and therapists in the interview. Mullan and Sangiuliano have reached similar conclusions in their phenomenological approach to multiple therapy:

> Multiple-therapy is the simultaneous therapeutic approach by two or more separate and yet related therapists to a single patient, married couple, a family or patient group. ....Its therapeutic effectiveness is felt not alone by the patient by also by the therapist. Thus, for the former it makes available a uniquely charged milieu in which there is such openness and spontaneity that growth becomes a necessity. For the latter, supported by a close colleague,

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[1] Bill L. Kell and Josephine M. Burow. Developmental Counseling and Therapy (Boston: Houghton Mifflin Co., to be published Spring, 1969), 372-373.

there is offered an unlimited possibility to search for and to find new meanings.[1]

The power of multiple therapy is based on the creation of a therapeutic milieu in which numerous highly dynamic interactions take place, to the mutual benefit of clients and therapists. It approximates the family situation with siblings present. It increases the number of possible interpersonal relationships and evokes more conflicts related to developmental problems than does that of one-therapist approaches.

Purpose of the Study

The purpose of the study is to present a history and theory of the use of multiple therapists in group therapy, to derive testable hypotheses from the theory, and to obtain and examine research data to compare outcomes of clients' experiences of therapy between one-therapist groups and a multiple therapy group.

Hypotheses

The following general hypotheses were formulated for the study and will be considered in detail in Chapter IV, Chapter V and Chapter VI:

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[1]Hugh Mullan and Iris Sangiuliano. The Therapist's Contribution to the Treatment Process (Springfield, Ill.: Charles C. Thomas, 1964), 164.

I. Clients' experience in a multiple therapy group will be such that at the end of therapy they will report they perceive their fathers as being more accepting than will clients in one-therapist groups.

II. Clients in a multiple therapy group will have more positive perceptions pertaining to mother acceptance than will clients in one-therapist groups at the end of therapy.

III. Multiple therapy clients will have more feelings of adequacy, of ego strength, than will one-therapist clients.

IV. Self-acceptance, which is composed of clients' perceptions of themselves as worthy physicial, social, moral, family and personal beings, will be more positive for multiple therapy clients than for one-therapist clients.

V. At the time of termination, one-therapist clients will be less improved in social adjustment than will multiple therapy clients.

Overview

In Chapter II the history of multiple therapy will be considered, followed by a theory pertaining to the client's experience of multiple therapy in a group setting.

A review of research literature and descriptive reports pertaining to multiple therapy comprises Chapter III.

In Chapter IV, the design and instrumentation involved in the experimental investigation of research hypotheses is presented.

Results of the study are reported in Chapter V. The results are interpreted and discussed in Chapter VI, and suggestions for further research are made.

CHAPTER II: HISTORICAL AND THEORETICAL CONSIDERATIONS

A History of Multiple Therapy

The use of more than one therapist in the therapy interview was advocated by Adler and his colleagues in the 1920's, when they reported having two counselors meet with a parent and child to openly discuss problems created by an impasse in the child's therapeutic progress.[1] They found that this open consultation facilitated the child's therapy, that he responded favorably. In 1939, Reeve formed a "joint interview" team consisting of a female social worker and a male psychiatrist, and reported that they were successful in treating several kinds of client problems. There were two major advantages to this type of interview: therapists' understandings of the clients were enhanced, and clients tended to respond to the therapists as parental figures. Reeve acknowledged the increased complexity of multiple therapy over one-therapist interviews, but wrote:

> It presents a greater flexibility to the patient by giving him an opportunity to react to one or the other. Theoretically, it affords an opportunity for the patient to love and hate without having to direct this toward any one person. It

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[1]Rudolf Dreikurs, Techniques and Dynamics of Multiple Psychotherapy, Psychiatric Quarterly, 1950, 24, 788.

> further affords him an opportunity to react with a minimum fear of retaliation.[1]

A few years later, in the middle 1940's, John Warkentin and Carl Whitaker formed a therapeutic partnership that led to the expansion of the practice of multiple therapy and gave it professional respectability. They began their work by seeking in-interview consultation from each other. The availability of a trusted consultant gave the therapists courage to deal with a wider range of problems, such as those experienced by marital couples. Warkentin described his feelings about the advantages of multiple therapy:

> Impasse situations during treatment and problems in the ending of therapy became much less threatening, with the certainty that there was a consultant available to share the responsibility. Similarly, group psychotherapy became a more intense experience for both therapist and patients because we became less afraid of 'transference-countertransference jams.'[2]

Both men entered into practice at the Atlanta Clinic, in Atlanta, Georgia. They and their colleagues began experimenting with multiple therapy approaches and in 1949 they published an article in which they described the results of three years of work.[3] They found that the treatment of one client by two therapists helped therapists

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[1]George H. Reeve. Trends in Therapy: V.A. Methods of Coordinated Treatment. American Journal of Orthopsychiatry, 1939, 9, 747.

[2]John Warkentin. Partners in Psychotherapy. Voices: The Art and Science of Psychotherapy, 1967, 3, 10.

[3]Carl A. Whitaker, John Warkentin, and Nan Johnson. A Philosophical Basis for Brief Psychotherapy. Psychiatric Quarterly, 1949, 23, 439-443.

perceive the therapeutic process in depth, it helped them understand their own emotional functioning, and it increased their capacity for effective psychotherapy. Principles concerning the therapists' relationship to the client were formulated from the point of view that the therapists' personal attention to the subjective life of the client helped the client experience forces deep in his personality. If the therapist was unable to give warmth, and if he needed the client for his own satisfaction, his relationship to the client might be pathological. The therapist's feelings are therapeutic if they are like those of a nurturant parent:

> The giving of the mature therapist is best described in terms of the feeling the child should get from the parent. The mature therapist is consistently parental. This parental role, as the therapist lives it, includes emotional support, definition of limitations, the capacity to accept aggression and the ability to give without needing repayment.[1]

The following year, 1950, the Atlanta group published a paper on the use of multiple therapy as a means of resolving therapeutic impasse, which was defined as a stalemate or deterioration in the therapeutic relationship.[2] A consultant was called in to carry part of the responsibility for the client, which freed the therapist and patient to express feelings of inadequacy in handling the relationship. The Atlanta group continued their innovative approaches to therapy by using up to ten therapists in the treatment of one client.

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[1] Ibid., 433.

[2] Carl A. Whitaker, John Warkentin, and Nan Johnson. The Psychotherapeutic Impasse. American Journal of Orthopsychiatry, 1950, 20, 645.

They concluded:

> In the multiple therapy situation some patients seemed much more free than in individual therapy to act out their feelings, both positive and negative....(The client) felt safer in his dependence on the therapists as a powerful unit, and less guilty over his sexual or hostile responses.[1]

In an article in 1956, practitioners in the Atlanta group stated that on the basis of their experiences they found multiple therapy was a more effective form of treatment with all clients than was individual psychotherapy.[2] They noted that in multiple therapy there was greater freedom for the therapists to be personally involved than there was in individual therapy. Multiple therapy also offered specific advantages to the client:

> The patient can express more varied and more intense needs simultaneously...The patient can express his positive and negative transferences, separately and simultaneously, toward the two therapists. The multiple therapy situation thus provides a matrix for a group experience similar to that of a family group, even though it still remains symbolic.[3]

Whitaker and his colleagues described multiple therapy as an interpersonal matrix in which a client underwent corrective emotional experiences. The crucial dynamic in therapy was a feeling interchange

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[1]Carl A. Whitaker, John Warkentin, and Nan Johnson. A Comparison of Individual and Multiple Psychotherapy. Psychiatry, 1951, 14, 416.

[2]Carl A. Whitaker, T. P. Malone, and John Warkentin. Multiple Therapy and Psychotherapy. In F. Fromm-Reichmann and J. L. Moreno, Progress in Psychotherapy (New York: Grune and Stratton, 1956), 1, 211.

[3]Ibid.

between client and therapists that had as its model the parent-child relationship and which consisted of insights that were felt rather than verbalized. It was assumed that clients entered therapy out of their own expectation that it would be possible for them to grow. Growth was facilitated by the mobilization of constructive anxiety which was felt by the client when he simultaneously perceived the two therapists in different ways: one was perceived realistically, the other was perceived in the context of a transference projection.[1]

Other early contributions to the understanding and practice of multiple therapy were made by Rudolf Dreikurs.[2,3,4] He found that the presence of a second clinician made the therapy relationship objective and helped the client develop an accurate understanding of himself. He also found that therapists' frustrations were minimized because of the support given by a colleague.[5] Multiple therapy was regarded as advantageous for the patient because of the way it facilitated termination: "The constant inclusion of the second therapist prevents too dependent a relationship on one therapist and

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[1] Ibid., 212-214.

[2] Rudolf Dreikurs. Techniques and Dynamics of Multiple Psychotherapy. Psychiatric Quarterly, 1950, 24, 788-799.

[3] Rudolf Dreikurs, Bernard H. Schulman, and Harold Mosak. Patient-therapist Relationship in Multiple Psychotherapy: I. Its Advantages for the Therapist. Psychiatric Quarterly, 1952, 26, 219-227.

[4] Rudolf Dreikurs, Bernard Schulman, and Harold Mosak. Patient-therapist Relationship in Multiple Psychotherapy: II. Its Advantages for the Patient. Psychiatric Quarterly, 1952, 26, 590-596.

[5] Dreikurs, 1950, 789-795.

makes it easier for the patient to carry over his newly found relationship to people other than the therapist.[1]

After the popularization of multiple therapy by the Atlanta group and by Dreikurs there was an increase in the numbers of practitioners who used the new technique and wrote about it. Throughout the 1950's multiple therapy was being practiced in diverse settings with a variety of client populations. Haigh and Kell advocated its usefulness for training new therapists and providing opportunities for conducting counseling and psychotherapy research.[2] Buck and Grygier used a heterosexual cotherapy team with juvenile delinquents.[3] Cameron and Stewart had two therapists meet with a group of psychoneurotic patients, and reported that it was a new and successful form of group therapy.[4] Male and female therapists were used in a parents' group by Grunwald and Casella,[5]

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[1]Dreikurs, et al., 1952, 224.

[2]Gerald Haigh and Bill L. Kell. Multiple Therapy as a Method for Training and Research in Psychotherapy. Journal of Abnormal and Social Psychology, 1950, 45, 659-666.

[3]Alice E. Buck and T. Grygier. A New Attempt in Psychotherapy with Juvenile Delinquents. American Journal of Psychotherapy, 1952, 6, 711-724.

[4]John L. Cameron and Ronald A. Y. Stewart. Observations on Group Psychotherapy with Chronic Psychoneurotic Patients in a Mental Hospital. The International Journal of Group Psychotherapy, 1955, 5, 346-360.

[5]Hanna Grunwald and Bernard Casella. Group Counseling with Parents. Child Welfare, 1958, 37, 11-17.

and in groups of chronic aged patients by Linden.[1]

Critical response to the practice of multiple therapy was for the most part voiced by Slavson, who felt that having more than one therapist present would create too much anxiety for patients, that creating a surrogate parent situation would cause acting out of feelings rather than achievement of insight.[2] Some support was given to Slavson's point of view in research investigations by Daniels[3] and by Staples,[4] both of whom concluded that the use of multiple therapy with eighth-grade students created oedipal anxiety that blocked therapeutic progress.

The expansion of multiple therapy into other therapeutic endeavors continued throughout the 1960's. Multiple therapy approaches were being used in family therapy,[5] with male

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[1]Maurice E. Linden. The Significance of Dual Leadership in Gerontolic Group Psychotherapy: Studies in Gerontolic Human Relations, III. The International Journal of Group Psychotherapy, 1954, 4, 262-273.

[2]S. R. Slavson. Common Sources of Error and Confusion in Group Psychotherapy. International Journal of Group Psychotherapy, 1953, 3, 3-28.

[3]Marvin Daniels. The Influence of the Sex of the Therapist and of the Co-therapist Technique in Group Psychotherapy with Boys. (Doctoral Dissertations, New York University). Ann Arbor, Michigan: University Microfilms, 1958. No. 58-660.

[4]Ethel Janes Staples, The Influence of the Sex of the Therapist and of the Co-therapist Technique in Group Psychotherapy with Girls. Dissertation Abstracts, 1959, 19, 2154.

[5]James L. Framo. Rationale and Techniques of Intensive Family Therapy. In I. Boszormenyi-Nagy and J. L. Framo (Ed.), Intensive Family Therapy. (New York: Harper and Row, 1965), 143-212.

homosexuals,[1] with college students,[2] and in an increasing number of group therapy and professional training programs. In two books, the subject of multiple therapy was covered in depth. In the first book, by Mullan and Sangiuliano,[3] two chapters were devoted to a phenomenological understanding of multiple therapy as it affected the therapists and as it was experienced by their clients. In the second book, by Kell and Burow,[4] there was included a personal and thought-provoking sharing of experiences and ideas about multiple therapy. The authors considered such matters as indications for multiple therapy, the nature of therapists' relationship, the use of fantasy and imagery in multiple therapy, and its meaning to them and to their clients.

The above were but a sampling of publications and studies which had made significant contributions to the development of multiple therapy as a new approach to counseling and psychotherapy. It was estimated there were one-hundred twenty-five available references on the subject, a great many of them having been written in the last ten years.

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[1]Melvin Singer and Ruth Fischer. Group Psychotherapy of Male Homosexuals by a Male and Female Co-Therapy Team. International Journal of Group Psychotherapy, 1967, 17, 44-52.

[2]Shirley M. Corrigan. Coeducational, Cotherapist Group Therapy. Journal of the American College Health Association, 1967, 15, 248-250.

[3]Mullan and Sangiuliano, 1964.

[4]Kell and Burow, 1969.

The Client's Experience of Multiple Therapy

The effectiveness of multiple therapy is attributed to the special meaning of the therapists' presence: clients experience the two therapists as symbolic parents. In the beginning stages of therapy conflicts which developed in a client's childhood and adolescence and which pertained to the client's problems with parents or other familial figures are brought into sharp focus by the client's relationship to the therapy team and by the therapists' relationship to each other. Once the client reduces his initial resistance to change and begins to trust the therapists the security of the multiple therapy situation helps him temporarily regress to deep levels of feeling and experiencing that previously had been unexpressed or uncontrolled. Subsequently, he begins to strengthen his ego functioning and personality integration. The client finds that the therapists' relationship to each other and to him helps him facilitate his self-differentiation and his acceptance of his sexuality. As concerns with family conflict and self-esteem are resolved the client will be free to deepen his relationships to his peers, using the therapists' relationship as a model for healthy social interaction.

Multiple therapy in a group setting is a process which facilitates personality change and development. Clients experience being in a family, they resolve developmental conflicts, they integrate their self-concepts, they develop a mature acceptance of

themselves, and they establish healthy relationships with others. In the remainder of the chapter these characteristics of multiple therapy are considered in depth.

Impaired Relationships with Parents

One of the indications for multiple therapy is that a client have a life history which is characterized by an impaired relationship with one or both parents. According to Kell and Burow: "The interest in these cases is to afford the client an opportunity to interact with two parental surrogates who will recreate the earlier conflict in such a way as to let the client experience the feelings which characterized the earlier relationships."[1] The usefulness of multiple therapy in correcting impaired parent-child relationships is described by Mullan and Sangiuliano:

> We hypothesized that one way to reverse the process of the sick patient-child is through the therapeutic reorientation of the key members (mother and father) of the family. If the patient is no longer at home, having made some attempt toward self-determination, or if the family cannot or will not enter therapy, there is still the possibility for a kind of reorientation of key family figures. This is through the patient's selection and use of a symbolic family, the multiple therapists.[2]

Correcting impaired relationships with parents is somewhat dependent on a mature and spontaneous relationship between the

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[1] Ibid., 377-378.

[2] Hugh Mullan and Iris Sangiuliano. Multiple Psychotherapeutic Practice: Preliminary Report. American Journal of Psychotherapy, 1960, 14, 552.

two therapists:

> The freer interactional state of multiple-therapy is assured when the mutually concerned therapists become responsible and express their feelings for one another. It can readily be seen that this setting offers the patient the opportunity not only to experience and respond to two different therapeutic agents but also as well, to observe and respond to the dynamic evolving relationship between the two. In this therapeutic triangle the patient realizes, as he struggles for identification and belonging, that his therapists are present not only for him but also for themselves as well. Questions which come immediately into focus confront the patient with his separateness, responsibility for self and his basic egocentricity.[1]

The critical difference between multiple therapy and other approaches to therapy is that multiple therapy forces the client to respond not only to two therapists but also to their relatedness and their separateness.[2] At first the client reacts to the multiple therapy configuration as if it were his family situation, attempting to act out the same roles in the group that he learned in his home. If he grew up with parents who were insecure in their relatedness he may attempt to divide the therapists, to have other clients side with him or against them, or to manipulate the therapeutic process. If he was encapsulated in a family where separateness was regarded with fear and anxiety, he may insist that therapists and other group clients not disagree with each other, that they be in complete harmony among themselves, that he not be forced to be

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[1] Mullan and Sangiuliano, 1964, 166.

[2] Ibid., 186.

different or to take responsibility for determining his own behavior apart from them. The multiple therapists do not respond to these kinds of demands, and clients must reorient themselves to a new kind of parental relationship that represents a healthy marriage. The following are examples of situations where multiple therapy would be appropriate for helping clients in their reorientation.

(1) A client from a family in which there was an inadequate parent presents a problem for the therapists because the client may attempt to divide the therapy team. For example, a male client who rejected his father and formed a dependent attachment to his mother may reject the male therapist by refusing to accept any help from him, by not being receptive to a relationship with him. The client is likely to want to be closer to the female therapist and to direct his needs for help exclusively to her. It is possible he may try to take the place of the male therapist by competing with him in the group. In the process of therapy the client finds he will not be allowed to displace the male therapist, that the female therapist accepts and supports the male therapist's adequacy as a man. The client is encouraged to break his tie with his mother and to go to a man who is able to give him a meaningful relationship.

(2) Where there was deprivation with one or both parents multiple therapy helps clients experience themselves as part of a whole family. In this case a short-term intense relationship with one therapist might be appropriate, as long as the other therapist

is not unwillingly excluded.

(3) If parents were not secure in their relationship it might have been possible for the client to enlist one of the parents to side with him against the other parent and siblings. A female client, for example, may attempt to attract the male therapist into an alliance with her against the female therapist and against other group clients, which is a repetition of a family situation in which she was father's choice of a companion over that of her mother and her brothers and sisters. In this case the client experienced a parental relationship into which she was able to intervene because the parents were not close to each other. In multiple therapy she finds she cannot get the male therapist to side with her, that he maintains his intimacy with the female therapist, the result being that she must give up her fantasied bond with her father. This frees her to break away from him, to be the maturing young woman that she is, and it encourages her to turn to her peers for companionship.

(4) In some families the tie between parents and between parents and children was somewhat symbiotic, resembling such an intertwining of personalities and interweaving of needs that children were not able to free themselves without feeling excess guilt, fears of punishment, or insecurity. The identity of the client was not his own, nor were his behaviors. He was made to feel that in order to keep his parents he had to meet their needs unquestioningly,

that he was somehow responsible for holding the family together. Clients who experienced such situations find in multiple therapy they are not responsible for the therapists maintaining their relationship together. They also discover the therapists can be separate from each other without there being subsequent deterioration in their symbolic marriage. More significantly, however, clients discover their therapists wish them to be free, and they are permitted to put their lives in order without having to first meet the needs of parental figures.

Once clients clarify their feelings about the nature of their relationships to their parents, and they understand their parents' strengths and weaknesses, they develop healthy acceptance of their fathers and mothers as human beings. Idealized, distorted perceptions become reality-based, and there is a settling down of the agitation and impasse that characterized impaired relationships. Because of their relationships to the multiple therapists clients feel they are accepted and cared about in a new, symbolic family. They feel free from involvement in the entanglements which inhibited their growth out of childhood.

Regression and Ego Development

In the process of developing a trusting relationship with the therapists clients loosen their defenses and begin to experience their needs at deep feeling levels. They become aware of emotions

and fantasies that had been repressed, denied, confused or uncontrolled since childhood. This is the regression experience, which Whitaker, Malone and Warkentin described as the "core phase" of therapy:

> This regression appears to be necessary for the development of a healthy self-esteem and, subsequently, a healthy integration. The core experience is apparently an essential need for the satisfaction of infantile deprivations, and is basic to all therapeutic experiences, even though the illness which the patient presents may arise out of later experiences.[1]

The multiple therapy relationship provides the security necessary for the client's regression to a child-like emotional state. In the presence of the two therapists a client feels it is safe to regress. One of the therapists may regress with him while the other gives both of them support in working through the regression.[2] For example, a male client may own his feelings of dependency on women, and express them by asking the female therapist to comfort him and perhaps even to hold him as would a mother. She responds by relating to the client at deep feeling and fantasy levels. The male therapist supports their being close in their mutual expressions of feeling and needing. After the client clearly experiences himself as a dependent child regression gives way to mature feelings and behaviors. If the client and the female therapist prolong the regression, the male therapist intervenes in order that a regressive

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[1]Whitaker, et al., 1956, 215.

[2]Kell and Burow, 1969, 448.

impasse might not develop. Symbolically it is like a father who helps his son break away from a symbiotic tie with the mother and begin coping with life outside of the family. At the same time the two therapists resume their intimate contact with each other, which signals to the client they are capable of meeting their needs without being dependent on him. He will be encouraged to develop his sense of self apart from them.

The healthy integration following regression is a matter of the client's learning to understand and handle his feelings and of his finding ways to cope with his environment which are reality-oriented. This may be regarded as the strengthening of his ego, his self-directedness. The stronger his ego, the stronger his sense of being capable of assuming responsibility for handling his feelings and behaviors. The development of personal adequacy and stability indicates a client has made a break from childhood and has begun to define for himself the direction his life will be taking. He is capable of handling both his phenomenological and his physical environments.

Self-Differentiation and Sexuality

A client's growth depends on how well he differentiates himself from his family and from other persons close to him. University students express the need for individuation when they participate in groups and activities regarded by society as non-conformist, by

their frequent insistence they be treated as adults rather than as immature adolescents, and through their criticisms of established values, traditions and organizations. Many of the students who come to counseling centers feel they have no sense of individuality. In multiple therapy the client's individuation occurs by means of the discovery that his therapists and peers respond to him and to each other in ways that are sometimes differing and sometimes similar. Kell and Burow write: "We think our different ways of responding are not only appropriate in helping us, the therapists, to be differentiated both individually and from each other, but also that such different responses promote differentiation in a client."[1]

The client experiences the two therapists as persons who are not bound to being alike, who respect the differences they find in each other, yet who are able to have a mutually fulfilling relationship. The implication is that one can be an individual, but it does not mean he will be isolated from others. When a client discovers he is perceived in sometimes contrasting ways by the therapists and by other group members he no longer can feel and behave as a stereotyped child nor can he look to others for a definition of himself. He finds he must develop his individuality apart from them. As persons differentially respond to him, so can he differentially respond to others. This helps him establish himself as separate from his family and from other significant persons in his life. Male and female

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[1] Ibid., 432-433.

clients understand themselves as men and women, rather than as children who have little personal integrity of their own.

A part of the individuation process is the client's acceptance of his sexuality. The multiple therapy group facilitates acceptance in two ways. The first is the client's experiencing of the same-sexed therapist as an adequate and competent individual who is comfortable with his sexuality. The second is the development of close relationships with male and female peers.

It is important that clients respond to their therapists as competent, individualized men and women. Out of it will come their own adult sex and role identifications. Elizabeth Mintz writes: "In a group with male and female therapists, both of whom presumably are clear about their sexual identity and reasonably happy with it, a patient of either sex has an especially good chance to introject this sexual self-acceptance."[1] Kell and Burow write that such identification takes place in the multiple therapy situation, where a client will identify with the therapist of the same sex and should have the encouragement of the other therapist in being adequate in the appropriate sex role.[2]

It is possible that a male client, for example, may identify with the masculine attributes and feelings of the male therapist.

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[1]Elizabeth Mintz. Transference in Co-Therapy Groups. Journal of Consulting Psychology, 1963, 27, 36.

[2]Kell and Burow, 1969, 379.

He may look to the therapist for help he did not get from his own father in learning about being a man. At the same time he will be encouraged by the therapist to maintain his individuality, his separateness as a person. The female client may find that she can learn something from the woman therapist about being feminine. She may need permission to have sexual feelings, to accept her needs to be independent and competent as well as dependent, and to enjoy her relationships with men.

Not only can the same-sexed therapist be helpful to a client but it is also important that the opposite-sexed therapist be supportive in the client's attempts to define and strengthen his sexual identity. The problem experienced by the client may have had its beginnings in punitive, confused or rejecting behaviors on the part of an opposite-sexed parent who was anxious about the client's developing sexuality. As a result the client may have repressed or distorted his sexual feelings. For example, a male client who has fears of becoming homosexual may indicate considerable dissatisfaction with his father's inadequacy and punitive competitiveness, and complain about his mother's dominance over him. He is likely to develop fear of the female therapist's power and he may attempt to frustrate the male therapist's offers to be helpful to him. He first needs the female's encouragement to trust the male therapist, and assurances she cannot prevent him from asserting his masculinity. The male therapist will encourage him

to own his adequacy and to pull out of his developmental impasse with his mother and his father. He may demonstrate by his own feelings and behavior with the female therapist that a man can have relationships with women which are enhancing rather than regressive and destructive.

The client's individuation leads to his acceptance of his sexuality. His feelings of value, worth and adequacy become more pronounced. He is able to perceive himself as a physical and emotional entity apart from and in relationship to the persons around him. He is comfortable with his humanness.

Interpersonal Relationships

When clients develop confidence in their identity and become comfortable with their sexuality they are free to establish intimate and fulfilling relationships with their peers. It is a difficult task for some. Sullivan wrote that a person assumes certain risks when he allows someone to become important to him. One's security and satisfaction is often dependent on others and for these reasons, according to Sullivan, people are susceptible to the circumstances which destroy people close to them or which destroy the effectiveness of their relationships.[1] Clients who have begun to reach out to others may experience the anxiety that risk-taking elicits. It is

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[1]Harry Stack Sullivan. Clinical Studies in Psychiatry (New York: W.W.Norton and Co., 1956), 106.

a theme often expressed in group therapy, one that seems to have considerable personal meaning to students. Feelings of alienation and isolation are expressed by persons who wish to be closer to each other but who have not felt free to risk establishing intimate relationships.

It will be important that clients learn from the therapists' interaction how persons mutually enhance one another, how they work through their conflicts, how they openly express their feelings, how they depend on one another, and how they are able to keep their separate identities. Clients can learn from each other how to acquire and maintain meaningful friendships, how to deal with each other in heterosexual relationships, and how to handle competition in their educational and occupational pursuits. By means of feedback from other group members clients discover how others feel about them, what kinds of impressions they make, whether or not they can be comfortable being open with their feelings, how they handle feelings of anger and confusion elicited by experiencing rejection from others, and what it is like to be accepted and cared for on the basis of intrinsic worth rather than extrinsic performance.

The outcome of increased adequacy in handling relationships in the multiple therapy group is a healthy involvement in social life outside of the group. Clients initiate companionships when they are lonely, they no longer fear dating, they are capable of being intimate with others without inappropriate fear of loss and rejection.

Termination

Once clients develop means of satisfying their needs outside of the therapy group they will have less reason to remain in treatment. They feel they no longer are dependent children, but are adults who are capable of assuming responsibility for themselves and who can ask for help when they need it. As termination nears they may experience some ambivalence about leaving, and some may even think of new problems for the group to consider, but the therapists are ready to see them go and they do not enter into a new therapeutic contract. The termination of therapy becomes an act of self-affirmation in which vacillation between remaining and leaving gives way to a definitive separation from the symbolic family of the past and from those in the group who became partners, friends, and confidants in the struggle that led to their growth and maturation.

Clients then enter into their environment with an increased clarity about themselves, with a sensitivity to the feelings and needs of others, and with confidence in their capability of handling the problems with which they are confronted. Their experience of life becomes similar to their experience of therapy: multi-dimensional, changing, challenging, self-fulfilling.

Summary

The client's experience in the multiple therapy group is essentially that of a process of maturation which is facilitated by the symbolic meaning of the therapists' relationship. It begins with working through problems that developed from impaired relationships with one or both parents. The experiences of regression and self-differentiation help the client own and understand his feelings. He develops his individuality and makes appropriate sex and role identifications. The final stage in the process of therapy is the establishment of mature interpersonal relationships.

In Chapter III, consideration will be given to research investigation and descriptive reports pertaining to the use of multiple therapy in groups and to the variables discussed in the preceeding paragraphs.

CHAPTER III: REVIEW OF RESEARCH AND DESCRIPTIVE LITERATURE

In a review of research literature concerning the use of multiple therapists in group counseling and psychotherapy only two completed experimental studies were found. Private communications indicated that other experimental studies were underway but no data had been published. Most of the literature on multiple therapy was descriptive and theoretical and for the most part concerned mental patient populations, but there were two reports which described the use of multiple therapy in groups of college students. Studies in which theoretical assumptions received support on the basis of other therapists' experience with multiple therapy were also considered.

Experimental Research

The two studies in which experimental designs were employed were doctoral dissertations written by two therapists who used male and female eighth grade students from the same school

population.[1,2] Daniels investigated the influence of the sex of the therapist and the multiple therapy technique in group psychotherapy with boys. In Staples' project groups of girls were used. Since design, procedures and outcomes were similar only the thesis by Daniels was considered.

Daniels used four groups of eighth grade boys who had exhibited problem behavior in school. Subjects were randomly assigned to a no-treatment control group, a group with a male therapist, a group with a female therapist, and a group with male and female cotherapists. His purpose was to demonstrate that remedial methods would cause positive changes in attitude toward school, that the two therapist group would lead to more improvement than single therapist groups, and that the female therapist alone would have less success with behavior problem boys than would the male therapist alone.

Both therapists were school psychologists. Neither were specialists in group psychotherapy. The female therapist was 43 years of age, the male therapist was 28. The female therapist had

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[1]Marvin Daniels. The Influence of the Sex of the Therapist and of the Co-therapist Technique in Group Psychotherapy with Boys. (Doctoral Dissertation, New York University) Ann Arbor, Michigan: University Microfilms, 1958. No. 58-660.

[2]Ethel Janes Staples. The Influence of the Sex of the Therapist and of the Cotherapist Technique in Group Psychotherapy With Girls. Dissertation Abstracts, 1959, 19, 2154.

worked in the school for four years; the male therapist had been there for four months. The theoretical orientation of the two therapists was primarily Freud and Sullivan.

Subjects were rated on behavior by teachers before and after therapy. They were pretested and posttested on measures of intellectual functioning, achievement levels, conscious attitudes toward school, and on ten personality dimensions. Intragroup comparisons were made by using t-tests on pretest-posttest differences in scores. Between group comparisons were made by using two-tailed median tests, since pretest scores were found to have skewed distributions. Tape recordings were analyzed for qualitative variables.

Regarding the effectiveness of the multiple therapy group, the results were not significant. The multiple therapy group improved in discipline and in overall behavior, but it deteriorated in attitudes toward school, become more anxious, showed a drop in self-confidence, and tended to be more emotionally disturbed. Neither the male therapist group nor the female therapist group showed deterioration. An analysis of tape recordings revealed that the multiple therapy group was tense and non-verbal.

Daniels wrote the following in interpreting his findings:

> These boys were drastically affected merely because they were confronted with a male and female adult in a replication of the family setting. The situation itself...was too threatening for them to tolerate with equanimity. Perhaps oedipal overtones in that situation stimulated and augmented the unconscious castration anxiety which

> is present, according to Freudian theories, in all boys at or near puberty.[1]

Daniels' thesis was comprehensive. His theoretical considerations were thorough and he used a number of measuring devices (behavior ratings, objective tests, projective tests, process variables). He used an adequate experimental design that controlled well for internal validity.

There were some problems which might have contributed to negative findings, however. The first was the relative difference in ages of the therapists. If the family constellation was symbolized in the multiple therapy group, then the "mother" was much older than the "father", by fifteen years. A second difficulty was related to the population used. Eighth grade problem boys were not likely to be stable behaviorally or emotionally, and they might not have been appropriate subjects for group therapy.

Daniels was aware of the problems in his study. He suggested that the investigation be replicated with adult groups rather than with groups of eighth grade students.

Descriptive Studies

Rabin prefaced his study with the observation that recent interest in the uses of multiple therapy in group therapy warranted investigation, and he asked the question: "How does co-therapy

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[1]Daniels, 1958, 154.

compare to regular, one therapist, group psychotherapy along dimensions crucial to theory and practice?"[1] He designed a study in which he assessed the attitudes of group therapists about the differences between two forms of group therapy. A 50-item Co-Therapy Rating Scale was given to 38 experienced group therapists who had worked with both types of groups. Descriptive statistics were used. Rabin found that the therapists preferred multiple therapy groups for a variety of reasons: there was moderate positive therapeutic movement, transference patterns were complete and were worked through effectively, the self-understanding of the therapist was enhanced and, multiple therapy offered special advantages in dealing with oedipal problems by, "providing the reality stimulus for the transference to paternal and maternal objects."[2] Multiple therapy also facilitated identification with a healthy person of the same sex, it provided clients with an opportunity to work through problems of masculinity, femininity, and heterosexual fears, and it furnished a context for the understanding of patient resistances.[3] Rabin found that a good relationship between the two therapists was regarded as the most important criterion in developing a multiple therapy group, and he concluded:

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[1]Herbert M. Rabin. How Does Co-Therapy Compare with Regular Group Therapy? American Journal of Psychotherapy, 1967, 21, 244.

[2]Ibid., 252.

[3]Ibid., 252-253.

> It is this investigator's hunch that the relationship has some basic parallels with a good working partnership or marriage; it deepens with the successful mastery of personal conflicts and with the sharing of achievements and pleasures.[1]

The study was exploratory, and based on a small sample, but it indicated there was favorable response to the use of multiple therapists in groups.

Corrigan published a report of her study of coeducational, group therapy with college students who were clients at the University of Minnesota Mental Hygiene Clinic.[2] The clinic staff counseled about one-hundred students in groups over a three-year period of time, using multiple therapists. She reported that experience in multiple therapy with groups of college students had been valuable, that a family-surrogate situation had been created where problems with parents, siblings and heterosexual inhibitions could be resolved.

Corrigan mentioned that many students had an aversion to group therapy, which was attributed to problems in relating to others, inordinate dependency, embarrassing sexual problems, and a perception of group therapy as not being "real" therapy.[3]

Corrigan felt, however, that this technique of group therapy

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[1] Ibid., 253.

[2] Shirley M. Corrigan. Coeducational, Cotherapist Group Therapy. Journal of the American College Health Association, 1967, 15, 249.

[3] Ibid., 249.

was successful:

> It is our belief that if the patient stays with the group and becomes involved, he will, in fact, gain from the process. There are many aspects which transcend the individual therapeutic relationship: support in identification, understanding from real empathy, warmth without threat (demands), criticalness without rejection, friendliness without the necessity of friendship, heterosexual intimacy without commitment, confession without group sanctions, community of problems with heterogeneity of symptoms, concerns with the resolution of problems in terms of reality, and, finally, diffuse reinforcement. For some students, a diminution in the feelings of isolation and a reduction in the feeling of being different have, in themselves, contributed to initial improvement.[1]

Slipp reported his experiences with an open, multiple therapy group of college students which had been meeting for two years. He found that students used the group therapy experience to achieve individuation they had not achieved in their families. From observations of the group he outlined five types of family situations which perpetuated symbiotic attachments to children: (1) the child was a narcissistic extension of the family identity; (2) parents were dependent on the child to be a companion; (3) parents were inconsistant with permissiveness and with controls; (4) parents were alienated from one another and tried to force the child into taking sides; and (5) parents were emotionally withholding.[2]

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[1] Ibid., 249-250.

[2] Samuel Slipp and Madge K. Lewis. Separation Problems in College Students. In J. L. Moreno (Ed.), International Handbook of Group Psychotherapy (New York: Philosophical Library, 1966), 621-623.

According to Slipp, students attempted to cope with their problems by placing some sort of distance between themselves and their parents. It was done by physical separation, isolation and withdrawal, identifying with the role of helper in the family and acting out against parental expectations and values. Slipp felt that group therapy helped students with problems by permitting them to assert their sexual identity.[1]

Related Descriptive Reports

Clients became less defensive when in a multiple therapy group, according to Grunwald and Casella, because their needs for accepting parental figures were satisfied. It had the two-fold result of freeing clients to use their energies to work on constructive personality change rather than having to look for a set of adequate parents, and it permitted therapists to be helpful to them.[2]

Mintz found the use of male and female multiple therapists was of special value since it enabled clients to simultaneously relate to two parental figures where it may have been lacking in real life.[3] It was also necessary for a client to confront the therapist of the sex which most threatened him. In addition to the

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[1] Ibid., 624-625.

[2] Hanna Grunwald and Bernard Casella. Group Counseling with Parents. Child Welfare, 1958, 37, 15.

[3] Elizabeth Mintz. Transference in Co-Therapy Groups. Journal of Consulting Psychology, 1963, 27, 37.

transference phenomena, according to Mintz, there was the matter of a client's sex and role identification being facilitated by multiple therapy in the group, which was helped by the therapists' acceptance of their own masculine and feminine roles.[1]

Demarest and Teicher studied transference feelings which developed in therapy groups with multiple therapists present:

> The presence of male and female therapists made it possible for the patient to structure a family group, which allowed the acting out of family conflicts and the setting up of familial constellations in which problems of sibling rivalry, mother-son, and father-son struggles could be perceived and worked through.[2]

The authors found that using therapists of different sexes committed the client to relating to a figure of one sex alone, to a figure of one sex in the presence of the other, and to both figures together.[3]

In their approach to multiple therapy Mullan and Sangiuliano indicated that transference reactions could be used in group therapy to begin a positive reorientation of the key family figures, which reversed nontherapeutic processes of living experienced by the

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[1] Elizabeth Mintz. Male-Female Co-Therapists: Some Values and Some Problems. American Journal of Psychotherapy, 1965, 19, 294.

[2] Elinor Demarest and Arthur Teicher. Transference in Group Therapy: Its Use by Co-Therapists of Opposite Sexes. Psychiatry, 1954, 17, 195.

[3] Ibid., 201.

client in his family.[1] The client was not allowed to repeat his life theme of dividing and conquering his parents.[2] In the multiple therapy group relationships between group members and the therapists were sometimes strikingly similar to those that clients experienced in their families:

> Some members are more attached to one therapist than the other....some respond to one and not to the other;...some wish to defeat the one and not the other; and...some are hateful or fearful to one therapist and not the other.[3]

The symbolization of the multiple therapy relationship as a healthy marriage was considered by Sonne and Lincoln, whose experiences in family therapy indicated that a multiple therapy team must maintain a good relationship in order that clients who experienced a "family image deficit" might benefit from therapy.[4] A strong multiple therapy relationship was necessary to prevent therapists from being incorporated into the pathological processes of the sick family:

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[1]Hugh Mullan and Iris Sangiuliano. Multiple Psychotherapeutic Practice: Preliminary Report. American Journal of Psychotherapy, 1960, 14, 552.

[2]Hugh Mullan and Iris Sangiuliano. The Therapists' Contribution to the Treatment Process (Springfield, Ill.: Charles C. Thomas, 1964), 174.

[3]Ibid., 214.

[4]John C. Sonne and Geraldine Lincoln. The Importance of a Heterosexual Co-therapy Relationship in the Construction of a Family Image. Psychiatric Research Reports, No. 20, 1966, 197.

> They can accomplish this, in part, by virtue of their mutual validation and appreciation of the essential value present in each one of them in his role as a helping human being, with his own unique point of view. In addition to this, they are able to give clear recognition and re-enforcement to each other of their gender identification, and in so doing can enjoy the male and female points of view.[1]

Summary

A review of descriptive literature indicated that multiple therapy was a widely-used and well-liked approach to group therapy. Therapists who participated in multiple therapy groups reported it was effective, it facilitated the expression of feelings regarding conflict with parents, it was helpful in resolving problems in sex and role identification, clients were helped to form healthy heterosexual relationships, and therapists benefited from the experience of working together. Research data, however, was lacking. In two studies with eighth grade boys and girls results favoring the use of multiple therapists were not evident. Other investigations were not completed. It was believed that the widespread use of multiple therapy groups merited experimental investigation which would make available definitive information concerning the nature of the multiple therapy experience.

In Chapter IV an experimental design to investigate the use of multiple therapists in group therapy is presented.

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[1] Ibid., 199.

CHAPTER IV: DESIGN OF THE STUDY

The research hypotheses developed in the study were tested by means of an experimental design in which outcomes of multiple therapy in group therapy were compared with outcomes of single-therapist group therapy. Three therapy groups were used, one with a male therapist, one with a female therapist and one with the two therapists working together as a multiple therapy team. It was hypothesized that the work of the two therapists in combination would account for differences in the therapeutic effectiveness of the multiple therapy group over that of single-therapist groups.

Selection and Description of the Sample

Clients selected for the study were single, male and female undergraduate students who visited the main office of the Michigan State University Counseling Center for the purpose of receiving help for their personal and social problems. They were typical of students who dropped in at the Counseling Center office and did not require referral, long-term depth psychotherapy or short-term educational and vocational counseling. They were selected in accordance with the following criteria: they had problems pertaining to relationships with one or both parents; they experienced feelings of lowered

self-esteem or confused self-perceptions; they were distressed about their handling of interpersonal relationships; and, they were willing to be in a therapy group.

Clients were interviewed by intake counselors as a part of the regular screening procedure established by the Counseling Center. During the initial interview, a counselor made an evaluation of the client's needs, then recommended an appropriate therapy procedure in which he indicated the urgency of the need, the level of therapist experience required (practicum student, counseling intern, or senior staff), the preferred sex of the counselor, and the desired form of therapy (individual, multiple, or group). The recommendation was reviewed by the Counseling Center Screening Committee, which was composed of staff psychologists, a staff social worker, a counseling intern and a consulting psychiatrist. The committee then made the specific counselor assignment. Clients who met the previously stated criteria were assigned to group therapy by this procedure.

As soon as the names of clients were acquired the two therapists participating in the study jointly interviewed each client and talked with him about the process for entering a therapy group. Clients were told they would be expected to take some personality tests before and after therapy, that the tests would be used in a Counseling Center research program. The nature of the research was not discussed with clients until the conclusion of their participation in the study. Twenty-one clients were selected but three subsequently

declined participation in the study.

Clients' and therapists' schedules were collected and examined to determine possible meeting times. Three different times were chosen, and clients were assigned as they became available for group therapy. Therapists were assigned to groups without regard to group composition. Data describing clients by group, sex, age, class, and number of sessions attended is presented in Appendix A. A descriptive report of the activities that took place in the groups may be found in Appendix B.

Setting and Procedures for Group Therapy

Each of the three groups began meeting for two-hour sessions the first week in February, 1968, and continued through the third week in May, 1968, for a total of thirteen meetings before the post-tests were given. The time period spanned Winter and Spring Terms at Michigan State University. Each group met at a designated time of the week in the same Counseling Center office. The multiple therapists' group met on Thursday afternoons, the male therapist's group met on Monday evenings, and the female therapist's group met on Wednesday afternoons.

The nature of the therapy was phenomenologically and interpersonally-oriented, with attention being given to historical factors when it was appropriate for working out conflicts being expressed in the present moment. Clients were expected to talk about matters

important to them. The therapists were actively engaged in relationships to individual clients and extended therapist-client interactions often occurred. Socialization among clients took place in the Counseling Center waiting area and sometimes after group meetings. There was no interaction between clients of different groups.

Therapist Training and Experience

The study required the participation of two therapists who had previous experience as multiple therapists and who had worked together as a therapy team in a group. Of the available therapists in the Counseling Center only the writer and another Counseling Intern met these criteria. Having had previous experience and having worked through their mutual needs and conflicts, the therapists were able to concentrate primarily on facilitating client change and growth.

The female therapist received her Ph.D. in March, 1968, and was a clinical psychologist and senior staff member at the Michigan State University Counseling Center. She was 27 years of age and married. Prior to the study she had four and one-half years supervised experience in group and individual psychotherapy. Work settings included a Veterans Administration Hospital, a psychological clinic, a University Counseling Center, and counseling practicum courses. She had participated in group therapy as a member, had accrued two years experience as a therapist in group counseling, and had three

years experience as a multiple therapist in treatment of both individuals and groups.

The male therapist was a Counseling Intern at the Michigan State University Counseling Center. He was 33 years of age, married, and was completing the requirements for a Ph.D. degree in Counseling Psychology. Preceding his enrollment in the doctoral program he had been a counselor in a Veterans Administration Hospital and in church-related programs for young people, for a total of three years experience. He received his Master of Arts degree in Guidance and Counseling from Michigan State University. At the time of the study he had been supervised for one year as a practicum student and for a year and a half as a counseling intern. His work with university students included short-term and long-term psychotherapy and educational and vocational counseling. He had participated as a member in group therapy, and had two years practice as a group counselor and therapist. He had one year of experience as a multiple therapist with individual clients and with groups.

The Instruments Used in the Study

There were three instruments used in the study: the Family Relations Inventory, the Tennessee Self Concept Scale, and the Minnesota Multiphasic Personality Inventory. Each of the instruments was administered to clients before and after their therapy.

Consistent with the theoretical position taken prior to the beginning of the study only selected scales from the instruments were used in the statistical analysis.

The Family Relations Inventory (FRI)

The FRI was originally developed by Brunkan and Crites for the purpose of measuring the perceived parental attitudes defined by Roe in her theory of vocational choice. The attitudes were: parental acceptance, parental concentration, and parental avoidance.[1] The authors decided to measure the perceived attitudes of each parent separately, and to keep item content general enough so the FRI would be applicable for both male and female subjects.[2] They constructed a 202-item instrument that was scored on six scales: Father Acceptance, Father Concentration, Father Avoidance, Mother Acceptance, Mother Concentration and Mother Avoidance. The purpose of the instrument was: "...to measure the individual's perceptions of his parents' attitudes toward him in childhood and adolescence."[3] It was suggested that although the FRI was developed to assess attitudes related to vocational choice

> ...it would be interesting to determine whether a client's perception of his parents change as a result of counseling

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[1]Richard Brunkan and John O. Crites. An Inventory to Measure the Parental Attitude Variables in Roe's Theory of Vocational Choice. Journal of Counseling Psychology, 1964, 11, 2.

[2]Ibid., 5.

[3]Ibid., 6.

> or psychotherapy and what the direction of the change is if one occurs.[1]

It was hypothesized in Chapter II that a client's healthy relationship to the multiple therapists would lead to feelings of being more accepted by his parents. Two scales of the FRI were used to assess this outcome: the Father Acceptance (FA) scale and the Mother Acceptance (MA) scale. According to Brunkan and Crites:

> Acceptance means that the parents regard the child as a full-fledged member of the family, who needs a certain degree of independence and who has the capacity to assume responsibility.[2]

Reliability Brunkan and Crites determined the test-retest reliability on a sample of 72 male and female college students who took the inventory twice with an intervening period of one month.[3] For the FA scale the reliability coefficient was .93. For the MA scale it was .90.

A KR 20 internal consistency reliability on the FA and MA scales was estimated from the pretest responses of students used in the study. The results are listed in Table 4.1.

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[1] Ibid., 11.

[2] Ibid., 3.

[3] Ibid., 7.

Table 4.1 KR 20 Internal Consistency Reliability Estimate for Students Participating in The Study: N = 20.

Scale	Mean	Standard Deviation	Standard Error of Measurement	KR 20 Reliability
FA	20.75	7.14	2.47	.880
MA	23.60	5.47	2.35	.815

Validity Brunkan and Crites selected items for the FRI scales on the basis of content validity judgments of three psychologists. Of the 202 items finally used, the judges reached unanimous agreement on the content validity of 187 items. On the remaining 15 items, which were added to the Father Concentration scale, two judges reached agreement.[1]

On the basis of an analysis of intercorrelations of the FRI scales, Brunkan and Crites concluded that acceptance and avoidance scales were measures of different constructs. They also reported that for two different samples of college students intercorrelations for FA and MA scales were .55 (N = 100) and .32 (N = 142).[2] The intercorrelation between the FA and MA scales on the pretests used with clients in the study was .30 (N = 20).

[1] Brunkan and Crites, 1964, 5-6.

[2] Ibid., 8.

The data presented above indicated that the FA and MA scales had high test-retest reliability (FA = .93, MA = .90), and good internal consistency reliability (FA = .88, MA = .82). Parental acceptance was a construct defined by items in the FRI. The FA and MA scales measured respectively separate characteristics of parental acceptance.

The Ego Strength Scale of the MMPI (Es)

The Es scale was developed by F. Barron originally for the purpose of predicting the response of psychoneurotic patients to psychotherapy. The Es scale was not limited to this one usage, however. Barron indicated that a broader psychological interpretation could be made of the scale, that it would be useful for assessment, "in any situation where some estimate of adaptability and personal resourcefulness is wanted."[1]

Variables which were measured by the scale were somewhat global in nature. Dahlstrom and Welsh interpreted the ego strength construct in the following manner:

> Ego strength when high implies ability to deal with the environmental pressures facing one, the motivational pressures prompting one to various conflicting actions, and the emotional pressures acting to disorganize and disrupt usual patterns of behavior. It means sufficient control to deal with others, to gain their acceptance and create favorable impressions upon them. It means using

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[1]F. Barron. An Ego-Strength Scale Which Predicts Response to Psychotherapy. In G. S. Welsh and W. G. Dahlstrom (ed) Basic Readings on the MMPI in Psychology and Medicine. (Minneapolis: Univ. of Minnesota Press, 1956), 226.

> available skills and abilities to full advantage. It means the person can work within the cultural, social, and personal limits of ethics and self-respect.[1]

Dahlstrom and Welsh indicated, as did Barron, that the Es scale could be used as a measure of improvement following psychotherapy. It was used in the study to assess outcomes in therapy which pertained to the client's ego-integration, to his acceptance of personal adequacy and responsibility after having placed his childhood conflicts behind him.

Reliability The test-retest reliability of the Es scale, as reported by Barron, was .72. The estimate was based on a sample of 30 cases, with a period of three months between tests.[2]

A Kuder-Richardson 20 internal-consistency reliability estimate was obtained on a sample of 20, for the MMPI pretests used in the study. The KR 20 reliability for the Es scale was .685, with a mean of 43.15, a standard deviation of 6.07, and a standard error of measurement of 3.41.

Validity Items for the scale were selected from the MMPI on the basis of identification of pre-therapy attributes which correlated with improvement in psychoneurotic patients who had undergone six months of treatment. A group of 17 improved patients was compared

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[1]W. Grant Dahlstrom and George S. Welsh. An MMPI Handbook. (Minneapolis: Univ. of Minnesota Press, 1960), 356.

[2]Barron, 1956, 226.

to a group of 16 unimproved patients on Es scale scores. The mean score of the improved group was higher than that of the unimproved group. Even though the sample was small, Barron concluded it was well-enough studied it would be possible to base a new scale on the data.[1]

In a study of the construct validity of the Es scale Kleinmuntz obtained scores for a random sample of 50 adjusted male and female college students and compared them with scores for a sample of 33 maladjusted students. He found the mean Es scale score for adjusted students was higher than the mean score for maladjusted students.[2]

In a later study Stein and Chu used a cluster analysis of Es scores obtained from a sample of 310 subjects classified as normals, anxiety reactions, or schizophrenics.[3] Five oblique clusters were isolated: emotional well-being or freedom from disabling anxiety and depression, cognitive well-being or freedom from disabling primary process thinking, physical well-being, religious attitude of non-belief or non-participation, and, seeking heterosexual stimulation and escape from boredom. In a discussion the authors stated:

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[1]Barron, 1956, 226.

[2]Benjamin Kleinmuntz. An Extension of the Construct Validity of the Ego Strength Scale. Journal of Consulting Psychology, 1960, 24, 463-464.

[3]Kenneth B. Stein and Chen-Lin Chu. Dimensionality of Barron's Ego-Strength Scale. Journal of Consulting Psychology, 1967, 31, 155.

> Not all of the clusters in the present study could be related empirically to the concept of ego strength. The first three clusters, those pertaining to different facets of well-being, showed consistent differences between the normal and psychiatric groups across the initial and replicated samples.[1]

Comparisons among psychiatric subgroups did not fare as well. The conclusion was that Barron's Es scale was related to the construct ego strength "conceptually and empirically only in part."[2]

The test-retest reliability (r = .72) and internal consistency reliability (r = .69) scores for the Es scale indicated that some caution needed to be exercised about the accuracy of measurement of pretest-posttest changes in therapy. The reliability coefficients were lower than the desired .80. Data pertaining to the validity of the Es scale indicated that it measured constructs representing a sense of personal adequacy, emotional freedom and control, healthy cognitive functioning, and physical well-being. The Es scale differentiated normal college students from maladjusted students on dimensions similar to the ones discussed in Chapter II of the study.

The Tennessee Self Concept Scale

The Tennessee Self Concept Scale was developed for the purpose of providing a well-standardized measure of self-concept that could easily be administered, was widely applicable, was

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[1] Ibid., 156.

[2] Ibid., 160.

multi-dimensional, and could be used for counseling and research purposes.[1] The author developed scores for twenty-nine scales, some of which were summation, distribution and variability scores for other scales, and some of which were scales pertaining primarily to clinical variables not relevant for the study. According to the manual, one of the most important scores was the "Total P Score," which reflected 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 are doubtful about their own worth; see themselves as undesirable; often feel anxious, depressed, and unhappy, and have little faith or confidence in themselves.[2]

The Total P Score was divided into eight subscales which reflected an individual's satisfaction with himself from both internal and external frames of reference. Subscales pertaining to the internal frame of reference were labeled as: Identity, how one perceived himself; Self-Satisfaction, which reflected self-acceptance; and, Behavior, how one viewed his functioning. Subscales which reflected an external frame of reference were: Physical Self, one's perception of his body, state of health, skills, and sexuality; Moral-Ethical Self, feelings of being good or bad; Personal Self, adequacy as a person of individual worth; Family Self, feelings of

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[1]William H. Fitts. Tennessee Self Concept Scale, Manual. (Nashville: Counselor Recordings and Tests, 1965), 1.

[2]Ibid., 2.

adequacy and worth as a family member and as a close friend to others; and, Social Self, one's adequacy in relationships to people in general.[1]

To measure the client's evaluation of himself as a person who had achieved some degree of differentiation and self-acceptance the Total P scale was used.

Reliability As reported in the manual reliability for the Total P Score, based on test-retest data for 60 college students over a two week period, was .92.[2]

A Kuder Richardson 20 internal consistency reliability estimate was obtained on a sample of 20 clients on pretest scores from the Total P scale. The reliability was .91, the mean 71.45, the standard deviation 11.15, and the standard error of measurement 3.30.

Validity Items on the Tennessee Self Concept Scale were selected from a pool of self-descriptive items from other self-concept measures and from written descriptions by patients and nonpatients. A two-dimensional 3x5 scheme was used by the author to classify the items. The items utilized in the Total P part of the scale were those upon which seven clinical psychologist judges had reached

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[1] Ibid., 2.

[2] Ibid., 14.

perfect agreement regarding classification and scoring.[1]

In a study testing the effectiveness of the Tennessee Self Concept Scale in discriminating between outpatients who had received six to eight months of therapy (N = 30) from outpatients who served as a wait-control group (N = 24), Ashcraft and Fitts found that on a test-retest basis the experimental group changed on the Total P score in a positive direction at the .005 level of significance. The direction of change for the control group was negative, and was not significant. Similar results, at significance levels of .05 or better, were obtained for all the subscales of the Total P scale.[2]

The Total P scale was found to have high test-retest reliability (r = .92) and high internal consistency reliability (r = .91). The scale also appeared valid for assessing changes in therapy along several dimensions of self-acceptance, when a non-therapy control group was compared with a group receiving therapy.

The Social Introversion Scale of the MMPI (Si)

The Si scale, which was coded as Scale O, was developed by Drake for the purpose of obtaining a measure of social introversion and extroversion from the MMPI that would be useful in counseling

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[1]Fitts, 1965, 1.

[2]Carolyn Ashcraft and William H. Fitts. Self-Concept Change in Psychotherapy. Psychotherapy: Theory, Research and Practice, 1964, 1, 115-118.

with students.[1] Drake and Oetting wrote: "Since Scale O was derived and cross validated on a college group, it is not surprising to find that patterns including this scale are related to various aspects of social adjustment in college."[2]

For men, patterns with a high coding of Scale O were found among persons showing introvertive characteristics, "especially shyness, social insecurity, and social withdrawal...." Low coding of the Si scale indicated adequate social adjustment. For women the same general interpretations were applicable. High coding indicated "social shyness, insecurity, shyness in the interview, and lack of skills with the opposite sex...."[3] Low coding indicated good general adjustment, especially socially.

In Chapter II it was hypothesized that an indication of the client's therapeutic progress would be his increased openness to establishing and maintaining close relationships with others. It was believed that the Si scale would be appropriate for assessing socialization.

Reliability Hathaway and McKinley reported: "For the Si scale... a test-retest reliability coefficient of +.93 has been found using 100

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[1]L. E. Drake. Scale O (Social Introversion). In George S. Welsh and W. Grant Dahlstrom. Basic Readings on the MMPI in Psychology and Medicine (Minnesota: Univ. of Minnesota Press, 1956), 181-183.

[2]L. E. Drake and E. R. Oetting. An MMPI Codebook for Counselors (Minneapolis: Univ. of Minnesota Press, 1959), 15.

[3]Ibid., 16.

normals with intervals of one day to four months between testings."[1]

An internal consistency reliability was obtained on the Si scale of the MMPI pretests used in the study (N = 20). The KR 20 reliability estimate was .85, with a mean of 34.2, a standard deviation of 9.52, and a standard error of measurement of 3.675.

Validity There were seventy items on the Si scale. They described a person's uneasiness in social situations, they covered a variety of special sensitivities, insecurities, and worries, and a high scorer would be found to deny many impulses and mental aberrations.[2] Items were chosen in the following manner:

> An item analysis of the MMPI was made by contrasting the percentage responses of two groups of students to the items. One group consisted of 50 students who obtained centile ranks of 65 and above on the T-S-E Inventory when scored for social introversion-extroversion. The second group consisted of 50 students who obtained centile ranks below 35 on the T-S-E Inventory.[3]

Drake found that for females the correlation between the social introversion-extroversion scores on the T-S-E and the Si scale was -.72, and for males it was -.71.[4] The negative correlation was

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[1]S. R. Hathaway and J. C. McKinley. Minnesota Multiphasic Personality Inventory Manual. (New York: The Psychological Corp., 1951), 6.

[2]Dahlstrom and Welsh, 1960, 77.

[3]L. E. Drake, 1956, 181.

[4]Ibid., 183.

attributed the Si scale being an inverted scale.

Drake and Thiede further validated the scale. They tested 594 female students then compared their scores to the number of reported high school social activities. The Si scale significantly discriminated between low-active and high-active groups. Similar results were obtained on 283 cases where Si scores were compared with participation in college social activities.[1]

The Si scale had an internal consistency reliability of .85, and a test-retest reliability of .93. Validity data indicated it differentiated socially active college students from students who were not as active.

Statistical Hypotheses

There were five characteristics of client experiences in multiple therapy groups which were tested: perceptions of father acceptance, perceptions of mother acceptance, increase in ego-strength, acceptance of self, and social introversion. Five hypotheses pertaining to these outcomes were formulated for investigation.

The following symbols were used in the hypotheses: H_o = null hypothesis; H_a = alternate hypothesis; M_{mf} = mean of the multiple therapy group; M_m = mean of the male therapist's group;

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[1]L. E. Drake and W. B. Thiede. Further Validation of Scale O (Si). In Welsh and Dahlstrom, 1960, 184-186.

and, M_f = mean of the female therapist's group.

I. Perceptions of Father Acceptance

Null hypothesis: No difference will be found in adjusted mean scores on a measure of father acceptance between the multiple therapy group, and each of the one therapist groups.

Symbolically: $H_o : M_{mf} = M_m = M_f$

Alternate hypothesis: The adjusted mean score for the multiple therapy group on a measure of father acceptance will exceed that of each of the one therapist groups.

Symbolically: $H_{1a} : M_{mf} > M_m = M_f$

II. Perceptions of Mother Acceptance

Null hypothesis: No difference will be found in adjusted mean scores on a measure of mother acceptance between the multiple therapy group and each of the one therapist groups.

Symbolically: $H_o : M_{mf} = M_m = M_f$

Alternate hypothesis: The adjusted mean score for the multiple therapy group on a measure of mother acceptance will exceed that of each of the one therapist groups.

Symbolically: $H_{2a} : M_{mf} > M_m = M_f$

III. Development of Ego Strength

Null hypothesis: No difference will be found in adjusted mean scores on a measure of ego strength between the multiple therapy group and each of the one therapist groups.

Symbolically: $H_o : M_{mf} = M_m = M_f$

Alternate hypothesis: The adjusted mean score for the multiple therapy group on a measure of ego strength will exceed that of each of the one therapist groups.

Symbolically: $H_{3a} : M_{mf} > M_m = M_f$

IV. Acceptance of Self

Null hypothesis: No difference will be found in adjusted mean scores on a measure of self-acceptance between the multiple therapy group and each of the one therapist groups.

Symbolically: $H_o : M_{mf} = M_m = M_f$

Alternate hypothesis: The adjusted mean score for the multiple therapy group on a measure of self-acceptance will exceed that of each of the one therapist groups.

Symbolically: $H_{4a} : M_{mf} > M_m = M_f$

V. Social Introversion

Null hypothesis: No difference will be found in adjusted mean scores on a measure of social introversion between the multiple therapy group and each of the one therapist groups.

Symbolically: $H_o : M_{mf} = M_m = M_f$

Alternate hypothesis: The adjusted mean score for the multiple therapy group on a measure of social introversion will be exceeded by that of each of the one therapist groups

Symbolically: $H_{5a} : M_{mf} < M_m = M_f$

Analysis to be Used

The design used in the study was a variation of the pretest : posttest nonequivalent control group design which Campbell and Stanley described as useful for studies in which the experimenter had relative rather than absolute control over random assignment of subjects to treatments.[1] The design is represented schematically as follows:

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[1]Donald T. Campbell and Julian C. Stanley. Experimental and Quasi-Experimental Designs for Research. (Chicago: Rand McNally and Co., 1963), 47-48.

O_1 X_1 O_2

O_1 X_2 O_2

O_1 X_3 O_2

X_1, X_2, and X_3 represent the multiple therapy group, the male therapist group, and the female therapist group. O_1 is the pretest. O_2 is the posttest. The dotted lines indicate nonequivalence between the groups. An improved design would have been possible if subjects could have been randomly assigned to treatment groups or to matched pairs.

The statistic used in the study was the analysis of covariance, with pretest scores as the covariate. Covariance analysis is appropriate for use with a design in which it is desirable to make an adjustment for sampling error when matching or blocking procedures are not possible or when random sampling methods have to be modified to suit situational limitations. In the study, subjects were assigned to groups on the basis of their schedule availability, which was not an ideal method of assignment. With a statistical adjustment for the initial differences which occurred between the groups, however, sampling differences were taken into account in the analysis of results.

Another advantage of the covariance method is that it takes into account the degree of correlation between pretest and posttest variables, the size of difference between groups on pretest

variables, and variance in the posttest scores.[1] It is preferable to gain score comparisons because the assumption of a correlation between pretest and posttest of 1.00 does not have to be met. Covariance analysis is less susceptible to unreliability.

Pretest and posttest data was tested for the purpose of determining whether or not assumptions underlying the use of the analysis of covariance had been met. The assumption pertaining to linearity of regression was verified for all of the scales by computer analysis. The assumption concerning the relationship of pretest variables to posttest criteria was tested by Pearsonian correlations. The results are reported in Table 4.2. Other correlation data may be found in Appendix C.

Table 4.2 Pearsonian Correlations Between Pretest Scores and Posttest Scores for the Father Acceptance Scale, the Mother Acceptance Scale, the Ego Strength Scale, the Total P Scale, and the Social Introversion Scale

Scale	Pearsonian Correlation Coefficient
Father Acceptance Scale	r = .79
Mother Acceptance Scale	r = .69
Ego Strength Scale	r = .46
Total P Scale	r = .63
Social Introversion Scale	r = .60

[1] Quinn McNemar. Psychological Statistics (New York: John Wiley and Sons, Inc., 1962), 372-372.

Only the Ego Strength Scale failed to meet the desired minimum correlation of .60.

A third assumption called for random assignment of clients to the groups. This could not be done by absolute randomization, nor could clients be blocked on pretest variables. They had to be assigned to groups on the basis of times that were available in their class schedules. While not a pure method of random assignment, this procedure was accepted as adequate for the study.

An analysis of variance was obtained on the pretest variables to test the equivalency of the groups. The results, which are reported in Appendix D, indicated there were no differences between any of the groups on any of the scales except that of Social Introversion ($p = .031$).

A final assumption was met by giving the pretests before group therapy began to assure that pretest scores were not influenced by the treatment.

Summary

Clients were selected for participation in the study by the criteria of expressed needs for help with problems pertaining to relationships with parents, of lowered feelings of self-esteem, and of impaired interpersonal interaction with peers. Clients were assigned to one of three therapy groups on the basis of their time availability. Two therapists met with one group together, and they

each met with one group by themselves. Therapists were found to have somewhat similar approaches to therapy, and to have common experience and training prior to the study.

Five scales from three instruments were used to measure pretest to posttest changes in the following variables: father acceptance, mother acceptance, ego strength, self-acceptance, and social introversion. The scales were found to have adequate validity and reliability. An analysis of covariance statistic was selected for use in comparing outcomes of therapy between the multiple therapy group and each of the single therapist groups.

Assumptions for use of the covariance statistic were found to be verified. The exceptions were: the Es scale had a low pretest-posttest correlation, and one of the groups differed significantly from the others on the pretest Si scale.

In Chapter V, data pertaining to predicted outcomes will be presented.

CHAPTER V: ANALYSIS OF RESULTS

An analysis of covariance was used to compare outcomes of therapy between the multiple therapy group, the male therapist group, and the female therapist group as measured by five scales. Where F-tests were significant at the .05 level or better, post hoc comparisons were made to determine if the adjusted mean score for the multiple therapy group differed from the adjusted mean scores of each of the single therapist groups.

Hypothesis I: Perceptions of Father Acceptance

The first null hypothesis was formulated as follows:

> No difference will be found in adjusted mean scores on the Father Acceptance scale of the Family Relations Inventory between the multiple therapy group and each of the one-therapist groups.

The results, which are summarized in Appendix E, were interpreted to mean the null hypothesis was rejected, which indicated there were differences between the adjusted mean scores for the multiple therapy group, the male therapist group and the female therapist group. The obtained and adjusted mean scores

are presented in Table 5.1.

Table 5.1 Obtained and Adjusted Mean Scores for the Father Acceptance Scale of the Family Relations Inventory

Group	Pretest Mean	Posttest Mean	Adjusted Mean
Multiple Therapy	23.33	29.16	27.38
Female Therapist	19.83	21.00	22.17
Male Therapist	20.50	18.66	19.28

To test for adjusted mean differences between the male therapist group and the multiple therapy group, and the female therapist group and the multiple therapy group, Sheffé's method of multiple comparisons for an analysis of mean differences was used.[1] On the basis of the test for differences between the multiple therapy and male therapist groups the following alternate hypothesis was accepted:

> H_{1a} : On a measure of perceptions of Father Acceptance, the adjusted mean score for the multiple therapy group is higher than the adjusted mean score for the male therapy group.

No differences were found between the female therapist group

[1]William C. Guenther. Analysis of Variance. (Englewood Cliffs, New York: Prentice Hall, Inc., 1964), 150.

and the multiple therapy group, nor were there differences between the female therapist group and the male therapist group.

Hypothesis II: Perceptions of Mother Acceptance

The second null hypothesis was formulated as follows:

> No differences will be found in adjusted mean scores on the Mother Acceptance scale of the Family Relations Inventory between the multiple therapy group and each of the one-therapist groups.

The results of the covariance analysis, which are listed in Appendix E, indicated the null hypothesis was not rejected, that there were no differences in the adjusted mean scores. Failure to reject the null hypothesis meant that the alternate hypothesis of differences between the multiple therapy group and each of the one-therapist groups on measures of mother acceptance was not accepted. In Table 5.2, obtained and adjusted mean scores for the M.A. scale are listed.

Table 5.2 Obtained and Adjusted Mean Scores for the Mother Acceptance Scale of the Family Relations Inventory

Group	Pretest Mean	Posttest Mean	Adjusted Mean
Multiple Therapy	21.33	24.00	25.06
Female Therapist	24.17	23.83	23.03
Male Therapist	23.33	24.67	24.41

Hypothesis III: Development of Ego Strength

The third null hypothesis was formulated as follows:

> No difference will be found in adjusted mean scores on the Ego Strength scale of the Minnesota Multiphasic Personality Inventory between the multiple therapy group and each of the one-therapist groups.

In accordance with the data summarized in Appendix E the null hypothesis was not rejected. The alternate hypothesis of differences in ego strength measures between the three therapy groups was not accepted. See Table 5.3 for obtained and adjusted mean scores for the Es scale.

Table 5.3 Obtained and Adjusted Mean Scores for the Ego Strength Scale of the Minnesota Multiphasic Personality Inventory

Group	Pretest Mean	Posttest Mean	Adjusted Mean
Multiple Therapy	48.33	59.17	60.06
Female Therapist	50.16	56.67	56.72
Male Therapist	52.33	56.67	55.72

Hypothesis IV: Self-Acceptance

The fourth null hypothesis was formulated as follows:

> No difference will be found in adjusted mean scores on the Total P scale of the Tennessee Self Concept Scale between the multiple therapy group and each of the one-therapist groups.

According to data summarized in Appendix E, the null hypothesis was not rejected, indicating there were no differences between the therapy groups on measures of self-acceptance. Obtained and adjusted mean scores for each of the groups may be found in Table 5.4.

Table 5.4 Obtained and Adjusted Mean Scores for the Total Positive Scale of the Tennessee Self Concept Scale

Group	Pretest Mean	Posttest Mean	Adjusted Mean
Multiple Therapy	37.00	46.50	48.00
Female Therapist	37.83	44.33	45.24
Male Therapist	42.50	45.83	43.43

Hypothesis V: Social Introversion

The fifth null hypothesis was formulated as follows:

> No difference will be found in adjusted mean scores on the Social Introversion scale of the Minnesota Multiphasic Personality Inventory between the multiple therapy group and each of the one-therapist groups.

On the basis of data presented in Appendix E the null hypothesis was not rejected. Failure to reject the null hypothesis indicated there were no differences in social introversion among the three therapy groups, and the alternate hypothesis was not accepted. The data is presented in Table 5.5.

Table 5.5 Obtained and Adjusted Mean Scores for the Social Introversion Scale of the Minnesota Multiphasic Personality Inventory

Group	Pretest Mean	Posttest Mean	Adjusted Mean
Multiple Therapy	65.50	58.66	56.07
Female Therapist	63.50	59.00	57.29
Male Therapist	50.00	48.83	53.14

Summary

Five hypotheses pertaining to the following outcomes in group therapy were tested: perceptions of father acceptance, perceptions of mother acceptance, development of ego strength, self-acceptance, and social introversion. An analysis of covariance was used to determine differences between the multiple therapy group, the female therapist group, and the male therapist group.

The hypothesis of no differences in measures of father acceptance was rejected. Post hoc comparisons led to acceptance of the alternate hypothesis that the multiple therapy group differed from the male therapist group on perceptions of father acceptance. None of the other null hypotheses were rejected.

In Chapter VI, the data presented above will be interpreted and discussed, and implications for further research will be considered.

CHAPTER VI: SUMMARY, CONCLUSIONS, DISCUSSION, SPECULATIONS, LIMITATIONS, AND IMPLICATIONS

Summary

The purpose of the study was to measure the effectiveness of multiple therapy, using male and female therapists, in group therapy with university counseling center clients. It was hypothesized that the multiple therapy approach would be more effective than the traditional one-therapist approach to group therapy on the following outcomes: (1) perceptions of father acceptance; (2) perceptions of mother acceptance; (3) improvement on a measure of ego strength; (4) increase in feelings of self-acceptance; and, (5) decrease in social introversion.

A history and theory of the multiple therapy experience emphasized the symbolization of a family situation with both parents present. The process of therapy was regarded as a process of personal maturation in the context of a family-like setting. It was believed that in the early stages of therapy conflicts pertaining to clients' problems with parents would be brought into sharp focus. Once a trusting relationship with the therapists was established clients would be secure in regressing to deep levels of feeling.

Subsequently they would be encouraged to strengthen their adequacies in coping with their feelings and their environment. Clients' self-acceptance and self-differentiation would be helped by their experience of the two therapists' sometimes contrasting and sometimes similar perceptions of them. The final phase of the therapy process for clients would be the establishment of close relationships to persons outside of the therapy setting.

In a review of experimental studies no research evidence was found which supported the effectiveness of multiple therapy. However, authors of descriptive reports pointed out that in their experience multiple therapy was an approach that appeared to be consistently effective with both individual and group clients.

The design of the study was a pretest-posttest design in which the multiple therapy group was compared with a group led by a male therapist, and a group led by a female therapist, on five variables of therapeutic outcome. The variables were: perceptions of father acceptance, perceptions of mother acceptance, ego strength, self-acceptance, and social introversion. Scales from three instruments, the Family Relations Inventory, the Minnesota Multiphasic Personality Inventory, and the Tennessee Self Concept Scale, were used as operational statements of the five variables.

The clients were male and female undergraduate students who were selected for participation in the study according to the following criteria: (1) expressed needs for help with problems pertaining to

relationships with parents; (2) depressed feelings of self-esteem; and (3) dissatisfaction with relationships to peers. Clients were assigned to groups on the basis of their time availability. The groups met for thirteen sessions, for twenty-six hours of therapy. There were six clients in each group.

An analysis of covariance statistic was used to analyze data obtained before and after therapy. Where results were statistically significant, post hoc comparisons of adjusted mean scores were used to test differences between separate means. The results showed that clients in the multiple therapy group perceived their fathers as being more accepting than did clients in the male therapist group. There were no statistically demonstrable differences between the groups on measures of mother acceptance, ego strength, self-acceptance, and social introversion.

Conclusions

On the basis of the analysis of results in Chapter V, four conclusions were formulated and are presented below. They are discussed in the next section of the chapter. Other data obtained in the study was considered to have speculative value only, and is presented in a section following the discussion. The conclusions were:

1. Clients who were in the group led by multiple therapists perceived their fathers as being more accepting than did clients in the male therapist group. There was no difference between the one-therapist groups on perceptions of father acceptance. There were no differences between any of the groups on perceptions of mother acceptance. The data provided partial support for the theoretical notion that multiple therapy is effective in helping clients work through impaired relationships with one or both parents.

2. The use of multiple therapists was not proven to be more effective than the use of one therapist in group therapy for increasing feelings of ego strength, feelings of self-acceptance, and social adjustment.

3. There was no indication that one-therapist groups improved more than the multiple therapy group on any of the five variables which were measured. The one-therapist method was not more effective than the multiple therapy approach to group therapy.

4. There were no results which could be interpreted to mean that the multiple therapy group deteriorated on any of the variables used to assess therapeutic progress.

Discussion of Results

The discussion of the results follows the same outline used for the presentation of conclusions.

Perceptions of Parents It was concluded that clients in the group led by multiple therapists had, by the end of therapy, perceived their fathers as being more accepting of them than did clients in the group with the male therapist.[1] The outcome partially supported the notion that a unique characteristic of multiple therapy is its effectiveness in creating a family-like milieu in which a client is able to focus on problems he experienced with one or both of his parents.

In theory, however, it had been postulated that clients would change in their perceptions of both parents, not just the father. The absence of meaningful change in mother acceptance scores makes it necessary to consider an alteration of theory to include the following hypothetical notion: A multiple therapy setting is more likely to engender measurable changes in perceptions of father acceptance than in mother acceptance because of the presence of a father-surrogate who, contrary to clients' past experience and expectations, is continually present in the group along with the mother-surrogate and who is capable of helping clients sharpen reality perceptions

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[1]See Appendix F for a sample of items from the Father Acceptance Scale.

and strengthen adequacies in coping with their feelings and their environments.

In many families in American society fathers are often absent from the home or have not been adequate in helping guide the growth and maturation of their children. A child might grow up experiencing much more of a relationship with his mother than with his father, especially if he is in a home where economic status and achievement is highly valued and the father works for long periods of time away from the family. In such a situation, a child develops a rather acute awareness of his mother's presence while his father remains somewhat undifferentiated in the general family gestalt. Since mastery of developmental conflicts includes learning to recognize, understand and cope with reality and with feelings about reality, the guidance of one's father, who is the member of the family most likely to be in touch with life outside of the family, becomes very important. If he is in some way not available it is possible that a child will grow up lacking personal adequacy and may experience incomplete or impaired personality functioning. A common source of distress in college students, for example, may be traced to their not having been taught how to cope with their personal feelings and with the pressures environmental situations place on them.

The student who requests counseling and is assigned to a multiple therapy group finds he is confronted with a surrogate family in which there is a major change from what he experienced in his

own family: the father figure is present along with the mother figure, all the time, with equal adequacy. The client is at first acutely aware of the female therapist and remains so throughout the therapy process. He is not at first inclined to acknowledge the presence of the male therapist, but by the end of therapy he has been able to relate to him as an accepting, caring person who does not absent himself from the relationship. The work of the female therapist is important in the process. She relates to the client as a good mother-figure and permits him to develop confidence in himself. She supports him in establishing a relationship with the male therapist.

When a client is asked where his perceptions have changed the most, he is likely to report that his father has taken a place in his life that heretofore was not occupied. Since the client's perceptions of his mother were always acute, it seems reasonable to assume they might not change as much in the course of therapy as would the client's perceptions of his father.

Ego Strength, Self-Acceptance, and Social Adjustment The results did not support hypotheses in which statements were made that clients in the multiple therapy group would improve more than clients in each of the one-therapist groups on measures of ego strength, self-acceptance, and social adjustment. Adjusted mean scores were higher for the multiple therapy group on measures of ego strength and self-acceptance, but not for social adjustment. The implications of

the results involve speculations which are considered in the next section of the chapter.

Improvement in One-Therapist Groups An examination of the data pertaining to changes in mean scores on each of the five scales (Chapter V, Tables 5.1 through 5.5) failed to indicate that either the male therapist group or the female therapist group improved more than the multiple therapy group. The implication was that the use of multiple therapists did not prove to be less effective than the use of one therapist in group therapy.

Absence of Deterioration There was no deterioration by the multiple therapy group on any of the measures of improvement which were used in the study. No support was provided for the contentions of Slavson (Chapter III) that the use of two therapists would cause clients to act out feelings in such a way it would be detrimental to their therapy. There was also no repetition of the problems experienced by Daniels and Staples in their studies with eighth-graders (Chapter III), where therapeutic improvement was impaired by client anxiety about oedipal conflicts. It may have been that university students in multiple therapy did not feel as anxious about oedipal conflicts as did eighth-graders. It was also possible that using two therapists who were relatively close in ages avoided a relationship which was interpreted by the clients as that of parent-child.

Speculations About the Data

The following discussion is not a report of findings which are supported by the data analysis used in Chapter V. It consists of speculative interpretations formulated for the purpose of revising theory, and making suggestions for further research. Because such interpretations are based on results that are not free from experimental error, caution must be exercised while they are being considered.

The Fantasied Parent-Surrogate A comparison of adjusted mean scores (Chapter V, Tables 5.1 and 5.2) and of pretest to posttest changes in obtained mean scores (Appendix H) showed some moderate but interesting differences between the three therapy groups on measures of parental acceptance. Clients in the female therapist group had an increased average score in perceptions of father acceptance and a decreased average score in perceptions of mother acceptance, while clients in the group led by the male therapist had a decreased average score on perceptions of father acceptance and an increased average score on perceptions of mother acceptance. Multiple therapy clients showed increased average scores on both variables.

The first tentative conclusion was that some of the clients in the one-therapist groups experienced feelings of threat and competitiveness because of their relationships to their therapists.

Their feelings led them to assign positive perceptions to a fantasied, non-threatening parental figure of the opposite sex from that of their therapist. In some instances, oedipal tones were present: males in the male therapist group accounted for most of the change toward increased negative perceptions of father and toward increased positive perceptions of mother, and in the female therapist group all of the change toward increased negative perceptions of mother was accounted for by female clients.

A second speculation was that fantasy pertaining to the absent parent-surrogate was a wish on the part of some clients to complete the partial family image represented in the one-therapist groups. The group with one therapist present symbolized a family with one parent absent. Client fantasy pertaining to the absent member could have been expressive of a need to continue a relationship with a favored parent, of a wish to experientially resolve a problem with a person of the sex opposite to that of the therapist, or of a need to have a healthy parental dyad on which they could depend for help.

Finally, it was possible that each therapist encouraged clients to have increased positive perceptions of parents of the sex opposite to the therapists' own. The therapist may have felt it necessary to defend or support an opposite-sexed parent who was being rejected or criticized by a client. Such an approach was attributed to the therapists' feelings that clients may have inappropriately excluded one parent, or clients may have experienced deprivation with the

absent parent.

The probable reasons that clients in the multiple therapy group did not deteriorate on measures either of father acceptance or of mother acceptance were that the family image was complete, clients were given the opportunity to deal with both male and female therapists and clients were supported in developing positive relationships with both therapists. Feelings and conflicts pertaining to competitiveness with therapists, to oedipal wishes, and to the threats of confrontation were not confined to fantasy but were openly expressed and resolved in the multiple therapy configuration.

Ego Strength The adjusted mean score for the multiple therapy group was higher on the ego strength variable than were adjusted mean scores for one-therapist groups (Chapter V, Table 5.3). Also, examination of data in Appendix I revealed that none of the six clients in multiple therapy deteriorated on ego strength scores, while five of the twelve clients in the other groups did. A Sign Test was used to determine whether the number of clients who showed improvement was significant. The result supported the contention for the multiple therapy group, but not for the one-therapist groups. Only tentative speculations could be made from the data. First, it was possible that because of the configuration of multiple therapy as a symbolic family clients experienced developmental maturation in which they clarified and resolved feelings

pertaining to infantile conflicts and anxiety, they established good contact with reality, they became free to express feelings and behaviors, and they felt adequate about their ability to cope. Second, the presence of two therapists instead of one gave clients extra support in strengthening their feelings about ego functioning. Either one or both of the reasons given could have accounted for the improvement by the multiple therapy group, and for the number of multiple therapy clients who improved.

The tentative conclusion was reached that multiple therapy led to more improvement in ego strength than did the one-therapist approach to group therapy. It was regarded as speculative because analysis of covariance statistics did not demonstrate there were differences between the groups, and because reliability coefficients for the Es scale were lower than desirable.

Self-Acceptance and Self-Differentiation On the basis of adjusted mean scores on the Total Positive scale, which was used as a global measure of constructs pertaining to self-differentiation and self-acceptance, the speculation was made that there was more improvement in the multiple therapy group as a whole than in the other groups (Chapter V, Table 5.4). There was tentative reason to believe that multiple therapy clients regarded themselves more positively than did clients in the one-therapist groups.

Interpreting the results of the data was complicated by the fact

that the Total P scale was a composite of eight subscales which had overlapping items. An examination of data from two of the subscales, reported in Appendix G, revealed some interesting information. Adjusted mean scores pertaining to the subscales Personal Self and Family Self were higher for multiple therapy clients than for one-therapist clients, although they were not statistically significant.

The first subscale, the Personal Self subscale, was defined as a measure of an individual's sense of personal worth apart from his body or his relationship to others. High scores for the multiple therapy group on the Personal Self subscale indicated that the experience of self-differentiation might have occurred to a degree it did not occur for one-therapist clients.

The second subscale, the Family Self subscale, was described as a measure of the client's feelings of worth as a family member. The construct was one which was meaningful in light of theoretical notions that multiple therapy represented a family-like setting. Speculation indicated that multiple therapy clients saw themselves as being of more worth as family members than did clients in the one-therapist groups, which provided additional even though very tentative support to theoretical statements made in Chapter II, and to claims made in the literature reviewed in Chapter III, that multiple therapists symbolized the parental dyad.

Of the other subscales of the Total P scale the multiple therapy group slightly improved on those which reflected the client's internal

frame of reference, the Identity, Self-Satisfaction, and Behavior subscales. On the subscales Physical Self and Moral-Ethical Self, there were no appreciable differences in improvement scores.

Social Introversion Multiple therapy clients changed more in the direction of less social introversion than did one-therapist clients, but the adjusted mean score of the multiple therapy group was not as low as that for the male therapist group (Chapter V, Table 5.5). Differences between the groups on the Si scale were less evident than were differences on any of the other scales. Data from a related scale, the Social Self subscale of the Tennessee Self Concept Inventory, revealed the same trends.[1] The tentative assumption was made that social adjustment was a variable not likely to be uniquely influenced by multiple therapy in a group setting.

Two Other Indications of Improvement A tentative conclusion was made that the multiple therapy group improved more than the other groups on each of the five outcome variables. The comparison was made by examining changes in pretest to posttest mean scores, which are listed in Appendices H and I. On all five scales the multiple therapy group showed a greater amount of average improvement than did either one of the one-therapist groups.

A second speculation was that more multiple therapy clients

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[1]Appendix G

were improved than were one-therapist clients. A comparison of clients whose mean scores demonstrated improvement on all five scales showed that five multiple therapy clients improved, while two of the male therapist's clients and two of the female therapist's clients improved. The data may be found in Appendices H and I.

Implied in the above two speculations was a notion that the use of multiple therapists had therapeutic value which went beyond that of the one-therapist approach to group therapy. It was indicated in two different ways: the amount of over-all improvement by the multiple therapy group, and the number of multiple therapy clients who improved.

The speculations in the preceding paragraphs were not based on solid research data, since they were without statistical support. The number of trends which were present seemed to be a function of more than just chance occurrences, which presents some intriguing possibilities for additional theory-building and research.

Limitations of the Study

There were some limitations placed on the study by virtue of the situation in which it was undertaken. The first was that of obtaining a sample of clients sufficiently large enough to increase reliability in the statistical analysis, and to assign clients to groups on a purely random basis. A second problem pertained to the

occurrence of high within-group variance because of the heterogeneity of the clients in the groups. Finally, the treatments may have been influenced because of the therapists' awareness of the nature of the study.

Selecting enough clients for therapy groups to have a number large enough for more reliable statistics was complicated by the fact that clients who came to the counseling center did not expect to receive group therapy, which was attributed to the relatively infrequent occasions on which group therapy was offered to students with personal and social problems. Several clients who would have been appropriate for therapy groups refused because they were not familiar with the process or they did not have confidence in it. Those who accepted group therapy were not available to meet at times which coincided with dictates of pure random assignment, so they were placed in groups on the basis of times they had available in their daily class schedules. It was possible that selection bias was present in obtaining clients and in assigning them to groups.

The second problem in the design was that of the heterogeneity of the clients accepted into the groups. Several broad criteria were used in selection: clients had to be single undergraduate students with problems pertaining to relationships with parents or with peers, or to lowered feelings of self-esteem. It was decided that although homogeneous groups would be better for the sake of a more adequate

research design, heterogeneous groups would be better for the clients' therapy. Male and female students of all class levels were, therefore, included in the groups.

A third problem was that of possible therapist bias, which could have been a factor influencing outcomes in the study since both therapists were aware of the nature of the design. Some control was exercised, however, by the therapists' not examining the specific items of the instruments until after the posttests were given. Their awareness of the content which was being measured was restricted to general rather than specific variables. A less tangible control was that of the therapists' investment in having their clients improve regardless of the type of group to which they were assigned.

The question may be raised concerning the absence of a wait-control group in the design. It was the policy of the Counseling Center that where counselors were available clients would not be asked to wait to receive therapy. Adequate counseling help was available to all clients when the study began.

Implications for Further Research

In a replication of the study a design is needed that is somewhat sensitive to the moderate amount of change that must be measured and evaluated after multiple therapy. How well it is undertaken depends on the availability of a sufficient number of

clients to give statistical analysis the power to detect changes, the availability of research instruments which can measure the nebulous variables present in personal maturation, and the availability of experienced competent multiple therapists who have established healthy personal and professional relationships. Specifically, the following suggestions should be considered:

1. Reduce the variability within groups by limiting the criteria for selection of clients to one presenting problem, such as conflict concerning relationships with one or both parents, and by selecting clients of the same age, the same sex, or both.

2. Use pretherapy tests to block clients within and across groups on relevant variables.

3. Use therapists who are not aware of the purpose and design of the study.

4. Include in the study an investigation of the effect of the relationship between the therapists on therapeutic outcomes.[1]

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[1]Jerry Treppa, 1968, initiated a study of the mutual needs of multiple therapists, which would be useful in such an investigation.

5. Use a modified design in which a second multiple therapy team works in a therapy group together, and in therapy groups separately, in the same manner as the first therapy team. Such a design is schematically represented as follows:

	Multiple Therapy	Male Therapist	Female Therapist
R_1	AB	A	B
R_2	CD	C	D

A Final Word

There were several indications that multiple therapy was more effective than the one-therapist approach to group therapy, but they were without statistical significance. The trends cannot be ignored, however, and it remains for additional research to prove or disprove the contention that more than just chance variation accounted for the consistent improvement of clients in the multiple therapy group.

What was learned in the study, on the basis of responses to written true-false questions, was only part of a story about the kinds of experiences some students had in group therapy. As in all other research only a part of reality was examined, not the whole. It may well be that multiple therapy is about the same as other approaches to therapy, or it is effective with some clients and ineffective with

others, or it is effective with just about any disturbed student wanting help with his problems.

It is a rule of scientific procedure that if differences in therapy outcomes are not proven significant, they can only be attributed to chance. In adherence to this maxim all that might be said to have taken place in the study is that clients who experienced multiple therapy were able to say they felt better about their relationships with their fathers. That in itself, taken alone, in a society where family life has weakened, where personal maturation and adequacy is developed only with difficulty, and where interpersonal alienation is a growing phenomenon, is a good place to begin.

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APPENDIX

APPENDIX A

DESCRIPTIVE DATA PERTAINING TO CLIENTS'

GROUP MEMBERSHIP, SEX, AGE, CLASS,

AND ATTENDANCE

Client Code	Sex	Age	Class	Number of Sessions Attended
Group MF				
AA	Male	21	Senior	12
AB	Male	23	Junior	12
AC	Female	21	Senior	11
AD	Female	18	Freshman	11
AE	Female	20	Junior	13
AF	Female	19	Sophomore	12
	Mean Age	20.3		72
Group M				
BG	Male	18	Freshman	12
BH	Male	21	Senior	13
BI	Male	18	Sophomore	13
BJ	Female	19	Sophomore	11
BK	Female	22	Junior	13
BL	Female	19	Sophomore	10
	Mean Age	19.5		72
Group F				
CM	Male	21	Senior	13
CN	Male	18	Freshman	12
CO	Female	21	Sophomore	10
CP	Female	22	Senior	13
CQ	Female	18	Freshman	13
CR	Female	19	Freshman	11
	Mean Age	19.8		72

MF=Multiple Therapy; M=Male Therapist; F=Female Therapist

APPENDIX B

A BRIEF DESCRIPTION OF THE GROUPS

Eighteen male and female clients participated in the study, with six clients being assigned to each group. Clients' attendance ranged from ten to all thirteen of the meetings. Each group had the same average attendance of 12 sessions per client. The groups developed their own identities when therapy began and remained characteristically different throughout the therapy process.

The group led by the female therapist was from its inception social, cohesive, and somewhat self-directing. The therapist reported that after the Spring Term was underway the group had a party, and they held another one about the time therapy ended. The parties were planned spontaneously and without the therapist's participation. In marked contrast to the other two groups clients in this group congregated together in the Counseling Center waiting area before therapy and were quite active in interacting with each other. A good part of the therapy process was given over to clients' concern about how they could be close to other people and still retain some individuality. Feelings of loneliness and lack of identity were often expressed. The therapist received very few requests for individual

extra-therapy sessions.

Clients in the male therapist's group were not as social or as cohesive as were clients in the other groups. The problems and feelings expressed by clients centered around themes pertaining to symbiotic attachments to parents, girl friends and boy friends, to self-depreciation and to mistrust of others. The therapist felt that although clients related to him quite well they were reluctant to talk with each other about their more disturbing problems. He received requests for individual extra-therapy sessions from three clients. One other client continued in individual therapy after the group terminated.

Clients in the group led by the male and female therapists were psychologically open to each other and were helpful to one another in resolving relatively disturbing conflicts. Problems pertaining to relationships with parents, to feelings of loneliness and isolation, and to difficulty in growing up were the ones most often expressed in therapy sessions. All but one of the clients in the multiple therapy group showed improvement, and the one who did not was able to benefit from short-term individual therapy after the group terminated.

In the multiple therapy group there were aspects of client-therapist interactions which elicited fantasies and behaviors pertaining to feelings about parent-child and parent-parent relationships. There were occasions when a male client would

attempt to have the female therapist side with him against the male therapist, and when a female client would interact with the male therapist in a hostile exclusion of the female therapist. When such dyads were formed the excluded therapist would use the opportunity to make the symbiotic or oedipal nature of the client-therapist relationship evident to both participants.

In some instances the therapists were called on to help a client express feelings regarding one parent who in some way was absent and was badly needed.

There was considerable therapeutic interaction in the group, which was attributed to the presence of both male and female therapists. The two therapists were free to concentrate on their relationships to the clients because of the mutual support they gave each other. If one was tiring or was at an impasse with a client he could relax while the other was active. The presence of male and female therapists made it possible for clients to experience themselves in relationships to both a man and a woman, to be responded to from perspectives that were sometimes similar and sometimes at variance, and to strengthen appropriate masculine and feminine identifications. It was also believed by the multiple therapists that their combined sensitivities helped them understand clients' feelings and conflicts in ways they could not have had they been working alone.

APPENDIX C

PEARSONIAN CORRELATIONS FOR PRETEST AND POSTTEST SCORES FOR THE FATHER ACCEPTANCE, MOTHER ACCEPTANCE, EGO STRENGTH, TOTAL POSITIVE AND SOCIAL INTROVERSION SCALES

	Pre Si	Post Si	Pre Es	Post Es	Pre TP	Post TP	Pre FA	Post FA	Pre MA	Post MA
Pre Si	1.00	.60	-.52	-.19	-.50	-.20	-.28	.01	-.23	-.14
Post Si	--	1.00	-.19	-.46	-.42	-.43	-.48	-.36	-.33	-.66
Pre Es	--	--	1.00	.46	.54	.22	.47	.16	.03	-.07
Post Es	--	--	--	1.00	.60	.47	.37	.38	.00	.22
Pre TP	--	--	--	--	1.00	.63	.33	.02	.03	.03
Post TP	--	--	--	--	--	1.00	.21	.24	.02	.35
Pre FA	--	--	--	--	--	--	1.00	.79	.30	.47
Post FA	--	--	--	--	--	--	--	1.00	.21	.59
Pre MA	--	--	--	--	--	--	--	--	1.00	.69
Post MA	--	--	--	--	--	--	--	--	--	1.00

APPENDIX D

ANALYSIS OF VARIANCE DATA FOR PRETEST AND POSTTEST SCORES FOR THE FATHER ACCEPTANCE, MOTHER ACCEPTANCE, EGO STRENGTH, TOTAL POSITIVE AND SOCIAL INTROVERSION SCALES

	SS_b	SS_w	F	p	SD^2-MF	SD^2-M	SD^2-F
F.A.							
Pre	41.4	815.7	.38	.690	28.2	52.3	82.6
Post	364.8	830.2	3.30	.065	19.8	56.7	89.7
M.A.							
Pre	25.4	481.5	.40	.680	41.9	21.8	32.6
Post	2.3	416.2	.04	.959	28.3	12.3	42.5
Es							
Pre	48.1	1585.5	.23	.799	82.6	59.8	174.6
Post	25.0	1357.5	.14	.872	90.2	139.7	41.5

Appendix D (continued)

	SS_b	SS_w	F	p	SD^2-MF	SD^2-M	SD^2-F
T.P.							
Pre	105.4	1124.3	.70	.511	115.6	39.1	68.4
Post	14.8	1301.7	.09	.919	97.4	27.8	135.0
Si							
Pre	853.0	1445.0	4.43	.031	84.6	104.2	99.8
Post	400.3	1406.2	2.14	.153	146.7	44.6	90.1

SS_b = Sum of Squares Between Groups
SS_w = Sum of Squares Within Groups
F = F-Ratio
p = Obtained Significance Level
SD^2 = Variance
MF = Multiple Therapy Group
M = Male Therapist Group
F = Female Therapist Group

APPENDIX E

ANALYSIS OF COVARIANCE DATA FOR THE FATHER ACCEPTANCE, MOTHER ACCEPTANCE, EGO STRENGTH, TOTAL POSITIVE AND SOCIAL INTROVERSION SCALES

Table E.1 Analysis of Covariance Data for the Father Acceptance Scale

Source of Variation	Sum of Squares	Mean Square	Degrees of Freedom	F	p	Hypothesis Tested
Between	195.37	97.69	2	5.50	.017	Reject
Within	248.73	17.77	14	--	--	--
Total	444.10	--	16	--	--	--

Appendix E (continued)

Table E.2 Analysis of Covariance Data for the Mother Acceptance Scale

Source of Variation	Sum of Squares	Mean Square	Degrees of Freedom	F	p	Hypothesis Tested
Between	12.38	6.19	2	0.42	.667	Fail to reject
Within	207.69	14.83	14	--	--	--
Total	220.07	--	16	--	--	--

Table E.3 Analysis of Covariance Data for the Ego Strength Scale

Source of Variation	Sum of Squares	Mean Square	Degrees of Freedom	F	p	Hypothesis Tested
Between	60.30	30.15	2	0.41	.670	Fail to reject
Within	1023.54	73.11	14	--	--	--
Total	1083.84	--	16	--	--	--

Appendix E (continued)

Table E.4 Analysis of Covariance Data for the Total Positive Scale

Source of Variation	Sum of Squares	Mean Square	Degrees of Freedom	F	p	Hypothesis Tested
Between	59.35	29.67	2	0.57	.581	Fail to Reject
Within	735.52	52.54	14	--	--	--
Total	794.87	--	16	--	--	--

Table E.5 Analysis of Covariance Data for the Social Introversion Scale

Source Variation	Sum of Squares	Mean Square	Degrees of Freedom	F	p	Hypothesis Tested
Between	37.53	18.76	2	0.23	.794	Fail to Reject
Within	1119.15	79.94	14	--	--	--
Total	1156.68	--	16	--	--	--

APPENDIX F

A SAMPLE OF ITEMS FROM THE FATHER ACCEPTANCE SCALE OF THE FAMILY RELATIONS INVENTORY

If I was right about something, my father generally told me so.

If I got into a quarrel my father would try to show me who was right and why.

My father would explain things to me when I was working with him.

I felt that my father understood me.

If I asked my father about sex matters he would explain them in a manner that I understood.

My father tried to look at my companions through my eyes.

Some of the best times in my childhood were when my father brought me toys as a surprise.

If I got into serious trouble my father would do what he could to help me out.

I can remember my father encouraging me to make "small" decisions when I was quite young.

My father had the knack of knowing just when to "put his foot down."

When my father promised me something, I knew that he would keep the promise.

My father asked for my opinion and considered it seriously.

My father would explain things to me just to the point of satisfying my curiosity.

APPENDIX G

ADJUSTED MEAN SCORES FOR THE

SUBSCALES OF THE TOTAL

POSITIVE SCALE

	MF	M	F	p
Identity	47.83	42.43	45.24	.537
Self-Satisfaction	51.53	48.29	51.51	.747
Behavior	43.90	40.45	38.16	.263
Physical Self	41.77	41.17	40.73	.957
Moral-Ethical Self	50.56	49.05	51.72	.795
Personal Self	51.81	43.14	46.39	.310
Family Self	49.08	40.85	43.41	.283
Social Self	46.30	48.85	45.68	.846

MF = Multiple Therapy Group
M = Male Therapist Group
F = Female Therapist Group
p = Obtained significance level

APPENDIX H

INDIVIDUAL SCORES, MEAN SCORES AND CHANGES IN SCORES FROM PRETEST TO POSTTEST: FATHER ACCEPTANCE AND MOTHER ACCEPTANCE SCALES

	Father Acceptance			Mother Acceptance		
	Pre	Post	Change	Pre	Post	Change
Group MF						
AA	19	27	+8	17	20	+3
AB	22	31	+9	31	31	0
AC	31	34	+3	19	23	+4
AD	19	25	+6	13	22	+9
AE	20	24	+4	22	18	-4
AF	29	34	+5	26	30	+4
$\bar{X}$	23.3	29.2	+5.9	21.3	24.0	+2.7
Group M						
BG	18	14	-4	28	26	-2
BH	31	22	-9	19	23	+4
BI	18	21	+3	17	24	+7
BJ	11	8	-3	27	23	-4
BK	18	17	-1	22	21	-1
BL	27	30	+3	27	31	+4
$\bar{X}$	20.5	18.7	-1.8	23.3	24.7	+1.4

Appendix H (continued)

	Father Acceptance			Mother Acceptance		
	Pre	Post	Change	Pre	Post	Change
Group F						
CM	32	35	+3	33	33	0
CN	19	28	+9	24	30	+6
CO	21	18	-3	20	16	-4
CP	7	8	+1	19	20	+1
CQ	27	21	-6	29	24	-5
CR	13	16	+3	20	20	0
$\bar{X}$	19.8	21.0	+1.2	24.2	23.8	-.4

MF = Multiple Therapy Group
M = Male Therapist Group
F = Female Therapist Group

APPENDIX I

INDIVIDUAL SCORES, MEAN SCORES, AND CHANGES FROM PRETEST TO POSTTEST ON THE EGO STRENGTH, TOTAL POSITIVE AND SOCIAL INTROVERSION SCALES

	Ego Strength			Total Positive			Social Introversion		
	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change
Group MF									
AA	45	45	0	19	28	+9	82	77	-5
AB	32	56	+24	34	46	+12	62	47	-15
AC	54	64	+10	47	53	+6	64	50	-14
AD	51	70	+19	36	50	+14	64	49	-15
AE	58	67	+9	49	46	-3	54	68	+14
AF	50	53	+3	37	56	+19	67	61	-6
$\bar{X}$	48.3	59.2	+10.9	37.0	46.5	+9.5	65.5	58.7	-6.8
Group M									
BG	54	64	+10	41	39	-2	68	53	-15
BH	62	56	-6	51	52	+1	44	47	+3
BI	41	56	+15	45	47	+2	54	48	-6
BJ	47	42	-5	33	47	+14	45	56	+11
BK	51	47	-4	39	40	+1	50	52	+2
BL	59	75	+16	46	50	+4	39	37	-2
$\bar{X}$	52.3	56.7	+4.4	42.5	45.8	+3.3	50.0	48.8	-1.2

Appendix I (continued)

	Ego Strength			Total Positive			Social Introversion		
	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change
Group F									
CM	69	62	-7	44	48	+4	49	45	-4
CN	40	59	+19	32	55	+23	72	51	-21
CO	65	62	-3	41	44	+3	55	64	+9
CP	45	58	+13	48	57	+9	75	69	-6
CQ	41	54	+13	37	35	-2	67	58	-9
CR	41	45	+4	25	27	+2	63	67	+4
$\bar{X}$	50.2	56.7	+6.5	37.8	44.3	+6.5	63.5	59.0	-4.5

MF = Multiple Therapy Group
M = Male Therapist Group
F = Female Therapist Group