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No. 2210

ACCURATE EMPATHY AND RORSCHACH INTERPRETATION

DISSERTATION

Presented to the Graduate Council of the
North Texas State University in Partial
Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOSOPHY

By

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August, 1984

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Freeze, Sandra Joanna Davis, Accurate Empathy and Rorschach Interpretation. Doctor of Philosophy (Clinical Psychology), August, 1984, 84 pp., 6 tables, references, 84 titles.

Although the Rorschach is one of the most widely used psychological assessment techniques, its empirical support has been equivocal. One possible explanation for this lack of empirical support is the tendency for researchers to study only the assessment tool with little regard for the clinician using it. The current study examined one clinician variable (empathy) and its relationship to accuracy of interpretation of the Rorschach. The literature regarding Rorschach theory and research and empathy theory and research was reviewed in an attempt to clarify the similarities between empathy as an important factor in psychotherapy and its importance in the assessment process.

The present study measured empathy by using the Davis Empathy Questionnaire and a Taped Excerpt Response Measure. Scores on these measures were compared to interpretation error scores obtained by comparing clinician-generated 16-PFs to actual client 16-PFs. Pearson correlations and analyses of variance were performed and revealed one significant relationship between empathy and accuracy of interpretation of a normal Rorschach protocol. In addition, an auxiliary variable measuring clinician self-monitoring was included

and was found to be significantly correlated with level of therapist empathy as measured by the Taped Excerpt Response Measure.

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The present study is a report on one aspect of a jointly-conducted investigation. The companion report by Terry Lynne Walters, entitled *The Effects of Cognitive Flexibility on Rorschach Interpretation*, is also a North Texas State University dissertation (August, 1984).

ACCURATE EMPATHY AND RORSCHACH INTERPRETATION

The validity and reliability of the Rorschach have been the source of much controversy since Hermann Rorschach first introduced his ink blot test over 60 years ago. It is perhaps the most popular and unpopular of all projective techniques (Howes, 1981) and has been criticized on the basis of lack of reliability, validity, and sound theoretical foundation (Anastasi, 1968; Cleveland, 1976; Cohen, 1973; & Eysenck, 1959). The Rorschach has alternately been described as a sample of behavior, a clinical technique, a standardized interview, and a semantic interpretation (McArthur, Rabin & Reznikoff in Buros, 1972; Schwartz & Lazar, 1979). It has also been described as providing a projection of the examiner's psyche as well as that of the client (Schaffer, 1967), and there is evidence to support such a description (Cohen, 1973; Harrower, 1976; Picuicco, 1976).

The question of the Rorschach's validity seems to be rather vague and, perhaps, inappropriate. It seems somewhat akin to the "grand prix" question regarding the effectiveness of psychotherapy (Garfield & Bergin, 1978). Perhaps a better question would be "for which clinicians is the Rorschach a valid instrument?" Research has indicated that certain clinicians are more accurate in their interpretations of the

Rorschach than others (Chambers & Hamlin, 1957) and for these clinicians, the Rorschach may be very valid.

Typically, clinicians want a high level of understanding with a limited amount of data. Some clinicians seem to be able to accomplish this task quickly and accurately while others cannot (Potkay, 1971). This suggests that there may be some clinician characteristics that influence the validity of the Rorschach. Chambers and Hamlin (1957) found that different clinicians use different approaches to interpretation with better "judges using higher levels of abstraction" (p. 10). These clinicians were able to shift from one level of interpretation to another and integrate data from these various levels to form a more accurate picture of the client.

The present study proposes to examine one clinician variable that may prove to be influential in determining accuracy of the Rorschach interpretation. As Reik (1948) suggests, the clinician's own personality may be his/her most important tool in that it both colors how she/he perceives and analyzes data as well as how interpretations of data are conveyed to the client. It has also been proposed that good therapists have a "central core of facilitative conditions" (Strup, et. al., 1969) and that one of the conditions is the therapist's capacity for empathy toward the client (Rogers, 1957).

It seems intuitively reasonable to assume that level of clinician empathy might also influence one's accuracy in the interpretation of the Rorschach since the process of analyzing and interpreting test data is quite similar to the ongoing assessment process which takes place in therapy. During each of these processes the clinician seeks to better understand the client's perceptual world by attending to certain client behaviors. In therapy the clinician responds to the verbal and non-verbal cues that occur within the therapeutic context. When the clinician interprets Rorschach test data, she/he is also responding to various verbal and non-verbal cues that occur in the context of the testing situation. Therefore, a clinician skill, such as empathy, that enhances one's therapeutic efficacy might also influence one's accuracy. In an effort to clarify and develop this line of reasoning, a brief look at theoretical and research issues regarding both the Rorschach and empathy seems to be in order.

Rorschach Theory

The criticism leveled at the Rorschach regarding its lack of a sound theoretical foundation seems to be largely inappropriate because many authors have, in fact, been quite specific regarding the rationale for projective testing. If "sound foundation" means empirical support for the extant formulations, then this criticism may be more reasonable.

One theory of projective testing is based upon the premise that all contemporary perceptions are influenced and organized

by memory traces of previous stimuli. Bellack (1975) refers to this as apperceptive distortion, but the phenomenon is related to Freud's (1943) concept of projection. Projection, along with allowing one to attribute subjective undesirable or threatening impulses to objective stimuli, also colors one's perceptions even when there is no conflict involved (Freud, 1938). This coloring of one's perceptions has been referred to by Bellack (1975) as apperception. It has been defined by C. P. Herbart (as cited in Bellack, 1975) as "the process by which new experience is assimilated to and transformed by the residuum of past experience of any individual to form a new whole. The residuum of past experience is called the "apperceptive mass."

Based upon this apperceptive mass, the client will project his/her own needs, drives, and conflicts into the test performance, e.g., Rorschach responses. By interpreting the data, the clinician can make inferences from manifest to latent levels about how the client perceives and organizes stimuli and the defense mechanisms used and their adequacy. Consequently, projective techniques seemingly give a much richer description of an individual's personality than personality or psychopathology inventories (e.g., 16 Personality Factors test or M.M.P.I.) and allow the examiner to believe he/she perceives more subtle nuances of personal dynamics. By presenting the client with an ambiguous stimulus, such as an inkblot, the examiner can elicit responses which are believed reflective of the client's general approach to

the world. Based upon the client's responses, the clinician can formulate hypotheses regarding the client's life interests, intensity and variability of emotions, problem solving processes, and tendency to either impose structure or tolerate ambiguity in unstructured situations (Howes, 1981; Pitrowski, 1957).

Perhaps the criticism of the Rorschach referred to as lack of theoretical basis is more reflective of the inconsistency with which the Rorschach has been scored and interpreted. There have been almost as many scoring techniques used as there are interpreters to use them (Beck, 1950; Hertz, 1951; Klopfer, 1937; Pitrowski, 1937; Rappaport, Gill & Schaffer, 1946). A recent attempt at creating a cohesive scoring system has been made by John Exner (1974) and this may be the first step toward unifying the interpretive process used by different examiners. However, even though there have been numerous scoring techniques used, there does seem to be an underlying component of unity upon which all interpretations are based.

This unity is due to the fact that all of these techniques refer to the client's verbalization about the card. Of all the scores, clinicians appear to rely more heavily on those based upon content analysis (Burstein, 1973; Potkay, 1971; Powers & Hamlin, 1957). In addition, content analysis has received the most consistent empirical support of any of the Rorschach variables (Howes, 1981).

Most rationales for projective testing imply that the content of the responses originates in a subsemantic, unconscious manner arising from both ego and other mental functions and, as such, is less controlled or censored than most communications. There has been proposed a continuum which describes the degree of control in imaginative productions (Bellack, 1975; Hartmann, 1951; Kris, 1950). This continuum ranges from minimal to maximal levels of control as indicated by the following sequence: dreaming, hypnagogue phenomena, preconscious fantasy, daydreaming, free association, artistic productions, test behavior on projective techniques, and problem solving (Bellack, 1975). This continuum implies that a person has an oscillating function which permits varying degrees of self-exclusion. This oscillating function was perhaps first discussed by Jung (Hall & Linzay, 1970) in regard to problem solving and creativity and has been referred to as adaptive regression in the service of the ego by some authors (Bellack, 1975).

Just as the client "regresses" when he/she responds to the test stimulus (e.g., inkblots), one might postulate that the clinician perhaps suspends some of his/her own control functioning in order to become receptive to the client's unconscious material. Such a suspension may result in what Blanck and Blanck (1974) refer to as coenesthetic reception. This reception is a global, pre-verbal type of perceiving,

intense, and largely visceral. While common in children, the capacity for coenesthetic receptivity atrophies in most adults. This occurs possibly as a result of the societal emphasis placed upon linear logic and verbal processing although some adults do retain a degree of this receptivity. People who retain such receptivity may be perceived by others as gifted in certain areas, and perhaps one of these areas is in the realm of interpersonal responsiveness and accuracy.

Rorschach Research

Projective techniques view personality in a global or configural manner and, as such, may be amenable to contemporary research methodology only with great difficulty (Cronback, 1949). Given the complexity of the Rorschach and the interaction of its variables, it is not surprising that there have been relatively few studies yielding positive results when traditional evaluation methods have been used. Rorschach, as well as others, stressed the importance of interpretation based on the interaction of the various components of the test (Howes, 1971; Pitrowski, 1957), yet as Wyatt (1968) pointed out, most of the research on the Rorschach has been conducted from a trait isolation perspective in which specific response determinants are studied in relation to specific behaviors. According to Exner (1974), this approach is relatively useless in evaluating the Rorschach. He suggests that designs emphasizing a more global context would be much more useful and appropriate.

Allport's (1961) distinction between common traits and personal dispositions provides another rationale for the discrepancy between professional belief and empirical findings of Rorschach validity. Many of the same authors who support Rorschach use because of its presumed ability to tap deeply personal information attempt to study it in the context of statistically common traits. If the Rorschach's strength is its ability to investigate the unique personal attributes of clients, then it perhaps should fail to correlate highly with group based common traits.

Goldfried, Stricker, and Weiner (1971) have used a global method to identify and evaluate factors such as hostility, suicide potential, and schizophrenia. The interdependence of various Rorschach variables is also suggested in a study by Exner and Wylie (1977) in which a constellation of 11 variables were identified as being predictive of suicide. These global, or configural, interpretations seem to be very consistent with the theoretical foundation for projective testing mentioned earlier and seem to belie the criticism regarding lack of any empirically supported theoretical conceptualization.

Numerous studies have been conducted which support the validity of common interpretations of certain content categories. Among the many categories for which validity of interpretation has been supported are human content as the ability to empathize with and relate to others (Fernald & Linden, 1966; Goldman, 1960; Rosenteil, 1969), preponderance

of animal content as being related to stereotypic thought and poor intellectual functioning (Rickers-Ovsiankian, 1960; Richter & Winter, 1966), and popular responses as an indication of degree of conformity to social norms (Bloom, 1962; Tutko, 1964).

While Chambers and Hamlin (1957) address the critical issue of clinician influence upon interpretation, there seems to be a relative dearth of subsequent research in this area. It may be that the empirical validity of the Rorschach will remain equivocal until the role and personal characteristics of the clinician are taken into account.

Most Rorschach validation studies have been based upon the assumption that the traditional scoring variables, determinants, form quality, et. cetera, constitute the basis for clinicians' interpretations. However, it is not clear that accurate Rorschach interpreters utilize these traditional variables in the ways in which these were initially defined (Chambers & Hamlin, 1957; Levine, 1959; Aritage & Perl, 1957). Interpreters have been found to value Rorschach information differentially, and Levine (1959) postulates that the inability to empirically validate the Rorschach may be due to investigators "scoring the Rorschach for 'traditional' Rorschach categories while clinicians utilize different variables, perhaps without scoring them, in their day to day work" (p. 439).

Empathy Theory

Much research conducted during the past 20 years has focused upon what has variously been described as instinctive

and intellectualized sympathy (Smith, 1975), empathic understanding (Means, 1973), and accurate empathy (Truax & Carkhuff, 1967). Various definitions have been used to describe this capacity and it may prove helpful to briefly discuss the definitions offered by various authors. Perhaps the most comprehensive definition of empathy is that given by Webster (1977) as: (a) "the imaginative projective of a subjective state whether affective, conative, or cognitive into an object so that the object appears to be infused with it: the reading of one's own state of mind or conation into an object. (b) the capacity for participating in or the vicarious experiencing of another's movements to the point of executing bodily movements resembling his" (p. 373).

Definitions relating specifically to empathy in the therapeutic process have also been developed, perhaps the most generally accepted being that of Truax and Carkhuff (1967). They describe accurate empathy as "both the therapist's sensitivity to current feelings and his verbal facility to communicate this understanding in a language attuned to the client's current feelings" (p. 46). Empathy has also been discussed as having a multidimensional nature in that it can be either affective/instinctive or cognitive/intellectual (Davis, 1980) and passive or active (Havens, 1978). Instinctive, or affective, empathy is an involuntary, emotional reaction to the experience of another, while intellectual, or

cognitive, empathy represents a more objective perspective taking, i.e.: recognizing what another is feeling but not actually feeling that way oneself. This dimension focuses on the "as if" aspect of empathy. The distinction between the two has been a central issue in discussions of this concept for many years.

Deutsch and Madle (1975) cite Mead (1934) as the originator of the affective/cognitive distinction. A central premise of this distinction is that of self/other differentiation. According to Deutsch and Madle, several authors do not think that the self/other differentiation is necessary for the development of empathy (Gordon, 1934; Ferreira, 1961; Freud, 1961; Fromm-Reichman, 1950; Stotland, 1971; Sullivan, 1940). These authors propose that an emotional link between mother and child is established early in life and that this link provides a "psychological umbilical cord" through which the infant can perceive the mother's inner cues. This link is strikingly similar to the coenesthetic response that Blanck and Blanck (1974) mention. Deutsch and Madle (1975) suggest that this responsiveness could be more accurately explained by a classical conditioning paradigm by which the child becomes sensitive to the mother's cues. Stotland, et. al. (1971) believe that sharing feelings is reflecting empathy. One recognizes another's affective state and reacts to it subjectively, thus there is no self/other differentiation.

According to Deutsch and Madle, Aronfreed (1968) also feels that "perceiving another's emotional state by means of affective responses reflects an empathic relationship, whereas, perceiving the emotionally arousing situation and affect refers to a vicarious relationship" (p. 270).

Other authors, however, are very clear in stating that self/other differentiation is necessary to accurately empathize with another (Dymond, 1950; Mean, 1936; Rogers, 1957). Rogers (1957) views empathy as the ability "to sense the client's private world as if it were your own, without ever losing the 'as if' quality" (p. 99). Mead (1934) feels empathy is the capacity to take the role of another. He views role playing as very important in the development of one's capacity for empathy in that it provides the opportunity to develop interpersonal images. It thus enhances one's ability to understand others in various situations.

The controversy surrounding the issue of self/other differentiation is probably the result of confusion over several different terms which overlap with the concept of empathy. Sympathy, projection, identification, and imitation all have been suggested as overlapping concepts (Deutsch & Madle, 1975; Dymond, 1950). Dymond (1950), in a comprehensive review of the literature, provided various distinctions between empathy and these concepts. She cites Mead (1934) as saying "Sympathy always implies that one stimulates himself to his

assistance and consideration of others by taking, to some degree, the attitude of the other person whom one is assisting" (p. 366). She also cites Koestler (1949) as saying "Empathy can be described as a process of projection or introjection; both are metaphors referring to the experience of partial identity between the subject's mental processes and those of another with the resulting insight into the other's mental state and participation in his emotions. Empathy becomes sympathy when to this mental resonance is added the desire to collaborate or help" (p. 360).

While Koestler views empathy as a form of projection, Dymond (1950), as well as others (Deutsch & Madle, 1975), see it as an antithetical process to empathy in that when one projects, one attributes his/her own feelings to another rather than accurately understanding the person's actual feelings. This may have some relevance to the charge that the Rorschach is a projection of the examiner's psyche rather than the client's. If the clinician projects rather than empathizes, this may well occur. However, this in itself would seem to provide support for the rationale for projective testing.

Identification has also been linked with empathy, but it has also been differentiated from it by various authors (Bachrach, 1968; Dymond, 1950). These authors suggest that identification, like empathy, is a form of role taking, but identification is permanent, occurs relatively infrequently,

and requires a substantial emotional investment whereas empathy is transient, can occur frequently, and requires a smaller emotional investment.

Imitation has also been studied in regard to empathy. As early as 1926, Lipps (in Deutsch & Madle, 1975) posited that imitating the movements, postures, and expressions of another would create inner cues which would subsequently lead to the understanding and sharing of the other person's emotions. Bandler and Grinder (1975) have developed a neurolinguistic programming model based on the operation of certain representational systems. These representational systems are used to process internal and external information and are sensory specific (Hammer, 1973). Bandler and Grinder believe that people have preferred ways of receiving and processing information and these preferred modes can be ascertained by noting the perceptual predicates people use. For example, some people prefer the perceptual predicate "see" and may typically use sight words to express their feelings, i.e.: "I don't see how I can accomplish this." Bandler and Grinder suggest that therapists can adopt perceptual predicates similar to their clients when communicating with them and this should enhance empathy. Indeed, in a study by Hammer (1983), matching perceptual predicates did result in a significant increase in perceived empathy.

Havens (1978) distinguishes between active empathy in which "one puts into language what the other is feeling" and

passive empathy in which "one echoes the patient's statements and, above all, supports and echoes his feelings" (p. 340). He also delineates a position between active and passive empathy in which the clinician is highly sensitive to the cues of the client and at the same time is trying to understand the whole person. He gives as an example the smiling depressive who will appear happy to most people but will give subtle cues regarding his/her depression to the discerning therapist.

Empathy Research

While the relationship between empathy and assessment skills has been rarely researched, much work has focused upon the relationship between empathy and therapeutic outcome. Empathy was cited by Rogers (1957) as one of the necessary and sufficient conditions for therapeutic change. It has been suggested by others (Rogers, 1967; Truax & Carkhuff, 1967) that empathy serves as a foundation upon which the other helping dimensions (genuineness, unconditional positive regard, and concreteness) are based. Truax and Carkhuff (1967) believe that the ability to accurately and sensitively perceive and communicate, the feelings of the client and the meanings of these feelings is central to psychotherapy. They interpret their findings as an indication that assuming the internal frame of reference of the client allows the therapist to experience the world and events as if she/he were the client. In this way, the therapist can recognize the client's emotional

components while at the same time retaining her/his objectivity. Such a recognition and understanding of the client is seen as essential for encouraging the client to understand himself/herself at a deeper level (Carkhuff, 1969b).

Means (1973) also stresses the importance of empathy in the therapeutic process. He views empathic understanding as "one dimension in which a counselor can have therapeutic impact on a client, a dimension that has logical continuity and distinctiveness" (p. 1). He suggests that such empathic understanding enables the therapist to use relevant affective and cognitive information about the client and her/his way of perceiving the world to form a basis for pertinent and accurate communication during therapy.

Bachrach (1968) conducted a study in which he considered empathy as a personal characteristic of the therapist. This study attempted to determine the relationship between empathy and the therapist's capacity for adaptive regression in the service of the ego. The two were found to be significantly correlated as measured by the therapist's Rorschach responses and ratings on two empathy measures. As a result of his research, Bachrach outlines a conceptual model for thought organization. He postulates four quadrants representing different levels of cathectic mobility and ego activity and offers the following definitions for these terms. "Cathectic mobility, a principle underlying the displacements and

condensations of primary process thinking, refers to the extent to which any impulse is free to seize upon any available path for discharge, regardless of the dictates of adaptation or logic. Ego activity, a concept introduced by Rapaport (1951), refers to the individual's "ability to regulate and postpone drive pressures of cathectic discharges. When he is helpless to do so, ego passivity exists" (p. 204).

Appendix A is a reproduction of Bachrach's conceptualization. Quadrant II represents the process involved in empathy and other creative processes such as problem solving and, possibly, Rorschach interpretation. Bachrach views empathy as "a process dependent upon an interplay between different levels of thought organization. The therapist must be able to relax his psychological controls (i.e., defenses) and temporarily suspend more accustomed, logical modes of thinking in the service of freely formulating hypotheses regarding the patient's thoughts and feelings" (p. 205). Along with being able to relinquish control and suspend typical ways of thinking, the therapist must also be able to re-establish control and logically evaluate his/her hypotheses.

Empathy/Rorschach Relationship

It seems reasonable to assume that the capacity for accurate empathy would aid the clinician in accurately interpreting test data as well as in employing effective therapeutic interventions. Several parallels can be drawn between the importance of empathy in the therapeutic process and its importance in

assessment, particularly in interpretation of the Rorschach. Means (1973) identifies six elements that may be present in any statement the client makes and claims that the therapist may then respond to any or all of them. Since these same elements might also be expected to appear in a client's Rorschach protocol if the therapist is perceptive enough to recognize them, they will be enumerated here. They include: (a) the client's expressed or obvious feelings, (b) the identification of environmental stimulus, (c) the identification of the client's behavior pattern, (d) the client's feelings toward himself/herself as a result of interaction with the environment, (e) expectations of oneself, and (f) basic beliefs about oneself.

Further comparisons between the role of empathy in therapy and assessment can be made based upon the views of other authors as well. Rabkin (1976) stresses "the perception of the patient's experience of his life, not the recognition of the pathological organization that gives rise to his problems, as essential as this is" (p. 254). This idea would seem to be relevant to Rorschach interpretation, given the call for expanded use of the Rorschach to identify areas of maximal, even creative, functioning as well as areas of dysfunctioning (Howes, 1981). She also compares empathy to "spontaneous interventions that seem to emerge from nowhere" (p. 254). Since a great number of clinicians continue to use the Rorschach and a great number of them do not really know why, given the

equivocal status of its validity, it seems that this idea would also pertain to Rorschach interpretation. Many clinicians can very quickly develop profiles of clients based upon this interpretation of the client's Rorschach responses. However, if pressed to enumerate exactly which pieces of information led to the development of such a profile, they are unable to do so.

According to Rabkin (1976), Greenson (1960) feels that empathy enables the therapist to identify with the client's "perspectives and feelings, almost to become him for a moment, and thereby are able to see and to reveal to him a hidden, unrealized truth about himself" (p. 255). This revelation of a "hidden, unrealized truth" is consistent with what the Rorschach presumably allows the clinician to discover through accurate interpretation.

A model for accurate interpretation of the Rorschach might be constructed on the basis of Carkhuff's (1969) various stages and levels of empathy. (See Appendices B and C for a full description of these stages and levels.) It would seem that just as the counselor proceeds through various stages of empathy in order to achieve higher levels of understanding, so does the assessment clinician. Accurate interpretation of the Rorschach may be representative of Carkhuff's (1969a) highest level of empathy, level five, in which the clinician responds "with a full awareness of who the other person is and with a comprehensive and accurate, empathic understanding of that

individual's deepest feelings" (p. 175). Based upon this understanding, the clinician can proceed to stage three of empathy (Carkhuff, 1969b) in which "there is a directionality that emerges from understanding" (p. 85). This directionality may take the form of the clinician's diagnosis of the client, recommendations for treatment planning, and the prognosis.

In reviewing the literature, one study was found which indirectly considered empathy in regard to Rorschach interpretation. Halpern (1957) postulated an approach to Rorschach interpretation which would enable the examiner to test hypotheses about the meaning of the client's responses. This procedure would provide feedback regarding the accuracy of the "direction" the clinician was providing. In his study, Halpern administered the Rorschach one day and the next day asked the client questions based on the clinician's interpretations. The questions were constructed by assuming a position described in the client's percept in order to more fully appreciate the kinesthetic and proprioceptive cues that prompted the percept. Halpern proposes that by putting oneself in the percept and tempering that with what one knows about the client, the clinician can validate with the client what she/he thinks the client is communicating. This process is quite similar to the empathic processes described above. Halpern offers two indications that the questions promote a more meaningful understanding of the client's inner life. In answering the questions the next day, the client would frequently

use a metaphor similar to the percept given the previous day. For example, in one response the client referred to "a quiet cove...like it's never been inhabited by any man" (p. 16). The next day when he was questioned about feelings of loneliness, the client replied that he felt there was "a secret island in myself that no one would ever reach or inhabit" (p. 16). The second indication that the questions were meaningful in a highly personal way was evident in the client's reactions to the questions. In most cases, they were very willing to elaborate on their feelings and were impressed with the accuracy with which the clinician identified pertinent areas for discussion.

Statement of Problem and Hypothesis

The preceding reviews of the literature regarding the Rorschach and empathy indicate that there may be some commonalities between the two processes. It was thought that an investigation of the relationship between the two certainly appeared to be in order and might prove quite helpful in illuminating the heretofore mysterious process of Rorschach interpretation. By examining one specific characteristic of the clinician (i.e., empathy), it was hoped that progress could be made toward empirically validating the Rorschach as a useful assessment tool. Specifically, it was hypothesized that clinicians with a higher level of accurate empathy (as defined by Rogers, 1957) will more accurately interpret the Rorschach.

Method

Subjects

Subjects included 42 graduate psychology students (21 males and 21 females). All subjects had taken their program's required course in projective assessment techniques. They were recruited by asking for their voluntary participation (see Appendix A for consent form) in the study and were randomly assigned to interpret two of the following three protocols--normal, moderately disturbed and severely disturbed. Thus, 84 observations were generated. Because of the difficulty in obtaining a sufficient number of qualified subjects, no direct control was applied to the balancing of subject variables (e.g., age, sex) in the assignment of conditions.

Instruments

Materials used included the following--three 16-Personality Factor Questionnaires (Cattell, et. al., 1970; see Appendix E), three Rorschach protocols (see Appendix F), the Empathy Questionnaire (Davis, 1980; see Appendix G), five video tapes of clients from three diagnostic categories (an obsessive-compulsive personality disorder, an affective disorder, and a histrionic personality disorder), cassette tapes to record subjects' responses, a tape recorder, and client excerpts adapted from Carkhuff (1969; see Appendix H).

The 16-PF questionnaire is an objectively scored personality test which yields 16 primary factor scores. These scores include the following--reserved versus outgoing (A), less

intelligent versus more intelligent (B), affected by feelings versus emotionally stable (C), humble versus assertive (E), sober versus happy-go-lucky (F), expedient versus conscientious (G), shy versus venturesome (H), tough-minded versus tender-minded (I), trusting versus suspicious (L), practical versus imaginative (M), forth-right versus shrewd (N), self-assured versus apprehensive (O), conservative versus experimenting (Q1), group dependent versus self-sufficient (Q2), undisciplined self-conflict versus controlled (Q3), and relaxed versus tense (Q4). Alternate form reliability for this instrument is reported to be .70 and criterion validity coefficients are as high as .56 (Buros, 1975). A Sten score is obtained and scores 1-3 and 8-10 are interpretable.

While the Rorschach addresses some aspects of personality that are different from those addressed by the 16-PF, both are used and conceptualized as general assessment tools. Indeed, a comparison of the 16-PF traits to Exner's (1974) method for interpretation of the Rorschach indicates that all 16 of the traits are interpretable by some aspect of Exner's system. Because of this considerable overlap as well as the conceptual width of the 16-PF, it was chosen as the measurement of accuracy of interpretation for this study.

Empathy Questionnaire. This is a 28-item empathy measure, chosen because it measures both the cognitive and affective aspects of empathy. For each question, subjects indicate how well the item describes them on a five-point scale ranging

from 0 (does not describe me well) to 4 (describes me very well). The questionnaire is comprised of the following four groupings of items: (a) fantasy items which denote the subject's tendency to identify with characters in fictional works, (b) perspective-taking items which reflect the subject's ability to assume the perspective of another, (c) empathic concern items, which assess the subject's tendency to experience compassion and concern in response to the negative experience of another, and, (d) personal distress items, which indicate the subject's tendency to experience discomfort and anxiety in response to the negative experience of another. The standardized alpha coefficients for the seven-item, unit-weighted scales range from .70 to .78 (Davis, 1980). The test-retest reliability coefficients for the four scales range from .60 to .81 (Davis, 1980).

Tape Excerpt Response Measure (TERM). The TERM consisted of a series of five videotapes of clients from the following diagnostic categories: obsessive/compulsive personality, affective disorder, and histrionic personality. This measure is similar to a measure used by Abramowitz, et. al. (1976) in which simulated client problems were portrayed by student volunteers. Subjects were then asked to write their responses to the portrayed client. In the present study, however, each tape presented excerpts from an actual interview with the client and subjects were asked to audiotape their responses. This measurement has been chosen to allow the subject to respond immediately and

open-endedly to client excerpts. The TERM will measure empathy from the aspect of perspective taking.

Carkhuff Excerpts. A list of 14 therapy excerpts was adapted from Carkhuff's (1969) scale for discriminating empathic responses. The original scale consists of 16 excerpts accompanied by four possible responses for each excerpt ranging from low (1) to high (5) levels of empathy. The scale is used to train raters to recognize accurately empathic responses. Trainees are instructed to rate each response of the five-point scale and those achieving interrater reliability of .50 are actually used as raters. The adapted version used in the current study consists of 14 excerpts with one response given for each excerpt. Responses were distributed in the following manner: four responses previously rated by Carkhuff's trainees as low (1) in empathy, six responses previously rated as moderate (3) in empathy, and four responses previously rated as high (4) in empathy.

Procedure

The design of the stimulus presentation was that of an overlapping incomplete lattice (see Table 1) in which each subject was given a Rorschach protocol from two of the following three conditions: normal, moderately disturbed, and severely disturbed. The conditions were formed by the diagnostic categories of the persons providing the protocol. Subjects were given two transcribed Rorschach protocols to interpret.

Table 1
 Data Design for Error Scores Based Upon
 Estimated Trait Scores

Blocks	Subjects	Estimated 16-PF Trait Scores														
		Normal				Moderate				Severe						
		A	B	C	. . .	Q4	A	B	C	. . .	Q4	A	B	C	. . .	Q4
A	A ₁	X	X	X	. . .	X	X	X	X	. . .	X					
	A ₂	X	X	X	. . .	X	X	X	X	. . .	X					
	A ₃	X	X	X	. . .	X	X	X	X	. . .	X					(Not given)
					
					
					
	A _n	X	X	X	. . .	X	X	X	X	. . .	X					
B	B ₁	X	X	X	. . .	X						X	X	X	. . .	X
	B ₂	X	X	X	. . .	X						X	X	X	. . .	X
	B ₃	X	X	X	. . .	X						X	X	X	. . .	X
	.	.	.	.	. . .	.					(Not given)	.	.	.	. . .	.

	B _n	X	X	X	. . .	X						X	X	X	. . .	X
C	C ₁						X	X	X	. . .	X	X	X	X	. . .	X
	C ₂						X	X	X	. . .	X	X	X	X	. . .	X
	C ₃				(Not given)		X	X	X	. . .	X	X	X	X	. . .	X

	C _n						X	X	X	. . .	X	X	X	X	. . .	X

For each protocol, the subject was asked to generate a 16-PF profile of the client tested based upon these interpretations.

In addition, each subject participated in two measures of empathy. Subjects were first instructed to complete the Empathy Questionnaire. They were then administered the Tape Excerpt Response Measure (TERM). Before viewing the videotapes, the subject was given a 3 X 5 notecard upon which the following definition had been typed: "Empathy will be defined as the ability to 'sense the client's private world as if it were your own'" (Rogers, 1957, p. 99). They were allowed to keep the definition before them at all times during the administration of the TERM and were instructed to refer back to it as necessary during their responses. Subjects were instructed to view each videotape, stop it at the appropriate point, and dictate his/her response to the excerpt. Subjects were instructed to respond in as empathic a manner as possible based upon the definition of empathy provided. All measures were administered individually.

Upon completion of the TERM tasks, each subject's responses were rated, using a Q-sort method. Each response was placed in one of the following categories: least empathic (1), less empathic (2), moderately empathic (3), more empathic (4), and most empathic (5), and given the corresponding numerical value as a score. Individual response scores were then totaled to produce a total TERM score for each subject.

A preliminary pilot study was conducted to determine the convergent validity of the Q-sort method of rating with the five-point rating scale that Carkhuff (1969) uses. Subjects were instructed to Q-sort the responses into least empathic, moderately empathic, and most empathic. A summary of the inter-rater agreement and between method agreement is given in Table 2.

Table 2
Between Method Agreement for Q-Sort and
Carkhuff Ratings

Subject Number	Absolute Agreement	*Within One Level Agreement
1	50%	93%
2	43	100
3	36	78
4	57	93
5	100	100
6	70	100

Note. *Subject's rating was within one level of Carkhuff's ratings. Example: Subject's rating of moderately empathic versus Carkhuff's rating of most empathic.

Raters for the current study were trained to use this Q-sort method, and two raters obtaining an interrater reliability of .70 were used to sort subjects' responses.

For each Rorschach protocol, an error score was derived based upon the difference between the predicted and actual 16-PF profile of the client. The squared difference between

actual and predicted 16-PF scores was used in order to make the weight of errors proportionate to the size of these error scores, and the 16 factors were summed to provide a score of overall accuracy.

Scores on the separate scales of the Empathy Questionnaire were obtained by totaling the point values assigned to the questions by the subjects.

Results

Pearson correlations and analyses of variance were used to analyze the data collected from 42 graduate students (21 males and 21 females). Table 3 contains basic demographic

Table 3
Demographic Data.

Variable	Range	Mean	Median	Standard Deviation
Age	23-52	30	29	6.46
Number of Rorschachs previously administered	1-99	23	12	26.6
Fantasy	5-28	18.17	18.5	4.79
Perspective Taking	12-26	19.29	20	3.68
Concern	12-28	20.36	21	3.55
Personal Distress	3-17	10.79	10.5	3.57
TERM Total	-5.64-5.12	-0-	.64	2.75
Total Empathy	46-90	68.60	69	8.99

Table 3--Continued

Variable	Range	Mean	Median	Standard Deviation
Error Score on Protocol A	20-205	67.9	57	40.02
Error Score on Protocol B	47-304	142.47	146	53.74
Error Score on Protocol C	59-225	122.66	115	45.67

data on the subjects, including age, number of Rorschachs previously administered, measurement means, and standard deviations.

The hypothesis that clinicians who scored higher on measures of empathy would more accurately interpret the Rorschach was partially confirmed as indicated in Table 4. While no significant relationship was indicated in two of the groups of protocol interpretations (moderately disturbed and severely disturbed), a significant negative correlation was found between error in interpretation of Group One protocols (normal) and the Taped Excerpt Response Measure (TERM) total score ($r = -.44$; $p = .009$). In addition, although not statistically significant, a trend indicated a negative relationship between error in interpretation and level of empathy as measured by the TERM in the other two groups. No significant relationships between any of the other measures of empathy and error of interpretation was produced by any of the analyses. A summary of these findings, however, is included in Table 5.

Table 4
Pearson Correlations Between Empathy and Error Scores

Empathy Measures	Error Score on Protocol 1: Normal	Error Score on Protocol 2: Moderately Disturbed	Error Score on Protocol 3: Severely Disturbed
Fantasy	-.12 $\underline{p} = .3$	-.01 $\underline{p} = .4$	-.29 $\underline{p} = .1$
Perspective Taking	-.23 $\underline{p} = .1$	.24 $\underline{p} = .1$	-.12 $\underline{p} = .2$
Concern	.13 $\underline{p} = .2$	.2 $\underline{p} = .2$	.19 $\underline{p} = .2$
Personal Distress	.01 $\underline{p} = .5$	.29 $\underline{p} = .07$	.12 $\underline{p} = .3$
TERM Total	-.44 $\underline{p} = .009$	-.11 $\underline{p} = .3$	-.25 $\underline{p} = .1$

In addition to the previously discussed variables, an auxiliary variable was included in this study which measured subjects' degree of self-monitoring. A significant correlation ($r = .49$; $\underline{p} = .001$) was found between subjects' level of self-monitoring and their TERM scores and a discussion of this finding is included in a substantive appendix (Appendix I).

Table 5
Analyses of Variance Comparing Error Scores and Empathy

Empathy Measure	Error Score on Protocol 1: Normal	Error Score on Protocol 2; Moderately Disturbed	Error Score on Protocol 3; Severely Disturbed
Fantasy	F = 2.726 <u>p</u> = .11	F = .459 <u>p</u> = .50	F = .084 <u>p</u> = .77
Perspective Taking	F = .788 <u>p</u> = .38	F = .3 <u>p</u> = .59	F = .001 <u>p</u> = .97
Concern	F = .836 <u>p</u> = .37	F = .661 <u>p</u> = .42	F = 2.931 <u>p</u> = .10
Personal Distress	F = .315 <u>p</u> = .58	F = 2.757 <u>p</u> = .11	F = .00 <u>p</u> = .99
TERM Total	F = .775 <u>p</u> = .39	F = .857 <u>p</u> = .39	F = 2.928 <u>p</u> = .10

Discussion

While the results of this study do not indicate a profound relationship between accuracy of interpretation of the Rorschach and level of clinician empathy, they do suggest a trend in that direction. This trend, as well as the significant correlation between accuracy of interpretation of the normal protocol and level of clinician empathy, will be discussed from a theoretical perspective, but a preliminary discussion

of methodological considerations seems to be in order first. Although the relative lack of significant results may indeed be reflective of little relationship between empathy and accuracy of interpretation of the Rorschach, it may also be reflective of some of the methodological problems that plague Rorschach researchers. For this reason it seems appropriate to discuss some of the problems that became apparent as this study was being conducted.

One factor that was not taken into consideration prior to conducting this study was the clinicians' degree of familiarity with the 16-PF. Although it was assumed that the factors listed on the 16-PF profile were self-explanatory and subjects were given the opportunity to ask questions if they were unsure how to complete the projected profile, no control was included for this source of variance. For this reason it is difficult to assess how much the projected 16-PFs actually reflect the clinicians' interpretation of the Rorschach protocols versus how much they reflect the clinicians' understanding and skill at interpreting the 16-PF.

Another factor to be considered in regard to methodology is the possibility that the 16-PF may not be an accurate or sensitive enough instrument to measure accuracy of interpretation of the Rorschach. While the present study was designed in an attempt to emphasize a more global approach to interpretation as suggested by Exner (1974), it may be that by forcing subjects to quantify their interpretations in terms

of discrete scores on particular personality factors, a substantial degree of measurement accuracy was lost.

Perhaps an anecdotal example would help clarify this point. A colleague who was not included in this study for various reasons interpreted one of the protocols and verbally gave his clinical impressions gained from the interpretation. He then projected a 16-PF for the client. While his verbalized interpretation was quite accurate regarding life circumstances, age, behavioral and emotional style, etc., his projected 16-PF did not reflect this degree of accuracy. Such a discrepancy indicates that the Rorschach may indeed give the clinician a "richer" description of the client, but that this description is difficult to reduce to quantitative personality traits. Perhaps some of the assumptions of Gestalt theory would be applicable here, i.e., the whole is greater than the sum of its parts. Although such individual traits give pertinent and valuable information to the clinician, they may not provide the same type of holistic or configural, picture of the client as the Rorschach purportedly does.

If, as suggested by Chambers and Hamlin (1957), clinicians who are better at interpreting Rorschachs are able to abstract at higher levels than those who are less accurate, then perhaps it would be more fruitful to devise a measurement that would allow them to express their interpretations in more abstract terms while at the same time measure their degree of accuracy as well. Such a measurement may only exist currently

in fantasy, but it seems like a worthwhile direction for future research.

A relevant point regarding allowing subjects to respond more abstractly can be made in regard to the empathy measures as well. It is interesting to note that none of the other empathy measures were significantly correlated with accuracy of interpretation. One explanation for this might be that the TERM allowed subjects a more flexible mode of expression than the other measures and therefore, may be a more accurate measure. Another feasible explanation, however, is that the TERM measures a different aspect of empathy, one that is perhaps more reflective of one's ability to express empathy for another rather than solely experiencing empathy for another. Many factors might enter into one's capacity to express empathy, not the least of which is one's capacity for verbal processing. Perhaps subjects who were more adept at expressing empathy and thus scored higher on the TERM were more able to utilize the empathy they felt to extrapolate a more accurate 16-PF profile from the data obtained in the Rorschach.

Given that the above-mentioned variables may have contributed substantially to the extraneous variance among clinicians, it is perhaps surprising that any significant relationship was found between empathy and accuracy of interpretation. It is not surprising, however, that the strongest support for this hypothesis was produced by analysis of the data for subjects in

Group One (normal protocol). If one assumes that clinicians would be more likely to be situated on the normal end of a continuum describing psychological functioning, then it seems reasonable that they would, therefore, be more able to assume the perspective of a client who was less disturbed. Clients who were more disturbed would probably be responding from a frame of reference that was less similar, perhaps even strikingly different, from that of the clinician. Thus, it would be more difficult for the clinician to subsume the constructs (Kelly, 1955) and accurately interpret the Rorschachs of the more severely disturbed patients.

This, of course, would not explain why the trend toward increased accuracy as empathy increased was not linear in regard to severity of disturbance. As indicated in Table 4, the relationship is curvilinear with subjects interpreting the protocols in Groups One and Three more accurately than those in Group Two. If similarity to one's client was the sole element necessary to establish empathy with the client and increased empathy resulted in more accurate interpretation, then the correlation for Group Two should have been higher than that for Group Three. This was not the case, however, which raises several interesting theoretical considerations.

One would think that it would be more difficult to empathize with severely disturbed patients just because they were so different from the clinician. But perhaps the clinician is very well aware of the discrepancy between the severely

pathological client and himself/herself and therefore tries harder to put himself/herself "into the client's shoes." The clinician is thus more cognizant of the relinquishing of conscious control in which she/he supposedly has to engage in order to assume her/his client's perspective (Bachrach, 1968). She/He may, therefore, make a stronger effort to allow herself/himself to experience the stimulus as the client did. With a less severely disturbed client, however, the clinician may work less industriously at trying to subsume the constructs of the client because she/he does not recognize the degree of difference between the client and himself/herself. She/He, therefore, may not be as adept at decoding the information provided by a moderately disturbed client because she/he may be using a faulty frame of reference.

Another possible explanation for the decrease in accuracy of interpretation of the pathological protocols is the influence of degree of training in and familiarity with diagnosing and understanding psychopathology. Since all of the subjects in this study were drawn from a homogeneous pool of graduate students with relatively little experience in dealing with pathological clients, one might expect them to be less adept at interpreting data from disturbed clients than they would be at interpreting data from "normal" protocols. As indicated in Table 4, this was indeed the case. The mean error scores for Groups Two and Three were higher than that for Group One, which indicates that, in general, subjects

were better able to predict the 16-PF scores for the normal group than either of the other two groups, regardless of level of empathy.

Since there was not a significant relationship between number of Rorschachs administered and degree of accuracy, one might entertain the hypothesis that it is not merely the number of Rorschachs a clinician has administered and interpreted, but rather the degree of familiarity she/he has with various types of patients. Most of the subjects in the study had a relatively limited experiential base. For most, their primary experience had been in a university psychology clinic in which most of the clients were experiencing problems in living as opposed to moderate or severe psychopathology. As such, they had relatively little exposure to more disturbed clients and the exposure they did have was primarily in the form of textbook case studies. Through the case studies they were exposed to more severely psychopathological clients rather than the moderately disturbed person which may also serve to account for the higher level of accuracy for Group Three compared to Group Two.

Several interesting avenues for future research are suggested by the findings of the present study. Although the correlation between empathy and accuracy of interpretation of the Rorschach is not a particularly strong one and accounts for only .16 of the total variance, it does indicate that there may indeed be a relationship between the two if only

there were instruments sensitive enough to measure it. As mentioned earlier, development of such an instrument would certainly be a laudable, albeit very challenging, task.

In addition, future studies might address other clinician characteristics, i.e., similarity to the client, degree of training in recognizing and diagnosing psychopathology, and familiarity with various types of clients. The examination of such clinician characteristics seems to offer the most probable course for unraveling the mystery of the Rorschach. It is evident from the results of this study and others (Chambers & Hamlin, 1957) that there is variance among clinicians regarding their ability to interpret the Rorschach and use the information from their interpretation to better understand the client. The task facing future Rorschach researchers is to identify what variables account for this variance.

In summary, the data obtained in this study cannot be accepted as the basis for any definitive statement. They can, however, be interpreted as interesting and provocative, and may perhaps increase the amount of cognitive dissonance (Festinger, 1964) surrounding the reasons for the continued clinical popularity of the Rorschach sufficiently to prompt further research.

Appendix A

CONSENT FORM

CORRELATES OF RORSCHACH INTERPRETATION

The exercises which follow are part of a research study. The goal of this research is to better understand the processes involved in interpreting projective personality tests. If you wish to know the results of the study, write your mailing address on the following page.

Participation in this study is completely voluntary. If you choose not to participate you may discontinue at any time by not returning this material. If you choose to volunteer for this study, the filling out of the following material will show your consent to serve as a subject.

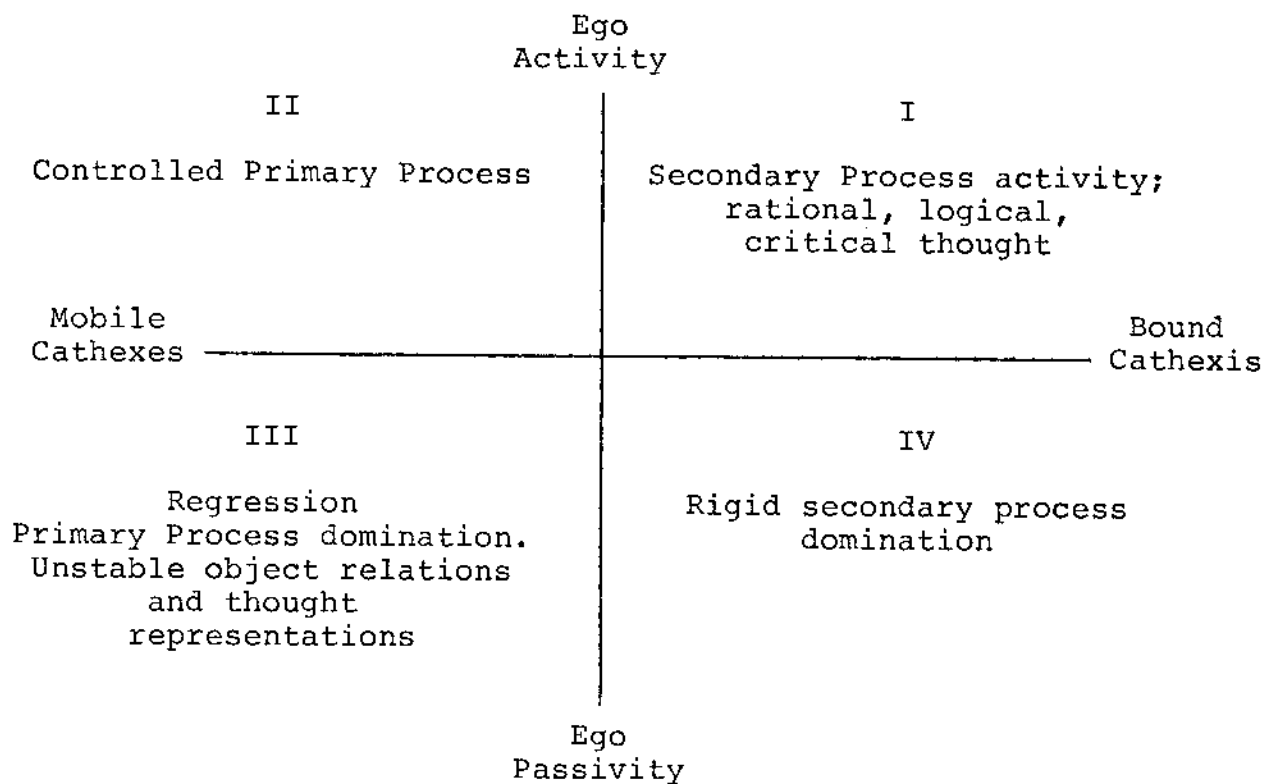
Thank you for your participation in our study. You've made two graduate students very happy.

Joanna Freeze
Terry Walters

If you have any questions, please contact: Leon Peek, Ph.D.
Ron Maresh
Dept. of Psychology
N.T.S.U.

Appendix B

Outline for a Conceptual Model of Thought Organization



Bachrach, 1968

Appendix C

Stages of Empathy

Stage One

During the initial stage of empathy as well as during the initial phases of helping the focus is upon interchangeable formulation in both discrimination and communication. Reflections and other such interchangeable communications are most effective here. The establishment of such a base of communication enables the helper to identify with the ways in which the helpee is expressing himself. So to speak, an interchangeable basis for communication allows the helper to try the helpee's expression of himself "on for size."

Stage Two

During the second stage of helping the helper attempts to extend the limits of his own understanding of the helpee and thus the helpee's self-understanding particularly in the areas of functioning in which the helpee does not demonstrate a depth of understanding. Here it is as if the helper, having successfully formulated the helpee's world, stands up in it and stretches out his arms and legs to reach its corners and crevices.

Stage Three

The third stage of empathy like the second phase of helping concentrates upon the problem solving activities that emanate from a depth of understanding of the problem areas. It is as

Appendix C--Continued

if the helper, having extended himself to the limits of the helpee's experience, discovers that, given this helpee at his developmental level, there really are few alternatives available to him. There is a directionality that emerges from understanding.

Adapted from Carkhuff, 1969.

Appendix D
Levels of Empathy

Level One

The verbal and behavioral expressions of the helper either do not attend to or detract significantly from the verbal and behavioral expressions of the helpee(s) in that they communicate significantly less of the helpee's feelings and experiences than the helpee has communicated himself. The helper does everything but express that he is listening, understanding or being sensitive to even the most obvious feelings of the helpee in such a way as to detract significantly from the communications of the helpee.

Level Two

While the helper responds to the expressed feelings of the helpee(s), he does so in such a way that he subtracts noticeable affect from the communications of the helpee. The helper tends to respond to other than what the helpee is expressing or indicating.

Level Three

The expressions of the helper in response to the expressions of the helpee(s) are essentially interchangeable with those of the helpee in that they express essentially the same affect and meaning. The helper is responding so as to neither subtract from nor add to the expressions of the helpee. He does not respond accurately to how that person really feels

Appendix D--Continued

beneath the surface feelings; but he indicates a willingness and openness to do so. Level three constitutes the minimal level of facilitative interpersonal functioning.

Level Four

The responses of the helper add noticeably to the expressions of the helpee(s) in such a way as to express feelings a level deeper than the helpee was able to express himself. The helper's responses add deeper feeling and meaning to the expressions of the helpee.

Level Five

The helper's responses add significantly to the feelings and meaning of the expressions of the helpee(s) in such a way as to accurately express feelings levels below what the helpee himself was able to express or, in the event of ongoing, deep self-exploration on the helpee's part, to be fully with him in his deepest moments. The helper is responding with a full awareness of who the other person is and with a comprehensive and accurate empathic understanding of that individual's deepest feelings.

Adapted from Carkhuff, 1969.

Appendix E

16-PF Profiles 1, 2, and 3

Name: Protocol 1

Comments:

FACTOR	Raw Score			High Score	LOW SCORE DESCRIPTION	STANDARD TEN SCORE (STEN)	AVERAGE	HIGH SCORE DESCRIPTION
	Form A/C/E	Form B/D	Total					
A		16	9	9	RESERVED, DETACHED, CRITICAL, ALDOR, STIF (Stoic/High)	1	10	OUTGOING, WARMHEARTED, EASY GOING, PARTICIPATING (Interpersonal)
B		8	6	6	LESS INTELLIGENT, CONCRETE (Lower scholastic mental capacity)	1	10	MORE INTELLIGENT, ABSTRACT THINKING, BRIGHT (Higher scholastic mental capacity)
C		16	5	5	AFFECTED BY FEELINGS, EMOTIONALLY LESS STABLE, EASILY UPSET (Vulnerable/low ego strength)	1	10	EMOTIONALLY STABLE, MATURE (Higher ego strength)
E		13	6	6	HUMBLE, MILD, EASILY LED, DOCTILE, ACCOMMODATING (Submissiveness)	1	10	ASSERTIVE, AGGRESSIVE, STUBBORN, COMPETITIVE (Dominance)
F		17	7	7	SOBER, TACTFUL, SERIOUS (Demureness)	1	10	HAPPY, GO-LUCKY, ENTHUSIASTIC (Spontaneity)
G		13	5	5	EXPEDIENT, DISREGARDS RULES (Wheeler superiority strength)	1	10	CONSCIENTIOUS, PERSISTENT, MORALISTIC, STAD (Stronger superiority strength)
H		15	6	6	SHY, TIMID, THREAT-SENSITIVE (Theatrical)	1	10	VENTURESOME, UNINHIBITED, SOCIALLY BOLD (Pamit)
I		14	7	7	TOUGH-MINDED, SELF-RELIANT, REALISTIC (Morale)	1	10	TENDER-MINDED, SENSITIVE, CLINGING, OVERPROTECTED (Pamit)
L		7	5	5	TRUSTING, ACCEPTING CONDITIONS (Altruist)	1	10	SUSPICIOUS, HARD TO FORT (Protection)
M		12	6	6	PRACTICAL, "DOWN-TO-EARTH" CONCERNS (Pragmatist)	1	10	IMAGINATIVE, BOHEMIAN, ABSENT-MINDED (Avalid)
N		11	6	6	FORTHRIGHT, IMPETEROUS, GET-TO-POINT BUT SOCIALLY CLAUDEY (Anliness)	1	10	ASTUTE, POLISHED, SOCIALLY AARE (Shrewdness)
O		11	6	6	SELF-ASSURED, PLACID, SECURE, COMPLACENT, SERENE (Untroubled adequacy)	1	10	APPREHENSIVE, SELF-DENYING, INSECURE, SURVIVAL STRATEGIC (Youth premisses)
Q1		8	5	5	CONSERVATIVE, RESPECTING TRADITIONAL IDEAS (Conventionalism of temperament)	1	10	EXPERIMENTING, SOCIAL, FREE-THINKING (Individualism)
Q2		12	8	8	GROUP-DEPENDENT, A "JOINER" AND SOUND FOLLOWER (Group adherence)	1	10	SELF-SUFFICIENT, SELF-RELIANT, PREFERS OWN REFINED (Self-assertiveness)
Q3		13	6	6	UNDISCIPLINED SELF-CONFLICT, SEX DRIVE, UNRELIABLE, CARELESS OR (Sexual inhibition)	1	10	CONTROLLED, SELF-DENYING, SOCIAL, PRESERVE (Sexual inhibition)
Q4		6	3	3	RELAXED, TRANQUIL, UNSTATED, COMPOSED (Low ego tension)	1	10	TENSE, EXCITED, ANXIOUS, UNCOMPOSED (High ego tension)

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A score of 1 2 3 4 5 6 7 8 9 10 is obtained by about 23% 44% 63% 80% 93% 100% 100% 93% 73% 44% 23% of adults

16 PF TEST PROFILE

STANDARD TEN SCORE (STEN)

AVERAGE

HIGH SCORE DESCRIPTION

LOW SCORE DESCRIPTION

Appendix E--Continued

Name: Protocol 2

Comments:

16 PF TEST PROFILE

FACTOR	Raw Score			Item-Loaded Score	LOW SCORE DESCRIPTION	STANDARD TEN SCORE (STEP)										HIGH SCORE DESCRIPTION				
	Form A/C/E	Form B/D	Total			1	2	3	4	5	6	7	8	9	10					
A				3	RESERVED, DETACHED, CRITICAL, ALTOGETHER STIFF (Stoichymia)															
B				4	LESS INTELLIGENT, CONCRETE, (Lower scholastic mental capacity)															
C				1	AFFECTED BY FEELINGS, EMOTIONALLY LESS STABLE, EASILY UPSET OR ANGRY (Lower ego strength)															
E				6	HUMBLE, MILD, EASILY LED, DOCTILE, ACCOMMODATING (Submissiveness)															
F				6	SOBER, TACTFUL, SERIOUS (Disurgency)															
G				4	EXPEDIENT, DISREGARDS RULES (Weaker superego strength)															
H				7	SHY, TIMID, THREAT-SENSITIVE (Timidity)															
I				7	TOUGH-MINDED, SELF-RELIANT, REALISTIC (Hurtle)															
L				6	TRUSTING, ACCEPTING CONDITIONS (Altruism)															
M				6	PRACTICAL, "DOWN-TO-EARTH" CONCERNS (Pragmatism)															
N				4	FORTHRIGHT, UNPRETENTIOUS, GENUINE BUT SOCIALLY CLUMSY (Antisociality)															
O				6	SELF-ASSURED, PLAID, SECURE, COMPLACENT, SERENE (Untroubled adolescence)															
Q1				8	CONSERVATIVE, RESPECTING TRADITIONAL IDEAS (Conventionalism of temperament)															
Q2				10	GROUP-DEPENDENT, A "JOINER" AND SOUND FOLLOWER (Group adherence)															
Q3				8	UNDISCIPLINED SELF-CONFLICT, LACK OF CONTROL, UNRELIABLE (Low conscientiousness)															
Q4				8	RELAXED, TRANQUIL, UNFESTERED, COMPOUND (Low ego tension)															

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A score of 1 2 3 4 5 6 7 8 9 10 is observed by about 1% 2% 4% 6% 12% 16% 19% 19% 15% 9% 4% 1% of adults

OUTGOING, WARMHEARTED, EASY-GOING, PARTICIPATING (Affectothymia)

MORE INTELLIGENT, ABSTRACT THINKING, BRIGHT (Higher scholastic mental capacity)

EMOTIONALLY STABLE, MATURE, FEARLESS, CALM (Higher ego strength)

ASSERTIVE, AGGRESSIVE, STUBBORN, COMPETITIVE (Dominance)

HAPPY-GO-LUCKY, ENTHUSIASTIC (Surgency)

CONSCIENTIOUS, PERSISTENT, MORALISTIC, STAY (Stronger superego strength)

VENTURESOME, UNINHIBITED, SOCIALLY BOLD (Formot)

TENDER-MINDED, SENSITIVE, CLINGING, OVERPROTECTED (Feminile)

SUSPICIOUS, HARD TO FOOL (Preferential)

IMAGINATIVE, ROYALMAN, ABSENT-MINDED (Autia)

ASTUTE, POLISHED, SOCIALLY AWARE (Sophistication)

APPREHENSIVE, SELF-REPROACHING, INSECURE, WORRIED, TROUBLED (Court presence)

EXPERIMENTING, IDEAL, SELF-THINKING (Radicalism)

SELF-SUFFICIENT, SELF-RELIANT, PREFERENCES OWN DECISIONS (Self-sufficiency)

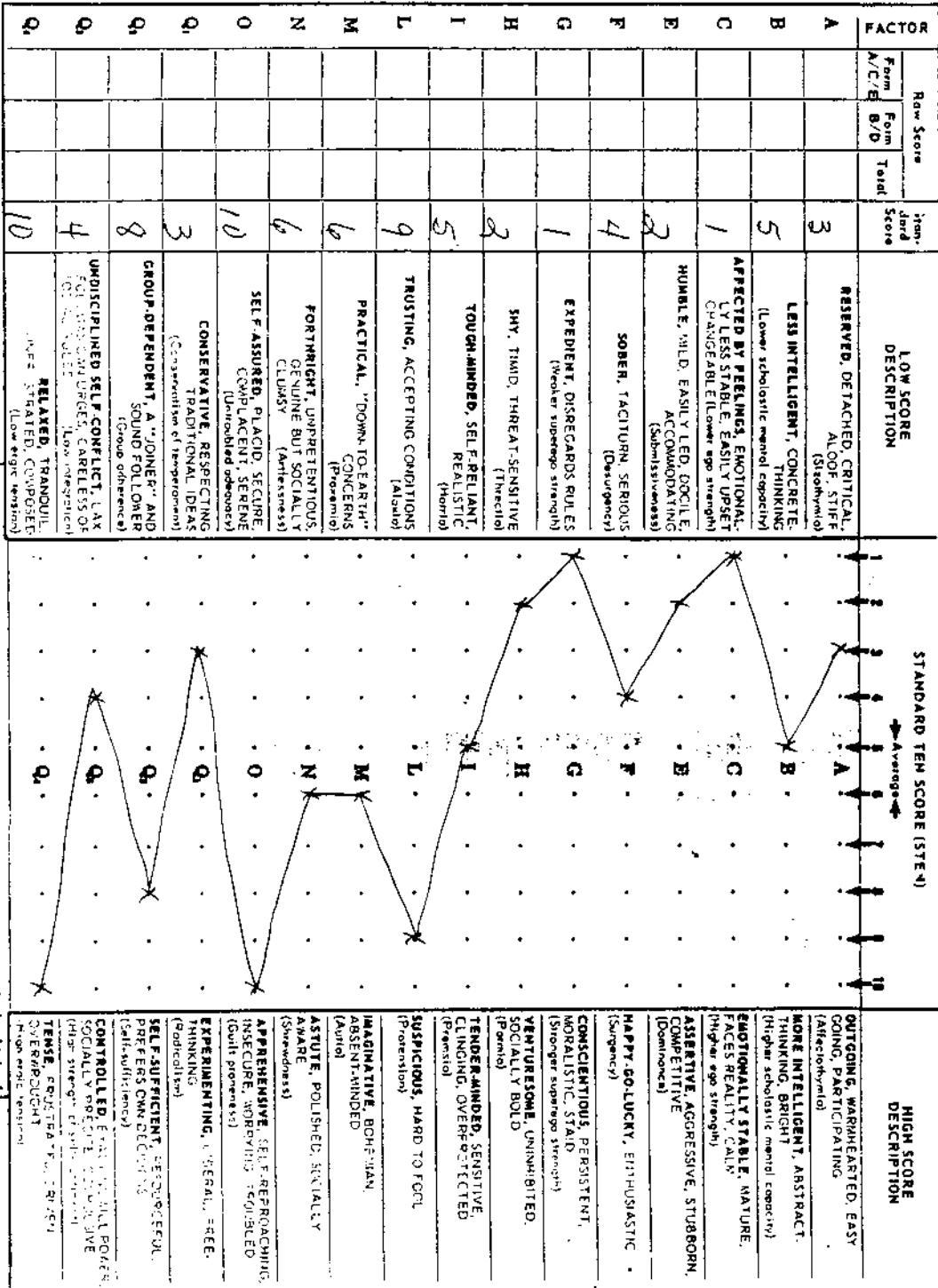
CONTROLLED, RESTRAINT, SOCIAL PROTECTIVE, SOCIALLY PROTECTIVE, HIGH STRENGTH, EGO STRENGTH, TENSE, EGO STRENGTH, TENSE, EGO STRENGTH (Ego strength)

Appendix E--Continued

Name: Wendell M

Comments:

16 PF TEST PROFILE



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A mean of 1 2 3 4 5 6 7 8 9 10 is obtained by about 23% 44% 62% 78% 91% 97% 99% 99% 99% 100% of adults

Appendix F

Rorschach Protocols 1, 2, and 3

Protocol #1 - 30-Year Old Female - Bachelor's Level EducationFree AssociationInquiryCard I - 10"

This middle looks like two people standing together with one of arms around each other and other arm up like this.

This part here. Looks like friend sometimes put arm around other. Like waving at someone.

(E: Waving?)

Yes

These two parts look like angels or something with wings and they're riding on something in middle. Kind of holding on here.

These are the wings and the rest of the angel.

Another thing, if take whole thing, is a fox's head.

Here's snout, cheeks, eyes, and ears. A little off on ears.

Card II - 6"

Looks like two animals with hands pressed together, looks like they're playing patty cake. Also looks like pretty involved in it because red part looks like in cartoons where they're working real hard and sort of sweating. Looks like that because little spots out here, looks like working industriously and sweating too.

They're also talking to each other because mouths are open. Hands, head, body, feet.

White part looks like rocket ship with fire coming out, exhaust.

Nose headed upward and red part looks like fire from exhaust. Sorts like when one lifts off.

Card III - 5"

Looks like two native women standing around cauldron of some sort and they're cooking.

Native women because of fuller lips. Reminds me of women because of chest.

(E: Cauldron?)

Appendix F--Continued

Red part in middle looks like butterfly.

These little deals remind me of puppets. Sorts like little duck or chicken in Groucho Marx that used to come down.

Card IV - 4"

This looks like motorcycle rider. Angle of it looks like taken from downward position so that his feet look bigger. Stereotyped macho man.

A big pot. This part.

Looks like a big butterfly.

Looks like on Happy Days where show scenes from old Marx show that used to come on every week, and they'd have at intermission or what they'd drop down duck or chicken of some kind of puppet suspended from a string.

Handle bars, wheels, feet. Sort of like crouched down like ready to take off or riding, I don't know.

(E: Stereotyped?)

Stereotyped because of the black leather.

(E: Leather?)

Color, I guess. And association with motorcycle.

Card V - 1"

Looks like a butterfly.

Also looks like two women lying down, leaning on a chair or something - this middle part is what they're lying on. Just lying there and thinking with arms folded like this. (Indicates arms crossed in front.)

Antennae here, wings.

Just leaning back contemplating. Head, arms folded, legs.

Card VI - 5"

Part at top reminds me of totem pole, has sorts an Indian flavor to it.

These look like features.

Also something about it that reminds me of a cat.

Doesn't really look like one but, these deals remind me of cat whiskers.

Appendix F--Continued

Also looks like animal rug of some sort. Like a bear skin or something.

Whole thing stretched out on floor, or laid out on floor.

Submarine, like yellow submarine like in Beatles movie. Not a real submarine because fat and chunky. A caricature, a cartoon of one.

Periscope.
This part could be the water swishing behind it.

Card VII - 4"

These two things look like clown faces.

(Subject points.) Pointed hat, nose, eyes, mouth.

If take this part up, looks like two Siamese dancers with hands extended kind of bent backwards, their necks like jutting they're chins out.

Chins, hands, neck. They're female.

These look like two Russian dancers, with big furry hats, the tall ones. Dressed in traditional Russian clothes and doing Russian dance where kick their feet out with arms folded in front of them.

Hats, legs, hands. Up on their toes, but very graceful.

Card VIII - 5"

This looks like two mountain lions climbing up side of a mountain.

Here are lions, and rocks.

Something about this part (top) reminds me of a wolf baying at the moon.

Snout part. Wolf stretching up looking at moon. And howling.

This part (in middle) reminds me of some part of anatomy like a rib cage or something.

Ribs, this part to side looks like lungs

Card IX - 3"

Ok, this looks like two wizards dualing with violins - playing violins, you know.

Violins hold up under their chins and playing them.

Appendix F--Continued

V
That's about it.

Card X - 7"

These two blue things look like crabs.

Down here have seahorses.

Whole thing looks like ocean life pictures. Has aquatic quality to it.

This deal up here looks like some kind of sea creature but I don't know what kind. Kind of ugly with a long face.

Pastel colors, blue reminds me of water, and green reminds of sea weed.

(E: Ugly?)

Sort of harsh looking and stupid looking.

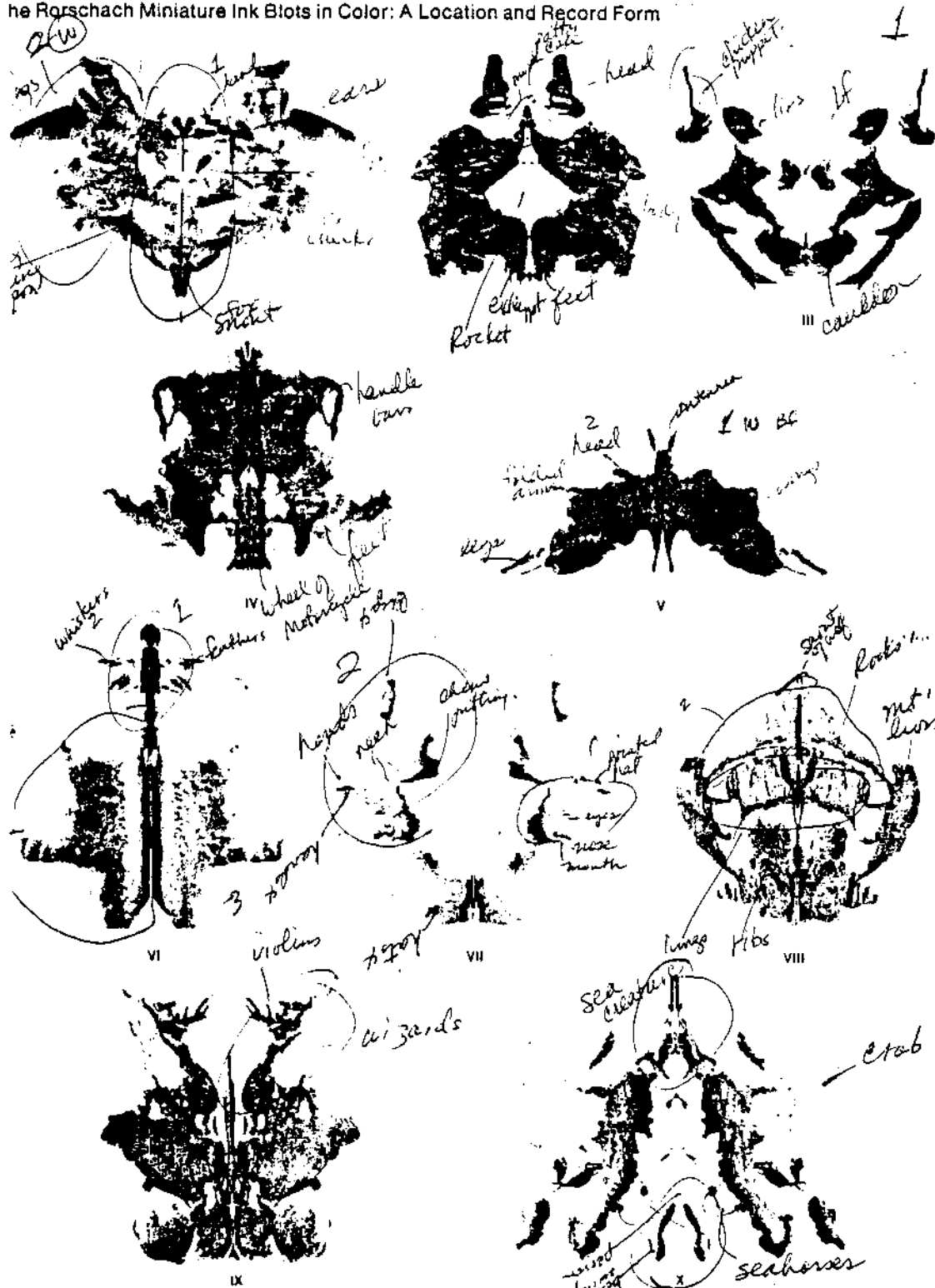
This reminds me of a person swinging but rope made out of very light material, like a boa.

(E: Boa?)

Light and fluffy looking. Very tranquil sort of idea.

Appendix F--Continued

The Rorschach Miniature Ink Blots in Color: A Location and Record Form



Appendix F--Continued

Protocol #2 - 38-Year Old Female - High School EducationFree AssociationInquiryCard I - 7"

(Laughs.) Looks like a monster, like some kind of demon. The more I look at it, it doesn't look like anything but a demon (laughs).

Those there've got two sets of eyes and these look like two horns here. Just looks like a demon's face.

(E: How much of blot?) Whole thing.

(E: Where are eyes?)

Eyes - see four of them - that's how I know it's a demon because if it was something else it would have only two. (Laugh.)

(E: See some more?)

Well, maybe a person there in the middle with their hands up like maybe reaching for something.

✓ Do you have to look at them right side up?

Yeah, probably a female person because it looks like she has on a dress and looks like she is reaching for something.

Hands here, there's the outline, feet are here and dress. It would have been easy to say monster to a lot of the black ones, but that's too easy. Better to look and see if there's really an answer there. Wonder what it would have meant if I'd said monster to everyone of them. Means I was in big trouble living in never-never land.

(E: What reminded you of that?)

Kind of an hour glass so it wouldn't really be a man.

Card II - 7"

This looks like two people playing a game, like patty cake.

That's their head and that's their hands touching each other and they're sitting facing each other, kneeling playing patty cake.

(E: Including lower red?)

Appendix F--Continued

No, I thought it might be a cushion.
Guess it's just as important when you
leave out as when you put in (laughs).

(E: What reminds you of people?)

Hands, hands touching.

(E: Male or female?)

No, that's all I see.

Probably male and I don't know why,
just their shape.

Card III

That way it looks kind of
like a beetle.

That way (✓) those look like their
front pincher arms. I don't know what
they're called. Those black areas look
like eyes and these look like, it is
mandibles I think they call it.

(E: Include red?)

Yeah, that was probably part of the
design on its back, but I didn't think
about the outside red spots.

Looks like two women and
there's a washtub or something
in the middle and a butterfly.

These women, tell their women because
there's their breasts and they're bent
over like they're washing clothes down
in this tub.

Do they really fold paper
together or are they supposed
to look like something?

Native women and the butterfly is just
in the picture maybe he just flew through
there while they're washing clothes.

(E: Native?)

Because of the shape of heads look more
like African women.

(E: Color?)

Probably because they're black and have
elongated heads.

Card IV - 27"

Kind of like a hill with trees.
Kind of a countryside hill with
trees sillouetted.

Little trees here, these are big trees
like weeping willows. Kind of V-shaped
like a hill and lot of bumpy places that
are probably trees and rocks and grass.

Appendix F--Continued

This is another that would have probably been easy to say it's a monster.

Just the silhouette, just looked at the outside.

V That way kind of looks like a bat.

When their wings aren't all the way out when they're at rest. This is probably claw feet (laughs) don't even know if they have feet and this is wings and this is it's head up here. Little eyes there and little feelers here - I've never seen a bat up but that's what I think it would look like. The wings is what is most suggestive of a bat to me.

(E: What reminds of bat?)

The wings raised up by their head.

Card V - 1"

Looks like a bat.

Looks like a bat in flight, his wings back.

(E: How much is bat?)

Whole thing.

(E: What reminds you of bat?)

Shape of the wings, his head and feeler things and his wings and feet straight back. He's flying. It will probably show I have a bat fixation (laughs).

The other way it looks like a butterfly.

A swallow tail butterfly. There's his tail and wings. He's in flight too.

(E: What reminds of swallow tail butterfly?)

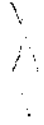
Why wings are up and forward and the way the tail is.

Card VI

Gee, I thought why don't you have anything pretty, and then I thought, well, it's just what you see, dear.

Appendix F--Continued

An Indian totem.



Just the part at the top here. This kind of looks like feathers and it's very straight and it just reminds me of pictures of totem poles they make in Canada, Alaska, around there.

A phoenix bird, is that what they call them, with their wings spread out. Yeah, an Indian totem of a phoenix, how they depict them in flight.

(E: What reminded you of totem poles?)
Shape.

Card VII - 25"

Think it's two dancing girls.

Sorta either direction. This way it's like they've got a headdress on. There's their heads and face. It's a female shape, an arm, a bustle and it comes down to their legs and feet.

I must not have a very good imagination (laughs).

Card VIII - 15"

(Sigh.)

(E: How much of blot?)

It's a wild, it's a wolf, and a tree and some rocks and at least it has color.

Yeah, right here, the pink part is the wolf, and there's rocks and some trees and that's probably water and this is the reflection. This looks like a wolf running. Could have been several different answers, but something about the legs and feet were more like a wolf.

(E: Shape?)

Yes.

Card IX - 23"

Kind of looks like an angel and a cloud.

(E: How much referring to?)

Whole thing.

Right there in the middle that would be part of the glow. The top part is yellow, kind of like a halo effect above its head.

(E: What reminds you of halo?)

The yellow halo, kind of like.

Appendix F--Continued

(E: Color?)

Yes. These would be like sunset clouds surrounding the angel, different color sunset.

(E: Clouds?)

Because that would be what is just naturally around an angel.

(E: Color?)

Like stormy sunset clouds because some of them would be dark and some of them will be light when the light hits them.

(E: Where are clouds?)

Everything but the angel.

(E: How much of blot?)

Whole thing.

Well, it looks like flowers and insects.

(E: Where?)

Angry insects.

This way looks like a grasshopper's face because they have a long pointed face and they have these green things on top their head. Here's their yellow eyes and their little orange mouth. And this is flowers surrounding. He's in the middle of them probably eating them up.

(E: Flowers?)

The yellow ones kind of look like a folded up rose, a yellow rose. And blue ones kind of look like asters, I think they're called.

(E: Why flowers?)

Color.

Appendix F--Continued

The Rorschach Miniature Ink Blots in Color: A Location and Record Form

1 K 101001-2

I a - demon face lands

II head knee

III beetle Native Women

IV silhouette swallow bat

V wire ground tree water

VI totem pole head + face

VII

VIII rock

IX angel

X face

Appendix F--Continued

Protocol #3 - 30-Year Old Female - Bachelor's Level EducationFree AssociationInquiryCard I - 35"

Only thing I can think of is a sort of female pelvic girdle.

Backbone, hips. Coming up to the hip.

(E: Q.)

Don't know. In studying anatomy. Just looks like belongs to female because they're wide. Don't know.

Also looks like a bunch of bats flying this direction towards me.

Bat here (points).

Looks like a big bug.

Looks like a bug with eyes, antenna, wings (points).

Card II - 50"

Looks like someone is having their period.

(Points.) Vagina, menstrual flow.

Could be a giant butterfly, too. Actually looks like a giant butterfly. And then a small butterfly.

Big butterfly giving birth to small butterfly.

Can't see anything else in it.

Card III - 50"

(Refused to pick card up.)

Small butterfly inside.

(E: What looks like a butterfly?)

Wings here, body in the middle.

Also looks like a woman with a uterus, ovaries, vagina, hips and cervix.

(Points to card.)

Red thing looks like patches of blood.

(Points to card.)

Appendix F--Continued

Two long skinny things at the bottom look like two different fish swimming in two different directions. I can't see anything else, wait a minute.

These are the fish, head, fins.

These two red things at the top look like seahorses hanging upside down or possums hanging from a tree. Maybe they could be a couple of fetuses, I don't know.

Shaped like seahorses; fins here, tail. Possum hanging from a tree upside down; head, body, tail.

Card IV - 15"

Looks like a giant bat.

Head, eyes. (Points.)

(E: Q?)

Head, body, wings make it look like it's flying.

Looks like someone's backbone. Maybe the muscles around it.

Backbone is straight and narrow. See cartilage on the backbone.

Looks like sex. Somebody's penis is sticking into somebody's vagina.

(Points to card.)

Also looks like some kind of leaf on a tree.

Shape is real skinny and goes down like a V.

Kind of like something after it has been burned. Maybe like a piece of paper sitting on by some pencil sharp pointing object.

Piece of paper after someone struck a match to it. It's colored black and been charred. The whole thing except for the middle.

Card V - 5"

Looks like a giant bat.

Body, wings, eyes (points).

Very large fly.

Same things.

Maybe like two half leaves stuck together.

Here. (Points to card.)

Appendix F--Continued

Card IV - 15"

Looks like a cat that's been run over by a steamroller.

The cat is basically squashed. Head, eyes, whiskers, backbone, and what's left of the feet.

Card VII - 75"

I think it to me looks like a woman's pelvis. Maybe her genital area.

Higher than hip, maybe up to the waist.

(E: Q.)

Because kind of looks like a woman's shape there - gets narrow at hips to waist, genital area where she goes to the bathroom - where she pees.

Looks like a pair of little big clouds. Weird looking clouds, the kind you see on a sunny day or maybe on a cloudy day, but something going in it. A plane or something because I see the wings or part of the wings. Looks like clouds when it's about to rain because it has a lot of black around the edges.

Card VIII - 75"

Also looks like a woman's pelvic area. The two pink things look like ovaries and the green is like the woman's uterus, womb. Green up here sort of like her backbone, you can see her spine coming through.

(E: What makes it look that way?)

The shape, the anatomy. Don't know.

The two pink things look like animals like holding on to a bush or tree. See legs, tail, and eyes.

(Points to card.)

Colors, don't know, look like something heaven would be. Golds, greens, and pink and grayish area like clouds.

Colors remind me of what would be in heaven. Pinks, golds, gray clouds.

Appendix F--Continued

Card IX - 120"

Maybe a butterfly coming out of its cocoon.

Could be a man and woman having sex. This being the man, penis coming this way through the vagina.

Looks like what would happen if we had an atomic explosion, everything burst out. What would happen if middle was coming out.

Looks like this part, the green part, the gold is some kind of big moth eating something. Probably a bat instead of a moth licking something like blood - what bats drink.

Card X - 125"

Giant female pelvic area with the green area being blue fallopian tubes.

Green yellow brown things look leaves.

Blue, big blue spiders on the sides.

Reminds me of different seasons if you took different parts out. If you take the blue, green, and pink out-fall season. Pink, brown, and black out-springtime. Green grass, yellow flowers, blue sky.

Things in the middle looks like a blue bat. (Points.)

Think of freaking out. Cocoon in the middle, breaking out of cocoon which is now body between the wings.

Pink area is the man.

(E: What makes it look like that?)

Looks like sort of shape of a woman's body, hip right here too. Looks like man and body and testicles. Maybe I just have sex on my mind.

Here. Here's the explosion and here's where the middle is coming out. (Points.)

(E: What makes it look that way?)

Some kind of bat that eats blood - seen in the zoo.

Shape again. Shape, area, vagina, uterus. Fallopian tubes come up to backbone again.

Here (points).

Here are the spiders. There are two of them.

Colors make it look like different seasons. Yellow is leaves and green is grass.

Appendix F--Continued

Gray thing reminds me something
of a mosquito-very funny looking
mosquito.

Shape of a mosquito. Eyes and little
legs.

Pink kind of like blood too.
Kind of like blood when you're
having your period or something.
When you're really flooding
and can't stop.

(E: Why remind you of blood?)

Because pink, like the first day of my
period. Because I'm having my period
now.

Green things like blades of grass. (Points.)

Appendix F--Continued

The Rorschach Miniature Ink Blots in Color: A Location and Record Form

I: bats, hips, backbone, tailbone, bug
 II: burned paper, vagina, leaf (w), penis, wings, backbone
 III: something coming from uterus - maybe ovaries, butterfly, Vagina, menstrual flow, smaller butterfly, seahorse, ovaries, blood, uterus
 IV: head, eyes, wings, leaf, body
 V: clouds, animal, wom, cervix, vagina
 VI: clouds, hips
 VII: genital area
 VIII: mosquito, eyes, spider, blood for period, blood
 IX: women, cocoon, butterfly, wings, head, blood, penis man
 X: grass blades, bat, wings, Calibian, spider, blood

Appendix G

Items Comprising the Final Four Empathy Scales

Fantasy Scale: (Standardized alpha coefficients: Males, .79; Females, .79)

26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.
5. I really get involved with the feelings of the characters in a novel.
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it. (-)
16. After seeing a play or movie, I have felt as though I were one of the characters.
1. I daydream and fantasize, with some regularity, about things that might happen to me.
12. Becoming extremely involved in a good book or movie is somewhat rare for me. (-)
23. When I watch a good movie, I can very easily put myself in the place of a leading character.

Perspective-Taking Scale: (Standardized alpha coefficients: Males, .71; Females, .75)

28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments. (-)
11. I sometimes try to understand my friends better by imagining how things look from their perspective.
21. I believe that there are two sides to every question and try to look at them both.
3. I sometimes find it difficult to see things from the "other guy's" point of view. (-)
8. I try to look at everybody's side of a disagreement before I make a decision.
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.

Empathic Concern Scale: (Standardized alpha coefficients: Males, .68; Females, .73)

9. When I see someone being taken advantage of, I feel kind of protective towards them.
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them. (-)
2. I often have tender, concerned feelings for people less fortunate than me.
22. I would describe myself as a pretty soft-hearted person.
4. Sometimes I don't feel very sorry for other people when they are having problems. (-)
14. Other people's misfortunes do not usually disturb me a great deal. (-)

Appendix G--Continued

20. I am often quite touched by things that I see happen.

Personal Distress Scale: (Standardized alpha coefficients: Males, .77;
Females, .75)

27. When I see someone who badly needs help in an emergency, I go to pieces.
10. I sometimes feel helpless when I am in the middle of a very emotional situation.
6. In emergency situations, I feel apprehensive and ill-at-ease.
19. I am usually pretty effective in dealing with emergencies. (-)
17. Being in a tense emotional situation scares me.
13. When I see someone get hurt, I tend to remain calm. (-)
24. I tend to lose control during emergencies.

Appendix H

Instructions

Attached are 14 excerpts taken from therapy sessions. Please consider these 14 excerpts in two groups of seven excerpts. For each group of seven excerpts, Q sort them in the following manner: Pick the two best responses, the two worst responses, and the three most neutral responses. Designate your response choices by marking them with a B for the best responses, a W for the worst responses, and a N for neutral responses. Please make your choices on the basis of level of empathy of each response. Use the following definition of empathy as a guideline: Accurate empathy is both the therapist's sensitivity to current feelings and his verbal facility to communicate this understanding in a language attuned to the client's current feelings.

Excerpt 1

I don't know if I am right or wrong feeling the way I do. But I find myself withdrawing from people. I don't seem to socialize and play their stupid little games any more. I get upset and come home depressed and have headaches. It all seems so superficial. There was a time when I used to get along with everybody. Everybody said, "Isn't she wonderful. She gets along with everybody. Everybody likes her." I used to think that was something to be really proud of, but that was who I was at that time. I had no depth. I was what the crowd wanted me to be -- the particular group I was with.

Helper Response

You know you have changed a lot. There are a lot of things you want to do but no longer can.

Excerpt 2

I love my children and my husband and I like doing most household things. They get boring at times but on the whole I think it can be a very rewarding thing at times. I don't miss working, going to the office every day. Most women complain of being just a housewife and just a mother. But, then, again, I wonder if there is more for me. Others say there has to be. I really don't know.

Helper Response

So you find yourself raising a lot of questions about yourself -- educationally, vocationally.

Excerpt 3

I get so frustrated and furious with my daughter. I just don't know what to do with her. She is bright and sensitive, but damn, she has some

Appendix H--Continued

characteristics that make me so on edge. I can't handle it sometimes. She just -- I feel myself getting more and more angry! She won't do what you tell her to. She tests limits like mad. I scream and yell and lose control and think there is something wrong with me -- I'm not an understanding mother or something. Damn! What potential! What she could do with what she has. There are times she doesn't use what she's got. She gets by too cheaply. I just don't know what to do with her. Then she can be no nice and then, boy, she can be as onery as she can be. And then I scream and yell and I'm about ready to slam her across the room. I don't like to feel this way. I don't know what to do with it.

Helper Response

While she frustrates the hell out of you, what you are really asking is, "how can I help her? How can I help myself, particularly in relation to this kid?"

Excerpt 4

I'm really excited the way things are going at home with my husband. It's just amazing! We get along great together now. Sexually, I didn't know we could be that happy. I didn't know anyone could be that happy. It's just marvelous! I'm just so pleased, I don't know what else to say.

Helper Response

Is your husband aware of these changes?

Excerpt 5

I'm so thrilled to have found a counselor like you. I didn't know any existed. You seem to understand me so well. It's just great! I feel like I'm coming alive again. I have not felt like this in so long.

Helper Response

Gratitude is a natural emotion.

Excerpt 6

Sometimes I question my adequacy of raising three boys, especially the baby. I call him the baby -- well, he is the last. I can't have any more. So I know I kept him a baby longer than the others. He won't let anyone else do things for him. If someone else opens the door, he says he wants Mommy to do it. If he closes the door, I have to open it. I encourage this. I do it. I don't know if this is right or wrong. He insists on sleeping with me every night and I allow it. And he says when he grows up he won't do it any more. Right now he is my baby and I don't discourage this much. I don't know if this comes out of my needs or if I'm making too much out of

Appendix H--Continued

the situation or if this will handicap him when he goes to school -- breaking away from Mama. Is it going to be a traumatic experience for him? Is it something I'm creating for him? I do worry more about my children than I think most mothers do.

Helper Response

So you find yourself raising a lot of questions as to if what you are doing is right for your child.

Excerpt 7

He is ridiculous! Everything has to be done when he wants to do it, the way he wants it done. It's as if nobody else exists. It's everything he wants to do. There is a range of things I have to do -- not just be a housewife and take care of the kids. Oh no, I have to do his typing for him, errands for him. If I don't do it right away, I'm stupid -- I'm not a good wife or something stupid like that. I have an identity of my own, and I'm not going to have it wrapped up in him. It makes me -- it infuriates me! I want to punch him right in the mouth. What am I going to do? Who does he think he is anyway?

Helper Response

It makes you furious when you think of the one-sidedness of this relationship. He imposes upon you everywhere, particularly in your own struggle for your own identity. And you don't know where this relationship is going.

Excerpt 8

They wave that degree up like it's a pot of gold at the end of the rainbow. I used to think that, too, until I tried it. I'm happy being a housewife; I don't care to get a degree. But the people I associate with, the first thing they ask is, "Where did you get your degree?" I answer, "I don't have a degree." Christ, they look at you like you are some sort of a freak, some backwoodsman your husband picked up along the way. They actually believe that people with degrees are better. In fact, I think they are worse. I've found a lot of people without degrees that are a hell of a lot smarter than these people. They think that just because they have degrees they are something special. These poor kids that think they have to go to college or they are ruined. It seems that we are trying to perpetrate a fraud on these kids. If no degree, they think they will end up digging ditches the rest of their lives. They are looked down upon. That makes me sick.

Helper Response

You really resent having to meet the goals other people set for you.

Appendix H--Continued

Excerpt 9

Gee, I'm so disappointed. I thought we could get along together and you could help me. We don't seem to be getting anywhere. You don't understand me. You don't know I'm here. I don't even think you care for me. You don't hear me when I talk. You seem to be somewhere else. Your responses are independent of anything I have to say. I don't know where to turn. I'm just so -- doggone it -- I don't know what I'm going to do, but I know you can't help me. There just is no hope.

Helper Response

I have no reason to try and not to help you. I have every reason to want to help you.

Excerpt 10

It's not an easy thing to talk about. I guess the heart of the problem is sort of a sexual problem. I never thought I would have this sort of problem. But I find myself not getting the fulfillment I used to. It's not as enjoyable -- for my husband either, although we don't discuss it. I used to enjoy and look forward to making love. I used to have an orgasm but I don't anymore. I can't remember the last time I was satisfied. I find myself being attracted to other men and wondering what it would be like to go to bed with them. I don't know what this means. Is this symptomatic of our whole relationship as a marriage? Is something wrong with me or us?

Helper Response

What's happened between you and your husband has raised a lot of questions about you, about him, about your marriage.

Excerpt 11

I finally found somebody I can really get along with. There is no pretentiousness about them at all. They are real and they understand me. I can be myself with them. I don't have to worry about what I say and that they might take me wrong, because I do sometimes say things that don't come out the way I want them to. I don't have to worry that they are going to criticize me. They are just marvelous people! I just can't wait to be with them! For once I actually enjoy going out and interacting. I didn't think I could ever find people like this again. I can really be myself. It's such a wonderful feeling not to have people criticizing you for everything you say that doesn't agree with them. They are warm and understanding, and I just love them! It's just marvelous!

Appendix H--Continued

Helper Response

That's a real good feeling to have someone to trust and share with.
"Finally, I can be myself."

Excerpt 12

Gee, those people! Who do they think they are? I just can't stand interacting with them anymore. Just a bunch of phonies. They leave me so frustrated. They make me so anxious. I get angry at myself. I don't even want to be bothered with them anymore. I just wish I could be honest with them and tell them all to go to hell! But I guess I just can't do it.

Helper Response

They really make you very angry. You wish you could handle them more effectively than you do.

Excerpt 13

I'm so pleased with the kids. They are doing just marvelously. They have done so well at school and at home; they get along together. It's amazing. I never thought they would. They seem a little older. They play together better and they enjoy each other, and I enjoy them. Life has become so much easier. It's really a joy to raise three boys. I didn't think it would be. I'm just so pleased and hopeful for the future. For them and for us. It's just great! I can't believe it. It's marvelous!

Helper Response

Hey, that's great! Whatever the problem, and you know there will be problems, it's great to have experienced the positive side of it.

Excerpt 14

Who do you think you are? You call yourself a therapist! Damn, here I am spilling my guts out and all you do is look at the clock. You don't hear what I say. Your responses are not attuned to what I'm saying. I never heard of such therapy. You are supposed to be helping me. You are so wrapped up in your world you don't hear a thing I'm saying. You don't give me the time. The minute the hour is up you push me out the door whether I have something important to say or not. I -- uh -- it makes me so god-damn mad!

Helper Response

I'm only trying to listen to you. Really, I think we are making a whole lot of progress here.

Appendix I

The inclusion of a measurement of clinician self-monitoring was not originally a condition of the present study. However, upon consideration of the process in which one engages to be empathic there seemed to be a basis for thinking there may be a similarity between one's level of self-monitoring and one's capacity for being empathic.

Self-monitoring has been defined as the observation and control of one's self-presentation and expressive behavior (Snyder, 1974). High self-monitors are people who are adept at such observation and control while low self-monitors are those who are not. It has been suggested that high self-monitors are variable in their interactions with others and respond to different stimulus people in situation specific ways whereas low self-monitors are more consistent in their behavior across situations (Snyder, 1974). In other words, low self-monitors are more self-directed and respond to others on the basis of their own dispositions while high self-monitors are more sensitive to the interpersonal cues of others and respond in ways they consider to be appropriate to the situation.

The level of one's sensitivity to interpersonal cues also seems to be part of being empathic. To respond empathically to someone, one first has to be able to identify how that person is feeling. This information is then translated into expressive behavior which conveys an understanding of what the stimulus person is feeling. Snyder (1974) identified a non-significant tendency for high self-monitoring individuals to be better judges of emotions portrayed by stimulus people. If this is indeed the case then one could hypothesize that there might be a positive correlation between level of empathy and degree of self-monitoring.

In an attempt to test this hypothesis, the Self-Monitoring Scale (Snyder, 1974) was administered to subjects in the present study along with the five empathy measures. The Self-Monitoring Scale (SMS) is a 25-item questionnaire containing True/False statements to which the subject is asked to respond as frankly and honestly as possible. The SMS is a generally recognized measurement of self-monitoring and has been used in many studies (Schaffer, et. al., 1982; Snyder & Gangestad, 1982). For example, Snyder (1974) compared SMS scores to peer ratings of subjects and found a significant correlation ($r = .45$; $df = 14$, $p < .05$) between the two.

Upon completion of all experimental tasks, a Pearson correlation was conducted to determine if a relationship exists

Appendix I--Continued

between degree of clinician self-monitoring and level of clinician empathy. The results of this analysis are shown in Table 4.

Although no significant relationship was found between self-monitoring and any of the scales of the empathy questionnaire, there was a significant positive correlation between degree of self-monitoring and level of clinician empathy as measured by the Taped Excerpt Response Measurement ($r = .4878$; $p = .001$).

Several factors may have accounted for this finding. It is possible that the TERM was a more accurate measurement of clinician empathy than the questionnaire and would, therefore, make any relationship with self-monitoring more apparent. While the Empathy Questionnaire was strictly a self-reported measurement, the TERM was determined by two trained raters. In addition, the TERM allowed subjects to respond in an open-ended fashion which may have provided a more accurate indication of the subject's ability to respond empathically. The TERM also allowed subjects access to non-verbal cues of the stimulus people. Both of these factors may have contributed to the validity of the TERM.

Another condition of the TERM which may have been very important in strengthening any relationship between empathy and self-monitoring is that subjects received specific instructions during the TERM in which they were told to use a specific definition of empathy (Rogers, 1957), and respond to the taped interview in as empathic a manner as possible. It has been suggested that high self-monitors seek out social situations and interpersonal contexts in which there are clearly defined situational guidelines, whereas low self-monitors seek situations in which they can respond in their preferred dispositional style (Snyder & Gangestad, 1982). In the TERM, the situational guidelines were clearly identified and subjects were instructed to respond in a specific manner. In addition, they were allowed access to auditory and non-verbal cues from the stimulus person which increased their information about the situation. Therefore, it was probably easier for high self-monitoring subjects to respond empathically. Conversely, it may have been more difficult for low self-monitors to respond in a prescribed way rather than in their preferred style.

In summary, the results of the present study suggest that there is a positive correlation between level of clinician empathy and degree of clinician self-monitoring. Further studies should be conducted to determine more precisely the

Appendix I--Continued

nature of such a relationship, but the implications of the present findings for clinical training are interesting nonetheless. If, as some authors (Rogers, 1957) suggested, increased levels of empathy are beneficial to the psychotherapeutic relationship, teaching new clinicians to become more self-monitoring might prove helpful. By learning to be more receptive to the interpersonal cues of others (specifically, clients), the clinician may become more skilled at interpreting such cues and as a result, increase his/her understanding of the client. In addition, since high self-monitors have been shown to strive to respond to others in more socially appropriate ways than low self-monitors (Snyder, 1974), increased self-monitoring might enhance the clinician's ability to communicate with the client in an appropriate, therapeutic manner. Such an enhancement of one's clinical skills would certainly be a worthwhile endeavor to pursue both from a practical and research perspective.

Table 6

Self-Monitoring Correlations

	Fantasy	Perspective Taking	Empathic Concern	Personal Distress	TERM
Self-Monitoring	.07	.10	.22	.17	.49*

* $p = .001$

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