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Object Representations in Clients' Verbal Discourse: An Exploratory Study.

By

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ABSTRACT

Object Representations in Clients'
Verbal Discourse: An Exploratory Study.

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This work explored clients' representations of self and others in brief excerpts from psychotherapy sessions. A stratified random sample involving 10 minutes of clients' conversation in early sessions and also in later sessions was made by typescripts of tape-recorded psychotherapy meetings for 48 completed outpatient files from MSU's Psychological Clinic. The goal was to determine whether the assessment of clients' object representations in verbal discourse could provide useful information regarding psychopathology and response to psychotherapy.

The findings encourage the assessment of object representations from verbal discourse. The clearest results were obtained using Krohn and Mayman's Object Representation Scale (ORS). A single judge's ORS ratings of clients' representational material were notably stable (r = .87) from early to late in therapy and showed several expected but modest (mean r = .34) significant correlations with measures of psychopathology. These findings suggest that object representations reflecting an increased capacity to understand the thoughts and motivations of self and others link positively to the individual's degree of ego-strength and freedom from psychological distress. Clients' evaluations of their psychotherapy experience were also positively linked to their object-relational level. Post-hoc analyses revealed that lower ORS groups reported feeling less valued by their therapists and less emotionally involved in their psychotherapy yet also more intense anger toward therapists. Unexpectedly, clients' ORS scores, which are suggestive of their internal object relational development, regressed to a small degree (nonsignificantly) from early to late in therapy.

Analyses of the content of verbal representations along dimensions of warmth and acceptance showed a preponderance of significant positive associations between acceptance of both self and others and lesser degrees of psychological distress. It was also found that the degree of warmth and acceptance in clients' early-therapy representations of others played a significant positive role in eventual response to the therapy.

An attempt to investigate the frequency of clients' use of content categories (e. g.,"family", "spouse", "social others") was hampered by frequencies so low that mostly nonsignificant findings resulted. Nevertheless, psychological distress was associated with clients' frequency of negative references to "generalized others" (e. g., "people are ...") early in therapy and also to their frequency of negative references to "social others" (e. g., "my friend Pat is ...") at therapy's end.

Finally, the study investigated clients' degree of articulation of their ideas and the degree of qualification in their statements. A composite articulation measure assessed clients' level of clarity and specificity of expressions, and their development of themes and ideas. While neither related either to psychological distress or to outcome measures, significant correlations were obtained between clients' articulation and their ORS scores.

To Sallie

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

> The rational processes function under certain optimum conditions only, and these are rarely encountered in 'thinking about' the self or about other persons for any reason particularly significant to the self. (Sullivan, [1930], 1972, p. 37).

When a person makes a reference or set of references about the self or about others, what kinds of inferences can be drawn about the speaker based on those references? If one were to examine a person's set of references made within a certain time period, devoid of any knowledge about the actual people involved, and devoid of the interpersonal context in which those references were made, would it be possible to learn anything about that person's psychological organization? Would it matter, for instance, whether a person talked much or little about the self or about others in a given time period? Would it matter, provided the opportunity to talk freely, whether a person confined other representations to his or her mother, father, friends, or some generalized other? Could one discern a difference in the psychological organizations of a speaker who generally represented others as kind, warm, and caring, and that of a speaker who represented others as harsh, cold, and rejecting? Would a speaker's expressive qualities relate to various psychological organizations? For example, would it matter whether the speaker was definite versus equivocal, articulate versus diffuse, specific versus general, or clear versus vague and ambiguous?

A good deal of psychological evidence indicates that self and other representations, or what is now referred to as "object representations," reflect levels of psychological development as well as different kinds of developmental psychopathologies such as psychotic, borderline, narcissistic, neurotic, and normal functioning. These findings have been obtained from responses to psychological tests such as the Rorschach, Thematic Apperception Test,

Loevinger's Washington University Sentence Completion Test, and other writing tasks, as well as from people's reports of early memories and dreams.

The present investigation, utilizing the groundwork set by projective test investigators, attempts an analysis of the kinds and qualities of object representations found in the verbal material clients provide in psychotherapy. This material is likely to provide information important in understanding clients' personality and psychological processes. Part of the task of this investigation involves the development of a methodological approach to analyze the highly unstructured verbal material provided in psychotherapy, and another part of this task involves the selection of relevant variables which could be used to differentiate representations. The present investigation also attempts to examine the relationships between indices of object representation, psychopathology, and patients' response to psychotherapy. A major purpose of this study is to determine whether clients' level of object representational functioning is an important client variable in psychotherapy outcome.

REVIEW OF THE LITERATURE

The first part of this review, "Research and Theory on Self and Other Representations and Psychological Development", examines research and theory from which relevant variables and/or dimensions will be extracted. The second section, "Psychotherapy Research" reports on psychotherapy research which can be used to guide the present investigation. The third section, "The Projective Hypothesis", examines the clinical theory, assumptions, and issues involved in the analysis of object representations and developmental levels from client verbal discourse; and the last section of this review provides an overview of the variables and methodology of this investigation.

Measures of Self and Other Representation and Psychological Development.

A. Precursor -- Werner's developmental theory

Some of the research lines to be discussed have proceeded from the theoretical work of Heinz Werner (1948, 1957). From psychological and anthropological sources, Werner postulated that mental development proceeds from a state of relative globality and lack of differentation to a state of increasing differentiation, articulation, and hierarchic integration. Werner used the following descriptive pairs to polarize this postulated continuum between primitive and advanced mental development: syncretic-discrete, diffuse-articulate, indefinite-definite, rigid-flexible, and labile-stable (Werner,1948).

Syncretic function or syncretic phenomena apply to contents or functions of mental phenomena "which would appear as distinct from each other in a mature state of consciousness, [but] are merged without differentiation into one activity or one phenomena" (Werner, 1948, p.53). Werner used as an example a person's dream images which are fused to be

representative of a few people in the dreamer's waking life. The converse, labeled "discrete," refers to all mental contents, acts and meanings which represent something relatively specific, singular, and unambiguous.

The "diffuse-articulate" dimension refers to the formal structure of the mental content. Articulate structure denotes a formal construction of such a nature that distinguishable parts constitute the whole. A "diffuse" structure represents the opposite: a structure "relatively uniform and homogeneous, one in which the parts have become more or less indistinct and are no longer characterized by a clear self-subsistence (Werner, 1948, p.54).

"Indefinite-definite" was not defined by Werner. Like the two other conceptual pairs, it implies a certain developmental movement which may be described in the direction of increasing differentiation.

Werner used the conceptual pairs "rigid-flexible" and "labile-stable" to refer to dynamic qualities. He believed that the more differentiated and hierarchically organized the mental structure of an organism, the more flexible (or plastic) its behavior. Flexibility or plasticity refers to the ability to vary activity, to mesh or comply, or to adapt with the demands of a varying situation. Werner used the pair "labile-stable" to connote and contrast quite different psychological meanings. The less differentiated and less hierarchically patterned, the *more* rigid and yet *less* stable the behavior is theorized to be. Werner states that "stability of behavior requires a flexibility of response in order to preserve the functional equilibrium of the organism in the face of mutable situations" (Werner, 1948, p. 55).

Another important concept by Werner is that in the mental life of the normal adult there is some variation from time to time in the level of development of mental activity. As Werner stated:

> Even if such states of consciousness as the dream are disregarded, the normal man does not always function on the same level of mental activity. The same normal individual, depending on inner or outer circumstances may be characterized by entirely different levels of development. His mentality, genetically considered, is not the same when he is utterly distracted as when he is in a state of perfectly organized concentration. It varies as he moves from sober scientific and practical work to emotional surrender to people or things. It may be said that mental life has different strata. At one time man behaves 'primitively' and at another he becomes relatively 'cultured' or 'civilized'. In general, then, developmental psychology attempts to demonstrate that primitive modes of behavior in the normal adult not only appear under certain extraordinary conditions, but are continually present as the basis of all mental being, and are of vital importance in supporting the highest forms of all mentality (Werner, 1948, p. 4).

Werner also noted that the capacity for more advanced mental life lies in decreasing specialization in adaptation to an organism's surroundings. Werner points out that those species which ultimately developed into higher forms of life were not specialized as early as those which did not rise beyond a lower level. Werner concludes that the lower branch of any genetic group is characterized by specialization on a more primitive level. "The lower group remains low because it adjusts itself through specialization of the means it already posesses, whereas the higher group develops new means" (Werner, 1948, p. 18). "A primitive, highly balanced, 'one-track' culture lacks that friction between individual and environment, that flexibility and freedom in increasing attempts to readjust, which is the very life and essence of higher, advanced cultures." (Werner, 1948, p. 19).

B. Theory and Research on Object Representation

Object relations theory has become a major psychoanalytic ego psychology and a major psychoanalytic formulation regarding psychopathology. Hartmann (1964, Chapter 7) is credited with laying the groundwork for object relations theory in psychoanalytic thinking by focusing attention on the existence of an inner world of mental representations of the self and of

objects attached by emotional interest to that self (Ryan & Bell, 1984). Klein (1948), Fairbairn (1952), and Mahler (1971) focused on the development of object relations and posited that the manner of object seeking and the organization of self-object representations in the first two years of life effect adult organization of object relations. Ryan and Bell (1984) and Kernberg (1966, 1976) followed up on their work by more strongly emphasizing the importance of "internal object relations." Kernberg (1972) stated that:

> My main thesis [of paper, Early Ego Integration and Object Relations] is that the structures determined by internalized object relations constitutes a crutial determinant of ego integration and an abnormal development of internalized object relations determines varying types of psychopathology (p. 233).
>
> Early maternal deprivation determines abnormal personality development through the intermediate variable represented by faulty internalized object relations (p. 233).
>
> Clinical evidence from studies of children with autistic and symbiotic psychoses and from psychoanalytic exploration of adolescents and adults with severe character pathology and borderline conditions indicates that the types and severity of psychological illness is, indeed, largely the expression of pathological structuring of internalized object relationships (p. 233-234).

Developments in research using projective testing data highlight the fundamental importance of object representations and internal object relations. This promising work has been based on psychoanalytic theory, Wernerian principles, and on the evolution of Rorschach scoring categories.

A developmental approach has been applied to many scoring categories on the Rorschach (Hernmendinger & Schultz, 1977). Judging the degree of quality of a Rorschach response, as, for instance, its level of form quality, has been a fundamental way of analyzing structural aspects of the Rorschach. A primary area of these investigations, one most aligned with object representational investigations, has been the analysis of the human figure responses. Such

analysis primarily with regard to human movement, has emerged as a highly important Rorschach category. Rorschach movement responses have been related to intelligence, creativity, fantasy, and quality of interpersonal relations (i.e., orientations towards people and a concern with positive and close relationships) (Dana, 1982).

Blatt, Brennis, Schimik and Glick (1976) studied the human figure response from the perspective of Wernerian principles of differentiation, articulation, and integration. "Differentiation" was defined in terms of the nature of the response, ranging from partial details with quasi-human figures through partial details of human figures to full human figures. "Articulation" was scored for the specification of perceptual (e.g., size, posture, and clothing) and functional details (e.g., sex, role, and specific identity). "Integration" was scored in four ways: "(a) the degree of internality of the motivation of the action (unmotivated, reactive, and intentional); (b) the degree of integration of the object and the action (fused, incongruent, nonspecific and congruent); (c) the nature, and; (d) the content of the integration of the interaction with another object (active-passive, active-reactive, active-active, and malevolent-benevolent) (Blatt, et al., 1976, p. 365).

Studying a sample of "normal" individuals over a 20-year period from early adolescence to young adulthood, these authors found important developmental changes; namely, "a marked increase in the number [percentage] of accurately perceived, well-articulated, full human figures involved in appropriate, integrated, positive (benevolent vs. malevolent) and meaningful interactions ... (and) a significant decline in the number of inactive human figures" (Blatt, et al., 1976, p. 367).

These authors also studied a group of disturbed adolescents and young adults and compared their scores to the normal group. A number of differences were observed between the normal group and the patient group. Patients produced significantly more human figures that were

inaccurately perceived, distorted, and partial and that were seen as inert or as engaged in unmotivated, incongruent, nonspecific, and malevolent activity. An unexpected finding was that patients gave significantly more human responses at developmentally lower levels on accurately perceived responses and significantly more human responses at developmentally advanced levels of inaccurately perceived responses than normals. Examination revealed that the more advanced responses were essentially preformed images bearing little relationship to external reality (i.e., the cards). The authors concluded that "psychotic patients appear more disorganized when they are struggling to deal with and integrate a painful reality and less disorganized when absorbed in unrealistic experiences" (Blatt, et al., 1976, p. 372).

Blatt et al.'s (1976) study is considered to involve the structural aspects of the human figure response. Another line of object representational research has involved human content analyses. In fact, one of the major recommendations in object relations research has been to focus on both thought content and thought form in attempting to assess levels of object representations (see Spear & Lapidus, 1981).

Content analyses research was initiated by Mayman's (1967) guiding theoretical formulations related to an "object-relational view". Mayman considered the role of object representation as central to the psychological life of the person. Mayman states that the existence within the self of images of others is a precondition of social development. The level of representation is considered to be related to "the availability of a repertoire of personal imagery, the range and emotional quality of one's representations of others, the degree of fusion which tends to occur between self and others, the characterization of self and others, and the kinds of expectancies one carries into each encounter with people and things of his world" (Mayman, 1967, p. 17). Mayman theorized that a person's most readily accessible object

representations called up under unstructured conditions, reveal the person's inner world of objects, and the quality of relationships with these inner objects toward which the person is predisposed, and a person's general capacity for forming object relationship. A loss or lack of these representations is equivalent to a total disappearance of support. Mayman believes that "without stable internalized good objects, the child (and psychotic adult) would be left to his own bewildered, panic-stricken state of aloneness and disintegrating sense of self" (Mayman, 1967, p. 19). On the other hand, the capacity for empathy which involves, in part, self/other differentiation and awareness of another's needs (even if those needs run counter to one's own) is considered the highest attainment of object representation (see also, Clark, 1980). According to Mayman,

> the more empathic representations of others in a Rorschach protocol will, on the whole, be more varied in content, more objectively described, and more likely to express warmth, interest, pleasure and amusement at the doings of others, but in a way that makes it clear that the perceiver is talking about a distinctive separate person (Mayman, 1967, p. 21).

A key contribution of Mayman and his colleagues has been the development and validation of the Object Relations Scale (Krohn & Mayman, 1974; Ryan, 1970, 1973; Ryan & Bell, 1984; Triman & Ryan, 1979; see also Spear & Lapidus, 1981). This scale, originally devised by Ryan and applied to early memories, has been adapted and condensed by Krohn and Mayman (1974) and applied to dreams, early memories, and Rorschach material. This scale, summarized in Table 1 (p. 11), is divided into five major levels of object relations: psychotic, borderline, narcissistic, neurotic, and normal. The continuum depicts the emotional quality of the representations of self and others, the integrity of these representations, and the quality of the interaction represented between self and others. The scale has been correlated with therapist/supervisor ratings of patients' psychopathology

Table 1

Krohn and Mayman's Object Representations in Dreams Scale with a Comparison of Mahler's Stages of Object Relations Development (Spear and Lapidus, 1981).

Krohn and Mayman Object Representation Scale	Mahler's Stages
8. Emotional mutuality, awareness of others' needs, nondistorted intimacy	
	Individuation
7. Affective relatedness but with childlike transference distortions	
6. Awareness of unique others but only with arms-length interactions	
	Separation
5. Stereotypical relationships with interchangeable people, "passers-by"	
4. Vague awareness of need-gratifying others arms-length interactions	
	Symbiosis
3. Some awareness of ephemeral others in nonbizarre ways	
2. Awareness of vague others only as primitive manifestations of bizarre, malevolent, and sadistic self-impulses	
	Autism
1. Isolated, lifeless, alien, unpredictable world, alone with no others	

(Krohn & Mayman, 1974) and with levels of ego development (Triman & Ryan, 1979). The following quotations highlight findings and understandings regarding the level of object representations.

> The fundamental conclusion ... is that level of object representation appears to be a salient, consistent, researchable personality dimension that expresses itself through relatively diverse set of psychological avenues, ranging from a realm as private as dream life to one as interpersonal as psychotherapy. Moreover, it is not a redundant construct synonymous with levels of psychopathology or severity of symptomology (Krohn & Mayman, 1974, p. 464).

> The explicit or implicit suggestion in much of this work is that object-relations patterns are set down in early childhood, become consolidated through late childhood and adolescence, and remain relatively fixed throughout adult life as the transference paradigms of character. Adult functioning, whether normal, neurotic or psychotic, is assumed to be dependent on the maturity of one's object relations, that is, on the relatively stable level one has achieved along the developmental continuum. From this point of view, improvement in object relations is possible only as a result of a mutative maturational process, apparently limited to natural developmental processes and/or psychotherapy (Ryan & Bell, 1984, p. 210).

C. Loevinger's Theory of Ego Development: Appraisal and Critique

The present author has mixed feelings about including Loevinger's theory of ego development. The desire to include it is related to the applicability of it's conceptions to what appears to be a central aspect of psychological life and development-- internal object relations. The desire to exclude it is related to this author's disappointment in the theory's priorities compared both to internal object relations theory of development and to what is here thought to comprise much of psychological life.

Loevinger (1966) asserts that ego development is not just "one interesting personality trait among many, but is a master trait. It is second only to intelligence in accounting for human variability." She states further in the same paragraph:

> We owe it to our discipline to be faithful to reality, not only in details but also where we invest our lives as scientists. When Brunswick said, let the order of our ideas be the same as the order of things, he did not mean anything so utilitarian or so banal as that the importance of an area in our science must reflect its importance in life. Surely he meant rather that the structure of our science should reflect the structure of life. On this basis ego development must become a focal construct in psychological theory and research (p. 205-206).

The question is: does Loevinger's conception of ego development prioritize the salient aspects of psychological life and maturation or development? To use Loevinger's words: does the structure of her theory reflect the structure of life? My impression is that it does not insofar as it does not adequately embody the importance of and priority of internal object relations to the psychological life of the person. Perusal of the stages of ego development (see Table 2, p.14) (Loevinger, 1976) highlights the impression that Loevinger's theory is more tied to a cognitive and/or moral epistomology than it is to a social or psychological one. The stages labeled *Presocial, Impulsive, Self-protective, Conformist, Self-aware, Conscientious, Individualistic, Autonomous, and Integrated*, do have aspects related to internal object relations and social development with the evaluation of concepts such as self vs. nonself, interpersonal perspective taking, interpersonal morality, empathy, individualism, and autonomy. However, the emphasis is on a cognitive or moral epistomology and a ego vis-a-vis the world more than on an ego that stands in relation to itself and in relation to others. To use Heidegger's existential terminology on the three basic modes of dasein (being), Loevinger has prioritized her theory in the UNWELT--the surrounding environment, the world of everyday and practical concerns, over the MITWELT--the modality of being-with-others, the communal world, the world of personal concern, and the EIGENWELT--the world of self relatedness, self-consciousness, the world of concern.

This criticism can be understood better if one tries to apply the stages to psychological

TABLE 2

Some Milestones of Ego Development (Loevinger, 1976).

STAGE	CODE	IMPULSE CONTROL, CHARACTER DEVELOPMENT	INTERPERSONAL STYLE	CONSCIOUS PREOCCUPATIONS	COGNITIVE STYLE
Presocial			Autistic		
Symbiotic	I-1		Symbiotic	Self vs. nonself	
Impulsive	I-2	Impulsive,fear	Receiving, dependent, exploitive	Bodily feelings, especially sexual and aggressive	Stereotyping, conceptual confusion
Self-Protective		Fear of being caught, externalizing blame, opportunistic	Wary, manipulative, exploitive	Self-protection, trouble, wishes things, advantages, control	
Conformist	I-3	Conformity to external rules, shame, guilt for breaking rules	Belonging, superficial niceness	Appearance, social acceptability, banal feelings, behavior	Conceptual simplicity, stereotypes, cliches
Conscientious-Conformist	I-3/4	Differentiation of norms, goals	Aware of self in relation to group, helping	Adjustment, problems, reasons, opportunities (vague)	Multiplicity
Conscientious	I-4	Self-evaluated standards,self-criticism,guilt for consequences, long-term goals and ideals	Intensive, responsible,mutual concern for communication	Differentiated feelings, motives for behavior, self-respect, achievements, traits, expression	Conceptual complexity, idea of patterning
Individualistic	I-4/5	Add: Respect for individuality	Add: Dependence as emotional problem	Add: Development, social problems, differentiation of inner life from outer	Add:Distinction of process from outcome
Autonomous	I-5	Add: Coping with conflicting inner needs,toleration	Add: Respect for autonomy, interdependence	Vividly conveyed feelings, integration of physiological and psychological, psychological causation of behavior, role conception, self-fulfillment, self in social context	Increased conceptual complexity, complex patterns, toleration for ambiguity, broad scope, objectivity
Integrated	I-6	Add: Reconciling inner conflicts renunciation of unattainable	Add: Cherishing of individuality	Add: Identity	

material. Stages and corresponding concerns such as conformity, conscientiousness, and individualism do not typify the issues which can be gathered from what is considered to be representative and characteristic psychological material found in dreams, early memories, Rorschach material, or patients' verbal discourse in psychotherapy (to be presented). Rather, issues such as the ability or lack of ability to comprehend others' actions and motivations, the degree of seeing others in terms of individual people versus incomprehensible and fragmented or only in terms of the needs they satisfy, and the degree of being able to comprehend one's own internal workings and motivations seem more salient. In the search for a theory which could enhance the insights into internal self and social development gained from Krohn and Mayman's (1974) object relations scale for dreams, Loevinger's prior (1966) theory appears inadequate.

Yet Loevinger's conceptions are useful when reflecting on their striking similarity and correspondence to conceptions used to describe object representation and development. The idea of a 'master trait", an individual's integrative processes and overall frame of reference ordered along a nonvariant developmental continuum appears to resemble conceptions of internal object relations and to describe the levels of object representation. The description of the stages as "marked by a more differentiated perception of one's self, of the social world, and of the relations of one's feelings and thoughts to those of others" (Candee, 1974, p. 621), the significant relationship between ego development and empathy (Carlozzi, Gee, & Liberman, 1983), and the ability of the test to show differences between delinquent versus nondelinquent girls (Frank & Quinlan, 1976) as well as the significant relationship found between levels of ego development and levels of object representation (Triman & Ryan, 1979), all highlight the similarities of construct and convergent validities between these two conceptions of development.

Why is Loevinger's theory more cognitive or more moral rather than psychological or social? Why has it prioritized a self vis-a-vis the world rather than a self being-with-others, or a self trying to comprehend its own self? Why does it have limited utility as a clinical theory? And why does Loevinger assert that the levels do not correspond to various degrees of psychopathology? (An assertion which the author thinks is likely to be false; see e.g., Gold, 1980).

I think an understanding of the limits involved in the methodology used to assess ego level will show the problem with this theoretical conception. Like the factor analytic understanding that what factors are derived depend on what items you analyze, the methodology upon which one builds a theory can limit the theory to the extent that it limits and organizes the original data. Perusal of the sentence stems shown in Table 3 (p. 17) suggests the problem.

Besides the limits imposed on experience by the structure of the sentence stems themselves, the abstraction of ego development is based on an analysis that involves giving equal weight between such stems as "My father" and "Most men think that women." First of all, an attempt to abstract along similar lines for 36 sentence stems, which are a combination of self-references ("What gets me in trouble is", "I feel sorry"), specific other references ("My father", "If my mother"), and non-human category references ("Education", "A woman's body"), will prima facie and a priori lead to a conception of the human psyche along more cognitive, abstract and moral lines than along more personal, psychological, and social lines. This approach is in line with a conception that confounds variables such as internal object relations and morality and intellect, and prioritizes human intellect and abstraction over a more in depth understanding of the human psyche based on internal object relations. The reason that Loevinger's theory is not a satisfactory theory of social development is because its methodology has axed the depth of internal object relations from its proported representative

Table 3

Sentence Completion Stems (for Women) Used in Deriving Ego Level

1. Raising a family
2. Most men think that women
3. When they avoided me
4. If my mother
5. Being with other people
6. The thing I like about myself is
7. My mother and I
8. What gets me into trouble is
9. Education
10. When people are helpless
11. Women are lucky because
12. My father
13. A pregnant woman
14. When my mother spanked me,
15. A wife should
16. I feel sorry
17. When I am nervous
18. A woman's body
19. When a child won't join in group activities
20. Men are lucky because
21. When they talked about sex,
22. At times she worried about
23. I am
24. A woman feels good when
25. My main problem is
26. Whenever she was with her mother, she
27. The worst thing about being a woman
28. A good mother
29. Sometimes she wished that
30. When I am with a man
31. When she thought of her mother, she
32. If I can't get what I want
33. Usually she felt that sex
34. For a woman a career is
35. My conscience bothers me if
36. A woman should always

"structure of life" both in terms of the constriction placed on experience by the sample and structure of sentence stems and by its attempt to comprehend psychic life over a wide range of phenomena.

An even more problematic aspect of the methodology used to extract ego development is the use of an analysis that gives equal weight to self references, specific other references, and generalized other references. The assumption that specific other references such as "My father" and generalized other references such as "Most men think that women" are equivalent in deriving an understanding of the self or ego is, I believe, a false assumption. Rather, while

both are alike in that they will both elicit the person to project internal experience, I propose that the generalized other reference by its very nature of being more abstract and general, will elicit a different kind of internal phenomena, one more likely to be of a lower developmental level and more psychopathological. Recalling Blatt et al.'s (1976) finding that disturbed patients gave significantly more human responses at developmentally lower levels on accurately perceived responses and significantly more human responses at developmentally advanced levels of inaccurately perceived responses than normals, it can be hypothesized that Loevinger's sentence stems confound stimulus quality. A Rorschach scoring equivalent would be to give equal weight to human responses to both good and poor suggestive Rorschach forms. The finding by Gold (1982) that both obsessive-compulsive and paranoid characterize higher ego levels and the finding by Kaan, Stroud, and Holstein (1973) that both defense mechanisms such as intellectualization and projection significantly increase with ego levels, suggest that there may be a confounding of increased psychological development and paranoid projection.

D. Cognitive Complexity of Interpersonal Constructs

The term "cognitive complexity" has received a number of varying definitions, yet the major research on this variable has been grounded in Werner's developmental psychology (Crockett, 1965). A cognitive system is considered complex if it contains a relatively large number of elements or constructs (degree of differentiation) and the elements are integrated hierarchically by relatively extensive bonds of relationships (degree of hierarchic integration) (Crockett, 1965). Thus cognitive complexity involves an increased differentiation and articulation of elements, and simultaneously, an increased interdependence of elements by virtue of their integration into a hierarchically organized system.

There are a few findings in this research area which are relevant to the present concern. An

individual's constructs are more complex for those persons with whom he or she interacts frequently and intimately than are his or her constructs relevant to categories of people with whom he or she interacts less intensely (Crockett, 1965). Also, evidence suggests that individuals high in cognitive complexity as compared to those who are low in complexity, are more likely to use both favorable and unfavorable constructs in their descriptions of others (Crockett, 1965).

Cognitive complexity research, like Werner's developmental psychology is based on a premise of adult development. The present investigation is based on a similar belief in adult development. The following statement is a good summary of how this development takes place, and suggests, to the present author, what is likely to be an important variable for client growth or change to take place in psychotherapy.

> [cognitive development] depends upon the interaction between an existing mode of cognitive organization with respect to some domain of events and the individual's actual experience with events in that domain. To the extent that a person seldom or never encounters events in some domain, his cognitive system with respect to those events may remain global, undifferentiated, and loosely organized. However, such lack of development is not at all likely to the same person's cognitive system with respect to domains whose events he meets frequently or whose events are functionally important to him. The increased differentiation and articulation of constructs with respect to such domains reflect the individual's growing awareness of subtle differences in the aspects of these events and, at the same time, helps him identify and respond differentially to such subtle differences. The relationship that develops among constructs reflects relationships among the actual events (at least as the individual has experienced them) and, (A) enable him to achieve a subjectively satisfying 'understanding' of complex events and (B) provide the basis on which he makes inferences that extend beyond the limited set of events he is able to observe at some particular time (Crockett, 1965, p. 54).

The present author sees elements of the above statement as pertaining to how psychotherapy is likely to enable growth or change in one's interpersonal constructs or to repair internal object relations. Whether the purpose of psychotherapy is stated to be improved self understanding, or to be able to work and to love, or more realism and a better management of stress and problems, a central factor appears to be a change or growth related to increased differentiation, articulation, and awareness of self, others, and patterns of interaction. Good psychotherapy facilitates and contributes to the overcoming of impediments in adult development and impediments in internal object relations primarily, I think, because of the illuminations gained from the interpersonal experience. Change and growth is brought about not only through identification, corrective emotional experiences, and the working through of past material elicited through the therapist/client interaction (Kell & Mueller, 1966), but also because psychotherapy and other types of interpersonal experiences provide the friction between the individual and other which promotes increased flexibility, freedom, differentiation, and complexity in increasing attempts to readjust and to adapt. This viewpoint asserts that involvement in interpersonal experiences is a central factor related to adult development and supports the contention by Sullivan and many other theorists that the "personal relationship between patient and therapist is the most important determining factor, positively or negatively, in the fate of the patient" (Greenberg & Mitchell, 1983, p. 93).

E. Self-acceptance and Acceptance of Others: Two Major Interpersonal Dimensions

In the model proposed thus far, internal object relations are hypothetical psychic structures or organizations built up through the years of interpersonal living and experience. These inferred psychic structures guide a person's constructions or interpretations of self and others. In other words, these inferred psychic structures manifest themselves through a

coherence or pattern in the kind and quality of a person's object representations. Similarly, to the degree that one's thoughts and understandings affect one's behavior, these inferred psychic organizations manifest themselves in the kind and quality of a person's interpersonal functioning.

Among likely interpersonal concomitants of developmental object relations, researchers in the field of interpersonal functioning have uncovered the fact that two major variables account for approximately ninety-one percent of the variance in interpersonal interactions (Conte & Plutchik, 1981). Leary (1956) and his colleagues were the first to conceptualize these dimensions, which they labeled as "affiliation versus hostility" or "love versus hate" and "dominance versus submission." Other researchers noted that that the dominance dimension or a person's degree of dominance was representative of or related to the person's degree of self acceptance. Hurley (1980), who reviewed the literature which investigated major interpersonal dimensions, renamed the dominance-submission dimension as "acceptance versus rejection of self" (ARS) and the affiliation-hostility dimension as "acceptance versus rejection of others" (ARO). In Hurley's schema, ARS is composed of a summary score from the bipolar scales, "shows feelings-hides feelings", "expressive-guarded", "active-passive", and "dominant-submissive." Acceptance versus rejection of others is composed of a summary score from the bipolar scales "warm-cold", "helps others-harms others", "gentle-harsh", and "accepts others-rejects others."

Because of the salience of these two interpersonal dimensions in human interaction, these variables are likely to be closely allied with developmental object relations. Besides the theoretical convergence between ideas like empathy and appreciation of unique others, and acceptance of others, research also supports the importance of the ARO and ARS dimensions. For instance, ARO and ARS have been found to be important variables in parental behavior and

attitudes towards children (Hurley, 1965, 1967; Symonds, 1939), in assessing the effectiveness of professional and para-professional mental health workers (Hurley, 1976; Small & Hurley, 1978) and in assessing interpersonal changes made by undergraduate participants in university-based experimental groups (Hurley, 1978; Hurley & Force, 1973).

Psychotherapy Research

This section reviews psychotherapy research involving analyses of clients' self and other representations. An overview of this research suggests that this research area is underdeveloped. Besides the early client-centered research on self and other acceptance and the more recent work by Krohn, Mayman, Ryan, and colleagues, there have been few research investigations. This seems surprising in light of the salience of human content and movement responses in Rorschach research and in the assessment of psychological functioning. In psychotherapy, clients usually focus on feelings and thoughts about themselves and others who are affecting their lives. Rich and meaningful representations of self and others seem especially likely to occur in clients' verbal discourse during psychotherapy, especially in comparison to the sporadic human responses to the Rorschach.

A. Client-Centered Therapy Research

Raimy (1948) was the first to measure change in self-concept as an important variable in psychotherapy. His work initiated a series of successful studies on changes in self and other acceptance by the early researchers of the client-centered school. Raimy postulated the importance of an individual's self-concept, especially on the dimensions of self-approval vs. self-disapproval. His scoring scheme, listed in Table 4 (p. 23), was applied to 14 completely

Table 4

Raimy's (1948) Scoring Schema for Classifying Client Statements*

The six categories	
P	Positive self-reference (SR) indicating a positive or favoring attitude toward self.
N	Negative SR indicating a negative or disapproving attitude toward self.
Av	Ambiguous SR in which some self-reference is manifested but either the value is too vague to be classified or the response lacks value altogether.
O	Other or External Reference in which the client himself is not implicated.
Q	A nonrhetorical question in which the client is actually asking for information—If a question is only part of a complete response, the question is ignored in the classification.

*All words spoken by the client between two responses of the counselor.

recorded counseling cases. Each client statement (i.e., all words spoken between two responses of the counselor) were scored. For successful cases, Raimy found an increase in positive self-statements at the end of therapy and a decrease in negative and ambivalent self-references. This was not true of unsuccessful cases.

Sheerer (1949) expanded on Raimy's research in two ways. For one, she was concerned "not merely with an investigation of the tone of valence of the clients' self reference in

successful counseling but also with the changing content of the self concept" (p. 169). In other words, Sheerer postulates *degrees* of acceptance in client statements. Secondly, she postulated a positive correlation between self-acceptance and acceptance of others. Sheerer developed five-point scales for self-acceptance and acceptance of others to test her hypotheses. The scales are not listed in the publication but representative examples are shown in Table 5 and

Table 5

Sheerer's (1949) Illustrations for the 5-Point Degree of Self-Acceptance Scale.

Step 1	"I haven't got what it takes to be a normally accepted person."
Step 2	"All the time with any group, I just have the expectancy that they're going to jump on my weak points ... and I don't assert myself. I have nothing to say because of a fear of condemnation, of ridicule ... and what I'm looking for is release from this inability or fright of just being a human being."
Step 3	"I think I'm seeing rather clearly now that most of the pain I suffer is because I am no one, and I am not following a pattern that is really me, but just a lot of patterns that people—alternative me's, do you see, and that's not a very good way to be."
Step 4	"When you're in a family where your brother has gone to college and everyone has a good mind, I wonder if it is right to see that I am as I am and I can't achieve such things. I've always tried to be what others thought I should be but I am wondering whether I shouldn't just see that I am what I am."
Step 5	"Well, I've just noticed such a difference. I find that when I feel things—even when I feel hate—I don't care. I don't mind. I feel more free now. I don't feel guilty about things."

Table 6

Sheerer's (1949) Illustrations for the 5-Point Degree of Other Acceptance Scale.

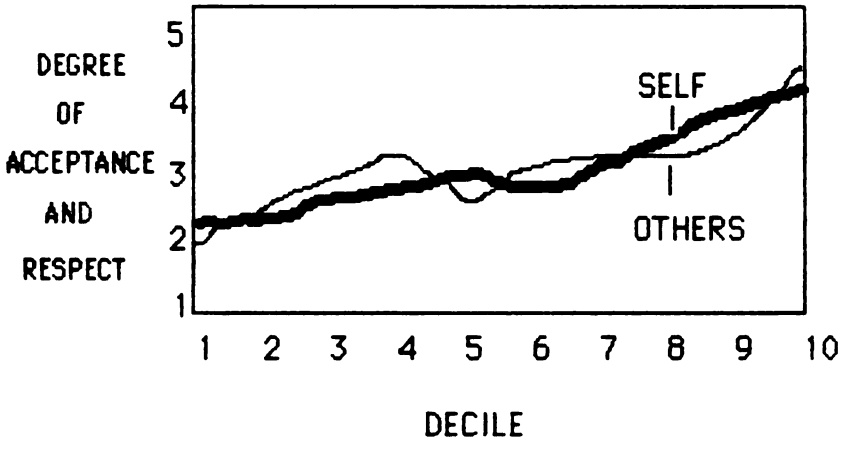
Step 1	"I get so miserable, and I can't stand to hear her talk—Why? And she's so foolish...and I keep saying to myself, 'I'm embarrassed that she's so foolish.' I keep yelling at her and pointing out to her where she's inconsistent and the mistakes."
Step 2	"My mother is now a widow without any friends. I'll have to try and see if I can't get her in a better social situation. We have been preaching at her for a long time that she must get herself into a better social situation, but I don't think she can."
Step 3	"I may have no patience with grownups, or little enough; I certainly have patience with children, with children and animals."
Step 4	"I believe that she is a rather selfish woman, and I can see her in a light possible that would excuse her, may understand her better."
Step 5	"I can accept Evelyn and her love more. I suppose my reaction with Evelyn was really a violent case of rejection which I didn't realize but now I do, and I accept her."

Table 6. As shown, step 1 on both the self-acceptance and the other-acceptance scales represent client expression of a lack of acceptance and respect, whereas both step fives represent an expression of acceptance and respect.

Sheerer rated a total of 1,366 statements based on ten successful cases entailing a total of 59 interviews. She found that 77.1% of the statements were relevant for the 'self' scale and 16.8% were found relevant for the "other" scale. Her findings indicated a significant correlation between client scores on the two scales ($r[10] = .51, p < .01$) indicating a

"positive relationship between the expressed attitudes of acceptance of self and the expressed attitude of acceptance of others" (p. 173). In addition, Sheerer found a "marked increase in self acceptance and respect throughout eight of the ten cases and a marked increase in acceptance of and respect for others in six cases" (p. 173) (see figure 1).

FIGURE 1. The relationship between the mean ratings of the "self" scale and the "others" scale through the course of psychotherapy in the ten successful cases combined (adapted from Sheerer, 1949).



Stock (1949) furthered this research also by differentiating the general area of "feelings about others" into more specific categories. Table 7 (p. 27) shows this useful category schema.

Stock (1949) supported Sheerer's (1949) findings of a positive correlation between each person's self-scale score and other-scale score for each interview. In a more detailed analysis, Stock found the self score to correlate the highest with referents representing social relationships ($r = .40$) (Category B in Table 7 (p.27)), and to some extent with referents toward generalized other ($r = .35$) (Category D) and counselor ($r = .35$) (Category E).

Table 7

Schema for Classifying Referents Towards "Others" (Stock, 1949).

A. Referents representing primary personal relationships: ordinary members of the immediate family—husband, wife, mother, children, etc.

B. Referents representing secondary social relationships: as individuals or as occupying certain roles, ordinary persons with whom there is less emotional involvement than the above—friends, employees, schoolmates, etc.

C. Referents representing impersonal relationships: with "abstract" individuals or groups — persons in service occupations such as bus drivers, saleswomen, etc., with whom contact is quite fleeting. Individuals as stereotypes such as "Negroes", "Germans" etc.

D. Referents representing the "generalized other": whom the client refers to as "people", "everybody", "anybody", etc.

E. Statements referring to the counselor or counseling situation.

Stock concluded that "attitudes towards individuals in a social relationship correlated more highly with self attitudes than did feelings in the areas of family relationships and more impersonal relationships" (Stock, 1949, p. 180).

B. Other Relevant Psychotherapy Research

1. Changes in internal object relations from psychotherapy.

A study by Ryan and Bell (1984) closely parallels the line of investigation being developed here. These authors investigated the changes in object representational developmental level over the course of psychoanalytically oriented psychotherapy for inpatient schizophrenics. Changes in object representational level was assessed at intake, termination,

and 6 months after treatment ended. Object representational quality was assessed via patients early memories; specifically, the earliest memory, earliest memory of mother, and the earliest memory of father, obtained at each of the data collection points. These authors used the Ryan Object Relations Scale (Ryan, 1973) which is the parent of the Krohn and Mayman Object Representations Scale.

The authors found a significant difference from intake to followup on the *earliest memory only* in the direction of positive change. Using a cut-off point to divide patients into relatively high versus relatively low object representational level for the earliest memory, the authors found a significant pre-post pattern of most scores going from low to high; those that were high remained high, and no scores went from high to low. Again, no significant differences were observed on the father or mother memory. In addition, the authors found that those scoring low compared to high at follow-up were approximately twice as likely to have been rehospitalized.

In all, among this group of schizophrenic subjects, only 14% remained at the psychotic level of object relational functioning from intake to follow-up, which averaged one and one half years. The authors concluded:

> The results suggest that object relations in psychotic patients as measured using their early memories can change over a relatively short period of time from breakdown to recovery. We may be observing the change from the breakdown of the patient's innerworld into psychotic disorganization of self-other representations to a reconstitution at an interpersonally barren but narcissistically satisfying defensive level of object relations that allows some degree of psychic equilibrium (Ryan & Bell, 1984, p. 213).

2. Pre-therapy interpersonal attitudes and psychotherapy outcome.

It is likely that the kinds of self descriptors a person checks on a psychological

questionnaire is likely to be interwoven with the person's internal object relations. In this regard, a study by Filak, Abeles, and Norquist (in press) appears relevant. These authors assessed clients' pretherapy interpersonal attitudes in relation to psychotherapy outcome. The attitudes assessed were along the interpersonal dimensions affiliation versus hostility, or acceptance versus rejection of others, and dominance versus submission, or acceptance versus rejection of self. The question was to what extent would clients' pretherapy attitudes of affliation versus hostility be prepotent variables in response to psychotherapy? The authors found that 72%, or 21 out of 29, of the patients whose predominant pretherapy interpersonal stance was characterized as affiliative had successful outcomes, as rated by both therapist and client, whereas only 38%, or 10 out of 26, of the clients whose predominant pretherapy interpersonal stance was characterized as hostile had successful outcomes. No significant differences were found on the pretherapy dominant-submissive dimension in relation to outcome; however, a significant number of successful therapy clients showed a pre- versus post-therapy shift in their interpersonal attitudes from one of submission to one of dominance.

The results suggest the importance in psychotherapy (and in other interpersonal relationships) of prepotent attitudes about the self, about the self in relation to others, and about others which will affect the course of the interaction. In the above study it was found that a person's description (or understanding or interpretation) of their interpersonal attitudes reflecting affiliation versus hostility, appeared to effect their adaptation to therapy. In addition, to the extent that interpersonal attitudes changed as a result of therapy, as was evident in clients' changes from a submissive to a dominant orientation reported above, it can be wondered: to what extent had clients' internal object relations (i.e. (hypothesized) relatively enduring psychic structures and organizations) changed or been altered?

3. Changes in personal constructs from psychotherapy

Large's (1976) single case study of psychotherapy outcome using the Kelly Role Construct Repertory Grid is suggestive of and relevant to the area of research being developed here. Large looked at changes in the kind of constructs and configuration of constructs from a six-month participation in a small psychotherapy group. Large found at posttherapy that there was a dramatic change in the client's constructs. There was no longer a tight clustering of constructs along one dimension, but rather a greater range of constructs varying in themes. There was also an inclusion in the construing system of more interpersonal types of constructs. While there were similar assessments of the self on the old coping constructs (pre-psychotherapy constructs), there was a more positive view of self in relation to the newer post-psychotherapy constructs.

The patient in this study had made no changes in symptom improvement. The presenting problems were exhibitionism and feelings of anxiety, depression, inadequacy, low self-esteem, and a poor body image. No symptom changes were evident on the Eysenck Personality Inventory or the Beck Depression Inventory. Yet, both the patient and therapist were left with a subjective impression of psychotherapy change. Large points out that this is not an uncommon experience in psychotherapy.

These "changes" in the client were evident on the Repertory test. The test results reflected the "impression that the patient had become less defensive and had shown some personality growth, dropping his emphasis of adequacy and widening his view of the world, becoming a more accepting, accessible person" (Large, 1976, p. 319). Large concludes that the study's findings reflect client changes not covered by more abstract inventories and symptom bound criteria and lends support to more subtle and subjective impressions of change.

Large's findings can be used to highlight a few issues relevant to the present investigation.

For one, Large found changes from psychotherapy that are not usually studied directly in the psychotherapy outcome assessment. These changes in the client's self (and perhaps other) constructs, and in the client's shift to a wider range of constructs suggest that the changes occurred in the areas of current concern: self and other representations. As Large proposed, these changes may usually be reflected only in broad outcome questions such as clients' and therapists' reports of clients' "improvement" or ""change". While a detailed list of symptom changes are ofted used in the assessment of outcome, psychotherapy research has not objectified or differentiated changes in self and other representations. Horowitz (1979) points out the inconsistency that psychotherapy is largely an interpersonal enterprise but that outcome is based primarily on diagnostic and symptom criteria.

In line with the other literature reported here, Large's (1976) study suggests the importance of self and other representations in understanding psychotherapy outcome. While Large found his change measure to be unrelated to symptom changes, it should be kept in mind that his research involved primarily pinpointing an area of assessment and change not covered by traditional outcome measures. It was not an intensive investigation of symptom-construct correlates. Based on the theory presented earlier, we are more likely to think that there is some correspondence between self and other representations and psychological symptoms.

The Projective Hypothesis

This section is included to orientate the reader to the projective hypothesis involved in this research. This section also highlights the fact that the rationale of this study, that is, the projective investigation of clients' self and other representations, could be grounded in the theory of projective techniques as readily as in the theory of psychoanalytic psychology.

The idea that one's personality, motivation, attitudes, etc. influence our perceptions of

the outer world has been a cornerstone of psychological thinking for some time. The term "projection" was initially given to the psychopathological elements of this phenomena by Freud in 1911, but later, Freud and others broadened the applicable phenomena labeled projection (Rabin, 1981). Projection came to define:

> a graduated continuum... extending from the internalization of a specific type of tension in paranoid projection to that of any kind of tension in infantile projection, to that of a whole system of attitudes and tensions in transference phenomena, to where it inperceptibly shades into externalization in the form of a private world defined by the organizing principles of one's personality (Rapaport, 1952 cited in Rabin, 1981).

The two major areas in which people's projective material has been explored has been in psychotherapy under the rubric of transference and in the area of projective tests. The essential feature of a projective test or technique is that "it evokes from the subject what is in various ways expressive of his private world and personality processes" (Frank, 1948, cited in Rabin, 1981). Generally, a key aspect of the elicitation process was considered to be an inherent ambiguity in the projective device, be it the analyst or the projective test. It is beyond the scope of this investigation to determine whether it is ambiguity per se and/or stimuli which may elicit various interpretations which is the important ingredient of a projective device. Nevertheless, with the expanding horizons of what is considered under the rubric of projection, and the understanding of transference phenomena as being a central aspect of all human relations, comes the understanding that all interpretations or constructions of self and others may have a predominant projective component. Few would dispute that one's understanding of others is, in part, a reflection of one's personality, needs, etc. In modern psychology, the issue is the extent to which representations are reality-based

and the extent to which they are projective (or "narrative"). Some schools of thinking, for instance, the narrative school of psychoanalysis, would either discard the issue of reality versus projective-based perceptions as irresolvable or irrelevant to treatment, or else take the extreme view that all perceptions of self, others, and personal history are constructions or projections (see for instance, Spence, 1982; see also, Greenberg & Mitchell, 1983 for issues bearing on this topic). The view taken here is that a person's self and other representations, in themselves (e. g., without a consideration of the actual objects impinging on or having affected the person), can illuminate the psychological life and development of the person.

Overview of Study

This study attempts to assess the quality of object representational level directly from client's verbal discourse in psychotherapy. One can imagine some potential difficulties of this task. One difficulty is that in comparison to projective assessment using tests, verbal discourse appears less structured than the most unstructured projective tests. Clients appear free to talk about anything they wish, and it can be imagined that there is probably a great range in the content and process of clients' discourse. Organizing such unstructured material is likely to present some initial difficulty. In addition, in the assessment of representations from verbal discourse, there appear to be no natural stimulus properties along which to assess the quality of response, as for instance with Rorschach comparing form versus color activated responses. Probably the greatest difficulty is the lack of previous research upon which known variables in verbal discourse have been established. For instance, when doing Rorschach analyses, an investigator knows that responses vary in form quality, quality of human figures, and human movement, etc. The relatively novel approach of assessing the kind and

quality of object representations in verbal discourse involves both the selection of likely relevant variables along both structural and content considerations, and the development of suitable methodology with which to implement the task. Nevertheless, the fact that there are other projective approaches enables the use of analogies from projective assessment to set up relevant kinds of investigation.

The potential advantages of assessing object representations via verbal discourse can also be imagined. For instance, unlike the Rorschach which contains one general category for human figures and responses, verbal discourse analyses allow the possibility of a number of categories such as mother, father, and generalized other categories. Verbal discourse also more clearly parallels a natural and spontaneous setting as opposed to whatever limitations are imposed by the introduction of a specific test or task, and whatever limitations are imposed by the structure of the particular task. In addition, regarding the viability of psychotherapy outcome research, the client, therapist, and the clinic setting are unencumbered by the introduction of projective testing. Outside of the consent to be taped, clients are not burdened with lengthy testing and are not asked to take the same test through the course of treatment. The analysis of representations from verbal discourse, if viable, provides one of the least intrusive methods of psychotherapy investigation.

A. Summary perspective

> From its origin in concrete experience and a real interpersonal situation, each personification has itself had a developmental history which is in turn completely understandable in terms of the functional adequacy of the person in the series of interpersonal situations which he has had to live (Sullivan, 1936, p. 79).

The way a person describes others and self, that is, the particular content and quality of the descriptions is likely to reflect some psychological aspects of the speaker. The reviewed literature suggests that what is reflected in the speaker may be nothing short of the psychological life, organization, or developmental level of the speaker. This perspective has two key features. One is that object representations are proposed to reflect psychological aspects of the speaker. The other is that psychological features portrayed are likely to be fundamental aspects of psychological functioning. Regarding the later point, the author considers it important to propose the "metaconstruct" nature of the psychological aspects thought to be reflected by object representations. Not to attempt this appears to undermine the potential worth of this variable.

B. Summary of study's purpose

This study has two major purposes. One is to attempt to obtain meaningful dimensions of object representaions from client's verbal discourse in psychotherapy. The other purpose is to investigate the relation between the kinds and qualities of object representations and psychopathology and psychotherapy outcome.

C. Overview of object representational variables

This section provides an overview of the object representational variables that will be used to assess client's verbal discourse. The variables are grouped into four types: structural, content, and category measures, and the Krohn and Mayman's Object Representational Scale for Dreams.

1. Structural variables

Structural variables refer to those variables that appear to assess more of the formal aspects of representational material than to its content consideration. Similar to the formal aspects of Rorschach investigation, there appear to be naturally occuring formal dimensions in verbal speech. Among perhaps numerous formal variables, the present author noticed four variables that occur in verbal speech. Three of these, *articulation*, *specificity*, and *clarity*, appear related to Werner's theoretical ideas involving increasing differentiation and specificity with increasing development. The other variable, *definity*, was devised based on the author's observation that a good percentage of verbal speech contains qualification. These scales are discussed further in the method section and in Appendix A.

2. Content Scales

The idea that object representations which show warmth and acceptance towards others are on a higher developmental level and/or are more indicative of psychological health is a recurrent theme throughout the literature review. The following content scales are used in this study: 1) self-acceptance or level of self-esteem, 2) level of self-efficacy, 3) movement towards others versus movement away, 4) hostile versus affiliative, 5) cold versus warm, 6) gentle versus harsh, and 7) accepting versus rejecting. In addition to these scales, the study employs Hurley's (1980) scales related to self-acceptance versus rejection of self (ARS) and self-acceptance versus rejection of others (ARO).

All the content scales are simple bipolar dimensions (shown in Appendix B). The self-acceptance scale and the level of self-efficacy are scales assessing attitudes towards the self. These two scales are likely to be pooled to represent the *self-acceptance* dimension. Movement towards others and hostile versus affiliative scales assess the dimension of *likes others*. The other three scales, cold versus warm, gentle versus harsh, and accepting

versus rejecting, taken from Hurley's (1980) scales, will be utilized to assess how *others are represented to be* in contradistinction to how one relates to others. This enables, for one, an examination of whether there are similarities and differences between how the speaker orients towards others (self-acceptance-rejection of others) and how others are represented as being towards others, including the speaker (others' acceptance versus rejection of others). The Hurley scales ARO and ARS will be used in their entirety also in the more traditional way of assessing speakers attitude towards self and others.

3. Category Counts

The category counts was suggested by the client-centered research (Raimy, 1949; Sheerer, 1949; Stock, 1949) which investigated both the number of positive and negative references and also looked for differences between categories, such as primary relationships versus secondary social relationships or generalized other. One interesting finding using the category approach was that attitudes towards the self correlated more highly with attitudes towards social relationships and generalized others than it did towards other categories such as family relationships. It is likely that different categories vary in their capacity as projective devices and that some categories such as *generalized other* may be especially suited for ridding the self of certain feelings or thoughts. When a person says, for instance, "people are masochists", we can wonder if the statement is used by the speaker as a vehicle for discharge of some psychic tension. It may be that all object representations, both generalized ones and references about specific people, besides being reflective of a person's developmental psychological organization, are used as vehicles for working out uncomfortable psychic tensions or feelings.

4. Krohn and Mayman's Object Representational Scale for Dreams (The Krohn Scale)

The Krohn scale has been used with Rorschach, TAT, and early memories material, and it appears easily suited to any type of verbal material. This scale appears to measure a dimension of psychic material not assessed by the other scales in this study. It is based on a detailed proposition of psychic development beginning with a stage in which the world appears totally chaotic and random and progressing to a developmental stage in which the person appears able to comprehend quite well the thoughts, feelings, and motivations of another. The developmental sequence of the stages also correspond to psychoanalytic developmental psychology ranging from a psychotic psychic organization through various other faulty organizations to a fully developed psychic capacity.

The Krohn scale appears to be a measure of internal object relations. It seems to measure the underlying psychic organization from which object representations are generated, which is the definition of internal object relations proposed by Kernberg. As a measure of internal object relations, this variable not only can be used to assess its relation to psychopathology and response to treatment but can also be used to explore the relation between internal object relations and the various measures of object representations used in the study.

HYPOTHESES

The purpose of the present study is to make an exploratory investigation into the relationship between the kinds and qualities of object representations found in a sample of clients' verbal discourse and 1) clients' psychopathology, and 2) the outcome of psychotherapy. Four kinds of variables serve in the investigation of object representations in clients' verbal discourse. These are 1) the Krohn and Mayman Object Representational Scale which is proposed by the present author to be a measure of internal object relational development, 2) the structural variables, *definity*, *articulation*, *specificity*, and *clarity*, which assess more of the formal qualities of a person's speech, 3) the content variables which primarily assess the degree of warmth and acceptance in clients' object representations, and 4) the category count variables which provide an estimate of clients' usage of various object representational categories.

The study uses quite a few measures of clients' psychopathology. These are 1) clients' responses to a symptom checklist which are scaled on nine symptom dimensions and a global pathology index, 2) clients' interpersonal pathology scores on the Interpersonal Checklist (the intensity measure called *A/N*), 3) ratings of clients' psychopathology provided at pretherapy by the clients' intake workers and at post-therapy by clients' psychotherapists, and 4) ratings of clients' psychotherapy based on judges readings of sample verbal discourse. Psychotherapy outcome is assessed using selected clients' and therapists' posttherapy ratings of outcome.

Based on the above discussion, there are eight hypotheses thus far-- a comparison of the four kinds of object representational measures with both clients' psychopathology and psychotherapy outcome. Each of the four object representational variables will be measured

in the same way for both the psychopathology and psychotherapy outcome comparisons. For the former (i.e., psychopathology comparisons), data sets are available to provide analyses at both pre- and post-therapy.

The first eight hypotheses formally listed are as follows:

Hypothesis I: The Krohn scale will be significantly related to clients' psychopathology.

Hypothesis II : The structural scales *articulation*, *definity*, *specificity*, and *clarity* will be significantly related to clients' psychopathology.

Hypothesis III : The content scales will be significantly related to clients' psychopathology.

Hypothesis IV : There will be a discernable pattern of significant relationships between clients' usage of referents within various categories, particularly negative referents and psychopathology.

Hypothesis IV is more of an exploratory hypothesis, thus it is stated very generally. It is set up to make a general investigation to determine whether clients' usage of referents within various categories (for example, the generalized other category) is associated with psychological distress.

Hypothesis V: The Krohn scale will be significantly related to both client-rated and therapist-rated outcome.

Hypothesis VI: The structural scales *articulation*, *definity*, *specificity*, and *clarity* will be significantly related to both client-rated and therapist-rated outcome.

Hypothesis VII: The content scales will be significantly related to both client-rated and therapist-rated outcome.

Hypothesis VIII: There will be a discernable pattern of significant relationships between clients' usage of referents within various categories particularly negative referents and both

client-rated and therapist-rated outcome.

In addition to the above analyses, two other analyses are planned using the Krohn scale. One analysis is based on the fact that the Krohn scale is likely to provide a significant measure in its own right of psychological functioning and psychological development. The scale is likely to be a measure of internal object relations development which has been proposed to be not quite synonymous with psychopathological versus normal functioning and apparently also includes some aspects of ego-psychological development. The other object representational measures, such as level of warmth and acceptance in representations, or level of articulation of statements, unlike the Krohn scale, have not as yet been consistently related to any kinds of psychological organizations. A comparison of clients' Krohn scores with these other measures of object representations could provide important information along two perspectives. One would be the determination of which easily observable object representational variables in speech, as for example, use of generalized other statements, are related to internal object relational development. Conversely, correlations obtained between the Krohn scale and the object representational measures may help illuminate some object representational variants of internal object relational development. In more abstract terms, the first additional data analysis can provide information on the relation between internal object relational development and object representational variables.

Hypothesis IX: The object representational measures hypothesized to be related to psychopathology and psychotherapy outcome will be related to scores on the Krohn scale.

The other data analysis involves further investigation between clients' scores on the Krohn scale and client functioning and response to psychotherapy. This hypothesis was developed post-hoc to the ratings of the transcripted material but previous to the statistical analyses

involving the Krohn scale. Post-therapy client and therapist questionnaires are available which can provide a more detailed examination between client and therapist response evaluations and clients' developmental functioning. It is hypothesized that clients' analyses of their psychotherapy and their relationship with their therapist will be significantly affected by their psychological developmental level. This analysis involves a prediction that developmental level will affect post-therapy ratings and so an analysis of variance design is in order. All other data analyses in this study involve correlations.

Hypothesis X: An analysis of variance using groups divided on level of psychological development as the independent variable and using post-therapy clients' and therapists' questionnaire responses as the dependent measures will show many significant relations. It is predicted specifically that: 1) both clients' and therapists' assessments of clients' functioning will be significantly affected by clients' developmental functioning, and that 2) clients' post-therapy assessments of their psychotherapy experience will be affected by their developmental functioning.

METHOD

Data

This study used data collected over a two year period (September, 1978 through June, 1980) for research purposes at the Michigan State Psychological Clinic, an outpatient clinic serving non-student members of the Michigan State University community and surroundings. The clinic is a training and research agency of the Department of Psychology and serves as a low cost clinic to adults, children, and families. The original data collection was based on the premise of obtaining relatively nonintrusive information on clients coming to the clinic. The purpose of the data collection was to provide later information on the process and outcome of therapy. The data for the present investigation consisted of psychotherapy tapes and pre- and post-therapy measures.

The psychotherapy sessions at the clinic were taped on the first, third, and then every fifth session until termination. Occasionally a defective record required an alternative taping near one of these sessions. For this study, the time points of interest were the beginning and the end of therapy. The first two taped sessions (usually the 1st and 3rd and occasionally the 8th) and the last two taped sessions (e.g., 18th and 23rd) were considered, respectively, the beginning and the end of therapy.

From the two tapes (occasionally one) used to represent the beginning of therapy and two tapes (occasionally one) used to represent the end of therapy, client transcript material was derived (see Appendix E for more detailed description of tapes used). Approximately 20 minutes of client verbal discourse was obtained per client: 10 minutes representing the beginning of therapy and 10 minutes representing the end of therapy. The sample of client material was obtained using a stratified random sampling procedure. On a tape recorder where

the counter averaged 800 units per session, samples were obtained at approximately points 200-225, 300-325, 400-425, 500-525, and 600-625. When a section of blank tape was found, the typist would rewind to a nonblank section. The typist sampled until, on the average, a page and a quarter was obtained per session. This yielded approximately 5 pages of verbal material per client.

The typist was instructed as follows: "Write down everything the client says except last names and pass over therapist remarks. Organize paragraphs or statements on the basis of all client words spoken between therapist remarks or until there is more than a few seconds pause in client's speech, suggesting a natural break in a paragraph or statement." The typist was also asked to number the sections 2 through 6, corresponding to the stratified samples (i.e., 200-225, 600-625) obtained. The division of these sections proved useful for rating some of the scales. The typist reported no difficulty in completing the assignment. The typist's work was not monitored; however, the product quality appeared satisfactory. A sample transcript is shown in Appendix D.

In addition to the transcripts obtained, there were a number of paper-and-pencil questionnaires. The data set at the beginning of therapy consisted of the transcript material plus client's SCL-90R and ICL, and intaker's SCL-90A. The data set at the end of therapy consisted of the transcript material plus client's SCL-90R and ICL, therapist's SCL-90A and client and therapist posttherapy questionnaires.

Besides client and therapist data, each set of transcripts was rated on a number of object relations scales. The transcript material was also utilized to rate client's psychopathology using questions selected for this study (see Appendix C).

Clients

Forty-eight adult clients who received outpatient individual psychotherapy served as

subjects in this study. The mean number of sessions was 24, generally offered on a once-a-week basis, and the range was from 5 to 71 sessions. The 48 clients were composed of 28 women (58%) and 20 men (42%). The mean age of the sample was 29.4 with a range of 20 to 57. The majority of these clients had an annual income of $10,000 or less. However, diverse income levels were represented, ranging from an annual income of $2,000 to $73,000, with a mean of $12,500 (more specific client data can be found in Appendix E, p. 114). These 48 clients represented 36% of all adult patients who had received an intake interview at the clinic and who agreed to participate in research. Thirty-six percent represented those clients who had not only all pretherapy and posttherapy forms needed for this study but also audible early and late psychotherapy tapes. This percentage is much lower than other reported university psychotherapy projects such as at the University of Pennsylvania where 66% of an available pool was used for a comparable investigation (Luborsky, Mintz and Auerbach, et al, 1980). Part of the discrepancy between the reported Penn statistic and the present figure is that the Penn statistic excluded all clients who had not begun therapy. In this sample, the attrition from intake participation was due primarily to referals to other agencies because of lack of openings, lack of a coordinated and vigorous followup to obtain posttherapy forms from clients, early dropouts (0-2 sessions), and seven clients who had either incomplete or inaudible audio tapes.

Therapists

The therapists were comprised of all clinicians at the clinic who consented to take part in the clinic's research. This included the full range of staff from beginning practicum students to experienced Ph.D. clinical psychologists. Yet, the predominance of the cases involved therapists who were advanced clinical psychology Ph.D. candidates serving half-time

internships at the clinic. These individuals were usually fourth and fifth year clinical students with M. A. degrees.

The 48 clients were seen by a total of twenty-four therapists. The average number of clients per therapist was two, with a range of one to five. Seven of the therapists worked with three or more clients for a total of 24.

Raters

The author made all object representational scale ratings. The structural scales, Definity, Specificity, Clarity, and Articulation were rated first. After completion of these for all clients, the content scales were rated, and after their completion the Krohn scale was rated. The author had no knowledge of any psychopathology or psychotherapy outcome scores of the therapy subjects. All ratings were done prior to investigation of these scores.

A small subsample of the transcripts was rated by another rater to obtain interrater reliability estimates. The second rater was an undergraduate student who was interested in gaining research experience and who received research credits for her participation. The second rater's scores were used to obtain the interrater reliability estimates only. The actual rating scores used for subsequent analyses were exclusively rated by the author.

For another set of scales, which included Hurley's ARO and ARS scales and psychopathology scales for external judges, two graduate students in clinical psychology did the ratings. Both these students had two years of psychotherapy experience and both had M.A. degrees in psychology.

The category variable counts, which involved listing the positive and negative references for each category group, were made by the undergraduate rater mentioned above. The decisions regarding which category (e.g., mother versus father category) the referent was

assigned to, as well as deciding whether the referent was positive or negative in tone, was fairly straightforward and did not appear to require a reliability check. The present author reviewed some of the rater's arrangement of the data into the categories and into positive and negative groups, and was satisfied with the rater's organization of the data.

Instruments

A. Object Representational Scales

1. Object Representational Scale for Dreams (Krohn & Mayman, 1974). This scale ranged from a low of one to a high of eight. Ratings roughly correspond to the continuum of psychotic, borderline, narcissistic, neurotic, and normal. The scale was accompanied with detailed clinical descriptions of each scale point, as well as two illustrative dreams for each point. Good construct validity has been established for the scale (see Krohn and Mayman, 1974). (Appendix G shows example ratings of transcript material).

2. Structural Scales: Definity, Specificity, Clarity, and Articulation. These scales were devised for this study based mostly on the theoretical ideas of Heinz Werner. The scales were devised after the author examined client material both from his own clinical work and from some of the transcripts in the study. The scales were based on what appeared to be naturally occurring features of the verbal material. Appendix A shows the structural scales, and their description.

3. Content Scales: These scales were also devised for this study based on what the literature suggested were common important content dimensions. The content scales are shown in Appendix B.

4. Category Count Variables: These categories were devised based on the client-centered work listed in the text. The categories in the present study are *self, mother, father, other family members, intimate, social relationships, therapist, and generalized other*. *Other family members* includes children, siblings, and grandparents. *Intimate* refers to the person's past and present primary relationship(s), if any, such as spouse. *Social relationships* includes friends, acquaintances, teachers, students, and other types of role relationships. *Therapist* includes all therapists, past and present. The *generalized other* category refers to references such as people, "they", everyone, anyone, etc., plus all groups of people such as teachers, psychologists, Negroes, policemen, foreigners, bus drivers, etc.

5. ARO, ARS (Hurley, 1980): ARO and ARS are construct names which refer to the two salient dimensions found in interpersonal relating (see Wiggins, 1983; Conte and Plutchik, 1981). *Acceptance vs. Rejection of Self* was composed of a summary score from the following bipolar scales, *Shows Feelings-Hides Feelings, Expressive-Guarded, Active-Passive*, and *Dominant-Submissive*. *Acceptance vs. Rejection of Others* was composed of a summary score from the following bipolar scales, *Warm-Cold, Helps Others-Harms Others, Gentle-Harsh,* and *Accepts Others-Rejects Others*. The bipolar scales range from 1 to 7; ARO and ARS therefore can range from 4 to 28. The bipolar scales are shown in Appendix B.

B. Rater Pathology Ratings

In addition to intakers', therapists', and clients' own self-ratings of psychopathology, external judges rated psychopathology ratings based on transcripted material. These judges, who were MA level clinicians with two years of psychotherapy experience, were not trained

for these ratings. Similar to other investigations involving psychologists as raters, these raters were asked to rate clients' psychopathology from their own established and professional point of view. General questions assessing pathology (shown in Appendix C) such as "How disturbed do you think this client is?" were gathered. Composite psychopathology ratings were planned to be pooled from these items.

C. Paper-and-Pencil Measures of Pathology

1. SCL-90 (Symptom Checklist, Derogatis, 1977).

a) Client form (SCL-90R): This measure consisted of 90 statements of problems. The problems comprised and loaded nine symptom dimensions and a global severity index. The symptom dimensions were somatization, obsessive-compulsiveness, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Clients were instructed to check those statements that were current problems for them and to rate the degree of distress (0-4) associated with each problem. Derogatis (1977) provided extensive evidence of the validity of this instrument.

b) Clinician form. (SCL90A, Derogatis, 1977). This consists of the same nine symptom dimensions and one global pathology index. Clinicians rate clients directly on these dimensions on the degree of symptomatology present on a 0-6 scale.

2. Interpersonal Checklist (ICL, Leary, 1957). The ICL contains 128 behavioral objectives intended originally to correspond to 16 or 8 interpersonal styles. Two major factors, dominant-submissive, and love-hate, undergird the circular ordering of the ICL items. In this study, the octant formula (Leary, 1957) for deriving axes scores was used.

D. Outcome Measures.

1. Post-Therapy Questionnaire Client Form. A 56-item client form (Strupp, Lessler & Fox, 1969, shortened version) was given to clients at the termination of therapy. This form tapped the client's subjective beliefs about the effectiveness of their therapy. Four questions ("How much have you benefitted from therapy?", "How satisfied are you with the results of your psychotherapy experience?", "To what extent have your complaints or symptoms changed?", and "How much have you changed as a result of your psychotherapy experience?") were pooled to represent client-rated outcome.

2. Post-Therapy Questionnaire Therapist Form. A 33-item therapist form included ten questions on the SCL-90A and 23 questions relating to the therapist's subjective beliefs about the effectiveness of therapy (Strupp et al, 1969, shortened version). Two questions ("Degree of client symptomatic improvement?" and "Overall success of the therapy?") were pooled to represent therapist-rated outcome.

Procedure

Adults who requested therapy at the clinic received an intake interview. At this time, the clients who agreed to partake in the clinic's research completed the SCL-90R, among other questionnaires. Intake workers were also required to write a case description and the case then became available for distribution. Clients were then selected by therapists, usually on an availability basis, and in consultation with supervisors. Some clients were assigned for therapy to their intake workers, but most were assigned to other therapists. At termination, clients and therapists completed posttherapy questionnaires which included their versions of the SCL-90R. These research forms were coded and filed, and neither clients nor therapists had access to these coded forms.

RESULTS

Interrater Reliabilities

The interrater reliabilities for the object representational scales are shown in Table 8. These reliabilities are based on a comparison of a small sample of the author's ratings (12 out of 96) with ratings by an undergraduate research assistant. The assistant was given only about an hour's instruction on the theory underlying the Krohn scale before using that scale. For the rest of the scales the assistant used the accompanying instructions and definitions only. Results show that statistically significant but only marginal to fair reliabilities were obtained for the structural scales and the Krohn scale, and generally weaker and nonsignificant reliabilities were obtained for the content scales.

Table 8

Interrater Reliabilities for the Object Representational Scales

Scale	N	Correlation	Scale	N	Correlation
STRUCTURAL SCALES			CONTENT SCALES		
Definity	13	.50*	Self-Acceptance	12	.29
articulation	13	.79***	Self-Efficacy	12	.12
Specificity	12	.67**	Movement Towards	12	.32
Clarity	12	.49*	Others		
KROHN SCALE	14	.66**	Affiliative vs. Hostile	12	.24
			Warm vs. Cold Others	12	.47
			Harsh vs. Gentle Others	12	.17
			Accepting vs. Rejecting	12	.53*
			Others		

* $p < .05$; ** $p < .02$; *** $p < .01$

Regarding the reliabilities between the graduate student raters on the Hurley scales and on the psychopathology ratings of clients, correlations were surprisingly low and often negative to a statistically significant degree. The author can not explain why the interrater reliabilities were so low. In part, these scales seem to have been the most adversely affected by the weak training given raters in the study. These raters appeared to be rating psychopathology from quite different perspectives. Further examination of their ratings showed little correspondence between either raters' ratings and therapist or client ratings. This suggests that rating clients from these sample transcripts may have been difficult.

The author's decision to drop these variables from the study did not threaten the integrity of the study. The content scales basically overlap with the Hurley scales, which enable the test of the dimensions self-acceptance and acceptance of others to be preserved. The raters' psychopathology ratings of clients was meant only to provide an additional perspective. The study retained psychopathology ratings by clients', therapists,' and intake workers'.

Pre-Post Stability Correlations for the Variables.

Table 9 (p. 53) shows the pre-post stability correlations for the Krohn scale and the structural and content scales. Variables "SELF-ACCEPTANCE", "LIKES OTHERS", AND "KIND OTHERS" are composites of the respective measures listed above each. Only these composites were used in subsequent analyses. Table 9 shows that the Krohn scale had very good stability, and the structural and content scales had fair stability. These findings need to be qualified by the fact that the author rated each pre and post client transcript sequentially for each scale and consequently these stability correlations were likely inflated.

Table 10 (p. 53) shows pre-post stability correlations for the category count variables. Category count variables are the number of references made within each respective category. As

Table 9

Pre-Post Correlations for All Object Representational Measures (n = 48).

Scale	Correlation	Scale	Correlation
STRUCTURAL SCALES		Movement Towards	.37**
Definity	.50***	Others	
Articulation	.58***	Affliative vs Hostile	.32*
Specificity	.61***	LIKES OTHERS	.41**
Clarity	.62***	Warm vs. Cold Others	.43**
KROHN SCALE	.87***	Gentle vs. Harsh Others	.43**
CONTENT SCALES		Accepting vs. Rejecting	.33*
Self-Acceptance	.46***	Others	
Self-Efficacy	.40**	KIND OTHERS	.43**
SELF-ACCEPTANCE	.46***		

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 10

Pre-Post Correlations for Category Count Variables (n = 48).

Category	Correlation	Category	Correlation
Self Positive	-.11	Intimate Positive	-.01
Self Negative	.17	Intimate Negative	.01
Mother Positive	-.14	Social Positive	.01
Mother Negative	.27	Social Negative	.46***
Father Positive	.11	General Positive	-.06
Father Negative	.13	General Negative	.18
Family Positive	.10	Therapist Positive	.07
Family Negative	.33*	Therapist Negative	.11

* $p < .05$; ** $p < .01$; *** $p < .001$

illustrated, only two showed perceptible pre-post consistency.

Correlations Among Types of Object Representational Variables.

Table 11 (below) shows the structural scales' pre- and post-correlations. As can be seen, the variables Articulation, Specificity, and Clarity were substantially correlated, implying that these variables could be aggregated to form a measure -- ARTICULATION. This variable measured the degree to which an idea, thought, or feeling in verbal discourse is articulated, developed, and explained. "Definity", which measured the degree to which the speaker makes a commitment to a statement, was not significantly related to the other three scales.

Table 11

Correlations Among the Structural Object Representational Scales for Pre and Post Therapy (n = 48).

	PRE				POST			
	Def.	Art.	Spec.	Clar.	Def.	Art.	Spec.	Clar.
Definity	-	.24	.35*	.23	-	-.14	.17	.11
Articulation	-	-	.72***	.80***	-	-	.60***	.78***
Specificity	-	-	-	.74***	-	-	-	.80***
Clarity	-	-	-	-	-	-	-	-

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 12 (p. 55) shows the pre- and post-correlations between the three composite content variables. These variables were: 1) the degree of self-acceptance or self-liking (SELF-ACCEPTANCE), 2) the degree of other-liking (LIKES OTHERS), and 3) the degree to which others were represented as benign (KIND OTHERS). As shown, there were significant relationships between these variables. This needs to be qualified by the fact that the author made all content ratings for each client on the same occasion, increasing the likelihood of

Table 12

Correlations among the Content Object Representational Variables (n = 48).

	PRE			POST		
	SELFACC	LIKEOT	OTHER	SELFACC	LIKEOT	OTHER
SELF-ACCEPTING	-	.30*	.41**	-	.36*	.39**
LIKES OTHERS	-	-	.46***	-	-	.54***
KIND OTHERS	-	-	-	-	-	-

* $p < .05$; ** $p < .01$; *** $p < .001$

confounding them. Nevertheless, the relationships between these variables can be taken as meaningful. As would be expected from the literature, self-acceptance and other-acceptance (LIKES OTHERS) were modestly correlated (but shared only about 16% of their covariance). Also, the degree to which a person likes others was significantly correlated with how benignly she/he depicted others.

Another set of correlations involved comparisons between the category count variables for both pre- and post-therapy. The findings showed that the positive counts of a category (e.g., social) usually correlated with the negative counts of the same category. This finding may merely be an artifact of clients' usage of the categories. In other words, a client who talked about his father, for instance, relative to a client who did not, was more likely to make both positive and negative father references. No other consistent relationships were found among the category count variables.

Object Representations and Psychopathology

A. **Hypotheses** I (The Krohn scale will be significantly related to clients' psychopathology.)

Hypothesis I compared the relationship between clients' scores on the Krohn scale and clients' psychopathology ratings (note: some of the therapists' psychopathology ratings of clients

are covered in Hypothesis X). The first line of numbers in Tables 13 and 14 shows the results. Variables *Som* through *GPI* refer to the 10 specific symptom scales of the SCL-90R. *AIN* refers to the ICL intensity index, with higher intensity scores reflecting greater interpersonal pathology. *Intake* and *Ther* refer to global pathology ratings made by intake workers at pre-therapy and therapists at post-therapy. The results show that the Krohn scale related significantly to 3 of these 12 psychopathology measures on both occasions and that a total of 10 out of the 24 comparisons were significant. Using GPI scores to represent the SCL-90R's

Table 13

Correlations Between Structural Object Representation Measures and *Pre*-therapy Psychopathology Indices (n=48).

	Som	Ob	Int	Dep	Host	Anx	Phob	Para	Psy	GPI	AIN	Intake
KROHN	**-.39***	**-.30**	-.18	-.25	-.05	-.26	**-.36**	-.23	-.24	**-.30**	**-.37**	**-.33**
DEFINITY	-.01	.03	.12	-.05	.03	-.08	-.14	-.04	-.09	-.03	.05	-.00
ARTICU	-.03	-.07	.08	.00	.11	-.10	-.15	.00	.03	-.01	-.05	-.26

* Significant correlations in boldface ($r \geq .28$, $p < .05$; $r \geq .37$, $p < .01$).

Table 14

Correlations Between Structural Object Representation Measures and *Post*-therapy Psychopathology Indices (n=48).

	Som	Ob	Int	Dep	Host	Anx	Phob	Para	Psy	GPI	AIN	Ther
KROHN	-.18	-.13	**-.28***	-.24	-.11	-.19	**-.35**	-.25	-.26	-.26	**-.28**	**-.50**
DEFINITY	.19	-.04	.14	.06	.23	.16	.12	.16	.04	.15	**.41**	.18
ARTICU	-.13	-.06	-.10	-.02	.08	-.07	.07	.11	-.03	-.02	.14	.03

* Significant correlations in boldface ($r \geq .28$, $p < .05$; $r \geq .37$, $p < .01$; $r \geq .45$, $p < .001$).

best single psychopathology index (Derogatis, 1977), the Krohn scale correlated significantly with five out of six interdependent assessments (the SCL-90R pre- and post-, the ICL's AIN measure pre- and post-, and intake workers' and therapists' psychopathology ratings) of clients' psychopathology. However, the amount of covariance shared between the Krohn scale and these psychopathology measures was generally small and averaged only 12 percent. Nevertheless, the pattern of results provided support for the proposed relationship between clients' object relational development as measured by the Krohn scale and psychopathology.

B. **Hypothesis II** (The structural scales will be significantly related to clients psychopathology.)

Tables 13 and 14 (p. 56) also gave these results. Because only one of these 22 correlations was statistically significant, the hypothesis must be rejected.

C.**Hypothesis III** (The content scales will be significantly related to clients' psychopathology).

Hypothesis III was proposed to investigate the relationship between the content of object representations along the dimension of acceptance, and psychopathology. Here three composite content variables were defined: *SELF-ACCEPTANCE* -- the degree of self-acceptance, self-esteem, and degree of self-efficacy, *LIKES OTHERS* -- the degree of affliation, and movement towards others, and *KIND OTHERS* -- the degree to which other people are represented by the client as being gentle versus harsh, warm versus cold, and accepting versus rejecting. As mentioned earlier, these three composites showed modest overlap. This suggested that, taken together, these content variables may have been assessing clients' predominant psychic styles or psychic organizations along a general dimension of warmth, affiliation, self-regard, and acceptance versus hostility, resentment, and rejection.

Tables 15 and 16 show the pre- and post-therapy relationships between the content variables and the psychopathology measures used in this study. As shown in Table 15, these variables linked significantly to so many psychopathology indicators at pre-therapy that it was difficult to discern any particular relationships between the different content indices and particular symptom scales. Table 16, which shows the same relationships at post-therapy, identified many fewer significant relationships (5 vs. 26) although nearly all (33 of 36) these linkages remained negative. Taken together, these pre-therapy and post-therapy results supported this hypothesis.

Table 15

Correlations Between Content Object Representation Variables and *Pre*-Therapy Psychopathology Indices (n = 48).

	Som	Ob	Int	Dep	Host	Anx	Phob	Para	Psy	GPI	AIN	Intake
Self-Acc	**-.35**	**-.41**	**-.43**	**-.52**	-.12	-.23	**-.40**	**-.39**	**-.41**	**-.44**	-.02	-.08
Like Oth	**-.33**	**-.33**	-.12	**-.31**	**-.34**	**-.38**	**-.30**	**-.34**	**-.33**	**-.37**	**-.37**	.12
Kind Oth	**-.40**	**-.40**	-.22	**-.40**	-.25	**-.31**	**-.35**	**-.29**	**-.37**	**-.40**	-.19	.09

* Significant correlations in boldface ($r \geq .28$, $p < .05$; $r \geq .37$, $p < .01$; $r \geq .45$, $p < .001$).

Table 16

Correlations Between Content Object Representation Variables and *Post*-Therapy Psychopathology Indices (n = 48).

	Som	Ob	Int	Dep	Host	Anx	Phob	Para	Psy	GPI	AIN	Ther
Self-Acc	-.05	.01	-.14	-.13	.10	-.12	-.24	**-.32**	-.17	-.14	-.20	-.16
Like Oth	-.25	-.21	-.15	-.18	-.15	-.13	**-.32**	**-.34**	**-.37**	-.27	-.27	**-.46**
Kind Oth	-.07	-.02	-.15	-.04	.22	.01	-.18	-.26	-.17	-.08	-.27	-.24

* Significant correlations in boldface ($r \geq .28$, $p < .05$; $r \geq .37$, $p < .01$; $r \geq .45$, $p < .001$).

D. **Hypothesis IV** (There will be a discernable pattern of significant relationships between clients' use of referents within various content categories, particularly negative referents and psychopathology.)

Hypothesis IV was developed to explore the relationships between the category count variables and the psychopathology indices. Tables 17 and 18 (p. 60) show the findings. As shown in Table 17, only one of these 16 measures (negative general other references) was consistently associated (9 of 11 instances) with psychological distress ratings. However, this pattern was not maintained at post-therapy (Table 18). The results at post-therapy showed

Table 17

Correlations Between Category Count Variables and *Pre*-Therapy Psychopathology Indices ($n = 48$).

	Som	Ob	Int	Dep	Host	Anx	Phob	Para	Psy	GPI	Ain
Self+	.11	-.07	-.03	-.01	.10	.02	.08	-.06	-.04	.01	-.00
Self+	.26	.09	.04	.21	.23	.22	.04	.24	.17	.20	.19
Mother+	-.11	-.07	-.09	-.13	-.04	-.15	-.08	-.06	-.02	-.10	-.06
Father-	.06	-.11	-.15	-.18	.01	-.09	-.10	-.13	-.05	-.11	.06
Father+	.32	.18	.08	.06	-.12	.18	.02	.07	.19	.12	-.09
Father-	.17	.15	.08	.12	-.04	.12	-.04	.11	.22	.12	.07
Family+	-.05	-.09	-.02	-.24	.11	.02	-.06	.04	-.16	.06	-.01
Family-	.09	.07	.13	-.03	.20	.08	-.04	.10	-.03	.08	.01
Intimate+	-.09	-.03	-.01	-.02	.06	.01	-.05	.01	.03	-.01	-.15
Intimate-	.02	-.09	-.03	.01	.09	.14	.04	.03	.11	.07	-.08
Social+	.00	-.01	.02	.03	.26	.17	-.02	.19	.03	.10	.14
Social-	.23	.09	.17	.09	.24	.17	.16	.20	.16	.20	.40
Therapist+	.04	-.01	-.15	.04	-.05	.02	-.02	-.09	-.02	-.04	.04
Therapist-	.10	.25	.12	.27	-.08	.20	.04	.24	.10	.17	.05
General+	.16	.08	.24	.05	.18	.10	.16	.26	.22	.20	.07
General-	**.44***	.33	.21	.29	.23	.40	.46	.38	.42	.42	.51

* Significant correlations in boldface ($r \geq .28$, $p < .05$; $r \geq .37$, $p < .01$; $r \geq .45$, $p < .001$).

Table 18

Correlations Between Category Count Variables

and *Post*-Therapy Psychopathology Indices (n = 48).

	Som	Ob	Int	Dep	Host	Anx	Phob	Para	Psy	GPI	Ain
Self+	-.01	.11	-.07	.08	.05	.01	-.02	-.17	-.07	-.00	-.21
Self-	.01	.19	-.06	.14	-.01	.03	-.01	.00	-.06	.04	-.18
Mother+	.27	.06	.15	.12	.02	.03	.11	.10	-.05	.11	-.09
Mother-	.10	.04	.05	.04	.37	.04	.11	**.29**	.10	.16	.16
Father+	.03	-.17	.01	-.12	.27	-.15	.08	-.06	-.07	-.02	.03
Father-	-.09	.08	-.09	.05	-.14	.07	.09	-.04	-.03	-.12	-.15
Family+	.00	-.16	-.08	-.08	.24	-.13	-.04	-.16	-.11	-.06	-.02
Family-	.12	.27	.13	.23	.24	.07	-.01	-.03	-.10	.14	.15
Intimate+	.06	-.12	-.03	.01	-.04	.03	-.15	-.10	-.20	-.07	-.05
Intimate-	.11	-.06	.08	-.05	-.12	-.04	-.01	-.05	-.15	-.05	-.01
Social+	.11	-.01	.13	.02	.06	.19	**.40**	**.39**	.17	.18	**.59**
Social-	**.39**	.19	**.34**	**.30**	.25	**.34**	**.63**	**.52**	**.61**	**.46**	**.63**
Ther.+	-.03	.01	.08	.08	.09	.14	-.11	-.02	.01	.05	-.12
Ther.-	-.18	-.10	-.07	-.14	-.11	-.08	.02	-.14	-.13	-.13	-.20
General+	-.20	-.09	-.29	-.21	-.18	-.23	-.12	-.22	-.12	-.23	.03
General-	-.05	-.05	-.18	-.21	.19	-.09	.07	-.09	-.09	-.07	-.09

* Significant correlations in boldface ($r \geq .28$, $p < .05$; $r \geq .37$, $p < .01$; $r \geq .45$, $p < .001$).

again that most of these variables were not associated with psychopathology. Two variables which were related to psychopathology were "social other" references (9 of 11 for negative; 3 of 11 for positive).

Taken together, these results weakly supported the hypothesis. Clients' use in terms of frequency of the number of either positive or negative self, therapist, or family references (including father and mother references) showed no relation to psychopathology. However, clients' use in terms of frequency of the number of negative generalized other references and the number of social references bear some relation to clients' psychopathology. The pattern suggests that more pathological clients may have produced more generalized other references at the

beginning of therapy and shifted to the use of negative social references near the end of therapy.

Object Representations and Psychotherapy Outcome

A. **Hypothesis V**. The Krohn scale will be significantly related to both client-rated and therapist-rated outcome.

B. **Hypothesis VI**. The structural scales Articulation, Definity, Specificity, and Clarity will be significantly related to both client-rated and therapist-rated outcome.

C. **Hypothesis VII**. The content scales will be significantly related to both client-rated and therapist-rated outcome.

D. **Hypothesis VIII**. There will be a discernable pattern of significant relationships between clients' use of referents within various categories, particularly negative referents and both client-rated and therapist-rated outcome.

The results of all four of the above hypotheses are shown in Tables 19 and 20, (p. 62).

The results for Hypothesis V (Table 19) showed that clients' scores on the Krohn scale at both pre- and post-therapy correlated significantly but weakly with therapist-rated outcome, and showed only a trend towards being associated with client-rated outcome. This finding generally supported the hypothesis.

The results for Hypothesis VI (Table 19) show that neither Definity nor the ARTICULATION composite were related to outcome, resulting in rejection of the hypothesis.

The results for Hypothesis VII (Table 19) showed some linkages between outcome and the content variables. Results suggested that clients' representations which reflected warmth and acceptance towards others were a significant pre-therapy outcome related variable from only the clients' view, whereas clients' acceptance towards self was significantly related to outcome when assessed at post-therapy.

Table 19

Correlations Between Structural, Krohn, and Content Measures at Pre- and Post-Therapy and Client-Rated and Therapist-Rated Outcome (n = 48).

	Structural Variables		Krohn Scale	Content Variables		
	DEFINITY	ARTICU-LATION	KROHN SCALE	SELF-ACCEPT	LIKES OTHERS	KIND OTHERS
Pre						
Cl.	.07	.06	.24	.20	.47***	.33**
Th.	-.09	.05	.31*	-.08	.04	.26
Post						
Cl.	.13	-.11	.23	.29*	.25	.14
Th.	-.11	.03	.31*	.29*	.19	.26

* $p < .05$; *** $p < .001$

Table 20

Correlations Between Category Count Variables at Pre- and Post-Therapy and Client-Rated and Therapist-Rated Outcome (n = 48).

	Category Count Variables															
	SELF		MO.		FA.		FAM.		INT.		THER.		SOC.		GEN. O	
	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-
Pre																
Cl.	-.05	-.47***	.03	-.18	-.04	.03	.12	-.12	.23	.12	-.16	-.21	.04	.16	.08	.15
Th.	-.05	-.10	-.04	-.23	-.23	-.05	.17	-.14	-.25	-.11	-.10	.18	-.16	.04	-.09	.03
Post																
Cl.	.19	-.08	.03	-.22	.00	-.10	-.14	-.11	.21	.10	-.06	-.11	-.31*	-.29*	.14	.26
Th.	.40**	.03	.08	.05	.10	.10	.13	.09	.18	-.20	-.02	-.24	-.11	-.16	.17	.16

* $p < .05$; ** $p < .01$; *** $p < .001$

The results for Hypothesis VIII (Table 20) showed very few (4 of 64) significant findings and did not support the hypothesis. However, one feature of these correlations was consistent with an earlier finding reported for Hypothesis IV. Table 20 showed that clients' use of social other references at post-therapy whether negative or postive, was associated with poorer

psychotherapy outcome as rated by clients only. Earlier, it had been reported that frequency of use of social other references at post-therapy was associated with greater psychopathology.

E. **Hypothesis X.** An analysis of variance using groups divided on level of psychological development as the independent variable and using post-therapy clients' and therapists' questionnaire responses as the dependent measure will show many significantly relationships. It is predicted specifically that both clients' and therapists' assessments of clients' functioning will be significantly affected by clients' developmental functioning, and that clients' post-therapy assessments of their psychotherapy experience will be affected by their developmental functioning.

Hypothesis X was developed post-hoc to provide a more detailed examination of the relationship between clients' object representational developmental level as measured by the Krohn scale and the process and outcome of therapy. The later was assessed through client and therapist post-therapy questionnaires. For these analyses, clients were divided into four developmental level groups based on their total pre and post scores on the Krohn scale. The groups were divided on a combination of the following factors: 1) naturally occurring breaks in the data, 2) a selection that would give adequate N in each group, and 3) somewhat along the lines of the theory underlying the scale. This resulted in Group 1 (lowest [1.48] through 2.81, n = 8) representing primarily psychotic and low borderline functioning, Group 2 (2.92 through 3.72, n = 16) representing primarily borderline functioning, Group 3 (3.80 through 4.41, n = 14) representing primarily narcissistic functioning, and Group 4 (4.59

through highest [6.27]), n = 10) representing primarily neurotic functioning. Results of the Analyses of Variance for these groups are shown in Table 21 (pgs. 65-66) for post-therapy therapist responses and in Table 22 (p.67-69) for post-therapy client responses.

Table 21 shows that many of the therapists' post-therapy descriptors of clients were significantly related to clients' developmental level. Thirteen of 33 responses were significant, providing support for the hypothesis. Although the data showed some variations, many of the comparisons showed the groups ordered as expected, with the lower developmental groups being rated as more disturbed by the therapists. In no instance was the lowest group rated higher than the highest group on any of the psychopathological ratings. In several instances, such as the ratings of Paranoid Ideation, Somatization, Psychoticism, and Global Pathology, the data showed that the lowest developmental group (those scoring in the psychotic-low borderline level of object developmental functioning) was rated more disturbed than each of the three others.

Table 22 (pgs. 67-69) shows the Analyses of Variance for the developmental groups and clients' post-therapy responses. Here 11 out of 49 correlations were significant, providing support for the hypothesis. Among the results an interesting pattern emerged in clients' evaluations of the therapy relationship. This pattern was that issues related to clients' perceiving the therapist as warm versus cold and distant, as thinking that their therapist regarded her/him as a worthwhile person, and clients' ratings of the degree of anger and emotional involvement in the therapy, appeared related to clients' developmental level. Questions such as "Degree to which intense anger was experienced toward therapist?" and the "Degree to which you felt the therapist thought you were a worthwhile person?", were basically ordered as expected with the lower the developmental group feeling more anger and feeling the therapist thought they were less worthwhile. Other questions such as "Degree to which therapy was an intensely emotional experience?", "Degree to which therapy was a painful emotional

Table 21

Analysis of Variance Scores for Therapists' Post-Therapy Evaluations

Based on Clients Grouped by Krohn Scale Scores

Post-Therapy Therapist Items	N	F ratio	Sig. level	Group means (1, 2, 3, & 4
SCL-90R Ratings				respectively) when significant
1) **Somatization** *	42	5.08	.005	2.33, 0.57, 1.50, 0.80
2) Obsessive-compulsiveness	43	6.13	.002	3.17, 1.13, 2.08, 1.00
3) Interpersonal Sensitivity	45	1.88	.15	
4) Depression	46	0.58	.63	
5) Anxiety	44	4.45	.009	3.63, 1.86, 2.25, 1.50
6) Hostility	44	2.07	.12	
7) Phobic Anxiety	43	2.50	.10	
8) Paranoid Ideation	41	3.50	.02	2.25, 0.69, 0.82, 0.30
9) Psychoticism	42	5.22	.004	2.63, 0.73, 0.54, 0.30
10) Global Pathology Index	45	6.36	.001	5.00, 2.87, 2.93, 2.11
Client in Relation to Other Clients				
11) Defensiveness	44	1.28	.29	
12) Anxiety	43	3.53	.02	5.00, 4.21, 3.23, 3.13
13) Ego strength	43	6.77	.0009	4.13, 5.46, 5.92, 7.00
14) Degree of disturbance	42	4.76	.007	5.13, 3.86, 2.82, 3.11
15) Capacity for insight	42	1.66	.19	
16) Over-all adjustment	39	2.59	.07	4.50, 5.15, 5.92, 6.00
17) Personal liking for patient	42	1.88	.15	
18) Motivation for therapy	41	.02	.99	
19) Improvement expected	43	2.15	.11	
20) Degree to which counter-transference was a problem	45	2.72	.06	
21) Degree to which you usually enjoy working with this kind of patient	46	.53	.66	
22) Degree of symptomatic improvement	42	3.30	.03	4.00, 5.20, 6.45, 5.60
23) Degree of change in basic personality structure	45	.53	.66	

Table Con't

Table 21 (con't)

Post-Therapy Therapist Items	N	F ratio	Sig. level	Group means (1, 2, 3, & 4 respectively) when significant
24) Degree to which you felt warmly toward patient	43	1.53	.22	
25) Degree of emotional investment in patient	42	2.58	.07	
26) Degree to which you think patient felt warmly towards you	42	2.03	.13	
27) Overall success of therapy	42	1.74	.17	
28) Working relationship with patient	42	.44	.72	
29) Patient's satisfaction with therapy results	45	2.08	.12	
30) Form of therapy with patient (supportive (low) vs. analytic (high)	**44**	**5.09**	**.005**	**3.75, 6.27, 5.41, 4.00**
31) Degree of pleasant experiences with patient	40	1.17	.34	
32) Degree of unpleasant experiences with patient	39	.53	.67	
33) Overall experiences with patient	**44**	**2.82**	**.05**	**4.88, 6.80, 6.54, 6.00**

* Statistically Significant Items in Boldface

experience?", "Degree to which you remember the details of therapeutic work?", "Degree to which therapist's attitude was cold and distant?", plus feeling warmth from the therapist, were shown to be significantly different for the lowest developmental group. This group felt fairly uninvolved emotionally in the therapy, felt that it was hardly a painful experience, remembered few details of the experience, and felt the therapist was cold and distant in comparison to how the other three groups viewed her/him.

Table 22

Analysis of Variance Scores for Clients Post-Therapy Evaluations

Based on Clients' Grouped by Krohn Scale Scores.

Post-Therapy Client Items	N	F ratio	Sig. level	Group means (1, 2, 3, & 4 respectively) when significant
1) Felt need for further therapy	**45**	**3.75**	**.02**	**4.71, 5.93, 4.23, 3.40 (higher shows greater need)**
2) What lead to termination of therapy	37	.48	.70	
3) Degree of benefit from therapy	45	2.17	.11	
4) Satisfaction with therapy experience	43	1.35	.27	
5) Impression of therapist's level of experience	44	2.37	.08	
6) How were you getting along before therapy?	44	.58	.63	
7) How long were you in need of help before starting therapy?	43	1.74	.17	
8) How disturbed you were at the beginning of therapy	45	1.01	.40	
9) Degree of anxiety felt when started therapy	45	.24	.87	
10) Degree of internal pressure to do something when first entered therapy	45	.22	.88	
11) Degree of change from therapy	43	.94	.43	
12) How are you getting along now?	**44**	**3.05**	**.04**	**3.00, 3.27, 2.85, 2.11 (lower denotes better)**
13) Adequacy in dealing with present problems	42	.86	.47	
14) Degree of change in symptoms as a result of therapy	41	2.25	.10	
15) Time after start of therapy before a marked change was felt	31	1.32	.29	
16) Degree to which you would recommend therapy to a friend with problems	43	2.17	.11	
17) Degree to which therapy was an intensely emotional experience	**44**	**4.53**	**.008**	**5.50, 2.00, 2.00, 2.11 (lower = more intense)**

Table con't

Table 22 con't

Post-Therapy Client Items	N	F ratio	Sig. level	Group means (1, 2, 3, & 4 respectively) when significant
18) Degree to which therapy was a painful emotional experience	**44**	**2.98**	**.04**	**5.00, 2.00, 2.00, 3.70 (lower = more painful)**
19) Degree to which you remember details of therapeutic work	**43**	**3.20**	**.03**	**4.67, 7.42, 7.93, 7.00 (higher = remember more)**
20) Degree to which therapist used technical terms	45	1.59	.21	
21) Degree to which feelings were experienced during therapy	41	2.47	.08	
22) Degree to which intense anger was experienced toward therapist	**43**	**3.17**	**.03**	**3.67, 3.86, 5.57, 7.44 (lower = more anger)**
23) Degree to which therapist was active	42	2.14	.11	
24) Degree to which therapist respected me as a person	44	1.00	.40	
25) Degree to which therapist was interested in helping	44	1.10	.37	
26) Degree to which you felt like just another patient	44	1.64	.20	
27) Degree to which therapist was attentive	44	1.9	.14	
28) Degree to which therapist used abstract language	45	.83	.48	
29) Frequency with which therapist engaged in small talk	44	.24	.87	
30) Degree to which therapist was stiff and formal	43	1.97	.13	
31) Degree to which therapist's manner was natural and unstudied	42	2.03	.13	
32) Degree to which therapist understood feelings	44	1.02	.39	
33) Degree to which therapist was passive	44	.64	.59	
34) Degree to which therapist's attitude was cold and distant	**42**	**2.95**	**.05**	**6.50, 8.50, 8.23, 8.78. (higher = less cold and distant)**

Table con't

Table 22 con't

Post-Therapy Client Items	N	F ratio	Sig. level	Group means (1, 2, 3, & 4 respectively) when significant
35) Degree to which therapist talked too much	44	1.09	.36	
36) Degree to which you felt the therapist thought you were a worthwhile person	**45**	**2.80**	**.05**	**6.29, 8.27, 7.92, 8.80 (higher = less questioning)**
37) Degree to which you trusted therapist's integrity	43	.88	.46	
38) Degree of warmth you felt in the way the therapist talked with you	**44**	**3.40**	**.03**	**7.50, 8.33, 8.54, 8.60 (groups 2,3,4, more warmth)**
39) Degree of coldness in tone of the therapist's statements	44	1.09	.37	
40) Amount of neutrality in therapist's statements	43	1.90	.15	
41) Amount of advise given in how to conduct life	45	.77	.52	
42) Degree to which therapist talked about psychoanalytic theory	45	.18	.91	
43) Degree to which the major emphasis in therapy was your attitudes and feelings towards the therapist	44	.80	.50	
44) Degree to which a major emphasis was relationships with people currently in your life	**45**	**5.27**	**.004**	**4.14, 1.47, 2.54, 2.30 (lower = more emphasis)**
45) Degree to which a major emphasis was childhood experiences	44	.73	.54	
46) Degree to which a major emphasis was upon gestures,tone of voice shifts, and bodily experiences	45	1.16	.34	
47) Degree to which you were given reassurances	**45**	**4.50**	**.008**	**5.57, 8.20, 7.38, 8.80 (group 1 felt less reassured)**
48) Degree to which therapist showed interest in dreams and fantasies	45	2.00	.13	
49) Degree to which you felt accepted by the therapist	44	2.49	.08	

Object Representations and Internal Object Relations

A. **Hypothesis IX.** The object representational measures hypothesized to be related to psychopathology and psychotherapy outcome will be related to scores on the Krohn scale.

This hypothesis involved an investigation among the experimental variables in this study. In particular, this hypothesis was used to investigate the relationships between the Krohn scale, which had been proposed by the present author to be a measure of internal object relations, and the other measures in the study. The other measures, particularly the content scales and the category count variables, were object representational measures. Since internal object relations had been proposed to be a psychological variable in its own right -- not quite synonymous with psychopathology, the variable was treated in this hypothesis as a criteria with which to assess the other variables.

The results are shown in Table 23 (p. 71). Nine of 42 comparisons reached significance, suggesting that most of the significant correlations did not occur by chance. Clients' Krohn scale scores correlated positively and significantly with 1) clients' pre and post *ARTICULATION* scores; 2) the post-therapy block of content variables: self-acceptance, other acceptance (Likes Others) and how benign others were represented to be (Kind Others); and 3) the number of positive family references at post-therapy. Clients' Krohn scale scores correlated negatively and significantly with 1) the number of generalized other references at pre-therapy; 2) the number of negative therapist references at post-therapy; and 3) a lower number of positive generalized other references at post-therapy. Since all of these associations were in the direction expected, the findings are basically in support of the hypothesis even though only the ARTICULATION variable showed a significant pattern at both pre- and post-therapy.

Table 23

Correlations Between Clients' Scores on the Krohn Scale and Other Object Representational Indices (n = 48).*

	Structural Variables		Content Variables			Category Count Variables														
	D	ART	SELF ACC	LIKE OTHERS	OTHER	SELF +	SELF -	MOTHER +	MOTHER -	FATHER +	FATHER -	FAMILY +	FAMILY -	INTIMATE +	INTIMATE -	THER +	THER -	SOCIAL +	SOCIAL -	GEN OTHR +	GEN OTHR -
Pre	.11	**.44**	.21	.18	.15	-.08	-.26	.23	.08	.05	.10	.26	.16	.24	.19	-.11	-.18	.06	-.27	-.02	**-.39**
Post	-.11	**.32**	**.32**	**.40**	**.43**	-.25	.05	.13	-.12	-.06	-.07	**.30**	-.05	.14	.14	.11	**-.37**	-.05	-.19	**-.30**	-.06

*Significant correlations in boldface ($r \geq .28$, $p < .05$; $r \geq .37$, $p < .01$).

DISCUSSION

The purpose of the present study was to explore whether certain aspects of a person's psychological functioning could be identified by analyzing a sample of his or her verbal discourse. Clients' self and other representational discourse in psychotherapy was utilized and investigated as if it was projective-test material. There was a deliberate sidestepping about the actual past and present objects that may have affected this object-representational material. The areas investigated were clients' psychopathology, response to psychotherapy, and the relation between internal object relations and object representations. Overall, the findings of the study were promising and encourage further exploration of this sector.

The first part of the discussion involves an overview of the methodology of the study and its strengths and weaknesses in light of the findings, while the second section involves a discussion for each set of variables used in the study.

Overview of Study

The following propositions regarding the study's methodology are based on an overview of the study and its findings.

1) Clients' object representations reflected, and were utilized to assess, important aspects of personal functioning such as level of general psychopathology or likely response to psychotherapy. The clearest results were obtained using the Krohn scale which appears to be a promising measure of internal object relational development.

2) An analysis of clients' object representations through a sampling of their psychotherapy speech appears a promising way to investigate the phenomena. The extent to which this

approach was as good as other projective approaches was not determined. However, there were no contraindications that this method could not be as rich for psychological investigation as other approaches. Even though only a few of the variables showed promise, the methodology gained credibility. The fact that about half of the study's variables did not lead to meaningful results may have been due to psychometric difficulties. The investigation of verbal discourse appears limited only by the lack of established research in this area.

3) The proposition that the self and other representations contained in speech could be analyzed as if it were projective material received support from the study. Such a finding supports the contention that representations are partially projective in nature. It was found that the analysis of representations outside of their interpersonal context and separated from the individual's social history provided useful information.

4) A major limitation was the lack of precision in the study which made it impossible to provide more specific and detailed information that may have been present in the data. For example, the use of a generalized other statement such as "people are masochists" appeared a developmentally lower statement compared to more personal representations. But the study did not allow one to infer important issues such as the following: Was a generalized other reference always indicative of a lower order of thinking? Was it ever reflective of fatigue, distraction, or anxiety? In other words, the study lacked more precision regarding the conditions when statements were indicative of lower psychological development and when were they not? These considerations suggest that the present investigation provided only a lead for future research and did not answer some important questions.

5) The *extent* to which the object representations were largely projective and indicative not of fact but psychological organization and development was not ascertained. Similarly undermined was the extent to which a vital aspect in understanding the representations was

missing because of the exclusion of past and present objects which may have affected these representations. This is certainly an important area towards which future research may be directed.

5) Whether or not the sampling approach used in this study was the best way to investigate object representational variables was not ascertained. The stratified random sampling approach seemed best for most of the variables. However, it was not suitable for the category count variables since the N was very low for most categories.

6) The design of the study favored stable variables over those which were more likely reflective of clients' moods and transient psychological states. The reason for this was that the study did not employ more session-oriented evaluations such as rating of clients during a particular session, or satisfaction with a particular session. This could be an important avenue for future research.

7) The study was hampered by low pre- versus post-therapy reliabilities for some of the variables (such as the category count variables) and it was not determined fully whether this was due to inherent instability in the measures or because of unsuitability of the sampling process.

8) The other raters employed in the study appeared insufficiently trained in most instances. Interrater reliability was a weak point. Determination of some variables' contributions was precluded because of this. A few variables had to be dropped. Some weaker reliabilities were partially offset by aggregating measures that had moderate correlations with each other.

9) To the extent that there was significant loss of variance in the study, it is difficult to get an accurate picture of how much variance was shared by the study's variables.

10) Using solely the author's ratings for the testing of the hypotheses made this study

easier, and reduced some of the training problems. However, this approach puts limited confidence in external validity. The extent to which the findings could be replicated by another researcher remains much less predictable then would be the case if more than one rater had been used.

11) While the significant relationships between some of the present variables provided some validity to the constructs in the way of concurrent validity, and to some extent reduced the need for interrater reliability, this was a fortunate consequence of some significant results. Had fewer significant results been obtained, it would not have been readily determinible whether poor results were due either to inadequate ratings or lack of support for the hypotheses.

Object Representational Variables

A) Krohn and Mayman's Object Representational Scale for Dreams

1) Description

The Krohn scale emerged as the most promising measure. The author views it as a likely indicator of internal object relations due to its properties and the configuration of results. The aspect of functioning measured by the scale appeared to be a social-developmental level, similar to Loevinger's notion of ego development, which organizes, constrains, and limits the ways individuals' experience and interpret their own and others' behavior and motivations.

A key aspect underlying the Krohn scale appears to be how well a person is able to see the world from another's point of view. In other words, the major aspect of internal object relational development appears to be how well a person is psychologically capable

of taking the perspective of others around him or her. Intertwined with this capacity to see the world as others may is one's psychic integrity and maturation. Development of the self and the capacity for empathy appear to go hand in hand.

The author noted that the eight-point Krohn scale represented approximately five diagnostic groups on its continuum which is congruent with what was proposed by the developers of the scale. In fact, the scale apparently offers the reader a good grasp of some vital psychopathological phenomena. The first level is the disorganized and chaotic world of the psychotic in which most human motivations and behaviors are incomprehensible. The second level is the low-borderline level where people seem to act out of vicious intent. People's motivations and behaviors appear ghastly and destructive. Level three is the borderline level where people's motivations and behaviors are essentially lifeless and meaningless. The person is not able to comprehend one's own or another's identity which guides one's actions. Level four is the narcissistic level where human motivation appears solely based on self-interest and need. The fifth level is a neurotic-hysteric one where people are understood as having a personality which motivates them but only the most superficial reasons are given for their actions. Here stereotypes predominate. Level six is the beginning of any real understanding of another, but on this level there are noticable transference distortions. People are often interpreted in terms of one's own motivations or are compared to someone else in the person's world. The last two levels, (seven and eight), which were found to be rare in this study of outpatients, characterize increasing levels of sophistication and psychological understanding of motivations and behaviors.

2) Findings

The properties of the Krohn scale were good, especially regarding its stability. Clients' scores on this measure were highly stable, even to the point of appearing unaffected by the psychotherapy ($r_{pre\ vs.\ post} = .87$). These findings need to be qualified by the fact that both the pre- and post-therapy ratings for each client were made consecutively by a single judge (the author) who was not blind to the clients' code numbers. (It was initially planned this way to provide the rater with additional context and understanding of the client when making ratings.) Nevertheless, the author observed little variation in individuals' scores on the scale. A person scoring in the borderline range, for instance, typically varied from low borderline-high psychotic at the lower end to only the high borderline-low narcissistic at top. Rarely, if ever, was it observed that someone who averaged in the borderline range would be able to make a statement rated as high as the neurotic range.

Other properties of the scale were favorable. Clients' mean scores across their set of transcripts ranged from 1.48 to 6.27 and they were fairly well distributed. The higher scores on the Krohn scale were underrepresented, as might be expected in a clinical population. Usually eight or more representations undergrid a client's score at each time point which would appear to contribute to accuracy and stability in the ratings obtained. Across a client's set of ratings there would be about twenty to thirty representations on which to base his or her average score. This high number on which to obtain a Krohn score appeared far more advantageous than previous dream research with the instrument which tended to base the individual's developmental score on only two dreams. The strong stability of the measure does suggest, however, that basing a score on a few representations would be adequate. The low inter-rater reliability perhaps due to the little training of the second rater and the fact that this rater had no clinical or

graduate training, was the central weakness of the variable.

Clients' Krohn scores showed a consistent pattern of relationships with several clinical variables. For one, clients' Krohn scale scores correlated significantly with their self-ratings on several of the SCL-90R's symptom scales, including somatization, obsessive-compulsiveness, phobic anxiety, and the global pathology index at pre-therapy plus interpersonal sensitivity and phobic anxiety at post-therapy. There was also a trend ($p. < .10$) for many of the other SCL-90R scales to be related to this measure. The significant associations with the various scales was likely to be due to the singular psychological distress factor which has been found to undergrid the SCL-90R (Halcomb, Adams, & Ponder, 1983). It seems reasonable to conclude that object relational development is inversely correlated with general psychological distress. This finding was also supported by clients' post-therapy responses which showed clients' Krohn scores inversely associated with their perceived need for further therapy and their ratings to the question "How well are you getting along now?"

The associations with the various SCL-90R scales makes it difficult to discern any particular relationship between the proposed object relational development and the symptom indices other than the consistent relationship with the phobic anxiety scale. Its items (*Feeling afraid in open spaces or in the streets; Feeling afraid to go out of your house alone; Feeling afraid to travel on buses, subways, or trains; Having to avoid certain things , places, or activities because they frighten you; Feeling uneasy in crowds , such as shopping or at a movie; Feeling nervous when you are left alone; and Feeling afraid you will faint in public*) suggest that this scale measures extreme social anxiety or panic.

Krohn ratings also correlated significantly at both pre- and post-therapy with the

ICL's AIN index. AIN measures the degree of exaggerated interpersonal behaviors along the dimensions of dominance versus submission, and love versus hate. The significant association here suggests that lower scorers on internal object relational development may exhibit more exaggerated and inappropriate interpersonal behaviors.

Krohn scores were also significantly associated with ratings made by intake workers and therapists. These linkages were generally stronger than to the self-ratings, suggesting that the behaviors associated with these ratings by psychologists may be especially salient in the interpersonal sphere. Object representational development significantly related to most (10 of 16) therapist post-therapy ratings of psychopathology. One of the most significant relationships was in the area of ego-strength ($p < .0009$). The group of clients assessed as functioning at a low object representational level were rated by therapists as having some to moderate ego strength. Those groups in the midrange of object representational functioning were rated by therapists as having moderate ego-strength, and those clients who scored more in the upper (neurotic) range of object representational functioning were rated by therapists as having "fairly great" ego-strength.

The post-therapy therapist ratings enable slightly more precision regarding the specific psychopathological characteristics associated with object-relational development. Therapists differentiated clients grouped by their Krohn scale scores on the somatization, obsessive-compulsive, anxiety, paranoid ideation, and psychoticism scales. The first three appear related to an anxiety factor. The author's examination of the somatization and obsessive-compulsive scales revealed that many of the items appeared related to an anxious state or symptoms caused by anxiety (see Derogatis, 1977, for these items and for the SCL-90A which contains the specific definitions used by therapists in rating

clients). These results suggest that the general psychological distress mentioned above as being inversely correlated with object relational development may involve a considerable anxiety component. Surprising, however, therapists showed only a trend ($p. < 10$) to differentiate the Krohn groups on the phobic anxiety scale, somewhat inconsistent with a stronger relationship found in clients' self-report.

Further scrutiny of therapists' ratings showed that the Krohn groups were basically ordered by therapists on their over-all adjustment, degree of disturbance, and global pathology. Also, as expected by the theory underlying the Krohn scale, therapists' rated the lowest Krohn group much higher in psychoticism and paranoid ideation than they rated the other groups. According to therapists' ratings, the other groups showed a virtual absence of paranoid ideation.

An interesting pattern of post-therapy client evaluations also seemed to be dependent on clients' internal object relations as measured by the Krohn scale. The results showed that groups differed significantly on a cluster of items related the evaluations of the therapy relationship and ratings regarding the degree of emotional involvement in the therapy. The tendency was for lower developmental scoring groups, in particular the group composed of psychotic-low borderline clients, to regard their therapists as feeling less warm and more cold and distant towards them, to provide less reassurance, and to value them less. They also rated themselves as feeling less emotionally involved in the therapy but also reported feeling more anger towards the therapist. These findings fit clinical theory on severe narcissistic disorders, including the theory underlying the Krohn scale. Clinical theory regarding narcissistic disturbances has reported that greater narcissistic injury is accompanied by greater narcissistic rage towards others. In the theory underlying the Krohn scale, the lower the level on the scoring schema, the

more difficulty with self issues such as feeling valued and respected, and the more difficulty feeling connected and involved with others because of the insubstantial feelings accompanying experience. Regarding the latter, it was also found that the lowest group reported remembering little details of their psychotherapy experience.

These findings on clients' evaluations of their psychotherapy suggest that the evaluations may have been partially based on clients' transference phenomena. Clients may have interpreted their therapists' behaviors within their own developmental organizations and perhaps they would have experienced the therapists as such regardless of how the therapists may actually have been. It is also possible that when evaluating the therapy, clients' tendencies were to rate it along the lines of how they interpret these kinds of experiences; that is , for instance, to report feeling less valued because that's how they think people respond to them.

Another possibility is that the therapists were actually more cold and distant towards these more disturbed clients. The present data do not permit clarification of this issue, but the possibility exists that therapists were acting-out counter-tranference feelings. In other words, therapists may have responded to those who felt less certain of their own value by valuing them less. The only available pertinent data are therapists' post-therapy responses. Examination of these responses showed that therapists' reported being more emotionally invested in psychotic-low borderline group then with the other clients, but also reported not having as satisfactory experiences with this group as therapists reported with other groups, and thought they provided more supportive psychotherapy and expected less improvement. These later points (i.e., expecting less and being more "supportive") hint that therapists may have been more distant with this group, although this cannot be determined from the present data. Independent ratings of

therapist-client interaction might clarify this issue.

Whether as a client or therapist process variable, clients' Krohn scores were positively linked with benefit from therapy. This was found for both pre- ($r = .31$, $p < .05$) and post-therapy ($r = .31$, $p < .05$) Krohn scores and therapist-rated outcome. The correlations with client-rated outcome were similar but nonsignificant ($r = .24$, $r = .23$). These findings are consistent with other psychotherapy research which has linked benefit from psychotherapy with lesser degrees of psychopathology.

One of the more intriguing unexpected findings of this study involved the lack of change in clients' Krohn scores from the early to later sessions. There was even a slight but nonsignificant decline in clients' scores. This finding can not be comprehended based on earlier speculation regarding the benefits of psychotherapy. Even though the Krohn variable proved extremely stable, and it can not be expected that an average of 24 sessions will change a more characterological aspect of psychological functioning (the few psychotic individuals remained unchanged and so did not move to a narcissistic orientation as in Ryan and Bell's [1984] study), nevertheless, these results are unexpected and open the possibility for a more rigorous investigation of the benefits of psychotherapy.

B) The Content of Object Representations Along the Dimension of Acceptance and Warmth Versus Rejection and Coldness.

The content of clients' object representations were also assessed along the dimension of acceptance and warmth versus rejection and coldness. This dimension was assessed for clients' self-representations, other-representations (that is; how clients' felt towards others), and representations related to how others were represented to be towards others, including the client. The degree of acceptance and warmth across these areas was

significantly related, but this needs to be qualified by the fact that a single rater made all of these judgements on the same occasion for each client which might account for their agreement. These variables also showed significant but modest pre-post stability, but this was also contaminated by the contiguity of ratings for each client's pre- and post-transcripts. The scales which composed these measures were simple bipolar scales with little description. Poor inter-rater reliabilities were obtained with them. The loss of variance from the weak reliability of the scales was partly corrected by pooling a group of scales together for each of the three areas.

Even though weak, these measures gave a general indication of the degree of warmth and acceptance of clients' representations, permitting a fair test of the relevant hypotheses. Findings showed that the degree of acceptance and warmth in representations was negatively and significantly related to most of clients' self-ratings of psychological distress at pre-therapy, although this relationship did not hold at post-therapy (see Tables 15 and 16). Clients' post-therapy ratings of acceptance and warmth towards others were the only significant linkages between these content measures and psychologists' ratings (Table 16). Nevertheless, the overall results support an inverse relationship between the degree of warmth and acceptance in representations and degree of psychological distress.

The content variables were also related to outcome. Findings showed a differential pattern between self and other representations. Results showed that the degree of warmth in clients' other representations at *pre*-therapy was positively and significantly related to client-rated outcome, and that clients' *post*-therapy self-representations were related to both client-rated and therapist-rated outcome. The later appears merely to support the fact that the better the client felt about him or herself, the more favorable

were psychotherapy evaluations.

The significant relationship between outcome and the degree of warmth and acceptance in clients' early therapy representations of others supports a prior finding with this same sample. Filak, Abeles, & Norquist (in press) found that clients' *pre-therapy* ratings of their interpersonal attitudes towards others on the ICL's love-hate (Lov) dimension was strongly predictive of their response to psychotherapy. The present finding, utilizing a different assessment procedure, supports the earlier work. In addition, the current finding was that the relationship held for client-rated but not therapist-rated outcome. This suggests that therapists' may have little awareness of the importance of clients' negative or hostile attitudes towards others as it may eventually impact unfavorably on the psychotherapy.

The relationship between clients' content scales and their Krohn object developmental level scores was statistically significant at post-therapy but not at pre-therapy (see Table 23). This suggests that warmth and acceptance in representations is *not* a major factor in object developmental level. The association at post-therapy but not at pre-therapy suggests that the degree of warmth and acceptance in a person's representations is associated with their object developmental functioning but cannot be taken as a fixed characteristic of lower object developmental functioning.

C) Object Representational Category Use

The original impetus to investigate clients' pattern of use of object representational categories was to explore whether there might be a relationship between the frequency of clients' use of various categories and their kind of difficulty (e. g., depression versus paranoid ideation). Also, it was thought that some pattern might exist between clients'

usage frequency and the degree of benefit from psychotherapy.

Unfortunately, while the stratified random sampling yielded a body of data sufficient to test the other variables, this was untrue for the category variables. The latter measures were hampered by low frequencies of representations per category (see Appendix E). These variables also showed generally poor pre-post stability which may also have been the result of the low frequency of representations per category. Consequently, the study was unable to provide definitive answers to the original formulations mentioned above. Findings were generally nil, which appeared primarily the result of unsuitable methodology for these variables.

The principal significant relationships between the category count variables and psychopathology involved the number of negative "generalized other" references and the number of negative "social references". The findings were that clients' frequency of negative "generalized other" references correlated with psychopathology at pre-therapy but not at post-therapy, while conversely, clients' frequency of negative "social other" references correlated with psychopathology at post-therapy but not at pre-therapy (see Tables 17 & 18). Each of these categories correlated with a wide group of symptom scales, suggesting that they correlated more with general symptom distress than with any particular kind of symptomatology. A likely interpretation is that clients with more general symptom distress made more negative "generalized other" references at pre-therapy that somehow switched to negative "social references" at post-therapy.

Another shortcoming of the study which appears worth mentioning was that the original conception of the study was to assess the quality of object representational organization among the group of persons that are represented in the client's life. This may have enabled an investigation of conflict and psychological regression. This was not

investigated because of the limited number of representations within each category group. Perhaps not to examine this was a misjudgement since their may have been enough representations for a portion of the clients. Such an investigation is open to future research.

D) Structural Scales: Defintiy, Specificity, Articulation, and Clarity.

The structural scales in this study were derived from an examination of what appeared to be naturally occuring variables in verbal speech. Clients ' speech seemed to vary considerably in the degree to which ideas were expressed clearly and articulately, the degree to which there was preciseness in the communication, and the degree to which there were qualifications in the person's communications (Definity). The three scales related to articulation of ideas -- Articulation, Clarity, and Specificity, appeared also to be grounded in Werner's developmental psychology in which emphasis is placed on the differentiation of objects in consciousness. The hypotheses were that clients' level of articulation of speech, as assessed by these dimensions, would have some relation to psychopathological functioning and that the degree to which clients' expressed their ideas well would be associated with the outcome of their psychotherapy experience. The extent that clients were vague and obscure would seem to reduce their ability to profit from a verbal experience.

The findings did not support the hypotheses. The structural variables were found unrelated either to any symptom dimension such as depression or anxiety (Tables 13 & 14), or to the outcome of psychotherapy (Table 19). This was a surprising disappointment of the study, specifically for aggregated ARTICULATION variable. The present author expected that this observable and measurable aspect of human

communication would hold much promise in the psychopathological domain. Since flaws were not apparent in the measurement and testing of the structural variables, the results suggest that clients' level of articulation of ideas and the degree of qualification of their statements appears unrelated either to clients' symptomatic functioning or their ability to profit from a psychotherapy experience.

The composite ARTICULATION measure, but not the definity dimension, was positively related to clients' Krohn ratings. The correlations were significant for both pre- (.44) and post-therapy (.32) comparisons. This combination suggests that ARTICULATION may relate to the broader ego developmental aspects of object developmental functioning but not to the psychopathological aspects of object developmental functioning. ARTICULATION might show more promise in a sample of higher functioning clients.

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APPENDICES

Appendix A

The Structural Scales: Definity, Articulation, Specificity, and Clarity

Appendix A: The Structural Scales: Definity, Articulation, Specificity, and Clarity.

A. Definity

1. Description

The Definity scale was developed to attempt to measure the degree to which the person makes a commitment to a statement or phrase. In an initial examination of transcripts, it was noted by the author that a fair percentage of a person's spoken communication contained qualifiers such as "perhaps" or "I guess" or "I just kinda". This scale was developed to quantify the degree of qualification found. The degree of qualification was ordered based on an examination of the range of the phenomena as well as observation of co-occurrences of various items. For instance, a speaker might say "I guess I hope" in one sentence and "I just more or less" in the following sentence.

Among the four structural scales developed for this study, Definity appears conceptually different from the others. In contrast to the other three scales, Definity does not appear to assess an articulate dimension of the person's expressions. The scale is shown on page 99.

2. Scoring

As with all the scales, Definity was used only on statements that contained one complete sentence or thought. Every separate statement on the transcript was rated. The author rated a statement by reading it and searching for certain examples or markers within it (e.g. think, just, kinda, etc.). From this an overall rating of the statement would be made. As with all the structural scales, a mean score taken from the clients' set of scores formed the Definity score.

B. Articulation

1. Description

The Articulation scale was developed to score the quality of clients' theme development. Like the other scales, it was based on an examination of some transcripts and consideration of the range and coherence of the phenomena found. Usually the initial theme was the one considered. For example, a person may start off the statement with the sentence "I'm angry at my father". The person may then elaborate why he's angry with more or less degree of articulation, or perhaps the person may then proceed with a tangential or unrelated thought such as "I don't like many people" or "Different parts of me are on fire" or "I feel cheery". The Articulation scale involved not only initial development, but especially how well the whole series of statements are used to either elaborate or constrict the person's ideas. This scale is likely to have some relation to a depth or experiencing scale, but it is intended to be used on any verbal output and assesses more of a cognitive dimension. The scale is shown on page 100.

2. Scoring

The scoring for this scale was done more broadly then the other scales. If a statement contained enough sentences it was usually rated by itself unless the same theme continued through to other statements in the time segment. The time segment was the one minute sample within the transcript and each transcript contained five time segments. A rating never crossed time segments. Often, when the client made short statements within a time segment, at least two, and often the whole segment was used to obtain one rating. Whether or not the statements were rated together depended also on whether the same theme was carried across segments. However, a

segment which contained only very short and unrelated statements was given one low score, since lack of elaboration is equivalent to poor elaboration in this scoring system. As with the other structural scales, an average score was given for the pre-therapy and for the post-therapy transcripts.

C. Specificity

1. Description

The Specificity scale was devised to assess the degree to which there was specificness or preciseness in the communication or the degree to which object phrases in sentences are spelled out. For instance, a person may say "I feel confused" or "I feel confused today" or "I feel confused about things" or "I feel confused about my feelings" or "I feel confused when Jim says he doesn't love me". These statements show increasing precision regarding the object phenomena to which the person is reacting to. It is likely that such specificity leads to resolution or understanding of difficulties as the person becomes knowledgeable about the antecedents of their reactions.

The idea of this scale was developed from the author's listening to clients and others talk about various feelings and experiences. The ordering of the scale was based on the apparent increase in object phrase development. The scale is shown on page 101.

2. Scoring

Every statement is rated separately and the mean score is used to represent the Specificity score for the transcript.

D. Clarity

1. Description

The Clarity scale (p. 101) was devised to deal with varying degrees of clearness in communication. The author noted that often there were varying degrees of clarity in communications even when people were talking as if they were being easily understood. For instance, the person might say "That's the way it works" without giving a clear sense as to what the "it" might refer to. The scale was also used to assess if part of the content of the communication was making sense in terms of appropriately meshing with other parts of the communication. For example, if a person is talking about their family and then mentions something supposedly in connection with this but which the listener or reader cannot either explicitly or intuitively fathom, then the communication was rated relatively unclear because of the juxtaposition of its parts.

2. Scoring

This scale, like the Articulation scale, was used broadly over the material. The author typically examined the whole series of statements within a time statement and rated the whole segment as one. As with the other structural scales, an average score was given for each of the set of transcripts for the client (pre and post).

SCORING DEFINITE-INDEFINITE

The degree to which a bonafide commitment is made to a statement.

	Description	Examples
7		I am a louse I have an awful feeling about myself I feel punished I get hell from her.
6	Feel that or think, some qualification, highest score for past or future tense, highest score for self in relation to others.	I feel that, too, I felt that, really, I feel both ways, still I think that
5.5	left out of sentence	I don't like it I felt myself locked in for I don't think extended periods of time. I didn't know We have I was I'd like I would
5	Better than 50% liked it statements there assertive question asking of self, contingencies (e.g. "the more it happened, the worse I felt) Passive vs. active voice Sentence begins with long phrase, Would Lacking subject	There's a good chance that, I found myself, I'm basically feeling, I can, but, Mostly, I did notice that, I find that, I'm pretty sure, I can force myself (some hypothe- I feel like, tical - less to it), There is It looks like, But.....Because (when by itself), I enjoyed it....,I think (later qualification) At least, It was, The more worse, I usually, It's like, There are times when...,I hope I don't, It seems, "People do things like she did to me, Also feel, By the time he's ready- I'm upset again, Also, alot Even though she likes me. I hate her. I would like to. I hope I don't. Got a feeling They would if it was not for me. about that. These sessions have gone differently.
4.5	Specifically fixed in time or place. Past or future (not present) "You" or "one" substituted for self. Many "ing" verbs. Distant past.	Question asking of therapist when really a statement is in order. I used to feel I would like It doesn't In the past There isn't It doesn't seem I'm starting to feel I don't feel like I'm beginning to feel A long time ago I felt It's like I didn't I'll keep trying I think eventually It's almost like
4	Some probability usually less than 50%	There is some chance that, Just, That's part of it, Sometimes I feel, I feel partly, or in part, I think that perhaps, Alot, I guess, Pretty much, It's somewhat likely, A little a little bit, pretty, It's possible that, Sort of, Suppose, I wish, Maybe I...., Not particularly, To some extent, Probably, To a point, Perhaps I, For all I know, Kinda,kind of, For some reason, In some ways,
3	Hypotheticals, shoulds Maybes (except maybe I) May (except I may) or it an ambivalent statement with qualities, multiple reasons put forth.	If (as hypothetical only) I just hope I wouldn't come here, it I admitted that. Might, or, maybe, may be, Should, could (when used hypothetically) Maybe yes, maybe no. Perhaps I am or am not. Well I don't know whether it was that The changes, or I was homesick, or what.
2	Double qualifiers Alot of distancing from statement	I guess that maybe I don't know if I guess I hope I'm not sure what I I just kinda feel. I should just I just more or less
1	Unacknowledgment Unacceptance Denial	I don't know (when used in a disclaiming way) I have no idea if this is true but If anything..... Who knows? Who knows if

ARTICULATE (DEVELOPED) VS. DIFFUSE (UNDEVELOPED)
A sentence or group of sentences on a similar theme

The degree to which the theme, idea or feeling is developed. Consider how well a series of statements get together (articulate).

	Description	Example
8	Theme develops well. Some real thoughtfulness is expressed. It has to have the feel of a real nice development of a theme, smooth. It can be concise.	I feel like I have some personal things that I want to work on. But if I'm trying so hard to be perfect and articulate, and say everything just right, I don't know if I will accomplish my goals here.
7.5	In-between	
7	Theme is developed but there is some excess baggage. Some repetition. Each sentence does not necessarily add. Theme gets slightly stuck. (or) concise development and articulation but little elaboration.	There's alot going on in my life. Reassessing my values and I feel shakey about that. I'm looking at my career goals and that's getting shifted. I'm real confused. I'm going through alot. It's like I deserve better than this. I keep feeling like just because I'm not a housewife I shouldn't have to put up with dirty dishes. I deserve some better shake.
6.5	In-between	
6	Articulate but a fair amount of repetition on a theme. Some development. Instead of development through one incident, there is jumping around to other examples which keeps the feeling from full development.	I'm angry to my father. He threw an ashtray at me once. He threw hot water on me once. He forced me to have sex with him and has called me a whore since.
5.5	In-between	
5	Articulate but not well-developed (or) monotonic and repetitive (or) jumping around as above but in a serial-like monotonic fashion where the feeling is not developed.	I'm angry at my father. He threw an ashtray at me once which cut the side of my head. I hate him for it.
4.5	One point with excess baggage or lacking much development.	I feel lost. Sometimes I feel I'm the last to know what's going on. I just feel lost.
4	In-between (or) theme is loosely connected. Gets somewhat lost by end.	I have such a horrible feeling about myself. I don't know how that comes to mind alot, and most people don't see that. I'm glad about that. I'm pleased that my friends don't know me well.
3.5	In-between. Impoverished development.	
3	Theme gets lost (or) theme is rarely understandable between 2 sentences (or) just more than one sentence (or) only one sentence with a decent subordinate clause.	I'm getting caught up in this relationship with my roommate, this woman I live with, and I'm not real comfortable with. I am but I'm not. Been having a lot of strange things happen to me. Been doing a lot of meditating and alot of running. I don't know how to explain it. Just feeling different parts of myself. Oh wow! That's so abstract. That bugs me. I don't know if I can go into detail. This person is alot of why I'm here.
2.5	In-between	
2	Theme is very loose, nearly articulate. One sentence or a very brief statement with little or no attempt at development	I think the reason that you're so uncomfortable with me and Henry, and these are my differences, and believe me I'm not pushing Henry as a beau or husband or anything, but that I think a bit of the discomfort has to do with, because of the insistence we've mentioned, or some sort of involvement
1	Incoherent string of sentences. Statements said in a series but unrelated in any apparent way.	I feel cheery. You know what I mean. There are differences between you and me, believe me.

Specificity or Singularity

The degree to which there is specificness or preciseness in the communication, or conversely, the degree to which generalities are involved.

Moderately Global **Somewhat Global** **A Little Global**

Very Global	Reference to an "All"	Vague Generalities		Role Specific Context Groups		Precise and SpecificStatements
I	I	I	I	I	I	I
1	2	3	4	5	6	7

I feel confused It's tough

always, everyone, etc.

I feel confused about things (3)

with Jim (4)

values, career goals

I feel confused about Jim's feelings towards me

I feel confused when Jim says he doesn't love me

Clarity vs. Ambiguity

The degree to which a statement or a series of statements are clear and unambiguious. Does the reader know exactly what is being talked about? Does the language tent to hide more than it reveals? How vague is the content?

Very Vague	Moderately Vague		Somewhat Vague	A Little Vague	Clear and Precise Little to Wonder About	
I	I	I	I	I	I	I
1	2	3	4	5	6	7

Appendix B

Content Scales

Appendix B: Content Scales

1) Self-acceptance-rejection or level of self-esteem

low	low-medium	medium	medium-high	high
1	2	3	4	5

2) Level of self-efficacy

low	low-medium	medium	medium-high	high
1	2	3	4	5
person seems to feel helpless and incapable of mastering enviroment		person seems mixed about ablility to master enviroment		person appears capable(through self-statements) of achieving goals and mastering enviroment

3) Movement towards others vs. movement away

low	low-medium	medium	medium-high	high
1	2	3	4	5
appears to be moving away from others		mixed about movement towards or movement away		wants to move towards others

4) Hostile vs. affliative

hostile				affliative
low	low-medium	medium	medium-high	high
1	2	3	4	5
appears rejecting of others		shows mixed acceptance vs. rejection of others		appears accepting of others

5) Cold vs. warm (Unless warmth is shown, tend to rate on the cold side.)

cold		warm		
low	low-medium	medium	medium-high	high
1	2	3	4	5

6) Harsh vs. gentle

low	low-medium	medium	medium-high	high
1	2	3	4	5
harsh		neither harsh nor gentle		gentle

7) Accepting vs. rejecting

low	low-medium	medium	medium-high	high
1	2	3	4	5
rejecting				accepting

Hurley Scales

Please rate the client on the following 7 point bipolar scales ("4" is somewhat neutral).

1 2 3 4 5 6 7

hides feelings shows feelings

1 2 3 4 5 6 7

guarded hostile

1 2 3 4 5 6 7

passive active

1 2 3 4 5 6 7

submissive dominant

1 2 3 4 5 6 7

cold warm

1 2 3 4 5 6 7

harsh gentle


1 2 3 4 5 6 7
harms others
helps others
1 2 3 4 5 6 7
rejects others
accepts others

Appexdix C

Psychopathology Scales

Appendix C: Psychopathology Scales

Please rate the client on the following:

Psychopathology

1. How disturbed do you think this client is?

0	1	2	3	4	5	6	7	8	9
very disturbed		moderately disturbed		somewhat disturbed		mildly disturbed		shows little disturbance	

2. Please rate client on the SCL-90R global pathology index.

3. Please rate the seriousness of client's problems, i. e., the degree to which they reflect personality disorganization.

0	1	2	3	4	5	6	7	8	9
very serious		moderately serious		somewhat serious		mildly serious		no personality disturbance	

4. Degree of client's subjective distress.

0	1	2	3	4	5	6	7	8	9
grave personality disorganization		high		moderate		some		little-none	

5. Degree of defensiveness.

0	1	2	3	4	5	6	7	8	9
none		little		some		moderate		high	

Psychological Health

1. How psychologically healthy do you think the person is?

0	1	2	3	4	5	6	7	8	9
no apparent strength		little		some		moderate		high	

2. How creative do the client's expressions seem?

0	1	2	3	4	5	6	7	8	9
none		little		some		moderate		high	

3. Degree of comfort in interpersonal relations.

0	1	2	3	4	5	6	7	8	9
low		some		moderate		high		very high	

low -- person feels extremely uncomfortable with others, feels that relationships with others are strained, never flow easily and relaxedly, are devastating to a sense of contentment. Relating to others is a source of dissatisfaction to him/her.

very high -- the person expresses a basic contentment with respect to relationships with others. In general his/her experience of interaction is of a smooth interpersonal flow - an experience of comfort and satisfaction in his/her personal and social exchanges.

Ego-Developmental Level (see Loevinger chart)

0 = I-1; 1 = I-2; 2 = Δ; 3 = I-3; 4 = I-3/4; 5 = I-4; 6 = I- 4/5; 7 = I-5; 8 = I-6.

Appendix D: Sample Transcript

8013 - 1

2 - I guess I'm feeling that I missed alot not having my dad around. It was really hard when I was younger cause I remember people talking about things that he did. He would ask what your father did and where is your father. I would say my father is crazy and in a mental institution.

There isn't a whole lot of people who understood that.

Yea, it really does.

3 - But there's not anybody that my brother took me to.

It's rather difficult. I think the reason is cause the messages that I get is like male people.

It's like their either incompetent type of, I shouldn't say incompetent. It's like they don't stay around. In my life they never stayed around or if they are around they use people to get to where they need to be and then they move out. It's funny because I was in a relationship when I was about 16, I was going with a guy then and he was a few years older then I was. He was around 21 and time pushed him out of my life and I think I was scared because he was saying that he loved me and let's settle down, and I wasn't ready for that. I think part of the thing that scared me was that that didn't seem to fit in, It wasn't normal for a male person to be saying that to me. I just, it didn't click right. Everytime somebody was nice to me, you're just saying that, you're gonna go away too. I think that ties in with what I, with why I was reluctant to work with a male therapist, because it's like everytime somebody like that comes along, they just, they're going to use me, or else they're not going to be around long, so

Appendix D

Sample Transcript

that's why I was reluctant to work with a therapist, cause that would tie in these messages. Then if you did stay around, then that says gosh, there is something that really must be wrong with me. Because it's not true and you're still staying around. It's like a cycle, I just want to get out of it.

4 - What's in my head, what I want to say is, the first thing that came into my mind was that this fragile little female that came in here referring and couldn't handle her or control her life, and I don't know.
I don't think I'm that way .

5 - I think so, I mean yea there is. If I was in the water drowning I would probably ask somebody to help at the last minute. But you know it's like I may be hurting inside but I'll be damned if all the people are going to know it. And yet when I think about it I'll be doing little things that, well my roommates can tell when I've upset. It's the way I go around the house and everything, with a solemn look on my face and don't feel like eating and I don't know, just different mannerisms and things that I do that I guess give way and tell people that hey, something is bothering me, but for me to come and go up and say hey I want to talk about this I wasn't used to doing that.

6 - I can remember when I was young and I asked my mom things she would just the only thing I got from her was because I told you so. And if you carry that on further and you say why, she says because that's the way it is. And I told you so or that's God's will. I mean you learn to just not say anything. It doesn't get you anywhere, so you either ask other people outside and that's kind of risky.
Okay.

Right now it is. I'm looking at getting a new job, so it may change. Like I should know in a few weeks. If it did it may have to be after 3 o'clock.

Anyday after 3 o'clock. Right now this is a good day and time.

8031 - 4

2 - I could step outside myself and see what I want to see.

I see myself most of the time as a pretty good person.

3 - You mean is this gonna go away too?

Maybe I expected it. I think that's normal.

4 - Maybe it would be impossible. But if it wasn't you would probably make it turn out to be right.

By telling myself that I was worse off. See me extra twice a week. Anything that's good I just,

Yea I don't either.

5 - No, it's like if I could see myself slipping into it before daring me to do something. I still think I can, but it's a heck of a lot harder. I need to communicate to other people what I need in a given time. If I need to talk or if I'm feeling bad and to be able to say that but I usually do all these nonverbal things. Then I withdrawn. My family was like that, we never talked about it when it was happening or trying to get what you needed.

I don't know good people? I won't stay in the same room.

6 - I remember when I got to my. I made it through it and then I felt good. Then I went on to the paramedic program and I got through that. Then I took the state boards and I'm still thinking of taking it but I did some thinking before I did that. Why I would and why I wouldn't go through it. There is some logical reasons, not just mentally.

Probably to me, it's my mother. Cause it doesn't matter what I do, she just says go ahead and do it and that's okay. If I was a plumber or a doctor, big deal as long as I was happy.

8813 - 23

2 - Where is she. Don't worry I'll pick them up later.

This is fun. I don't know how. I don't like feeling excluded from things. I don't care if I'm the one to fall or not, I just don't like it.

Yea, it does, it makes me really angry. I feel like I'm being condemned for something in the past, it's in the past as far as I'm concerned. I'm changing now, I'm working on, I'm attempting so I don't want that being helded against me. I feel it is. I don't think that's fair. See I have a real problem with that because you know I'm not sure if they're having a relationship, physical relationship or whatever, that bugs the hell out of me. It's almost like I don't know and I remember asking LInda once before if that occurred at a certain period of time when we were still in a relationship and she said nothing was going on then. Whether it is or not now, it's like if it is maybe it's my business, maybe it isn't. Yet if it's going on it's like I feel like I've been dumped.

3 - Well it may come down to. No it's like if this continues and there's just this big distance between us it's gonna come down to I'm gonna leave or it's gonna change. I mean if I'm making an effort to change and they're still responding to me in an old way then that's not good. It's not good for me. But if they start responding to me differently, if I respond in a different way and they respond differently then I may stay there. I think I know now that there is no way they can meet all my needs, they don't. Especially Linda, and if she's not willing to work on a relationship then fine, there's other people out there. It hurts a whole lot.
No, it really hurts.

4 - I hate her to lie to me about it.
That's right.
I hate your guts. Go die here.
I hate you for no being strict with me when you were pissed. You were pissed. Just cry, you said my poor kids, wasn't for my kids I'd be somewhere else. Pile of shit! You got pregnant, I didn't get you pregnant. You married my dad, it wasn't my fault. Quit blaming so much.

5 - You can all go to hell. Don't sit here and poor me for my dad. You don't know what it felt like not to have a dad around. Try to get one from somebody else's dad or somebody else out there. Even if something goes wrong with your car at least ask.
Never around for anything. If he would have been there maybe things would have been better between mom and I. I'm sick for thinking that way. Compete with her for my dad cause I think she considered that real well too. She never admits any of these things. The way you avoid everything, that everything is God's will and you avoid all my questions.

6 - They wanted me to save their marriage.

All the time I remember my mom saying Oh how much she wanted a little girl, she had my brother but she wanted a little girl. This is her second marriage you know, maybe it was falling apart. Ane the bits and pieces I got form all the times I had to be cute for everyone. Must have been it, huh? Didn't want me. Just wanted some little machine to run around and do everything that you wanted it to do. If it didn't work out between you you could always get Sara, she'll fix it for you. Well that sucks.

8013 - 27

2 - There is, there definitely is.

I guess that's why it's kind of sad. Kind of feels to me like I'm losing a friend in some ways. And yet I'm not you know. It's like you're gonna go on and continue and grow and change in your life and that's what I'll do.

3 - I guess that's why it's important for me to have another relationship. Cause then maybe I could kick some of my ideas arond with them and it could be an exchange and yet I don't know, it just seems like it would help things. Maybe it would balance things out. Maybe to make, you know there's this special closeness between Linda, Pat, and I that somehow I just feel that I don't fit in in some ways, so maybe that would take care of expressing my feelings to them. I don't want to talk about it anyway.

But I'm saying I've done alot of blaming in the past and said that they did this and they did that. There were times when they were available to me and I said forget you. They didn't meet my needs the way I wanted them to be met and to hell with them. Maybe some of that really wasn't

fair. I put up some walls you know, I'd isolate myself. I have the past year for a long time and it's almost like I feel like I don't know how to have fun anymore. Maybe I have to learn how to have fun in a new way becuase I'll go out once in a while and do things with other groups and then I'll get to the point and I'll just feel really out of it and I'll just come back home. I'll get really angry about it cause part of me wants to stay and is almost like the saying if you've been hurt you don't want to be hurt again. It's really scary for me.

4 - The hard part is deciding what does hurt me and what doesn't.
You know what really pisses me off? People who have it so easy.

5 - I don't understand how to do that.
Why would I pull in like that? Maybe I can see it with my mother, but I do that everytime that I'm hurt, then I really am playing with other people.
6 - It's gonna take another 50 goddamn years. The rest of my life I've gotta look for security in myself?
I guess cause I don't see people being secure without other people.

Appendix E

Client Data

Appendix E: Client Data

Client Code *	8004	8007	8008	8013	8015	8018	8019	8022	8025	8032	8035	8036
Age	24	35	29	23	57	29	24	23	22	26	23	25
Sex (1=men, 2=women)	2	2	2	2	2	2	2	1	2	1	2	2
* of sessions	42	28	15	27	16	43	34	43	26	43	11	46
Taped sessions used(early)	1,3	3	1,3	1,4	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3
(late)	39,42	23,28	13,15	23,27	13	41,43	28,34	23,28	24,26	39,43	8	44,46
outcome (1=high, 2=med., 3=low)	1	2	-	1	3	1	2	1	2	1	-	2
Pre (means)												
Definity	5.6	5.2	4.9	4.2	4.8	4.8	4.4	4.5	4.0	4.6	4.4	4.8
Articulation	5.9	5.9	3.7	4.9	4.2	5.7	4.7	4.7	4.4	4.3	4.6	3.5
Specificity	4.8	4.8	3.4	4.0	3.6	4.8	4.8	3.9	3.4	3.1	4.1	3.9
Clarity	5.0	4.1	3.3	4.5	3.7	4.7	4.8	3.9	4.0	3.8	3.8	3.4
Krohn score	4.4	4.6	2.9	2.9	2.3	4.1	3.3	3.4	2.7	3.1	3.5	2.9
Self-Acceptance	4.0	4.5	7.5	4.0	3.0	4.0	6.0	5.0	2.0	3.5	7.5	5.5
Likes-Others	9.0	6.0	10.0	5.5	7.0	6.0	6.0	8.0	3.0	6.0	6.5	5.5
Kind Others	10.0	3.5	11.0	6.0	3.0	4.0	8.0	5.5	4.5	8.0	8.5	8.0
Post (means)												
Definity	4.7	4.6	4.8	4.8	4.9	5.0	4.4	4.7	4.0	4.5	4.8	4.4
Articulation	5.1	4.9	3.5	5.8	4.3	2.9	4.1	5.1	3.7	3.8	4.0	3.6
Specificity	4.4	5.3	3.1	4.9	3.8	3.2	3.6	3.5	4.2	3.4	4.0	3.7
Clarity	4.2	4.1	3.2	5.4	3.2	2.0	3.3	3.5	3.8	3.0	3.4	3.2
Krohn score	3.4	4.2	2.1	3.3	2.4	3.8	3.3	4.3	2.5	2.0	3.5	2.9
Self-Acceptance	9.0	5.5	8.0	7.0	5.0	8.5	6.5	5.0	2.0	2.0	4.5	8.0
Likes-Others	6.0	6.0	2.0	6.0	4.0	8.0	8.0	6.5	4.0	7.0	7.0	7.0
Kind Othesr	14.0	5.0	4.0	5.5	3.0	4.0	7.5	7.5	4.0	9.0	10.5	7.0
Category Counts												
Pre												
Self + -	9,27	5,9	14,17	10,17	10,13	13,31	13,15	12,30	11,30	6,11	15,19	10,30
Mother + -	0,8	4,7	0,0	1,1	0,3	0,0	0,1	0,0	0,0	0,0	0,0	0,4
Father + -	0,3	0,0	0,0	0,2	0,0	0,0	0,0	0,1	0,0	0,0	0,0	0,0
Family + -	1,4	2,8	0,0	0,1	0,0	1,1	3,2	0,0	0,0	0,0	1,3	0,0
Intimate + -	3,1	1,3	6,8	1,3	0,0	3,18	0,0	0,0	0,0	0,0	0,0	0,11
Therapist + -	0,0	0,0	0,0	0,0	0,0	0,0	0,0	2,2	1,1	2,0	0,0	0,0
Social Relationships + -	1,3	0,1	1,0	0,1	0,1	0,1	0,9	4,5	0,0	0,0	0,0	2,1
Generalized other + -	2,5	0,1	0,2	0,5	0,4	1,0	0,0	0,4	1,6	0,4	3,4	0,0
Post												
Self + -	19,7	20,17	4,12	11,29	5,5	15,7	6,12	8,16	14,12	7,18	15,21	22,17
Mother + -	0,4	0,0	0,0	0,8	0,0	0,0	0,0	0,0	0,1	0,0	0,0	3,3
Father + -	2,0	0,2	0,0	0,1	0,0	0,0	1,0	0,0	1,1	0,0	0,0	0,0
Family + -	3,1	0,2	0,0	0,0	0,0	1,0	0,2	2,3	0,1	0,0	0,0	0,0
Intimate + -	0,0	0,3	0,0	0,1	0,0	0,0	0,0	4,5	0,0	0,0	0,0	1,1
Therapist + -	0,0	1,0	1,5	1,0	0,0	1,0	0,0	0,0	1,4	1,0	0,0	0,0
Social Relationships + -	0,0	0,0	0,0	1,4	0,6	0,1	2,3	0,0	1,0	0,0	1,2	0,0
Generalized other + -	0,4	0,0	0,2	1,2	1,0	0,0	0,0	0,0	0,1	0,0	1,2	0,0

Client Code *	8037	8038	8041	8044	8047	848A	848B	8057	8060	8062	8065	8067
Age	29	21	27	24	25	54	55	34	31	28	24	27
Sex	2	2	1	1	1	1	1	1	2	1	1	2
* of sessions	24	6	28	8	17	17	18	19	46	36	16	18
Taped sessions used(early)	1,3	1,3	1,3	1,3	1	1,3	3,8	1,3	1,3	2,4	1,3	1,3
(late)	23,24	6	23,28	8	13,14	13,17	14	18,19	39,46	33,36	13,16	13,18
outcome (1=high, 2=med., 3=low)	2	3	1	3	1	2	2	1	1	1	1	1
Pre												
Definity	4.6	4.5	4.6	4.3	4.7	4.7	4.6	4.1	4.5	4.3	3.9	4.2
Articulation	4.6	6.1	5.1	4.0	4.8	4.4	4.1	3.4	3.1	4.4	4.9	4.7
Specificity	4.5	4.7	4.1	3.4	4.2	4.1	3.5	3.5	3.3	3.7	4.4	3.0
Clarity	3.8	4.7	4.3	2.9	4.0	3.3	2.9	2.9	2.3	3.1	3.8	3.0
Krohn score	5.7	3.6	7.0	1.5	5.2	3.7	3.3	2.6	3.9	3.0	5.1	3.4
Self-Acceptance	7.0	2.5	6.5	5.0	5.0	3.0	4.5	2.0	4.5	8.0	7.0	4.0
Likes-Others	2.5	4.0	5.0	2.0	6.0	4.0	5.0	5.0	7.0	4.5	5.5	7.0
Kind Others	5.5	3.0	9.0	5.0	5.0	5.5	8.0	7.0	7.5	8.0	8.0	5.5
Post												
Definity	4.5	4.3	4.8	4.6	4.7	4.6	4.4	4.3	4.3	4.5	4.3	3.8
Articulation	4.3	6.0	3.9	3.3	4.3	3.8	3.7	4.1	3.9	4.4	5.4	4.6
Specificity	3.6	4.6	3.3	3.1	3.3	4.0	4.3	3.6	3.1	3.2	4.4	3.1
Clarity	3.5	4.6	2.8	2.5	3.0	3.4	3.2	3.3	2.6	2.6	4.0	3.0
Krohn score	4.6	4.0	5.6	1.5	5.0	3.8	3.3	2.8	4.0	3.3	5.5	4.2
Self-Acceptance	6.0	2.0	8.5	3.0	3.5	4.5	4.0	5.0	7.0	6.5	8.0	2.5
Likes-Others	6.5	4.5	7.0	2.0	6.0	5.0	6.0	8.0	4.5	5.5	6.0	4.5
Kind Others	12.0	8.0	11.0	5.0	7.5	6.0	9.0	8.5	8.5	8.5	12.0	5.5
Category Counts												
Pre												
Self + -	10,29	7,26	20,24	11,37	1,11	9,26	4,9	8,15	11,9	12,25	8,10	12,11
Mother + -	0,0	1,10	0,0	0,2	2,7	0,0	0,0	1,0	0,0	0,0	0,0	0,0
Father + -	0,0	2,0	0,0	0,1	4,8	0,0	0,0	0,0	0,0	0,0	0,0	0,0
Family + -	0,0	0,2	0,0	0,3	0,0	3,5	0,0	0,0	0,0	0,0	2,0	0,0
Intimate + -	4,8	0,3	1,4	0,1	1,3	1,6	1,0	0,0	1,2	0,0	0,4	0,3
Therapist + -	0,0	0,0	0,0	0,0	0,0	1,0	0,1	0,0	0,0	0,0	0,0	0,0
Social Relationships + -	6,3	0,0	2,0	3,20	0,0	1,0	1,0	0,1	3,0	0,0	0,0	2,1
Generalized other + -	0,4	0,0	1,0	0,7	0,3	0,2	0,1	0,2	0,1	0,2	0,4	3,3
Post												
Self + -	16,21	4,22	15,8	5,8	10,15	14,22	19,31	17,6	15,12	14,19	30,21	16,19
Mother + -	0,0	0,3	2,3	0,1	0,0	0,0	0,0	0,0	0,0	0,0	2,1	0,0
Father + -	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	1,1	0,0
Family + -	0,0	0,1	0,0	0,0	0,0	0,5	1,3	0,0	0,0	0,0	2,0	0,0
Intimate + -	1,1	0,1	0,0	0,0	1,2	0,1	2,2	0,0	1,2	0,0	0,0	1,4
Therapist + -	4,0	0,0	3,0	0,1	0,0	1,0	0,0	1,0	0,0	0,0	0,0	0,0
Social Relationships + -	1,2	5,0	1,1	1,10	0,1	0,0	1,1	0,0	0,0	1,0	2,4	1,5
Generalized other + -	0,0	0,5	0,1	0,1	0,0	0,2	2,2	2,2	0,0	0,0	0,4	0,3

Client Code *	8076	8078	8091	8094	8095	8099	8100	8104	8105	8113	8114	8116
Age	26	41	48	23	22	34	20	35	28	28	22	26
Sex	1	1	1	1	1	2	2	2	2	2	1	2
* of sessions	18	12	21	15	10	42	43	23	71	18	48	20
Taped sessions used(early)	1,3	2,3	2,3	1,3	1,3	1,3	1,3	1,4	1,3	1,3	1,3	1,3
(late)	13,18	41,43	18,21	13,15	8,10	38,42	38,43	18	70	13,18	43,48	18,20
outcome (1=high, 2=med., 3=low)	2	1	2	1	1	1	1	2	2	1	1	1
Pre												
Definity	5.0	4.2	4.8	4.6	4.5	4.9	4.5	5.1	4.7	4.5	4.5	4.8
Articulation	5.2	3.5	4.7	5.0	4.3	5.3	5.9	4.8	4.8	5.7	5.1	6.5
Specificity	4.3	2.7	4.7	4.4	3.8	4.4	5.6	3.7	4.7	5.6	3.7	5.6
Clarity	2.9	2.7	3.7	3.8	3.5	4.4	5.4	4.2	4.1	5.2	3.2	5.9
Krohn score	2.0	3.5	4.1	4.8	3.6	4.1	2.8	3.4	3.8	4.9	3.9	5.7
Self-Acceptance	5.5	3.0	8.0	6.0	5.0	3.5	2.5	2.0	2.5	6.0	4.5	4.0
Likes-Others	6.0	7.0	8.0	8.5	7.0	6.0	3.0	5.5	6.0	9.0	5.0	8.0
Kind Others	9.0	9.0	9.0	12.5	9.5	7.0	7.0	5.0	8.5	7.5	6.0	6.5
Pos												
Definity	4.2	4.2	4.0	4.5	4.6	4.8	5.1	5.1	4.1	4.5	4.3	4.6
Articulation	5.3	4.3	4.9	5.1	4.4	5.3	5.7	4.9	4.9	4.4	4.6	6.7
Specificity	4.2	3.3	4.2	3.9	4.1	4.1	5.4	4.2	3.3	4.8	3.8	5.7
Clarity	3.2	2.6	3.6	3.3	3.0	4.2	5.0	4.1	3.5	3.8	3.4	5.7
Krohn score	2.3	4.2	4.1	4.3	3.5	3.6	2.8	3.6	3.1	4.7	3.5	6.7
Self-Acceptance	5.0	9.5	9.0	8.0	5.0	6.0	2.0	4.0	4.0	4.0	4.0	6.0
Likes-Others	4.5	4.5	9.0	8.5	5.5	8.0	3.0	8.0	5.0	7.0	7.0	7.0
Kind Others	6.5	7.5	11.0	12.0	6.0	12.0	5.0	8.0	6.0	7.0	7.5	9.0
Category Counts												
Pre												
Self + -	18,34	3,9	18,21	9,27	8,5	12,27	20,31	7,24	7,29	6,20	7,11	8,7
Mother + -	1,3	0,0	0,2	0,2	1,1	0,3	1,0	0,0	0,0	3,9	0,0	2,1
Father + -	1,0	0,0	0,3	0,0	4,1	0,2	0,0	0,0	0,2	0,0	0,0	1,0
Family + -	1,0	1,0	1,0	5,5	2,0	2,5	2,0	0,0	2,7	0,1	0,0	0,0
Intimate + -	0,0	0,0	1,1	0,1	0,1	0,0	0,0	0,1	0,0	1,0	0,0	1,3
Therapist + -	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,1	1,0	0,0	0,0
Social Relationships + -	0,2	0,1	0,0	0,0	0,0	0,1	1,3	0,0	3,4	0,1	1,9	0,0
Generalized other + -	0,1	0,0	0,0	1,0	0,4	0,0	2,7	1,4	0,0	0,0	0,1	0,0
Post												
Self + -	8,32	17,12	17,25	26,20	7,12	23,23	8,15	6,9	14,26	11,11	10,9	9,27
Mother + -	0,0	0,0	0,0	0,0	0,1	0,3	0,0	0,0	1,3	0,0	0,0	0,0
Father + -	0,1	0,0	0,1	0,0	1,1	0,1	0,0	0,0	0,1	0,0	0,0	0,0
Family + -	0,0	0,0	0,0	1,0	0,1	0,0	0,1	0,0	0,1	0,0	0,0	0,0
Intimate + -	0,0	2,2	0,1	2,2	0,0	3,2	0,0	1,0	1,3	4,3	0,1	0,2
Therapist + -	1,7	0,0	1,0	0,0	0,0	0,0	0,0	0,0	1,1	0,0	0,0	0,0
Social Relationships + -	0,1	0,0	0,0	1,1	0,0	0,0	7,13	1,0	1,2	0,0	0,0	0,3
Generalized other + -	3,4	0,0	0,1	0,0	1,2	0,0	0,0	0,1	0,1	0,0	0,0	0,1

Client Code *	8121	8126	8130	8131	8132	8133	8140	8146	8147	8152	8157	8160
Age	26	23	26	26	21	24	43	22	35	30	32	29
Sex	1	2	1	2	2	1	1	2	2	2	2	2
* of sessions	34	30	16	43	10	14	20	23	28	14	5	18
Taped sessions used(early)	1,4	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	1,3	2	1,3
(late)	33,34	28,31	13,16	38,45	9	13,14	18,20	18,23	23,28	13,14	5	8,18
outcome (1=high, 2=med., 3=low)	1	1	1	1	1	2	1	3	1	2	3	1
Pre												
Definity	4.0	4.5	4.2	4.1	4.0	4.7	4.6	4.1	5.0	4.5	4.8	4.7
Articulation	4.5	4.5	4.6	6.2	5.2	5.0	5.4	5.4	5.3	4.4	5.3	5.8
Specificity	4.1	3.8	4.5	4.6	3.5	4.9	4.6	3.7	4.8	4.7	5.0	4.3
Clarity	3.1	3.0	3.9	5.4	3.8	4.3	4.2	4.1	4.6	3.1	3.6	4.3
Krohn score	4.4	3.1	4.0	3.8	3.5	3.8	5.1	4.4	3.9	4.8	4.4	5.8
Self-Acceptance	3.0	3.5	3.0	5.0	6.0	6.0	4.5	2.5	2.5	4.0	3.0	5.5
Likes-Others	6.0	7.0	4.5	8.0	7.5	6.0	9.0	3.5	5.5	7.5	3.5	6.0
Kind Others	7.5	6.0	7.5	9.0	6.0	6.0	9.0	7.5	3.0	7.5	4.5	7.5
Post												
Definity	3.7	4.4	4.2	4.4	4.5	4.2	4.6	4.0	4.7	4.2	4.8	4.3
Articulation	5.7	4.7	4.3	5.6	4.8	5.3	4.5	5.6	5.7	5.5	4.6	4.8
Specificity	4.0	3.5	3.3	3.6	3.6	4.1	3.8	3.4	4.5	5.0	4.0	3.3
Clarity	3.3	3.2	3.4	4.2	3.7	4.2	3.7	4.0	4.1	4.2	3.3	2.8
Krohn score	4.4	3.7	3.0	3.3	3.0	3.4	5.1	4.3	3.8	5.5	4.1	6.0
Self-Acceptance	4.0	6.5	3.5	3.5	4.0	7.5	6.5	2.0	4.5	8.0	6.0	7.0
Likes-Others	8.0	8.0	3.5	6.5	6.0	7.0	10.0	3.0	6.0	9.5	2.0	6.0
Kind Others	9.0	9.5	7.5	7.5	6.0	9.0	7.5	7.5	6.0	12.0	6.0	7.5
Category Counts												
Pre												
Self + -	12,12	9,22	15,23	23,39	8,13	9,11	6,13	15,31	15,15	6,12	9,19	13,6
Mother + -	0,0	0,0	0,1	0,3	0,0	1,0	2,1	0,0	0,0	1,1	0,0	0,0
Father + -	0,0	2,2	0,0	0,4	0,0	1,3	0,0	0,0	2,3	0,1	0,0	0,0
Family + -	0,0	0,1	0,0	0,0	0,0	0,2	1,2	0,1	1,7	1,3	0,0	7,5
Intimate + -	1,2	0,2	1,2	0,0	0,0	0,0	3,3	0,0	3,4	0,0	0,0	0,4
Therapist + -	0,0	0,1	1,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0
Social Relationships + -	0,2	0,0	1,2	0,2	3,2	0,2	0,0	0,3	1,1	2,10	1,2	0,0
Generalized other + -	0,0	0,2	1,1	1,0	0,0	0,0	0,0	0,1	0,0	0,0	0,3	0,1
Post												
Self + -	15,15	26,16	7,26	12,21	6,2	13,18	4,10	12,29	7,21	14,8	12,2	10,12
Mother + -	0,0	0,0	0,1	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0
Father + -	0,0	0,4	0,0	0,0	0,1	0,0	0,0	0,0	0,0	0,0	0,0	0,0
Family + -	0,0	0,0	0,0	0,0	0,0	0,0	2,1	0,0	0,1	4,0	0,0	0,0
Intimate + -	0,0	0,0	1,2	0,0	1,7	0,0	1,7	0,0	1,14	0,0	0,0	0,0
Therapist + -	0,0	0,1	2,3	1,0	1,0	1,1	0,0	0,0	1,0	0,2	0,0	3,0
Social Relationships + -	0,0	0,0	0,1	0,1	0,0	0,3	0,0	0,4	1,0	0,2	0,0	1,0
Generalized other + -	0,2	0,0	0,2	0,0	0,0	0,0	0,0	0,0	0,0	0,1	1,0	0,0

Appendix F

Sample Ratings of Krohn Scale

Appendix F: Sample Ratings of Krohn Scale

4 - You can be on guard all the time but I'm also afraid that I guess I never okay when I was about 14 I went with this guy, the very first guy I went with, it was the very first time in my life that I ever felt like a real human being and people even treated me like a human being they didn't treat me like some kind of outcast. And he sort of just up and dumped me really quickly without any warning and I felt like the biggest rug had been pulled out from under me. And I felt like everybody was laughing at me for trusting him. For being so naive, so gullable. I never wanted that to happen to me cause I almost killed myself over that to. And I was only 14, 15. I'm moped for months about that. I didn't want to live anymore. I've watched as if it would make any difference to see it coming and all that watching. Makes whoever it is miserable because usually he has the world's best intentions and feels like he's been teased for something he hasn't done. So the slightest little things feel like major rejections and I feel like daddy doesn't love me anymore. I'm afraid it will happen, I'm afraid i'll just really I'll trust some man and then he'll leave me and then there I'll be again. People will laugh at me . I'd carry on this affair in public, I was less then discreet about it for 4 people knew that I was getting a divorce. I didn't care what they thought. **Rating - 2.5**

5 - But I expect another real job, in a couple of weeks.
Maybe this time it'll be good. It's a long long involved sort of thing, I could ramble for ages. You may neen a score card to keep track of all these people. When I told my last therapist she kept them straight. **Rating - 3.5**

6 - You know it isn't easy to have your own mother tell you she wants to get rid of you.

and have her laugh in your face and have her say your husband never loved you, ha ha ha. You own mother.

I mean that takes an awful lot of hate to do to anybody. I can't imagine hating anybody that much. I knew I killed my husband, I hated him at that time I did.

Rating - 2.0

2 - They didn't know, they knew John and they had known me but they knew me when I was married and Bob was living here and all that sort of good stuff and they had no idea that some of them didn't even know Bob had moved to California much less that I was getting a divorce and I was having an affair with John. So they were a little surprised and we'd get double takes from people still.

Well we were together we sat together and danced together and we were there together obviously. That's terrible, that's terribly tacky that I don't behave and yet.

3 - But I don't want to tell them right away. I really don't want them to be angry. There's no need for them to know I don't think. Not yet and I don't want my husband to find out. I've never in my life confronted my father with something I did, something major that he didn't like. Some parents accept the fact that their kids do drugs or live with their boyfriends or girlfriends and some parents are really cool about it. I never found out whether mine were or not, I assume they're not because like my sister has this boyfriend that they really don't like and the thought that she would be sleeping with him, which she is, but they don't know that, drives my father right up the wall. He just really gets angry even at the thought and I just sort of keep quiet. You know I'm not supposed to know anything.

Yes, I think he would be very very angry. I think if I waited awhile and then said I'm going with this guy named John. My mother has met him before along with some of my other friends and he's very very nice. I think they would like him fine. I

think they'd think he was a good guy, but I think they'd be angry with me if they knew I had been carrying on an affair all the time I was married, and that sort of shit.
Rating - 7.0

2 - Not frightening no, it's irritating. I tell him to stop it and grow up. One time I tried to intervene and I'll never do that again because they don't listen to you anyway. Then she's gonna go ahead and do whatever they do until they, it's like you've wound up two dolls, and until that unwinds they're not gonna stop. So usually everybody just says um, let them go at it and when they get done they'll be done. My sister and brother-in-law disagree about something just some minor thing, he'll get in on it and he'll tell Pat she's wrong and he has no right to do that, he should keep his big mouth shut and I've told him that. But he still has to get in there boy he just has to let her know she's wrong and I don't know if he sees alot of himself in her. That's kind of a copout and my mother uses it alot and she says to my sister you're just like your father. Well she does have alot of his characteristics but she's not just like him. She's still herself and she hates that when they say that to her. Even though she admires and respects him very much in many ways, there are many ways that she doesn't.
Rating - 2.5

2 - I think children take more out of you then anything else.
Cause you have to be constantly on alert and ready for anything.
I had a kid once, I was right there with him and all the time I said no running, went up to the door, you know how you have to regiment children all your life, you just have to. But I stood there by the door and he filed out and one little kid he stopped at the drinking fountain and he just rolled around and away he came and the door came shut and he just like that . . . Oh God what a mess all over.

So everybody at the softball we got this kid to the hospital. One kid got lost at Greenfield Village. So the bus was a half hour late getting home and parents were there sitting there calling the police wondering if we had an accident. It's just life with children, all ages too, not just the little ones. In fact I think it's easier with the little ones, they are most apt to do what you say. **Rating - 2.0**

6 - Like I'm doing the right thing in terms of their needs as opposed to letting themselves take care of themselves. The thing I think of right now which is really interesting to me is an experience I had especially during the, between Christmas and New Years last year, I'm an organist and the only time during September and June I can go away is between Christmas and New Years. Cause I don't have rehearsals at the church so I always go away. So I went to visit my friend Nancy in New Orleans and Nancy and I spent the week and the day I was to leave we had lunch and we had a really pleasent lunch and then just before we were to finish having lunch she said you know I think you are really really self-centered. I said well what do you mean. She said all you do is talk about yourself. And I said well you asked me and I'll tell you and she said well I don't feel like you paid attention to my needs. **Rating - 4.0**

5 - It's like especially with my parents, they have a whole lot of feeling at present right now. I feel alot closer to them then I've ever felt. I really feel like they're my parents. I really feel like they're my family for the first time. It's like my anger, I can feel it but I can also feel, I feel like I see my parents so clearly now and see how tied up they are by their own problems and how all of their own problems, not touching, not being physically affectionate, not talking about sex like they just handed to me, here this is how it is. I feel really sad right now. I feel like I look at them and I say well you know you poor people, you're both in your late fifties and

you're never going to change now. You're going to live your lives out alot of oblivion about how things can be. I'm sure they are okay but it's like some of my anger just goes away. I look at them and I feel sorry for them. **Rating - 6.0**