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THE EFFECT OF A PHILOSOPHICAL COMMITMENT TO PSYCHIC DETERMINISM ON THE BEHAVIOR OF THE PSYCHOTHERAPIST

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CHAPTER I

INTRODUCTION

Contemporary psychotherapy is confronted with a seeming paradox that has long concerned philosophy, theology and jurisprudence (Knight, 1946; Lipton, 1955; May, 1958; Mazer, 1960; Szasz, 1961). This paradox is the acceptance by the psychotherapist both of the principle of psychic determinism and the simultaneous belief that the person in therapy may exercise choice, make decisions, and be held responsible for his actions. All schools of psychotherapeutic thought recognize the importance of past experiences in determining thoughts, feelings, and actions in the present; yet, the psychotherapeutic effort is based implicitly upon the conviction that people can become free to exercise choice, to make decisions, and to assume responsibility for overt behavior (Whitaker & Malone, 1953; Maslow, 1962).

Theoretical Background

The history of psychoanalytic theory illustrates well the dilemma posed by the acceptance of determinism as an assumption of science and the attempts of psychotherapy to produce choice, freedom, and responsible

behavior. In 1895 Breuer and Freud published their first observations of hysterical syndromes (Breuer & Freud, 1937). They observed that such symptoms as hysterical paralyses tended to disappear when, by means of hypnosis, these behaviors were related causally to past experiences. In other words, symptoms existing in the present were observed to change when the person recovered memories of related past experiences. According to Rapaport (1960, p. 39) Freud first explicitly formulated determinism as a principle governing experience and behavior in 1904.

In 1916 Freud issued a statement which has become a classic illustration of the place of determinism in psychoanalytic theory. Freud said, to see the content of dreams as accidental or capricious was a grievous error, an error based in ". . . a deeply rooted belief in psychic freedom and choice . . . . This belief is quite unscientific and must give ground before the claims of a determinism which governs mental life" (1943, p. 95).

Freud's articulation of determinism was profoundly influenced by the dominant scientific motif of his period, i.e., Newtonian mechanics (May, 1953; Szasz, 1961). As an analogy to causality in a Newtonian system, psychic determinism was formulated so that all human thought, emotion, and action would be subject to causal mechanisms and thus become inherently predictable. Within the framework of psychic determinism each thought, emotion, or action is sequentially (and causally) related to antecedent experiences and behavior. Individual behavior at any particular moment is the consequence of past experiences or stimulus conditions usually acting in various combinations or patterns. Thus within a rigorously deterministic framework there is no room for the

fortuitous, the capricious, the spontaneous, or the chaos of indeterminancy. Indeed, a strictly deterministic system of thought considers the common human experience of freedom to choose an illusion, the feelings of choice being determined by individual needs and the "choice" itself being a determinant of subsequent actions.

A classic post-Freudian statement on determinism and freedom has been made by Knight (1946). Knight maintains that whenever human experience seems to indicate the possibility of free will, it may be demonstrated, upon more careful clinical investigation, always to be based upon unconscious determination, i.e., causal mechanisms were operant outside of awareness to produce the illusion of choice within conscious experience.

The above position is an attempt to explain human acts on the assumption that behavior is actually lawful or may eventually be explained by laws; such an assumption is seen as basic to a scientific consideration of behavior. However, by thus objectifying man, the deterministic theorist would seem to conflict with the humanistic aspects of psychotherapeutic practice, for, from the latter point of view the goals of psychotherapy are an increased capacity to make free and sensible choices and to behave in a responsible fashion (May, 1958; Szasz, 1961).

Freud, as a scientist, was a strict determinist. As he defined the goals of psychotherapy, however, he was implicitly anti-deterministic. In The Ego And The Id, he wrote, ". . . analysis does not set out to abolish the possibility of morbid reactions, but to give the patient's ego freedom to choose one way or the other" (Freud, 1949, p. 72) (un-

derscoring his).

Farber (1961) calls attention to similar inconsistencies in Freud's conceptualization of the case of Dora. The differences in Freud's approach to this case appear to be related to whether he was writing in the role of psychotherapist or as a theoretical scientist. As a therapist reporting therapeutic activity Freud emphasizes choice-making behavior; he even indicated that the limits of psychotherapy were set by Dora's understanding and will. However, when reformulating the same data in scientific terms, he searched for an explanation within the framework of determinism. For example, in this context he traced Dora's will and choices to their presumed antecedents in unconscious sexual motivations. In the process Freud attenuated the concepts of will, choice, and decision and limited his scientific interest to the antecedent experiences of the patient. In Farber's words, "Freud . . . chose to limit himself to a fragment of the problem of will: its motivations" (Farber, 1961, p. 231). Only in footnotes did Freud give theoretical interest to freedom, choice, and responsibility; he did not explicitly incorporate these experiences into his theoretical framework.

Such has largely been the case with other analytic theorists. Knight (1946) unequivocally accepts rigorous determinism and explicitly holds that free choice does not constitute an idea which contradicts determinism. In his terms, determinism is a scientific construct within which to organize observations; free will simply refers to ". . . a subjective experience which is itself causally determined" (Knight, 1946, p. 256). Although Knight does not question the validity of determinism, he differentiates between the subjective experience of freedom which is

ego-syntonic, and which is the "psychological reward" of the "mature" individual, and the subjective experience of freedom which is spurious or illusory, and which is based upon a narcissistic exaggeration of psychic powers. The crucial point is that although Knight recognizes an area of experienced freedom in human psychology, he incorporates this experience into a theoretical framework which is strictly deterministic in such a way that freedom and personal responsibility are considered illusions--human experiences, to be sure, but not necessarily an accurate reflection of external reality nor a valid principle governing behavior or experience.

Lipton (1955), in discussing the problem of determinism and free will, assumes the same theoretical position as Knight. However, Lipton describes the subjective experience of determinism and the experience of freedom as a genetic development. He states that a feeling of determinism is genetically more primitive than a feeling of free will, and that an intellectual understanding of the principles of causality is a later acquisition in the life history of the individual.

Wheelis (1956) also asserts that free choice is a conscious experience fully as determined as any other and thus illusory, yet he is sensitive to the possibility that the premise of determinism could contribute to an endemic sense of helplessness in contemporary man: ". . . as determinism is won; determination has been lost" (Wheelis, 1956, p. 289). Thus, when he considers psychotherapy, he regards will as the crucial variable in therapeutic practice. "The crucial importance of will lies in the fact that . . . [it] may nevertheless be the decisive factor in translating equilibrium into a process of change"

(Wheelis, 1956, p. 294). The illusion of freedom thus is considered as having effects.

More recently Kohut (1959), noting the continuing confusion regarding the issue of free will and determinism, concludes that the experience of freedom of choice is an expression of active "I-experiences" which cannot be divided into components by the introspective method of psychoanalysis. Such "[I-experiences] . . . are, therefore, beyond the law of motivation, i.e., beyond the law of psychic determinism" (Kohut, 1959, p. 482).

These authors constitute representative samples of the current theoretical positions regarding free will and determinism as applied to psychotherapy and personality change. To summarize, deterministic theories of personality and of psychotherapy consider the experience of freedom and choice as causally determined illusions, and as illusions which, once experienced, may themselves act as determinants of subsequent behavior. Although this is by far the most dominant approach to the issue, there is still unsolved the problem that the practice of psychotherapy is an attempt ". . . to give the patient's ego freedom to choose one way or the other" (Freud, 1949, p. 72) (underscoring his). Thus, applying deterministic theory to the practice of psychotherapy, the goal of psychotherapy is to create or to restore an illusion. Indeed, Freud (1933) has stated that interpretation, the communication of understanding, is the greatest tool in the armamentarium of the psychotherapist. For these and other reasons, there is reflected in the recent literature a growing dissatisfaction with the application of a strictly deterministic theory to the practice of psychotherapy.

Implications for Psychotherapeutic Practice

Mazer (1960) theorized that the therapist's acceptance of determinism as a theory may cause the therapist, in his actual therapeutic practice, to deemphasize the patient's potentialities for organizing and controlling his own behavior; that, further, such a commitment on the part of the therapist may result in an emphasis upon rationalistic considerations of the patient's past, which may ignore or deemphasize the realities the patient may be struggling with in the present. Finally, Mazer contends that a commitment to determinism on the part of the therapist may contribute to an increased sense of dependence and helplessness on the part of the patient, particularly if the therapist communicates to the patient a theory which views him as the helpless victim of his past.

Szasz (1961) maintains that a strict determinism, for the patient as well as for the followers of the psychoanalytic movement, is an attempt to impose upon the chaos, flux, and indeterminance of reality an illusion of order which is comforting and reassuring but not necessarily real. In this position, he is reminiscent of Bergson who wrote, "We make up our minds and then deliberate to safeguard the principle of determinism" (Bergson, 1921, p. 158). Even earlier Adler had written that it was a principle of the neurotic's way of life that ". . . he should fail either through the guilt of others and thus be freed from personal responsibility, or that some trifle should prevent his triumph" (Adler, 1929, p. 236) (underscoring his).

In an attempt to escape the theoretical difficulties of a strict determinism, Hartman (1939, 1952) postulated an autonomously functioning

ego, and Erikson (1950, 1959) particularized a psychosocial theory of ego epigenesis. These contributions contrasted with classical Freudian ego concepts insofar as independent roots of ego development, i.e., primary autonomous ego functions, were posited which later in the life of the individual were differentiated, resulting in a measure of secondary autonomy in the fully functioning adult.

Greenacre (1959) cautioned therapists to guard the patient's sense of autonomy above all else. Rioch (1960), for similar reasons, conceived of the process of psychotherapy as an educational rather than a curative process because, in treating or curing in psychotherapy, the therapist assumes an implicit responsibility for the patient which is neither humanistic nor which can be administered effectively even if it were justifiable on ethical grounds. It is possible that to conceive of psychotherapy as simply another determining influence in the life of the patient is to increase the patient's sense of helplessness before fate and to exaggerate the superior powers and responsibilities of the therapist. This is the issue which has been stressed by many existentialist writers (Buber, 1957; Farber, 1958; Frankel, 1961; Maslow, 1962; May, 1961; Van Kaam, 1961).

Research Literature

Despite careful search of the research literature in psychotherapy not a single study was found which attempted to test experimentally the effects of whatever the therapist's deterministic commitment was upon his practice of psychotherapy. Indeed, no studies were found which explicitly involved testing the effect of any philosophical commitment upon the actual behavior of the psychotherapist. Thus, there appear to

be no published studies which are directly relevant to this research. There are, however, a number of investigations which have indirect relevance. Of particular interest in this regard is a group of studies on the character of the relationship which therapists of different schools establish with their patients.

Fiedler (1950a) recognized that all schools of psychotherapy believed that the personal relationship between the therapist and patient was of crucial importance in promoting personal change, and that therapists of different schools believed that their particular school created the most effective relationship. Fiedler attempted to test whether or not the type of therapeutic relationship did in actuality vary from therapists of one school to another. Therapists from psychoanalytic, non-directive and Adlerian schools at two levels of "expertness" were asked to describe by means of a Q technique an "ideal therapeutic relationship." A single factor was found regarding the therapists' descriptions of the "ideal therapeutic relationship." Expert therapists agreed with expert therapists of different schools more than they agreed with non-experts of their own school. In general, Fiedler's reported results suggested that the therapeutic relationship is primarily a function of professional experience rather than theoretical orientation.

Since this study only indicated that therapists of different orientations attempt to create the same therapeutic relationship, it remained possible that in actual practice differences might be evidenced. For this reason Fiedler (1950b) analyzed sound recordings obtained from the early part of treatment from ten different psychotherapists. These included four psychoanalysts, four non-directive therapists and two

Adlerian analysts. Half of the therapists were "nationally recognized experts" and half were "non-experts" who had "completed all or part" of their training. After listening to these recordings, judges used a Q technique to describe the therapeutic relationship. These results suggested that expert therapists actually create relationships with their patients which are more like the relationships created by experts from different schools than like the relationships established by non-expert therapists from the same school. Thus, Fiedler's (1950a) earlier findings were supported.

Fiedler (1950b) and others have shown that the degree of experience of psychotherapists appears to be an important determinant of psychotherapists' behavior in the conduct of psychotherapy. However, many psychotherapy research projects (Ashby, Ford, Guerney & Guerney, 1957; Jacobson & Whittington, 1960; Peterson, Snyder, Guthrie & Ray 1958; Rogers & Dymond, 1954) have been largely dependent upon data from inexperienced psychotherapists. The conclusions drawn from these researches, therefore, are subject to the criticism that the results may be artifacts of the therapist's inexperience. For example, Bone (1960), Ekstein & Wallerstein (1956) and Whitaker (1960) have all pointed out that beginning psychotherapists are more technique oriented than experienced psychotherapists regardless of theoretical orientation.

Heine (1950) has reported a study similar to Fiedler's in that patients of therapists of the same three schools used in the Fiedler studies (psychoanalytic, non-directive, and Adlerian) were asked to describe their experiences as patients by means of a Q technique. The patients described their experiences in therapy in verbal and theoreti-

cal terms which were quite similar to the orientation of their therapist's school; however, they described the therapeutic "atmosphere," i.e., the relationship, as being essentially the same regardless of the affiliation of their therapist to a particular school. It is of special interest that these subjects reported as the most significant aspect of their therapy the fact that the therapist never let the patient feel that he, rather than the patient, was responsible for the solving of problems brought to the therapeutic situation. In other words, responsibility for the solution of personal problems was left with the patient, and the patients, themselves, in retrospect, felt this variable to be the most important in their psychotherapy.

Quinn (1950) also studied the role of the therapist in determining the nature of the psychotherapeutic relationship. Quinn utilized the same data and the same Q technique as Fiedler (1950b) to show that trained judges could describe precisely the nature of the therapeutic relations from statements made by the therapist alone. Patient statements were erased from the sound recordings before the judges evaluated them. Listening only to the therapist's statements, with the context of the patient's statements removed, Quinn's judgments were as accurate as those in Fiedler's study which had been made on the basis of both patient and therapist comments. Since Quinn found that judgments based only on the therapist's verbal statements accurately described the entire relationship, the results indicate that therapist variables are of "critical significance" in psychotherapy.

Jacobson & Whittington (1960) found that the personality of the interviewer is of crucial importance in determining both the course and

the content of an initial contact with a patient. Four psychiatric residents were asked to conduct the type of interview that they "would normally do in an initial contact" with each of four different patients. Sound recordings were made of these 16 interviews. The same patient behaved in quite different ways in interviews with each of the four resident psychiatrists. In the case of the patient whose four interviews varied the most, striking differences were noted in the patient's opening responses. This suggested that the patient from the beginning responded to the personality characteristics of the examiners, and that these were crucial in determining how the patient would respond throughout the interview.

All of the findings reported above are in line with the thinking of the Washington School of Psychiatry (Colm, 1960; Fromm Reichmann, 1960; Searles, 1958, 1959; Will, 1961) that the motivations, values, attitudes, and the personality of the therapist are the most crucial variables in therapeutic practice.

Strupp (1957c) found that therapists' attitudes frequently are independent of theoretical orientations. Using a multidimensional system of analysis to be described in detail later, Strupp (1957a) studied typescripts of the electrically recorded hours of two expert therapists, Carl Rogers and Lewis Wolberg. Although differing radically in theoretical orientation, both of these therapists appeared in practice to be warm and accepting and to convey an attitude of respect for their patients' right to autonomous functioning.

In summary, Fiedler (1950a, 1950b), Heine (1950), Quinn (1950), and Strupp (1957c) consistently found that as far as an "ideal thera-

peutic relationship" is concerned, what the therapist does in the therapeutic situation is more a function of "experience" and "expertness" than a function of theoretical orientation. However, as Bordin (1955) pointed out, these findings do not mean that therapists of different theoretical orientations conduct psychotherapy in precisely the same manner because many other aspects of psychotherapy were not explored in these studies. For example, Strupp (1957c) presents evidence that in actual therapeutic sessions Rogers and Wolberg differ both quantitatively and qualitatively in several other respects even though both were warm and accepting. Wolberg assumed more "initiative," his verbal statements were "highly inferential," and he attempted to effect change in the patient primarily by means of "direct guidance" and "interpretation." Rogers, on the other hand, "reflected feelings" and did not make "highly inferential" interpretations or give advice.

Sundland & Barker (1962) also have obtained results which are contrary to the widely known and broadly generalized Fiedler studies. Their data were obtained by administering the Therapist Orientation Questionnaire to a random sample of members of the American Psychological Association who listed psychotherapy as a major interest. The questionnaire was composed of 133 items which were designed to reflect both poles of 13 scales of attitudes and methods pertaining to the practice of psychotherapy. The subjects were also asked to provide personal data concerning the "school" to which they felt most closely related and to indicate their number of years of experience. The differences obtained between the psychotherapists were found to be a function of orientation (Freudian, Sullivanian, and Rogerian) rather than a function

of different levels of experience. Sundland & Barker concluded that if one compared therapists by means of items upon which most psychotherapists are agreed, one will obtain results similar to those of Fiedler; however, if one compares therapists by means of items which are controversial, the results will reflect the differences which distinguish their orientation.

In an elaborate study Strupp (1960) compared the similarities and differences between groups of therapists of different orientations. A total of 237 psychotherapists of differing theoretical orientations and levels of experience were shown a scund film of a therapist conducting an initial interview. After viewing the film the subjects were asked to evaluate the interview from their perspective as "vicarious interviewers." Specifically, the therapists were asked to complete a 24 item questionnaire which included evaluation of the therapy with the patient in the film as well as items describing their own training, experience, and theoretical orientation. The entire experimental procedure required about two hours and many comparisons were made from this large mass of data. Certain statistically significant results are of interest here. In Strupp's words:

> Experienced psychiatrists tended to give a larger number of interpretive responses than did inexperienced psychiatrists. These communications tended to be more inferential, and their dynamic focus concerned dynamic interpersonal events in the patient's past and present life.
>
> Experienced therapists showed a higher degree of initiative in their communications than inexperienced practitioners.
>
> Experienced therapists tended to change the dynamic focus of their communications more than less experienced respondents (Strupp, 1960, p. 71).

As a part of the same research program an attempt was made to equate for experience two groups of therapists, orthodox Freudians and neo-Freudians. This grouping is of particular interest in this research because the orthodox Freudians' emphasis is upon genetic determinants whereas the neo-Freudian usually is less interested in historical antecedents and more interested in contemporary interpersonal relationships. Both of Strupp's groups had had considerable experience in psychotherapeutic practice, and all had completed personal analysis. However, statistical comparisons failed to reveal any significant differences between the questionnaire responses of the two groups. In general, these results appear to be consistent with Fiedler's (1950a) hypothesis that differences in therapeutic methods are more a function of experience than of theoretical orientation. Yet, a limitation of the study, which Strupp explicitly stated, was that the investigation was based upon the assumption that the audience therapists' hypothetical responses to the film bore a meaningful relationship to their actual performance in a "real-life" therapeutic situation.

Strupp (1960) also compared two groups of psychologists matched for experience: One group was made up of Rogerians and the other group of psychoanalytically oriented psychologists. Certain statistically significant differences were obtained. The psychoanalytically oriented psychologists tended to discourage obsessive ruminations about the past and to emphasize a sense of responsibility. The Rogerians, on the other hand, reported that they would discourage nothing and encourage nothing, leaving the course of psychotherapy to the patient. In other words, the psychoanalytically oriented psychologists responded in ways

which are congruent with a neo-Freudian point of view. The Rogerians, however, who have stressed a-historical treatment methods and a focus upon the client's responsibility in the present, responded as if they would passively permit defensive maneuvers which might well involve not only the patient's focusing on past events, but also avoiding current responsibilities. It is possible, however, that these results were influenced by a Rogerian antipathy to the frame of reference (psychoanalytic) in which the items of the questionnaire were couched, and that the Rogerians do not, in fact, view themselves as totally non-influential.

After reviewing his work with 237 psychotherapists and attempting to see the significant trends in the entire project, Strupp concludes that, ". . . we seem to be dealing with (two major) groups of psychotherapists whose philosophical orientation differs about determinism and free will" (Strupp, 1960, p. 99) (underscoring mine). Sundland & Barker refer to what appears to be a similar finding. Analysis of the results obtained by means of the Therapist Orientation Questionnaire found a general factor, labeled Analytic vs. Experiential, which cut across the majority of the scales, and which ". . . must be considered the most significant single continuum on which to compare psychotherapists" (Sundland & Barker, 1962, p. 205) (underscoring mine). They note that this sort of polarization of views is not new and has appeared in a variety of forms, e.g., Science vs. Art, Rationalism vs. Intuitionism, Nomothetic vs. Idiographic, and, most recently Positivism (the basic tenet of positivism is determinism) vs. Existentialism.

The above sample of recent literature shows that there is cur-

rently considerable dissatisfaction with the principle of determinism in therapeutic practice and even an explicit statement that determinism may have antitherapeutic consequences if utilized exclusively in working with people toward the goal of personality change. Yet, a careful survey of the literature indicates no empirical or experimental studies of the effects of determinism (or belief in the possibility of free will) upon the behavior of the therapist.

This study is an attempt to demonstrate empirically the effect, if any, of the theoretical commitment to determinism upon the behavior of the therapist in the actual conduct of his psychotherapy. This investigation examines the explicit verbal statements of two groups of psychotherapists, strict determinists and those theoretically committed to the possibility of freely chosen and spontaneous behavior. The study itself, of course, must proceed within a deterministic framework as it attempts to analyze the effect of a theoretical commitment upon the behavior of the psychotherapist.

The spirit of the research is reflected in a quotation of Einstein, who in discussing the methods of theoretical physicists, said: "If you want to find out anything from the theoretical physicists about the methods they use, I advise you to stick closely to one principle: Don't listen to their words, fix your attention on their deeds" (Einstein, 1934, p. 30).

CHAPTER II

STATEMENT OF THE PROBLEM

In accordance with the theoretical background presented in Chapter I, particularly the differences between orthodox psychoanalytic theory and existential theories of psychotherapy, it is possible to state this general hypothesis: The psychotherapist's commitment to the philosophical doctrine of determinism has effects upon his behavior in actual therapeutic practice which are different from the effects of a commitment to a belief in the existence of freely willed behavior. From this general hypothesis the following specific hypotheses were derived.

References to Past Experiences

Hypothesis I. A group of psychotherapists committed to a theoretical position of psychic determinism will verbalize, in a sample of their therapeutic practice, more explicit statements which refer to patient's past experience than will a comparable group of therapists who are committed to a belief in the possibility of free will.[1]

In other words, it is predicted that when the verbal statements

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[1]All three specific hypotheses will be defined operationally in terms of a coding system to be described later in this chapter.

uttered in a sample of the actual therapeutic practice of these two groups of therapists are compared, the determinist group will make significantly more references to the patient's past experiences than will the free-will group. The determinist group of therapists will tend to request more historical data, and they will request more elaborations and clarifications of different aspects of the patient's past. Similarly, the hypothesis predicts that the determinists will make more statements which will encourage and support the recovery of early childhood memories than will the free-will therapists.

Causal Explanations

Hypothesis II. A group of psychotherapists committed to a theoretical position of psychic determinism will verbalize in a sample of their therapeutic practice, more interpretations phrased in the form of hypothesized causal mechanisms than will a comparable group of psychotherapists who are committed to a belief in the possibility of free will.

In other words, it is predicted that when the verbalizations of both groups of psychotherapists are compared, the determinist group of therapists will make significantly more interpretations phrased in the form of causal explanations. By causal explanations is meant an interpretation which is maximally theoretical and which explains the patient's behavior in the present in terms of determinants which the therapist assumes to have operated in the patient's past. This form of interpretation may be rationalistic; it may consist of a series of statements having the quality of an explanation, as that given by an expert to a neophyte.

References to Choice, Decision, Responsibility

Hypothesis III. A group of psychotherapists committed to a theoretical position of psychic determinism will verbalize, in a sample of their therapeutic practice, fewer statements which refer to explicit issues of choice, decision, and responsibility than will a comparable group of psychotherapists who are committed to a belief in the possibility of free will.

In other words, it is predicted that when the verbalizations of both groups of therapists are compared, the determinist group will make significantly fewer references to the patient's responsibility for himself in the immediate present. This may involve confronting the patient with the possibility of choosing between accepting responsibility for his own behavior in the immediate present or considering himself to be driven by what has been called neurotic necessity. Confrontation may consist of an explicit recognition of the operation of conflicting attitudes within the self; however, the recognition is not aimed at explaining, nor is it couched in the form of an explanation. Rather, confrontation consists of facing the patient with the possibility of orienting himself to his experience in new ways and/or organizing and selecting his own behavior in the immediate present, regardless of the past.

CHAPTER III

METHOD AND PROCEDURE

Design

Primary data. The primary data of this investigation are typescripts of sound recorded psychotherapeutic interviews obtained from two groups of therapists: (a) Ten therapists committed to a theoretical position of psychic determinism, and (b) ten therapists committed to a belief either in the existence of freely willed behavior or in the possibility of freely willed behavior.

Initial selection of typescripts. The major problem involved in the initial selection of typescripts was the well known difficulty (Shakow, 1959) in obtaining typescripts of sound recorded psychotherapeutic interviews. Psychoanalysts, in particular, have been opposed to recording their therapeutic work in this fashion. Indeed, there have been cases of psychoanalysts being censured by their official organizations for recording analytic hours with their patients. More recently the value of sound recordings for didactic purposes has been more widely accepted, yet resistance to sharing such data with any individual or group not immediately affiliated with the therapist's school or psychoanalytic institute still persists.

This difficulty became crucial, although not finally insurmount-

able, in obtaining typescripts of sound recorded hours from therapists who could be classified as thoroughgoing determinists. The reason for this was that it was decided that the best operational definition of psychic determinists would be orthodox psychoanalysts who were members of the American Psychoanalytic Association. This definition was based upon the recognition that orthodox psychoanalysts are committed to the same theoretical position regarding determinism as was Freud and allow no deviation from this as an official position.

Conversely, it was thought that the best operational definition of free-will psychotherapists would be to define them as existential psychoanalysts, because, while existential analysts may have had comparable training and experience in the process of psychotherapy, they are committed in theory to the idea that man is, or may become, possessed of free choice.

The initial selection of typescripts was accomplished in the following manner. Fifty letters (See Appendix A for a copy of basic letter) generally describing the aim of this research and requesting participation were sent to a random sample of members of the American Psychoanalytic Association in order to obtain typescripts from therapists who might be classified as determinists. Fifty letters were sent to a random sample of therapists who were members of the American Ontoanalytic Association or who were either on the editorial boards or had contributed to the Review of Existential Psychology and Psychiatry, the Journal of Existential Psychiatry, or the Journal of Humanistic Psychology in 1961.

In addition, because of the difficulty in obtaining typescripts

of psychoanalytic recordings, contacts were made with five psychoanalysts who were known on a personal basis, with four psychoanalysts recommended by Dr. Hans Strupp of Chapel Hill, North Carolina as being sympathetic to systematic research in the area of psychotherapy, and four letters were sent to directors of research projects, who were known through publications in the professional journals to be involved in long range psychotherapy research. Thus, although some attempt was made to obtain a random sample, the attempt was of limited success. It is not known whether a systematic bias was introduced by the fact that some therapists will contribute typescripts for research purposes and some will not. This is one of the methodological limitations which exists in any psychotherapy research.

As may be noted in the basic letter (See Appendix A) each psychotherapist was promised that his participation in the investigation would remain anonymous. It was specified that both the name of the therapist and the name of the patient would be held in strict confidence. In addition, for both ethical and practical reasons, it was guaranteed that the actual statements of the therapist and the patient would not be reproduced in print either in whole or in part.

Responses were received from 46 psychotherapists; however, only 31 therapists finally (usually after further correspondence and guarantees of professional usage only of the data) sent a sound tape or typescript of a therapeutic hour. On a percentage basis the response may seem small, that is, of the 113 requests by means of the letters only about 25 per cent of the therapists actually did comply. However, considering the ordinary difficulties in obtaining psychotherapeutic recordings,

this response was most gratifying and suggests an increasing sympathy on the part of psychoanalysts toward systematic research in psychotherapy.

Criteria for classification within the determinist group. Therapists were considered to be classifiable within the determinist group if they met the following three criteria: (a) They were orthodox psychoanalysts. (b) They held membership in the American Psychoanalytic Association or the National Association for the Advancement of Psychoanalysis. (c) They described themselves as committed to determinism either on the basis of personal communication in response to the basic letter (seven cases) or by an explicit statement to this effect in print (three cases).

Criteria for classification within the free-will group. Therapists were considered to be classifiable within the free-will group if they met the following three criteria: (a) They were existential psychoanalysts. (b) They either held membership or were eligible for membership in those professional organizations with which existential psychoanalysts ordinarily affiliate themselves, e.g., The American Academy of Psychotherapists, The Association of Existential Psychology and Psychiatry, or the American Ontoanalytic Association. (c) They explicitly stated in response to the basic letter or in print that they practiced psychotherapy as if man were free to select and choose his own behavior at least under certain circumstances, e.g., among successfully analyzed people.

Final selection of typescripts. Only 20 of the 31 typescripts were used as data; 11 were discarded because they did not meet the

matching or control requirements listed below. Specifically, 3 typescripts were discarded, because the psychotherapist did not meet the experience requirements; 5 typescripts were not utilized because the therapist could not clearly be classified within either the determinist group or the free-will group; and 3 were discarded because they could not be matched in terms of the number of the therapeutic hour, i.e., the initial hour, the fiftieth hour, etc. (See Table 1 for a description of characteristics of therapists in the two groups.)

The experience requirement was five years experience in conducting intensive psychotherapy beyond completion of the advanced degree (either the Ph.D. degree in clinical psychology or the M.D. degree). This procedure was an effort to control those variables which may have been an artifact of inexperience.

The two groups of typescripts were roughly equated in terms of the number of the hours that the patient had been in treatment. This procedure was an attempt to control those differences between the verbal communications of the two groups of therapists which may have been a function of the stage of treatment. (See Table 3)

Final composition of the two groups. Table 1 presents certain characteristics of the therapists. All 20 psychotherapists, 10 in each group, were male. The groups were directly comparable in terms of age, the determinists having a median age of 45 years and the free-will therapists having a median age of 43 years. As may be seen in Table 1, the determinist group consisted of 9 therapists who held the M.D. degree and 1 who held the Ph.D. degree. The free-will group consisted of 2 therapists who held the M.D. degree and 8 who held the Ph.D. degree. This

Table 1

Characteristics of the Psychotherapists

	Determinists	Free-Will
Number	10	10
Sex	10 male	10 male
Age	36-61 years (45 median)	32-57 years (43 median)
Ph.D.	1	8
M.D.	9	2
Mean years of post-doctoral experience	9.5 years	7.6 years

is not a surprising distribution for the basic requirement for membership in the American Psychoanalytic Association is now the M.D. degree. Conversely, although there are no such medical requirements in most of the existential groups of analysts, it is interestingly noteworthy that the existential analysts predominantly held the Ph.D. degree.

The two groups of therapists were also comparable in terms of years of postdoctoral experience. The mean number of years of experience beyond the advanced degree for the determinist group was 9.5 with a standard deviation of 1 year. The free-will group had a mean experience score of 7.6 years with a standard deviation of 2 years.

Although it is not indicated in Table 1, all 20 psychotherapists were assumed to have completed a personal analysis. This assumption was based upon membership in psychoanalytic associations for which a completed personal analysis is a requirement of membership. Since Strupp (1960) has demonstrated empirical differences among therapists who had experienced a personal analysis and those who had not, this fact is important to the present investigation insofar as another control is thus

instituted. Although for the purposes of this study the kind of personal psychotherapy that each therapist had had was not determined, it might be interesting to speculate upon the effects of the therapist's personal experiences in psychotherapy concerning his later theoretical commitments. However, this is beyond the scope of the present investigation.

Table 2 presents certain characteristics of the patients in this investigation. As may be seen in Table 2, the groups of patients are

Table 2

Characteristics of the Patients

	Patients in the Determinist Group	Patients in the Free-Will Group
Male	6	8
Female	4	2
Age	22-51 years (36 median)	24-47 years (39 median)
Diagnostic Category	10 neurotic	10 neurotic

comparable as to age, sex, and diagnostic category. The term neurotic has been operationally defined for the purposes of this investigation as persons in psychoanalysis who did not require treatment within a hospital setting. More refined diagnostic labeling of the patients in this investigation was not considered practical because of the lack of validity and reliability for nosological categories.

Table 3 presents the approximate equating of the 20 typescripts by temporal sequence. Three typescripts in each group fell within the first five hours of therapy; four occurred within the twenty-fifth to the

Table 3

Comparison on the Basis of Temporal Sequence

Therapy Hour	Determinists	Free-Will
1st--5th	3	3
25th--50th	4	4
100th--200th	2	2
300th-------	1	1
	10	10

fiftieth hour; two were between the one-hundredth and the two-hundredth hour; and one typescript in each group was selected from approximately the three-hundredth hour.

Analysis of Typescripts

Each verbal statement made by each psychotherapist in each typescript was independently judged by two judges in terms of a modification of the multidimensional system of analysis developed by Strupp (1957a).

Strupp developed the multidimensional system of analysis as a means of providing systematic and objective evaluations of the verbal statements made by psychotherapists in the course of conducting psychotherapy. The system was developed as an attempt to compare the techniques of different psychotherapists; thus, it was deliberately intended to be general enough so that judges could assess the therapists responses without reference to a particular theoretical frame of reference. Therefore, the coding system reflects conceptual assumptions which are relatively noncontroversial. A survey of the literature revealed no other existing system of content analysis which would approach adequacy as a tool for the purposes of this investigation.

The multidimensional system consists of two sets of categories and three intensity scales; thus, five different assessments may be made of each therapist communication. The first set of categories, presented in Table 4 were based upon commonly recognized techniques or types of therapeutic activity. These categories were developed empirically by Strupp and modified for the present research; they are objective in that ratings as to type may be made independently of the rater's conceptualizations regarding psychotherapy. As may be seen in Table 4, any statement by the psychotherapist, whether a simple greeting or a complex interpretation, may be coded and classified within one of the eight major categories or within the subcategories. The categories are mutually exclusive.

Table 4

Types of Therapeutic Activity[a]

(00) Facilitating Communication (Minimal Activity)
- (01) Silence.
- (02) Passive acceptance, acknowledgement.

(10) Exploratory Operations
- (11) Simple questioning: asking for further information, clarification, examples, elaborations; simple probes, case history questions; accenting by repeating one or more words.
- (12) Focal Probes (with hypothesis), questioning to stimulate the patient's curiosity, encouraging self-exploration.

(20) Clarification (Minimal interpretation)
- (21) Reflection of feeling, restatements for purposes of clarification (may include "?").
- (22) Summaries (essentially noninterpretive).

(30) Interpretive Operations
- (31) Interpretations, analysis of defenses, establishing connections, definitions of the patient's problem (interpretive).
- (32) "Reality Model"; any operation by which the therapist's communication asserts the patient's rights, needs, and so on, and represents a reasonable model of reality (usually interpretive).

(Table continued on next page)

Types of Therapeutic Activity--Continued

	(33) Summaries (essentially interpretive).
	(34) Confrontation: interpretation in terms of the patient's immediate experience, emphasis upon maximal responsibility taking, face to face encounter, minimally theoretical: any operation by the therapist which interprets the patient's present experience of intrapsychic incongruity, or which shows the patient he has choices regarding his own behavior.[b]
(40)	Structuring
	(41) Structuring the therapeutic situation, describing the functions and tasks of therapy in general terms.
	(42) Discussions about theory (relatively abstract).
	(43) External arrangements, time, place, fees, and so on.
(50)	Direct Guidance
	(51) Direct suggestions for activity within the therapeutic framework.
	(52) Direct suggestions for activity outside the therapeutic framework.
	(53) "The therapist as an expert": Giving information, stating an opinion, answering direct questions, speaking as an authority. Such communications may seem primarily objective, but they may also convey reassurance (warmth) or rejection (coldness).
	(54) "The therapist as a human being": sharing personal experience, and personal feelings. This sort of operation conveys the therapist's affirmation of himself as a unique human being who is differentiated from the patient: personally making present.[b]
(60)	Activity Not Clearly Relevant to the Task of Therapy
	(61) Greetings, small talk, endings, and so on.
(70)	Unclassifiable

[a]Adapted from Strupp, 1960, p. 250.

[b]Additions to Strupp's categories.

The second set of categories, presented in Table 5, permits rating each therapist communication in reference to the way the therapist structures the therapeutic field. "The rating on dynamic focus reflects the manner in which the therapist focuses the therapeutic spotlight" (Strupp, 1960, p. 254).

Table 5

Dynamic Focus[a]

Sector A	Sector B
Therapist accepts the patient's formulation (minimal interference) without introducing a new frame of reference: Passive acceptance, facilitating communication, repeating a word or phrase, reflections of manifest feeling.	Therapist directs the patient's communication into a different channel and/or introduces a new frame of reference:
A-2 Acceptance of patient's focus upon dynamic events in past.[b]	B-1 Indications that additional informations, clarification, examples, elaboration, and so on are needed to further the therapeutic operation
A-3 Acceptance of patient's focus upon dynamic events in present.[b]	B-2 Focus on dynamic events in the past
	B-3 Focus on dynamic events in the present
	BT-4 Focus on the dynamics of the therapist-patient relationship (analysis of transference)
	B-4 Focus on the therapist-patient interaction (therapist emerging as a person, expert, or authority)

[a]Adapted from Strupp, 1960, p. 253.

[b]Additions to Strupp's categories.

Strupp's three intensity scales (Depth-Directedness, Initiative, Therapeutic Climate) were not utilized in the present study; therefore, they are not presented here.

In summary, the multidimensional system for analyzing psychotherapeutic techniques views each therapist communication as a datum upon which five simultaneous assessments may be made. The coding system has been used in research many times and has been subjected to successive refinements (Strupp, 1957a, 1957b, and 1957c). Nonetheless, Strupp

has presented the system as a methodological instrument which only approximates a goal of precise measurement. Although the system has less precision than many of the other measuring tools in psychological research, it is adopted as a basic tool for this study because no more completely adequate way of handling the data of psychotherapy in an objective fashion has as yet been developed.

Modifications of the multidimensional system. For the purposes of the present study several modifications of Strupp's system were introduced. Two additions were made to the Types of Therapeutic Activities, presented in Table 4. One addition was category 34 which is labeled Confrontation:

> 34. Confrontation: interpretation in terms of the patient's immediate experience, emphasis upon maximal responsibility taking, face to face encounter, minimally theoretical: any operation by the therapist which interprets the patient's present experience of intrapsychic incongruity, or which shows the patient he has choices regarding his own behavior.

This category was added because the literature of existential psychoanalysis considered confrontation (labeled as such) as a crucial part of the therapist's technical armamentarium (Buber, 1957; Cohn, 1960; Farber, 1961; Mazer, 1960; May, 1958; Searles, 1960).

The second addition was category 54 which is labeled, the therapist as a human being:

> 54. "The therapist as a human being": sharing personal experience, and personal feelings. This sort of operation conveys the therapist's affirmation of himself as a unique human being who is differentiated from the patient: personally making present.

Category 54 is based upon one element of Buber's "elements of the interhuman" which he calls "personal making present" (Buber, 1957, p. 109).

Two additions were made to Strupp's second set of categories,

Dynamic Focus, presented in Table 5. As may be noted Sector A and Sector B of Dynamic Focus differentiate between the therapist's simply "going along" and accepting the patient's statement and the therapist's introducing a different frame of reference. Strupp did not break down Sector A into further subcategories as he had with Sector B. However, in a preliminary exploration for the purpose of this research, it was found that more precise differentiations were possible within Sector A. These were included in the present investigation as A-2, an acceptance of the patient's focus upon dynamic events in the past, and A-3, an acceptance of the patient's focus upon dynamic events in the present.

The Responsibility Scale. The most important modification of Strupp's system involved substituting the Responsibility Scale for Strupp's Depth-Directedness Scale. Strupp's Initiative and Therapeutic Climate Scales were not relevant to the testing of the three hypotheses in this research and were, therefore, omitted.

Table 6

Responsibility Scale

1	2	3	4	5
Responsibility attributed to the past, physical symptoms, trauma, parents, and so on. Causal mechanism interpretation.	Milder degrees of 1	Therapist explicitly recognizes patient's immediate feelings. May include "?" regarding feeling	Milder degrees of 5	Direct affirmation of ultimate personal responsibility; autonomous selfhood; "I am" experience. Present and future behavior viewed as personal choices.

Strupp's Depth-Directedness Scale did not distinguish between deep interpretation and direct confrontation, a differentiation which seemed crucial for this research in that it provides one means of measuring the variable involved in a test of Hypothesis III. The Responsibility Scale, on the other hand, permits a differentiation between confrontation, which usually occurs in the present, and interpretations involving causal explanations, which usually are couched in terms of determinants operant in the past. Furthermore, the Responsibility Scale was considered to be useful, because it is based upon the concept of personal responsibility which is central to the whole determinism-free will controversy. Thus, it will be seen that the Responsibility Scale allows each therapist's verbal statement to be rated in terms of the degree to which the therapist refers to the patient's freedoms and responsibilities in the present or the degree to which the therapist defines the patient's behaviors as having been determined by variables operant in the past and over which he has no control. (See Appendix B for a complete presentation of the instructions regarding the use of the modified multidimensional system.)

Obviously certain therapist comments cannot be rated upon this scale either because they appear irrelevant to this dimension or because they seem neutral. For example, activities not clearly relevant to the task of therapy, such as greetings and small talk, and certain facilitating communications, such as silence, passive acceptance, or routine case history type questions, cannot always be judged in terms of the extent to which they place responsibility for the patient's behavior upon him. It was decided to allow each judge freedom to rate a response

on this scale, if, in his opinion, the response contained an explicit or implicit reference to causality. If either or both judges indicated that the response was non-classifiable on the Responsibility Scale, it was discarded.

Reliability of the Responsibility Scale

The reliability of the Responsibility Scale was established in a preliminary study as follows. Two judges, the author and the major professor, each judged two different therapeutic hours independently on two separate occasions three weeks apart. There were 38 therapist responses judged on one hour and 65 therapist responses on the other. Three intraclass correlation coefficients (Haggard, 1958) were computed. The test-retest correlation for the two successive ratings of both therapeutic hours for Judge A was .81, and for Judge B was .87. The interjudge correlation for the ratings of both hours was .79. The level of significance of an observed intraclass correlation coefficient can be tested by the F-ratio computed from the same mean squares as were used to obtain R (Haggard, 1958, p. 20). By this method F-ratios of 9.95, 14.64, and 8.42 respectively were obtained, each of which is significant at beyond the .01 level. Thus, on the basis of the preliminary study the Responsibility Scale was judged to be a satisfactorily reliable instrument, at least in the hands of experienced, trained judges.

In the absence of outside criteria a direct approach to the question of validity is impossible. In such a situation Speisman (1959) suggests that a relevant procedure is to provide a statement of the construct validity of the measure. As Speisman notes, however, there is an implicit circularity in this reasoning; therefore, the results must

be interpreted with caution as actual validity in the psychometric sense has not been established. As will be shown in Chapter IV, the Responsibility Scale proved in practice to be a highly reliable measure which provided statistically significant results, which would seem sufficient clarification for its use in the present research.

An additional comment regarding the validity of the Responsibility Scale may be made by following Sargent's (1961) reasoning. She notes that the concepts of reliability and validity were introduced by way of psychometrics. However, when carried over into rating techniques, judges become test surrogates and the term reliability is equated with the agreement between judges using the same scale. Sargent raises the following pertinent issue:

> Erroneously it is assumed that because reliability is measured by judge agreement, all judge agreement refers only to reliability, with no bearing on validity. The fact is that if judgements are separated in time. . . judge agreement may signify independent confirmation, hence validity. (Sargent, 1961, p. 106)

Since a high degree of judge agreement was obtained in the preliminary study of the Responsibility Scale and since, as will be shown in Chapter IV, a similarly high degree of agreement in the use of the scale was obtained for the two other judges who each rated 20 therapeutic hours, the validity of the scale is tentatively assumed. However, the task of establishing the external validity of the Responsibility Scale, in a psychometric sense, relative to independent criteria of personal responsibility remains to be established by future research.

Unit of Analysis. As with Strupp (1957a) the unit of analysis was a single therapist statement which was defined as a comment by the therapist bounded on both sides by a statement of the patient. Strupp found

that most communications of the psychotherapist were concise, brief, and to the point so that they tended quite naturally to make a logical unit. Only rarely was it necessary to divide a therapist communication into two or more units because of clearly shifting maneuvers on the part of the therapist. In such case this was decided by the judges; if the judges agreed, the unit was so divided.

Judges. Two judges, who were unfamiliar with the specific hypotheses of this study, independently evaluated each therapist statement in each typescript without knowledge of the group within which the material was classified. Both judges held the Ph.D. degree in clinical psychology and had had at least ten years experience as practicing psychotherapists. Each judge received training in the use of the system of analysis. The training was conducted by the writer who jointly evaluated typescripts of therapeutic hours with the judges. The training period was continued until the writer and the judge reached a criterion of 90 per cent agreement in the evaluation of 25 successive therapist statements. The typescripts utilized in the training sessions were subsequently discarded and constituted no part of the data in the investigation. The writer played no part in judging the actual primary data.

The rating process. The judges were presented with typescripts of the psychotherapeutic hours identified only by a code number. Thus the judges were not familiar either with the therapist, the patient, or the group into which the typescript had been classified. Each judge was provided with a manual containing directions for making the assessments of each unit (see Appendix B).

Although this study was exclusively concerned with the verbal

statements of the therapist as recommended by Strupp (1957a), the comments of the patients were included in the typescripts so that evaluations might be made in the context of the therapeutic process. Furthermore, in the case of one assessment, Dynamic Focus, the patient's comments provide a necessary point of reference for categorizing the therapist's comment.

If the two judges agreed on the categorizations of a particular unit, the unit was so considered in the statistical treatment of the results. Thus, 100 per cent agreement as to both Type and Focus was required between the two judges. If the judges disagreed, the item was discarded as ambiguous and therefore unclassifiable, e.g., if one judge classified a particular unit as a reflection of feeling (Category 21) and the other judge classified the same unit as a suggestion for activity within the therapeutic hour (Category 51), the unit was discarded. Such units played no part in the statistical evaluation of the results.

Complete agreement between judges was not necessary in the ratings on the Responsibility Scale, for inter-judge correlations could be computed, and in view of a significantly high correlation coefficient between judges, the ratings of a single judge, chosen at random, was utilized for purposes of comparing the two groups of therapists.

Tests of the Hypotheses Operationally Stated in Terms of the Coding System

In the following each hypothesis, presented in verbal terms as stated at the beginning of this chapter, is followed by the specific predictions, stated in terms of the coding system.

Hypothesis I. A group of psychotherapists committed to a theo-

retical position of psychic determinism will verbalize, in a sample of their therapeutic practice, more explicit statements which refer to the patient's past experience than will a comparable group of therapists who are committed to a belief in the possibility of free will.

The specific predictions stated in terms of the coding system are:

1. The determinists will have a significantly higher proportion of responses judged as accepting the patient's focus on dynamic events in the past (Category A-2) than will the free-will group of therapists.

2. The determinists will have a significantly higher proportion of responses judged as focusing upon dynamic events in the past (Category B-2) than will the free-will group of therapists.

Hypothesis II. A group of psychotherapists committed to a theoretical position of psychic determinism will verbalize in a sample of their therapeutic practice, more interpretations phrased in the form of hypothesized causal mechanisms than will a comparable group of psychotherapists who are committed to a belief in the possibility of free will.

The specific predictions stated in terms of the coding system are:

1. The determinists will have a significantly higher proportion of responses categorized as interpretation (Category 31) than will the free-will group of therapists.

2. The determinists will have a significantly higher proportion of responses categorized as analysis of transference (Category BT-4) than will the free-will group of therapists.

Hypothesis III. A group of psychotherapists committed to a theoretical position of psychic determinism will verbalize in a sample of their therapeutic practice fewer statements which refer to explicit

issues of choice, decision, and responsibility, than will a comparable group of psychotherapists who are committed to a belief in the possibility of free will.

The specific predictions stated in terms of the coding system are:

1. The determinists will have a significantly lower proportion of responses categorized as confrontation (Category 34) than will the free-will group of therapists.

2. The determinists will have a significantly lower proportion of responses categorized as therapist-patient relationship (Category B-4) than will the free-will group of therapists.

3. The determinists will have a significantly lower mean score on the Responsibility Scale than will the free-will group of therapists.

Hypothesis I was tested exclusively in terms of categorizations on Dynamic Focus. Hypothesis II required an accurate prediction both on Types of Therapeutic Activity and Dynamic Focus. Hypothesis III required an accurate prediction on each of the three different assessments.

CHAPTER IV

RESULTS

In this chapter data regarding the reliability of the system of analysis are presented before the results of the tests of the three hypotheses.

Reliability of the System of Analysis

Data on the reliability of the judges' ratings are presented in Table 7. Notice in this table that the judges' ratings for each group on both Type of Therapeutic Activity and Dynamic Focus were highly reliable. Percentage agreements range from a low of 82% (Hour XIII) to a high of 100% agreement (Hour XII) with the mean percentage of agreement being 89%. The percentage of agreement did not differ for the Determinist and the Free-Will Groups; that is, judges' ratings on Types of Therapeutic Activity and Dynamic Focus were equally reliable for the two groups. Parenthetically, it should be noted that the number of therapist communications in the Determinist Group did not differ significantly from the number of therapist communications in the Free-Will Group. Therapists of both groups were equally verbal.

Table 8 presents reliability data for the ratings on the Responsibility Scale. As may be noted in Table 8, a majority of the therapists' statements were rated on the Responsibility Scale. Hours XV and XX of

Table 7

Agreement Between Judges on Categorizations of Types of Therapeutic Activity and Dynamic Focus

Therapeutic Hour Determinist Group	No. of Therapist Statements	No. on which Judges Agreed	% Agreement	Therapeutic Hour Free-Will Group	No. of Therapist Statements	No. on which Judges Agreed	% Agreement
I	102	100	98	XI	101	94	93
II	116	103	89	XII	16	16	100
III	77	73	95	XIII	39	32	82
IV	82	76	93	XIV	60	51	85
V	161	146	91	XV	74	69	93
VI	157	131	83	XVI	121	100	83
VII	42	37	88	XVII	29	26	90
VIII	29	26	90	XVIII	113	98	87
IX	41	35	85	XIX	110	98	90
X	30	27	90	XX	68	57	85
Totals	837	754	91	Totals	731	641	88

Note.--There was no significant difference at the .05 level between the number of therapist statements in each group (Mann-Whitney $U=43.5$) or between the percentages of agreement for each group (Mann-Whitney $U=38.0$).

Table 8

Statements Rated on the Responsibility Scale

Therapeutic Hour Determinist Group	No. of Therapist Statements	No. Rated on Responsibility Scale	% Rated	Therapeutic Hour Free-Will Group	No. of Therapist Statements	No. Rated on Responsibility Scale	% Rated
I	102	68	68	XI	101	94	94
II	116	86	75	XII	16	16	100
III	77	41	53	XIII	39	30	77
IV	82	68	83	XIV	60	51	85
V	161	143	88	XV	74	15	20
VI	157	124	79	XVI	121	87	72
VII	42	29	69	XVII	29	18	62
VIII	29	21	83	XVIII	113	91	80
IX	41	24	59	XIX	110	67	61
X	30	20	67	XX	68	81	45
Totals	837	624	74	Totals	731	500	68

Note.--There was no significant difference at the .05 level between the percentages of therapist statements in each group which were ranked on the Responsibility Scale (Mann-Whitney U=50).

the Free-Will Group were the only hours in which the judges were not able to rate more than 50% of the statements on this scale. The low percentages in these hours may have been a function of the fact that both of these contacts occurred early in the therapeutic process, and a considerable number of the therapists' statements were either greetings and small talk (Category 61), discussions of external arrangements (Category 43), or simple case history type questions (Category 11). As such, they were irrelevant in terms of the extent to which the therapist placed responsibility upon the patient. However, as is noted in the footnote to Table 8, there were no significant differences between the two groups in the proportion of therapist communications rated on the scale. In short, the Responsibility Scale was utilized (approximately) an equal number of times in assessing the communications of both groups of therapists.

The intraclass correlation coefficient (Haggard, 1958) was used as a measure of the relationship between the ratings of the two judges on this scale. Intraclass correlation is considered to be a more stringent criterion of reliability than product-moment correlation since it takes into account any mean differences between raters as well as relative differences in individual ratings.

The intraclass correlations between the judges' ratings for the entire sample as well as separately for each experimental group are presented in Table 9. All correlations were significant at beyond the .01 level of confidence. Thus, as was found previously in the preliminary study of the Responsibility Scale, the scale appears to be highly reliable when used by experienced judges.

Table 9

Intraclass Correlations Between Ratings of the Two Judges

	R Judge 1; Judge 2	F	d.f.	Probability
Determinist Group	.84	11.14	624	.01
Free-Will Group	.70	5.77	500	.01
Entire Sample	.85	12.77	1124	.01

Results of the Tests of the Three Hypotheses

Hypothesis I stated that the deterministsw would verbalize more statements refering to the patients' past experiences than would therapists committed to a belief in the possibility of free will. In order to test this hypothesis, two specific predictions were made:

1. The deterministsw will have a significantly higher proportion of responses judged A-2 than will the Free-Will Group.

2. The deterministsw also will have a significantly higher proportion of responses judged B-2.

Table 10 presents the percentage of statements in each therapeutic hour labeled A-2 and B-2, while the significance of these data are presented in the footnote to the table.

As indicated in Table 10, there was no significant difference between the groups of psychotherapists at the .05 level on either the A-2 or B-2 dimensions. The orthodox analysts and existential analysts did not differ significantly on these categories of Dynamic Focus. Because the differences in Table 10 seem large upon inspection, particularly the

Table 10

Proportion of Responses Categorized as Accepting Patients' Focus in the Past (Category A-2) and as Introducing Focus in the Past (Category B-2)

Determinist Group	% A-2	% B-2	Free-Will Group	% A-2	% B-2
I	13	2	XI	0	1
II	9	10	XII	0	0
III	35	0	XIII	0	0
IV	1	3	XIV	0	0
V	2	1	XV	3	0
VI	1	12	XVI	0	0
VII	3	3	XVII	5	0
VIII	0	0	XVIII	0	6
IX	0	0	XIX	0	0
X	0	0	XX	5	7

Note.--There was no significant difference at the .05 level between the percentage of therapist statements in each group classified A-2 (Mann-Whitney U=31.0) or between the percentage of statements for each group classified as B-2 (Mann-Whitney U=34.5).

differences between the A-2 percentages, further checks were calculated. Yet, the Median test, the Kolmogorov-Smirnov test, and the parametric t test all failed to reveal statistically significant differences. It is possible that the failure to find significance is a function of the sample size. It is recommended in future research that a larger number of therapeutic hours be used to remove this doubt.

Hypothesis II stated that the groups would differ in the use of interpretations phrased in the form of hypothesized causal mechanisms. In order to test Hypothesis II, two specific predictions were made:

1. The deterministsw will have a significantly higher proportion of responses categorized as 31.

2. The deterministsw will have the highest proportion of responses

categorized as BT-4.

The percentage of responses in each therapy hour classified as Category 31 and Category BT-4 are presented in Table 11. No significant difference at the .05 level was found on either Category 31 or Category BT-4. In other words, this sample of orthodox and existential analysts did not differ with respect to the use of offering causal explanations as a therapeutic technique.

Table 11

Proportion of Responses Categorized as Interpretation (Category 31) and as Focus on Patient-Therapist Relationship (Category BT-4)

Determinist Group	% 31	% BT-4	Free-Will Group	% 31	% BT-4
I	1	0	XI	8	0
II	4	0	XII	0	0
III	0	0	XIII	0	0
IV	0	0	XIV	2	0
V	5	0	XV	0	0
VI	22	1	XVI	5	0
VII	8	0	XVII	8	0
VIII	15	0	XVIII	16	2
IX	9	0	XIX	0	0
X	0	0	XX	0	0

Note.--There was no significant difference at the .05 level between the percentage of therapist statements in each group classified as Category 31 (Mann-Whitney $U=39$) or between the percentage of statements for each group classified as Category BT-4 (Mann-Whitney $U=49.5$).

Hypothesis III predicted that the deterministsw would verbalize fewer statements which referred to explicit issues of choice, decision, and responsibility than would therapists committed to a belief in the possibility of free will. Three predictions had to be verified to con-

stitute a full test of this hypothesis. The first two predictions were:

1. The determinists will have a significantly lower proportion of responses categorized 34 than will the Free-Will Group.

2. The determinists will have a significantly lower proportion of responses categorized B-4.

Table 12 presents the percentages of responses in each therapy hour classified as 34 and B-4. Significant differences at the .01 level of confidence were found on both dimensions.

Table 12

Proportion of Responses Categorized as Confrontation (Category 34) and as Focus on Patient-Therapist Interaction (Category B-4)

Determinist Group	% 34	% B-4	Free-Will Group	% 34	% B-4
I	0	2	XI	54	16
II	4	1	XII	19	25
III	0	0	XIII	57	22
IV	0	0	XIV	62	73
V	0	0	XV	0	0
VI	9	1	XVI	42	23
VII	13	3	XVII	8	5
VIII	12	0	XVIII	38	10
IX	9	0	XIX	29	2
X	15	0	XX	2	0

Note.--There was a significant difference at the .01 level between the percentage of therapist statements in each group classified as 34 (Mann-Whitney U=20) and between the percentage of statements for each group classified as B-4 (Mann-Whitney U=15.5).

The third prediction which constituted a test of Hypothesis III was that the Determinist Group will have a significantly lower score on the Responsibility Scale than the Free-Will Group. Since interjudge

reliability on the Responsibility Scale was established as adequate both on the preliminary data and in the current data, one judge was selected at random and his ratings were used for purposes of comparing the two groups. Table 13 presents these mean Responsibility Scale ratings for each therapeutic hour.

Table 13

Mean Responsibility Scale Ratings

Determinist Group	Mean	Free-Will Group	Mean
I	2.24	XI	4.35
II	2.52	XII	2.94
III	2.06	XIII	4.67
IV	2.47	XIV	3.94
V	2.09	XV	3.06
VI	2.86	XVI	3.70
VII	3.00	XVII	3.05
VIII	3.14	XVIII	3.45
IX	3.21	XIX	3.45
X	3.20	XX	2.87

Note.--There was a significant difference at the .01 level between the Responsibility Scale means for each group (Mann-Whitney U=14.0).

All three predictions which constituted a test of Hypothesis III were significant at the .01 level of confidence. Therefore, the data are consistently in support of Hypothesis III. The data clearly indicate that the two groups differed in the extent to which reference was made to issues of choice and responsibility. The existentialists far exceeded the orthodox analysts in the proportion of statements concerning issues of choice and responsibility.

Summary of Findings

Hypothesis I. No significant differences were found in the extent to which deterministic and free-will therapists made statements referring to the patient's past.

Hypothesis II. No significant differences were found in the extent to which deterministic and free-will therapists utilized causal interpretations.

Hypothesis III. Free-will therapists were found to make significantly more statements which referred to explicit issues of choice, decision, and responsibility.

CHAPTER V

DISCUSSION OF RESULTS

Three specific hypotheses were derived from a theory which predicted that the behavior of psychotherapists committed to psychic determinism would differ from that of therapists committed to a belief in the possibility of free will. Determinism is a basic assumption of orthodox psychoanalysis, while a belief in the capacity of the individual to exercise free choice is a basic tenet of existential psychotherapy. It is possible, therefore, to consider the status of being an orthodox psychoanalyst or an existential psychoanalyst as operational definitions of therapists committed, respectively, to determinism and free will.

Hypothesis I

Hypothesis I predicted that the group of orthodox analysts would make more statements in actual therapeutic practice which referred to the patient's past history than would a comparable group of existential analysts. Yet, as indicated in Chapter IV, no statistically significant differences were found between the two groups as far as such references were concerned. These results suggest that, theoretical and philosophical differences to the contrary notwithstanding, in actual practice, psychotherapists of equivalent competence do not differ with respect to

the number of references made to the past experience of the patient. The results did approach statistical significance in the direction predicted, thus it is possible that with an increase in sample size statistical significance could be reached. However, it is necessary for the present to interpret the results as obtained. It is noteworthy to observe the minimal extent which therapists of both groups focused upon the patient's history: Approximately one-half of the therapists (three orthodox analysts and five existential analysts) made no response whatsoever which simply accepted the patient's focus upon the past or which introduced the past as a frame of reference. In this research, the 20 therapists made a total of 1568 classifiable verbal statements, and less than 4% of this figure were judged to be focused upon the patient's past experience or history.

These findings are particularly interesting when it is considered that all 20 psychotherapists were psychoanalytically oriented and thus trained in the deterministic tradition. Even the existential psychotherapists had had psychoanalytic background and training before they had adopted the existential viewpoint and began to conceive of themselves as existential analysts. Thus, these results appear to be consistent with Strupp's (1960) conclusion that the psychoanalytically oriented therapists who viewed a film in his sample of the therapeutic process would not have encouraged ruminations about the past if they had been the therapist. It is surprising to find such a slight congruence between therapeutic practice and therapeutic theory. While discussions of historical versus ahistorical techniques in psychotherapy have considerable <u>theoretical</u> interest (e.g., Combs, 1948, 1949; Combs & Snygg, 1959; Monroe,

1955), in the actual practice of experienced psychotherapists no empirical differences appear to exist. In general, the present results suggest that Rioch's theory is consistent with therapeutic practice as sampled in this study, for she maintains that: "Psychotherapy is supposed to liberate the person from his past. But can it really do this if the therapist looks at the patient as identical with his history--that is, with a fixed system of selected memories--rather than as the unique concrete person of the unique concrete present" (Rioch, 1960, p. 136)? Indeed, the results indicate that in spite of differences in theoretical positions, experienced therapists in their actual practice focus upon the patient's present behavior and experience.

Hypothesis II

Since psychic determinism is a basic assumption of psychoanalytic theory, it logically follows that psychotherapists committed to determinism would phrase their interpretations in terms of hypothesized causal relationships more often than would therapists not so committed. Thus, Hypothesis II predicted that orthodox psychoanalysts and existential analysts would differ in the number of interpretations phrased as hypothesized causal mechanisms.

The data did not support this prediction. Contrary to the hypothesis, the two groups of therapists did not differ significantly in their use of verbal statements phrased as hypothesized causal mechanisms. Indeed causal formulations were rarely used by therapists in either group. Only three therapists (two in the determinist group and one in the free-will group) phrased an interpretation in causal terms more than 8% of the time. Stated differently, of the 1568 classified verbal statements,

less than 5% were interpretations which connected the past with the present, and less than 1% were classically phrased analyses of transference.

Thus, psychoanalytic theory to the contrary notwithstanding, within the limitations of the present research, the data strongly suggest that experienced analysts probably do not frequently utter interpretations couched in terms of hypothesized causal mechanisms. This is a most surprising finding in view of the fact that the literature is replete with writings (see, for example, Ruth Monroe's survey of the entire field, 1955) that state or imply that psychoanalytic theory is based on determinism, and that therapy is an attempt to use this theory to help the patient understand himself in causal terms.

Hypothesis III

Hypothesis III predicted that the deterministsw would make fewer references to issues of choice, decision, and responsibility than would the existential group of psychotherapists. The hypothesis was inferred from the fact that existential analysts are, by definition, committed to a belief in the possibility of free choice, whereas orthodox analysts are, in theory, strict deterministsw. The data support Hypothesis III. All three predictions made in terms of Hypothesis III were confirmed. Specifically, the groups differed significantly in the predicted direction in their use of confrontation, in their dynamic focus upon the patient-therapist interaction, and in the extent to which the patient was held personally and immediately responsible. On each of these tests the differences between the two groups were significant at the .01 level of confidence. In actual practice, the existential analysts evidenced

significantly more interest in issues of choice, decision, and responsibility than did the determinists.

In a recent article significantly titled, The Therapeutic Function of the Belief in Will, Mazer (1960) postulated that psychotherapists committed to determinism might, in practice, be more highly intellectualistic or rationalistic than could be considered maximally therapeutic. Although this research did not consider the patients' behavior, and thus cannot be used to evaluate the therapeutic efficacy of a given theory, the determinists were not more rationalistic than the existential analysts. In short, the results do not support Mazer's position (on this particular point) and indicate instead, that experienced therapists are equally non-rationalistic, that they do not offer causal explanations with significant frequency. On the other hand, the results suggest that those therapists who have responded sympathetically to existential philosophy with its emphasis upon choosing, deciding, and personal responsibility do behave in their actual therapeutic practice in a manner which is congruent with such philosophical commitment.

The differences in technique between orthodox and existential analysts have remained vague (e.g., Allport, 1962; Machado, 1961; May, 1958, 1961; Van Kaam, 1961). As May (1958) explains, the lack of publication on existential technique exists precisely because many existential analysts feel technique has been over-emphasized in our culture and has not been placed in its proper perspective, i.e., subordinant to understanding. However, this research appears to have made one step in the direction of explicating the technical differences between orthodox and existential analysis.

Sources of Error

There are, of course, limitations to the present design which must be considered. These limitations for the most part are those which are characteristic of all research in psychotherapy (Parloff and Rubinstien, 1959; Strupp, 1960). First, it is impossible to obtain a random sample of American psychotherapy. One's sampling is biased in the direction of availability. In the present design this meant that the sample size was limited to ten cases in each group. It is not known to what extent the results would be the same were the number of cases multiplied by a factor of ten. However, this was not possible in terms of availability of data.

Second, there may be a sampling error. There is no way of knowing whether the therapists who contributed sound tapes or typescripts of their therapeutic hours were systematically different from therapists who would not. Indeed, there is at least some reason to suspect that there might be some differences, in the sense that therapists who were willing to submit samples of their therapeutic work for scientific study might be more "research-minded" (or less defensive, etc.) than therapists who would not. These qualities--if they exist--might have affected the data in an undetermined manner.

A third possible source of error is that the patients in the two groups were only roughly equated. It was impossible to match the therapists in the two groups with the same kinds of patients. It is not known the extent to which the behavior of the psychotherapist in the therapeutic contacts studied in this research were influenced by the personality of the particular patient. The evaluation of these factors will remain

for further research.

For the present, it is necessary to assume that such errors as those described above are probably distributed randomly, and that they did not unduly bias the findings.

Implications for Future Research

Several implications for future research follow from the sources of error presented above. First, an attempt should be made to increase the sample size. It may be possible, over a period of years to increase the number of therapeutic contacts in each group so that a broader sample of therapist behavior is possible. Nevertheless, the possibility seems remote that a truly random sample of either orthodox or existential psychoanalysis could be obtained.

Second, an attempt to match the patients in the two groups of therapists should be made. Although it is impossible to obtain patients who are precisely comparable because of the problem of individual differences, it might be possible to roughly equate patients. In such a design, hypotheses concerning differences in therapeutic practice as an interaction effect of the therapists' commitment and the personality of the patient, might be tested.

The Responsibility Scale, used as one of the three tests of Hypothesis III, proved to be highly reliable in judging one aspect of the verbal behavior of the psychotherapist. It would be extremely useful to adapt the scale so that it may be used to measure the analogous responsibility dynamics of the patients' verbal behavior. Such a scale might prove to have enormous value in measuring therapeutic progress. The patient's progress often seems to represent movement in the direction

of experiencing and actually assuming responsibility for his own behavior (Temerlin, 1963). If the Responsibility Scale could be applied to the verbal behavior of the patient, it would measure a dimension of basic importance to psychotherapy and thus become a tool for use in psychotherapy research.

CHAPTER VI

SUMMARY

In order to test three hypotheses regarding the effects of a philosophical commitment to psychic determinism on the verbal behavior of the psychotherapist, typescripts of actual sound recordings of therapeutic hours of two groups of therapists were compared. Orthodox analysts, were considered as committed to the principle of psychic determinism, and existential analysts were used as psychotherapists committed to free will. One therapeutic contact was obtained from ten therapists in each group. Each verbal statement made by each therapist in each contact was rated by experienced judges on the modified multi-dimensional system, and statistical comparisons were made between groups. It was found that:

1. Orthodox and existential analysts did not differ significantly in the number of verbal statements which referred to the patients' past experiences.

2. Orthodox analysts and existential analysts did not differ significantly with respect to the number of interpretations verbalized in the form of hypothesized causal relationships between the past and the present.

3. The two groups of therapists differed significantly with respect to the number of verbal statements which explicitly dealt with issues of

choice, decision, and responsibility. The existential analysts exceeded the orthodox analysts in the number of interpretive statements which dealt with these issues.

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APPENDIX A. BASIC INITIAL LETTER

Basic Initial Letter

Dear Dr. :

You and I do not know one another so I am presuming to write to you on the basis of (reference to addressee's publications, membership in a professional organization, or to a third person who served as a referral source). I would like, therefore, to share with you a brief description of a research project being conducted at the University of Oklahoma and then ask for your help and advice.

As you may know the current psychological literature contains many theoretical articles concerning the paradox that psychoanalytic theory (broadly defined) is strictly deterministic while the practice of psychotherapy is implicitly anti-deterministic. Most psychotherapists appear to agree with Freud's classic statement regarding the purpose of analysis as "giving the ego freedom to choose" while at the same time accepting a scientific and deterministic theory of personality. It would seem possible that commitment to the philosophical doctrine of strict psychic determinism would have effects upon the therapist's behavior which would be different from the effects of the therapist's commitment to a belief in the possibility of freely willed behavior for which the person assumes responsibility. It should be possible, if this general hypothesis holds, to demonstrate empirically the effect of a particular commitment to "free will" or, conversely, to determinism, upon the therapist's verbal communications in the actual psychotherapeutic situation. I would like to illustrate with two of the many possible hypothesis which seem testable: 1. A group of psychotherapists committed to a theoretical position of psychic determinism will verbalize, in a sample of their therapeutic practice, more explicit statements which refer to the patient's past experience than will a comparable group of therapists who are committed to a belief in the possibility of free will. 2. A group of psychotherapists committed to a theoretical position of psychic determinism will verbalize in a sample of their therapeutic practice more interpretations phrased in the form of hypothesized causal mechanisms than will a comparable group of psychotherapists who are committed to a belief in the possibility of free will.

Hypotheses, such as the above, may be translated into operational terms by expressing specific predictions regarding the differences between groups of psychotherapists in terms of Dr. Hans Strupp's multidimensional system for analyzing therapists verbal comments. (Strupp, H. H. Psychiatry, 20, 1957.) For the past several months we have been analyzing typescripts of sound recorded therapeutic hours which were locally available utilizing a modification of Dr. Strupp's system. On the basis of this limited data the predictions made in advance concerning the effects of differing philosophical commitments have been verified. However, before I can consider my work significant I need to increase the number of therapeutic hours analyzed, particularly with contacts from experienced psychotherapists like yourself, who are not contaminated by

local bias or familiarity with the research. As I am sure you know, it is tremendously difficult to obtain this kind of data, as many psychotherapists are reluctant to record their hours fearing that this may interfere with the therapeutic process. This is where I need help.

Could you refer me to experienced (arbitrarily defined as five or more years experience conducting intensive psychotherapy beyond professional training) psychotherapists who might be willing to contribute typescripts or sound tapes of therapeutic hours for research purposes. Because of the difficulty in obtaining these data, the research design has been deliberately kept as flexible as possible so that it does not matter where in the sequence of hours a particular tape or typescript falls, i.e., it may be the 10th or the 300th hour and still be relevant for my purposes. All I need to know is the general theoretical orientation of the psychotherapist, e.g., orthodox Freudian existential analyst, etc., and, very roughly, the diagnostic category which best characterizes the patient.

I have, perhaps unfortunately, been very brief in this initial letter. If there is any possibility of your being free to refer me to psychotherapists who may be interested in participating, or if you are personally interested, I would be more than pleased to send you a more extended description. In any event I would certainly appreciate any comments you might care to make as well as any advice you may be willing to share. Thank you very much.

Cordially,

APPENDIX B. INSTRUCTIONS TO JUDGES

Instructions to Judges

The following system for analyzing the verbal comments of psychotherapists is a modification of Hans Strupp's multidimensional system. For each therapist statement on each of the typescripts, with which you will be provided, you are asked to make three simultaneous assessments which are to be recorded on the data sheets provided. Be sure that the code number of the data sheet corresponds with the code number of the typescript and that the number of the therapist comment corresponds with the number on the data sheet.

The first assessment is to be recorded under "Type" on the data sheet; it has to do with the type of therapeutic activity which best describes the therapist's verbal statement. Record the appropriate category number from Table A.

The second assessment, entitled "Focus" on the data sheet involves your classifying the dynamic focus of the therapist comment in accord with Table B.

The third assessment involves your rating the therapist comment on the Responsibility Scale. The scale is designed as a continuum; thus, differences in <u>degree</u> may be recorded rather than differences in <u>kind</u>. Some therapists' comments will be difficult, if not impossible, to rate on this scale. In such case mark an "X" in the column on the data sheet labeled "R".

On the attached three pages you will find Tables A, B, and C, to which you will need to refer during the actual assessing process.

Table A

Types of Therapeutic Activity

(00) Facilitating Communication (Minimal Activity)
- (01) Silence.
- (02) Passive acceptance, acknowledgement.

(10) Exploratory Operations
- (11) Simple questioning: asking for further information, clarification, examples, elaborations; simple probes, case history questions; accenting by repeating one or more words.
- (12) Focal Probes (with hypothesis), questioning to stimulate the patient's curiosity, encouraging self-exploration.

(20) Clarification (Minimal interpretation)
- (21) Reflection of feeling, restatements for purposes of clarification (may include"?").
- (22) Summaries (essentially noninterpretive).

(30) Interpretive Operations
- (31) Interpretations, analysis of defenses, establishing connections, definitions of the patient's problem (interpretive).
- (32) "Reality Model": any operation by which the therapist's communication asserts the patient's rights, needs, and so on, and represents a reasonable model of reality (usually interpretive).
- (33) Summaries (essentially interpretive).
- (34) Confrontation: interpretation in terms of the patient's immediate experience, emphasis upon maximal responsibility taking, face to face encounter, minimally theoretical; any operation by the therapist which interprets the patient's present experience of intrapsychic incongruity, or which shows the patient he has choices regarding his own behavior.

(40) Structuring
- (41) Structuring the therapeutic situation, describing the functions and tasks of therapy in general terms.
- (42) Discussions about theory (relatively abstract).
- (43) External arrangements, time, place, fees, and so on.

(50) Direct Guidance
- (51) Direct suggestions for activity within the therapeutic framework.
- (52) Direct suggestions for activity outside the therapeutic framework.
- (53) "The therapist as an expert": Giving information, stating an opinion, answering direct questions, speaking as an authority. Such communications may seem primarily objective, but they may also convey reassurance (warmth) or rejection (coldness).
- (54) "The therapist as a human being": sharing personal experience, and personal feelings. This sort of operation conveys the therapist's affirmation of himself as a unique human being who is differentiated from the patient: personally making present.

(Table continued on next page)

Types of Therapeutic Activity--Continued

(60)	Activity Not Clearly Relevant to the Task of Therapy
(61)	Greetings, small talk, endings, and so on.
(70)	Unclassifiable

Table B

Dynamic Focus

Sector A	Sector B
Therapist accepts the patient's formulation (minimal interference) without introducing a new frame of reference: Passive acceptance, facilitating communication, repeating a word or phrase, reflections of manifest feeling.	Therapist directs the patient's communication into a different channel and/or introduces a new frame of reference:
A-2 Acceptance of patient's focus upon dynamic events in past.	B-1 Indications that additional informations, clarification, examples, elaboration, and so on are needed to further the therapeutic operation
A-3 Acceptance of patient's focus upon dynamic events in present.	B-2 Focus on dynamic events in the past
	B-3 Focus on dynamic events in the present
	BT-4 Focus on the dynamics of the therapist-patient relationship (analysis of transference)
	B-4 Focus on the therapist-patient interaction (therapist emerging as a person, expert, or authority)

Table C

Responsibility Scale

1	2	3	4	5
Responsibility attributed to the past, physical symptoms, trauma, parents, and son on. Causal mechanism interpretation.	Milder degrees of 1	Therapist explicitly recognizes patient's immediate feelings. May include "?" regarding feeling	Milder degrees of 5	Direct affirmation of ultimate personal responsibility; autonomous selfhood; "I am" experience. Present and future behavior viewed as personal choices.

APPENDIX C. PRELIMINARY RELIABILITY STUDY OF THE RESPONSIBILITY SCALE (RAW DATA)

Ratings of Judges A and B of Therapeutic Hour X
on the Responsibility Scale

	Judge A		Judge B	
Unit No.	1st Rating	2nd Rating	1st Rating	2nd Rating
1	2	3	2	3
2	2	3	2	3
3	2	3	2	3
4	3	3	4	4
5	4	4	4	4
6	4	4	4	4
7	4	4	4	4
8	4	4	4	4
9	2	3	3	3
10	3	3	3	3
11	3	3	3	3
12	3	3	3	3
13	3	3	3	3
14	3	3	3	3
15	4	5	4	4
16	5	5	4	4
17	5	5	4	5
18	3	3	3	3
19	2	2	2	3
20	3	3	3	2
21	3	3	3	3
22	3	3	3	3
23	3	3	3	3
24	3	2	3	3
25	2	2	2	2
26	4	4	4	4
27	4	4	4	4
28	2	2	2	2
29	3	3	3	3
30	5	5	5	5
31	3	3	3	3
32	3	3	3	3
33	3	3	3	3
34	3	4	3	4
35	3	4	3	3
36	3	3	3	3
37	3	3	3	3
38	3	3	3	3

Ratings of Judges A and B of Therapeutic Hour Y
on the Responsibility Scale

	Judge A		Judge B	
Unit No.	1st Rating	2nd Rating	1st Rating	2nd Rating
1	3	3	3	3
2	3	3	3	3
3	3	3	3	3
4	3	3	3	3
5	2	3	3	3
6	2	3	3	3
7	2	3	3	3
8	3	3	3	3
9	3	3	3	3
10	3	3	3	3
11	3	3	3	3
12	3	3	3	3
13	4	4	4	4
14	4	4	5	4
15	4	4	5	4
16	5	5	5	5
17	5	5	5	5
18	5	5	5	5
19	5	4	5	5
20	5	4	4	5
21	5	4	5	5
22	4	4	4	5
23	4	4	4	5
24	3	3	3	3
25	2	3	3	3
26	3	3	3	3
27	3	3	3	3
28	4	3	3	3
29	3	3	3	3
30	3	3	3	3
31	3	3	3	3
32	3	3	3	3
33	3	4	4	3
34	2	3	3	3
35	2	3	3	3
36	3	3	3	3
37	3	3	3	3
38	3	3	3	3
39	3	3	3	3
40	5	4	4	4

(Table continued on next page)

Ratings of Therapeutic Hour Y--Continued

	Judge A		Judge B	
Unit No.	1st Rating	2nd Rating	1st Rating	2nd Rating
41	3	3	4	4
42	3	3	3	3
43	3	3	4	4
44	4	3	4	3
45	4	3	4	3
46	4	4	4	4
47	4	4	5	4
48	4	4	5	4
49	4	4	5	4
50	4	4	4	4
51	4	4	5	4
52	4	3	5	4
53	4	3	4	3
54	4	4	4	4
55	3	3	3	4
56	4	4	4	4
57	4	4	4	4
58	3	4	3	4
59	5	5	4	5
60	5	5	4	5
61	5	5	4	5
62	3	3	3	3
63	3	4	3	3
64	3	4	3	3
65	3	3	3	3

APPENDIX D. RATINGS OF THE TYPESCRIPTS (RAW DATA)

Ratings of Judges 1 and 2 of Therapeutic Hour I

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	02	A-3	X	02	A-3	X
2	12	B-1	2	12	B-1	2
3	12	B-1	2	12	B-1	2
4	12	B-1	2	12	B-1	2
5	12	B-1	2	12	B-1	2
6	12	B-1	2	12	B-1	2
7	12	B-1	2	12	B-1	2
8	12	B-1	2	12	B-1	2
9	12	B-1	2	12	B-1	2
10	02	A-3	X	02	A-3	X
11	12	B-1	2	12	B-1	2
12	12	B-1	2	12	B-1	2
13	60	---	X	60	---	X
14	21	A-3	3	21	A-3	3
15	21	A-3	3	21	A-3	3
16	11	A-3	2	11	A-3	2
17	11	A-3	2	11	A-2	2
18	32	B-3	2	32	B-3	2
19	21	B-3	2	21	B-3	2
20	12	B-3	2	12	B-3	2
21	12	B-3	X	12	B-3	X
22	12	B-3	3	12	B-3	3
23	02	A-3	X	02	A-3	X
24	11	A-3	2	11	A-3	2
25	11	A-3	2	11	A-3	2
26	12	B-4	3	12	B-4	3
27	12	B-4	3	12	B-4	3
28	41	B-1	3	41	B-1	3
29	41	B-1	2	41	B-1	2
30	51	B-1	3	51	B-1	3
31	41	B-1	2	41	B-1	2
32	11	A-3	2	11	A-3	2
33	11	A-3	2	11	A-3	2
34	02	A-3	3	11	A-3	2
35	51	B-1	3	51	B-1	3
36	02	A-3	X	02	A-3	X
37	21	A-3	2	21	A-3	2
38	41	B-1	2	41	B-1	3
39	12	B-3	3	12	B-3	3
40	21	A-3	2	21	A-3	2

(Table continued on next page)

Ratings of Hour I--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
41	21	A-3	3	21	A-3	3
42	21	A-3	2	11	A-3	2
43	21	A-3	2	21	A-3	2
44	21	A-3	2	21	A-3	2
45	21	B-3	3	21	B-3	3
46	21	A-3	3	21	A-3	3
47	11	A-3	3	11	A-3	3
48	11	A-3	2	11	A-3	2
49	11	A-3	X	11	A-3	X
50	11	A-3	X	11	A-3	X
51	11	A-3	X	11	A-3	X
52	11	A-3	X	11	A-3	X
53	11	A-3	X	11	A-3	X
54	11	A-3	X	11	A-3	X
55	02	A-3	X	02	A-3	X
56	11	A-3	X	11	A-3	X
57	11	A-3	X	11	A-3	X
58	11	A-3	X	11	A-3	X
59	11	A-3	X	11	A-3	X
60	02	A-3	X	02	A-3	X
61	11	A-3	X	11	A-3	X
62	02	A-3	X	02	A-3	X
63	11	A-3	X	11	A-3	X
64	11	A-3	X	11	A-3	X
65	11	A-3	2	11	A-3	2
66	11	A-3	2	11	A-3	2
67	21	A-3	2	21	A-3	2
68	11	A-2	2	11	A-2	2
69	11	A-3	X	11	A-3	X
70	11	A-3	X	11	A-3	X
71	11	A-3	X	11	A-3	X
72	11	A-3	2	11	A-3	2
73	51	B-1	2	51	B-1	2
74	11	B-1	1	11	B-1	2
75	11	B-1	2	11	B-1	2
76	21	A-2	2	21	A-2	2
77	02	A-2	X	02	A-2	X
78	11	A-2	2	11	A-2	2
79	02	A-2	X	02	A-2	X
80	21	A-2	2	21	A-2	2

(Table continued on next page)

Ratings of Hour I--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
81	11	A-2	3	11	A-2	3
82	21	A-2	3	21	A-2	3
83	21	A-2	3	21	A-2	3
84	11	A-3	3	11	A-3	3
85	11	A-3	2	11	A-3	3
86	02	A-2	X	02	A-2	X
87	02	A-2	X	02	A-2	X
88	11	A-2	1	11	A-2	1
89	33	B-2	1	33	B-2	1
90	33	B-2	1	33	B-2	1
91	31	B-3	1	31	B-3	1
92	02	A-3	X	02	A-3	X
93	11	A-3	2	11	A-3	2
94	11	A-3	2	11	A-3	2
95	11	A-3	1	11	A-3	1
96	02	A-2	X	02	A-2	X
97	51	B-1	2	51	B-1	2
98	12	B-1	3	12	B-1	3
99	11	B-1	3	11	B-1	3
100	51	B-1	3	51	B-1	3
101	51	B-1	3	51	B-1	2
102	02	A-3	X	02	A-3	X

Ratings of Judges 1 and 2 of Therapeutic Hour II

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	61	---	X	61	---	X
2	11	B-1	3	11	B-1	3
3	11	A-3	3	11	A-3	3
4	11	A-3	3	11	A-3	3
5	12	B-1	3	12	B-1	3
6	12	B-1	2	12	B-1	2
7	02	A-3	3	02	A-3	3
8	12	B-1	2	12	B-1	3
9	51	A-3	3	51	A-3	3
10	11	A-3	X	11	A-3	X
11	11	A-3	3	11	A-3	3
12	02	A-3	3	02	A-3	3
13	11	A-3	1	11	A-3	1
14	52	A-3	1	52	A-3	1
15	12	A-3	3	12	A-3	3
16	21	B-3	2	21	B-1	2
17	11	A-3	3	11	A-3	3
18	11	A-3	3	11	A-3	3
19	31	B-3	3	31	B-3	3
20	11	A-3	3	11	A-3	3
21	12	B-3	3	12	B-3	2
22	21	A-3	1	21	A-3	2
23	11	A-3	3	11	A-3	2
24	33	B-3	3	33	B-3	3
25	02	A-3	X	02	A-3	X
26	51	B-1	3	51	B-1	2
27	51	B-1	3	51	B-1	2
28	11	A-3	X	11	A-3	X
29	12	B-1	3	12	B-1	2
30	12	B-2	3	12	B-1	2
31	11	B-2	3	11	B-2	3
32	11	B-2	3	11	B-2	3
33	11	B-2	3	11	B-2	3
34	21	B-3	3	22	B-3	3
35	11	B-1	3	11	B-1	3
36	22	B-3	3	22	B-3	3
37	12	B-1	3	12	B-1	3
38	12	B-1	3	12	B-1	3
39	33	B-3	4	33	B-3	4
40	53	B-2	2	53	B-2	1

(Table continued on next page)

Ratings of Hour II--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
41	53	B-2	2	53	B-2	1
42	21	A-2	2	21	A-2	1
43	53	B-2	3	53	B-2	3
44	21	B-4	3	21	B-4	3
45	21	B-4	X	53	B-4	2
46	53	B-2	2	53	B-2	1
47	21	A-3	3	21	A-3	2
48	02	A-3	X	02	A-3	X
49	12	B-3	2	12	B-3	2
50	02	A-3	X	02	A-3	X
51	11	A-3	X	11	A-3	X
52	11	A-3	2	11	A-3	1
53	11	A-3	2	11	A-3	1
54	21	B-3	3	21	B-3	2
55	21	B-3	3	21	B-3	2
56	21	B-3	3	12	B-3	2
57	02	A-3	X	02	A-3	X
58	21	A-3	2	21	A-3	1
59	21	A-3	2	21	A-3	2
60	12	B-3	X	12	B-3	X
61	12	B-1	X	12	B-1	X
62	12	B-1	3	12	B-1	3
63	12	B-1	3	12	B-1	3
64	12	B-1	3	12	B-1	3
65	12	B-1	3	12	B-1	2
66	51	B-1	2	51	B-1	2
67	12	B-2	2	12	B-2	2
68	02	A-2	2	02	A-2	2
69	21	A-2	2	21	A-2	1
70	02	A-3	2	02	A-3	1
71	32	B-3	3	12	B-3	2
72	32	A-2	2	32	A-2	1
73	34	B-3	4	34	B-3	4
74	53	A-3	2	53	A-3	1
75	02	A-3	X	02	A-3	X
76	53	B-2	X	53	B-3	X
77	12	B-3	X	12	B-3	X
78	53	A-2	X	53	A-2	X
79	53	A-2	X	53	A-2	X
80	12	A-2	2	12	A-2	1

(Table continued on next page)

Ratings of Hour II--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
81	02	A-2	X	02	A-2	X
82	11	A-2	X	21	A-3	X
83	21	B-3	3	11	A-3	2
84	21	A-2	4	21	A-2	3
85	21	B-3	4	21	B-3	4
86	31	B-3	4	31	B-3	4
87	31	B-3	4	31	B-3	3
88	21	B-3	4	21	B-3	3
89	32	B-3	4	32	B-3	3
90	21	A-3	4	21	A-3	3
91	02	A-2	2	02	A-2	2
92	21	A-3	3	21	A-3	2
93	02	A-3	2	02	A-3	1
94	70	---	X	70	---	X
95	33	B-3	4	33	B-3	3
96	21	A-3	2	31	A-3	2
97	31	B-3	4	31	B-2	3
98	21	A-3	4	21	A-3	3
99	21	A-3	3	12	A-3	3
100	34	B-3	5	34	B-3	5
101	34	B-3	5	34	B-3	5
102	34	B-3	5	34	B-3	5
103	21	A-2	3	21	A-2	3
104	33	A-3	4	33	A-3	4
105	11	A-3	3	12	B-3	2
106	11	B-3	3	12	B-3	3
107	02	A-3	2	02	A-3	3
108	02	A-3	3	02	A-3	3
109	11	A-3	3	11	A-3	2
110	02	A-3	3	02	A-3	2
111	21	A-3	3	21	A-3	3
112	02	A-3	3	02	A-3	3
113	32	B-3	3	32	B-3	3
114	02	A-3	2	02	A-3	1
115	11	A-3	2	21	A-3	1
116	61	---	X	61	---	X

Ratings of Judges 1 and 2 of Therapeutic Hour III

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	61	---	X	61	---	X
2	61	---	X	61	---	X
3	43	A-3	2	43	A-3	2
4	43	A-3	2	43	A-3	2
5	43	A-3	2	43	A-3	2
6	43	A-3	2	43	A-3	2
7	41	B-1	2	41	B-1	2
8	02	A-3	X	02	A-3	X
9	11	A-3	2	11	A-3	2
10	11	A-3	2	11	A-3	2
11	11	A-2	2	11	A-2	2
12	11	A-2	2	11	A-2	2
13	11	A-2	2	11	A-2	2
14	11	A-2	2	11	A-2	2
15	02	A-2	X	02	A-2	X
16	11	A-2	2	11	A-2	2
17	02	A-2	X	02	A-2	X
18	11	A-3	X	11	A-3	X
19	11	A-3	X	11	A-3	X
20	02	A-3	X	11	A-3	X
21	21	A-3	2	21	A-3	2
22	02	A-3	X	02	A-3	X
23	11	A-3	2	11	A-3	2
24	11	A-2	2	11	A-2	2
25	02	A-3	X	02	A-3	X
26	02	A-2	X	02	A-2	X
27	21	A-2	2	12	A-2	2
28	11	A-2	X	11	A-2	X
29	21	A-3	3	21	A-3	3
30	21	A-3	2	21	A-3	2
31	11	A-2	3	11	A-2	3
32	11	A-2	X	11	A-2	X
33	11	A-2	X	11	A-2	X
34	11	A-3	2	11	A-3	2
35	11	A-2	2	11	A-2	2
36	22	A-2	2	22	A-2	2
37	11	A-2	2	11	A-2	2
38	11	A-2	X	11	A-2	2
39	11	B-1	X	11	B-1	X
40	11	B-1	X	11	B-1	X

(Table continued on next page)

Ratings of Hour III--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
41	11	B-1	X	11	B-1	X
42	02	A-3	X	02	A-3	X
43	21	A-3	2	21	A-3	2
44	70	---	X	70	---	X
45	21	A-3	2	21	A-3	2
46	21	B-1	2	21	B-1	2
47	11	B-1	2	11	B-1	2
48	02	A-3	X	02	A-3	X
49	21	A-3	2	21	A-3	2
50	21	A-3	2	21	A-3	2
51	11	A-3	2	11	A-3	2
52	21	A-3	2	21	A-3	2
53	21	A-3	2	21	A-3	2
54	21	A-3	3	21	A-3	3
55	11	A-3	1	11	A-3	2
56	12	A-2	1	12	A-2	1
57	11	A-2	1	11	A-2	1
58	11	A-2	2	11	A-2	1
59	21	A-3	3	21	A-3	3
60	11	A-2	X	11	A-2	X
61	21	A-2	2	11	A-2	2
62	11	A-2	X	11	A-2	X
63	11	A-2	X	11	A-2	X
64	11	A-2	X	11	A-2	X
65	11	A-2	X	11	A-2	X
66	51	B-1	2	51	B-1	3
67	70	---	X	70	---	X
68	70	---	X	70	---	X
69	21	B-1	2	21	B-1	2
70	41	B-1	2	41	B-1	2
71	61	---	X	61	---	X
72	12	B-1	3	11	B-1	2
73	21	B-1	3	21	B-1	3
74	61	---	X	61	---	X
75	70	---	X	70	---	X
76	61	---	X	61	---	X
77	61	---	X	61	---	X

Ratings of Judges 1 and 2 of Therapeutic Hour IV

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	11	B-3	3	11	B-3	3
2	02	A-3	X	02	A-3	X
3	11	A-3	X	11	A-3	X
4	11	A-3	2	11	A-3	2
5	11	A-3	2	11	A-3	2
6	11	A-3	X	11	A-3	X
7	21	A-3	1	21	A-3	1
8	41	B-1	3	41	B-1	3
9	41	B-1	3	21	B-1	2
10	41	B-1	3	41	B-1	3
11	12	B-1	3	12	B-1	3
12	12	B-1	2	12	B-1	2
13	12	B-1	3	12	B-1	3
14	11	B-1	3	11	B-1	2
15	12	B-1	3	12	B-1	3
16	12	B-2	3	12	B-2	3
17	32	B-3	4	32	B-3	4
18	32	B-3	4	32	B-3	4
19	12	B-3	4	12	B-3	4
20	12	B-3	3	12	B-3	4
21	11	B-3	2	11	B-3	2
22	70	---	X	70	---	X
23	11	B-1	2	11	B-1	2
24	11	B-1	2	11	B-1	2
25	11	B-1	2	11	B-1	2
26	11	B-1	2	11	B-1	2
27	61	---	X	61	---	X
28	11	B-1	2	11	B-1	2
29	11	B-1	2	11	B-1	2
30	11	B-1	2	11	B-1	2
31	41	B-1	2	21	B-1	3
32	11	B-1	2	11	B-1	2
33	51	B-1	2	51	B-1	2
34	21	B-1	2	21	B-1	2
35	11	B-1	2	11	B-1	2
36	11	B-1	2	11	B-1	2
37	41	B-1	2	41	B-1	2
38	11	B-1	2	11	B-1	2
39	11	B-1	2	11	B-1	2
40	21	B-1	2	21	B-1	2

(Table continued on next page)

Ratings of Hour IV--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
41	11	B-1	2	11	B-1	2
42	11	B-1	2	11	B-1	2
43	11	B-1	2	11	B-1	2
44	11	B-1	2	11	B-1	2
45	11	B-1	2	11	B-1	2
46	11	A-3	3	11	A-3	2
47	12	B-1	3	12	B-1	3
48	02	---	X	12	B-1	2
49	12	B-1	3	12	B-1	3
50	11	A-3	3	12	A-3	2
51	21	B-1	3	21	B-1	3
52	12	B-1	3	12	B-1	3
53	11	A-3	2	11	A-3	2
54	11	A-3	3	11	A-3	2
55	11	A-3	3	11	A-3	2
56	12	B-1	3	12	B-1	2
57	11	B-1	3	11	B-1	3
58	12	B-2	3	22	B-2	3
59	12	B-2	2	12	B-2	2
60	11	A-2	3	11	A-2	2
61	51	B-1	3	51	B-1	3
62	11	B-1	3	12	B-1	2
63	11	B-1	X	11	B-1	2
64	12	B-1	3	12	B-1	2
65	12	B-1	3	12	B-1	3
66	12	B-1	3	12	B-1	2
67	11	B-1	X	11	B-1	2
68	21	B-1	3	51	B-1	2
69	41	B-1	X	41	B-1	3
70	41	B-1	3	41	B-1	3
71	41	B-1	2	41	B-1	3
72	41	B-1	3	41	B-1	3
73	41	B-1	3	41	B-1	3
74	41	B-1	3	41	B-1	3
75	41	B-1	3	41	B-1	3
76	41	B-1	3	41	B-1	3
77	41	B-1	3	41	B-1	3
78	41	B-1	3	41	B-1	3
79	41	B-1	3	41	B-1	3
80	41	B-1	3	41	B-1	3
81	41	B-1	3	41	B-1	3
82	41	B-1	3	41	B-1	2

Ratings of Judges 1 and 2 of Therapeutic Hour V

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	61	---	X	61	---	X
2	11	A-3	2	11	A-3	2
3	11	A-3	2	11	A-3	2
4	21	A-3	3	21	A-3	3
5	11	A-3	2	11	A-3	2
6	11	A-2	2	11	A-2	2
7	11	A-2	2	11	A-2	2
8	11	A-2	2	11	A-2	2
9	11	A-3	2	11	A-3	2
10	11	A-3	3	11	A-3	2
11	11	A-3	2	11	A-3	2
12	12	A-3	2	12	A-3	3
13	11	A-3	2	11	A-3	2
14	11	A-3	2	11	A-3	2
15	12	A-3	2	12	A-3	2
16	11	A-3	2	11	A-3	2
17	21	A-3	2	21	A-3	2
18	11	A-3	2	11	A-3	2
19	11	A-3	2	11	A-3	3
20	12	A-3	2	12	A-3	3
21	12	B-1	3	12	B-1	3
22	11	A-3	2	11	A-3	2
23	12	B-1	3	12	B-1	3
24	11	A-3	2	11	A-3	2
25	11	A-3	2	11	A-3	2
26	11	A-3	2	11	A-3	2
27	12	B-1	2	12	B-1	2
28	12	B-1	2	11	B-1	2
29	12	B-1	2	11	A-3	2
30	11	A-3	2	11	A-3	2
31	12	A-3	2	11	A-3	2
32	11	A-3	2	11	A-3	2
33	11	A-3	2	11	A-3	2
34	11	A-3	2	11	A-3	2
35	11	A-3	3	11	A-3	3
36	11	A-3	2	11	A-3	2
37	11	A-3	2	11	A-3	2
38	11	A-3	2	11	A-3	2
39	11	A-3	2	11	A-3	2
40	12	A-3	2	11	A-3	2

(Table continued on next page)

Ratings of Hour V--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
41	11	A-3	2	11	A-3	2
42	31	B-3	3	31	B-3	3
43	12	B-1	3	12	B-1	3
44	12	B-1	3	12	B-1	3
45	70	---	X	70	---	X
46	21	B-1	3	21	B-1	3
47	21	B-1	3	21	B-1	3
48	21	B-1	3	21	B-1	3
49	31	B-1	3	31	B-1	3
50	31	B-1	2	31	B-1	2
51	21	B-1	3	21	B-1	3
52	33	B-3	2	33	B-3	2
53	11	A-3	2	11	A-3	2
54	11	A-3	2	11	A-3	2
55	11	A-3	2	11	A-3	2
56	11	A-3	2	11	A-3	2
57	11	A-3	2	11	A-3	2
58	12	B-3	2	12	A-3	2
59	12	B-2	2	12	B-2	2
60	11	A-3	2	11	A-3	2
61	11	A-3	2	11	A-3	2
62	11	A-3	2	11	A-3	2
63	21	A-3	2	21	A-3	3
64	11	A-3	2	11	A-3	2
65	12	A-3	2	12	A-3	2
66	11	A-3	2	11	A-3	2
67	11	A-3	2	11	A-3	2
68	11	A-3	2	11	A-3	2
69	11	A-3	2	11	A-3	2
70	11	A-3	2	11	A-3	2
71	11	A-3	2	11	A-3	2
72	11	A-3	2	11	A-3	2
73	11	A-3	2	11	A-3	2
74	11	A-3	2	11	A-3	2
75	11	A-3	2	11	A-3	2
76	11	A-3	2	11	A-3	2
77	11	A-3	2	11	A-3	2
78	11	A-3	2	11	A-3	2
79	11	A-3	2	11	A-3	2
80	12	A-3	2	11	A-3	2

(Table continued on next page)

Ratings of Hour V--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
81	12	B-1	2	12	B-1	2
82	21	B-1	1	21	B-1	2
83	12	B-1	2	12	B-1	2
84	21	B-1	2	21	B-1	2
85	12	A-3	2	12	A-3	2
86	12	B-1	2	12	B-1	2
87	12	B-1	2	12	B-1	2
88	12	B-1	2	12	B-1	2
89	11	A-3	2	11	A-3	2
90	12	A-3	2	12	A-3	2
91	12	B-1	2	12	B-1	2
92	12	B-1	2	12	B-1	2
93	11	B-1	2	11	B-1	2
94	11	A-3	2	12	B-1	2
95	11	A-3	2	11	A-3	2
96	21	B-1	2	21	B-1	2
97	21	B-1	2	21	B-1	2
98	11	A-3	2	12	B-1	2
99	11	A-3	2	11	A-3	2
100	11	A-3	2	11	A-3	2
101	12	A-3	2	12	A-3	2
102	21	B-1	2	21	B-1	2
103	11	A-3	2	11	A-3	2
104	33	B-3	2	33	B-3	2
105	21	B-1	2	21	B-1	2
106	31	B-1	2	31	B-1	2
107	31	B-1	2	31	B-1	2
108	31	B-1	2	31	B-1	2
109	12	B-1	3	12	B-1	3
110	21	B-1	2	21	B-1	2
111	21	B-1	2	21	B-1	2
112	21	B-1	2	21	B-1	2
113	33	B-1	2	33	B-1	2
114	12	B-1	2	12	B-1	2
115	11	B-1	2	11	B-1	2
116	21	A-3	2	21	A-3	2
117	21	A-3	2	21	A-3	2
118	33	B-3	2	33	B-3	2
119	21	A-3	2	21	A-3	2
120	11	A-3	2	11	A-3	2

(Table continued on next page)

Ratings of Hour V--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
121	21	A-3	2	12	A-3	2
122	12	A-3	1	12	A-3	2
123	12	A-3	1	12	A-3	1
124	31	B-1	2	31	B-1	2
125	21	A-3	2	21	A-3	2
126	11	A-3	2	11	A-3	2
127	11	A-3	2	12	A-3	2
128	12	A-3	2	12	A-3	2
129	21	B-1	2	21	B-1	2
130	31	B-1	2	31	B-1	2
131	11	A-3	2	11	A-3	2
132	11	A-3	2	11	A-3	2
133	11	A-3	2	11	A-3	2
134	21	B-1	2	21	B-1	2
135	21	B-1	2	21	B-1	2
136	21	B-1	2	12	B-1	2
137	11	A-3	2	11	A-3	2
138	21	B-1	2	21	B-1	2
139	21	B-1	2	21	B-1	2
140	12	B-1	2	12	B-1	2
141	11	A-3	2	11	A-3	2
142	11	A-3	2	11	A-3	2
143	11	A-3	1	11	A-3	1
144	11	A-3	1	11	A-3	1
145	12	A-3	2	12	A-3	2
146	11	A-3	2	11	A-3	1
147	11	A-3	2	11	A-3	2
148	11	A-3	2	11	A-3	2
149	11	A-3	2	11	A-3	2
150	11	A-3	2	12	B-1	2
151	11	A-3	2	12	A-3	2
152	11	A-3	2	11	A-3	2
153	11	A-3	2	11	A-3	2
154	11	A-3	2	11	A-3	2
155	11	B-1	2	12	B-1	2
156	21	B-1	2	12	B-1	2
157	11	A-3	2	11	A-3	1
158	12	B-1	2	12	B-1	2
159	11	A-2	2	11	A-2	2
160	41	B-1	3	41	B-1	3
161	70	---	X	70	---	X

Ratings of Judges 1 and 2 of Therapeutic Hour VI

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	61	---	X	11	A-3	2
2	11	A-3	3	11	A-3	2
3	11	A-3	3	11	A-3	2
4	11	A-3	2	11	A-3	2
5	11	A-3	2	11	A-3	2
6	11	A-3	2	11	A-3	2
7	11	A-3	2	11	A-3	2
8	11	A-3	2	11	A-3	2
9	11	A-3	2	11	A-3	2
10	11	A-3	2	11	A-3	2
11	21	B-1	3	21	B-1	2
12	12	B-1	2	12	B-1	2
13	21	B-1	3	11	B-1	2
14	21	B-1	2	11	B-1	2
15	21	B-1	2	21	B-1	2
16	12	B-1	2	12	B-1	2
17	31	B-2	3	31	B-2	2
18	12	B-1	3	12	B-1	2
19	11	A-3	3	11	A-3	2
20	21	A-3	3	11	A-3	2
21	11	A-3	3	11	A-3	2
22	11	A-3	3	11	A-3	2
23	11	A-3	X	11	A-3	2
24	11	A-3	3	11	A-3	2
25	11	A-3	3	11	A-3	2
26	11	A-3	3	11	A-3	2
27	11	A-3	3	11	A-3	2
28	34	B-3	4	34	B-3	2
29	21	B-1	3	21	B-1	2
30	21	A-3	3	12	B-1	2
31	21	B-1	3	21	B-1	2
32	21	B-1	3	21	B-1	2
33	21	B-1	3	21	B-1	2
34	31	B-2	3	31	B-2	2
35	21	B-1	3	21	B-1	2
36	31	B-3	4	31	B-3	3
37	33	B-3	4	33	B-3	4
38	34	B-3	4	31	B-3	3
39	21	A-3	3	21	A-3	3
40	11	A-3	3	21	B-1	3

(Table continued on next page)

Ratings of Hour VI--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
41	11	A-3	3	21	B-1	3
42	34	B-3	4	34	B-3	4
43	21	B-1	3	21	B-1	3
44	33	B-3	3	33	B-3	4
45	21	A-3	X	12	B-1	3
46	34	B-3	4	34	B-3	4
47	21	B-1	3	21	B-1	3
48	21	B-3	3	34	B-3	4
49	21	B-3	3	34	B-3	4
50	21	B-3	3	21	B-3	4
51	34	B-3	4	34	B-3	4
52	11	B-1	3	11	B-1	X
53	11	B-1	3	11	B-1	3
54	11	B-1	3	11	B-1	3
55	22	A-3	4	43	B-3	4
56	11	B-1	X	11	B-1	X
57	11	B-1	X	11	B-1	X
58	12	B-1	3	12	B-1	3
59	21	B-3	3	21	B-3	3
60	12	B-1	3	12	B-1	3
61	12	B-1	2	12	B-1	3
62	12	B-1	3	12	B-1	3
63	31	B-3	4	31	B-3	4
64	31	B-3	4	31	B-3	4
65	34	B-3	3	12	B-1	3
66	12	B-1	3	12	B-1	3
67	31	B-3	3	31	B-3	3
68	31	B-3	3	31	B-3	3
69	31	B-3	3	31	B-3	3
70	31	B-3	3	12	B-1	3
71	11	B-1	3	11	B-1	3
72	12	B-1	3	12	B-1	3
73	31	B-2	3	34	B-1	3
74	31	B-2	3	21	B-1	3
75	31	B-2	3	31	B-2	3
76	31	B-2	2	31	B-2	2
77	31	B-3	3	31	B-3	3
78	21	B-1	X	21	B-1	X
79	31	B-3	1	31	B-3	3
80	31	B-3	4	31	B-3	3

(Table continued on next page)

Ratings of Hour VI--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
81	33	B-2	2	33	B-2	3
82	31	B-2	2	31	B-2	3
83	31	B-3	4	31	B-3	3
84	31	B-3	3	31	B-3	3
85	21	B-3	3	21	B-3	3
86	21	B-3	3	21	B-3	3
87	21	B-3	3	21	B-3	3
88	12	B-1	3	12	B-1	3
89	21	B-1	3	21	B-1	3
90	31	B-2	2	31	B-2	3
91	11	A-2	3	11	A-2	2
92	12	B-1	X	12	B-1	X
93	21	B-1	4	21	B-1	3
94	12	B-1	3	12	B-1	3
95	12	B-1	3	12	B-1	3
96	12	B-1	3	12	B-1	3
97	34	B-3	4	34	B-3	4
98	34	B-3	4	34	B-3	4
99	21	B-1	4	21	B-1	3
100	34	B-3	4	34	B-3	4
101	34	B-3	3	34	B-3	4
102	34	B-3	4	34	B-3	4
103	12	B-1	3	12	B-1	3
104	34	B-3	4	21	B-1	3
105	33	B-3	4	21	B-1	3
106	21	B-3	3	21	B-3	3
107	12	B-1	3	12	B-1	3
108	12	B-2	3	12	B-2	3
109	12	B-1	3	12	B-1	3
110	21	B-1	3	21	B-1	3
111	31	B-2	2	31	B-2	2
112	31	B-2	2	31	B-2	2
113	21	B-1	2	21	B-1	3
114	33	B-3	1	33	B-3	3
115	12	B-2	2	12	B-2	3
116	33	B-2	2	33	B-2	3
117	31	B-2	2	31	B-2	3
118	21	B-3	3	12	B-1	3
119	31	B-3	2	31	B-3	3
120	33	B-3	3	33	B-3	3

(Table continued on next page)

Ratings of Hour VI--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
121	12	B-1	3	12	B-1	3
122	33	B-3	3	33	B-3	3
123	21	B-1	3	21	B-1	3
124	31	B-3	3	12	B-1	3
125	31	B-2	3	31	B-2	3
126	33	B-3	4	33	B-3	4
127	34	B-3	4	34	B-3	4
128	12	B-1	4	12	B-1	3
129	32	B-3	4	32	B-3	3
130	12	B-1	3	12	B-1	3
131	12	B-3	3	21	B-1	3
132	12	B-1	4	12	B-1	4
133	34	BT-4	4	34	BT-4	3
134	34	B-3	3	34	B-3	3
135	33	B-3	3	33	B-3	3
136	34	B-4	4	31	B-1	3
137	33	B-3	4	33	B-3	3
138	31	B-3	3	31	B-3	2
139	31	B-3	3	31	B-3	2
140	31	B-3	3	31	B-3	3
141	31	B-3	3	31	B-3	4
142	31	B-3	3	31	B-3	4
143	02	A-3	3	53	A-3	3
144	12	B-2	3	12	B-2	3
145	32	B-3	3	32	B-3	3
146	31	B-3	3	12	B-1	3
147	12	B-3	3	12	B-3	3
148	31	B-3	4	31	B-3	4
149	12	B-3	3	31	B-3	3
150	33	B-3	3	33	B-3	3
151	32	B-3	4	34	B-3	3
152	21	B-1	4	21	B-1	3
153	12	B-1	3	12	B-1	4
154	12	B-1	3	12	B-1	3
155	32	B-4	4	32	B-4	3
156	61	---	X	61	---	X
157	61	---	X	61	---	X

Ratings of Judges 1 and 2 of Therapeutic Hour VII

	Judge 1			Judge 2		
Unit No.	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	02	A-3	3	02	A-3	2
2	21	A-3	3	21	A-3	3
3	21	A-3	3	21	A-3	3
4	11	B-1	3	11	B-1	X
5	34	B-3	4	34	B-3	3
6	12	B-1	3	11	B-1	3
7	12	B-1	3	12	B-1	3
8	12	B-1	3	12	B-1	3
9	34	B-3	4	34	B-3	3
10	21	B-1	3	21	B-1	3
11	34	B-4	4	34	B-4	4
12	31	B-3	3	31	B-3	3
13	12	B-1	3	11	B-1	3
14	12	B-1	3	12	B-1	3
15	34	B-3	3	34	B-3	3
16	34	B-3	3	34	B-3	3
17	12	B-1	3	12	B-1	3
18	70	---	X	70	---	X
19	31	B-3	3	31	B-3	3
20	21	B-3	X	12	B-3	3
21	12	B-3	X	12	B-3	X
22	11	B-1	3	11	B-1	3
23	70	---	X	70	---	X
24	11	A-2	X	11	A-2	X
25	12	B-1	3	12	B-1	3
26	12	B-1	3	12	B-1	3
27	21	B-3	3	21	B-3	3
28	31	B-2	3	31	B-2	3
29	12	B-1	3	12	B-1	3
30	11	A-3	X	11	A-3	X
31	12	B-1	3	12	B-1	3
32	21	B-3	3	21	B-3	3
33	21	B-3	3	21	B-3	3
34	11	B-3	3	12	B-3	3
35	12	B-3	3	12	B-3	3
36	21	B-3	3	12	B-3	3
37	12	B-1	3	12	B-1	3
38	12	B-4	3	12	B-4	3
39	12	B-1	3	12	B-1	3
40	02	A-3	3	02	A-3	3
41	61	---	X	61	---	X
42	43	---	X	43	---	X

Ratings of Judges 1 and 2 of Therapeutic Hour VIII

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	02	A-3	X	02	A-3	X
2	02	A-3	X	02	A-3	X
3	21	A-3	3	21	A-3	3
4	21	A-3	3	21	A-3	3
5	34	B-3	4	34	B-3	4
6	70	---	X	70	---	X
7	11	A-3	X	11	A-3	X
8	31	B-3	3	31	B-3	3
9	12	B-1	X	11	B-1	X
10	12	B-1	X	11	B-1	X
11	12	B-1	3	12	B-1	3
12	12	B-1	3	12	B-1	3
13	21	B-3	3	21	B-3	3
14	11	B-1	3	11	B-1	3
15	21	B-3	3	21	B-3	3
16	11	B-1	3	12	B-1	3
17	11	B-1	3	11	B-1	3
18	21	B-3	3	21	B-3	3
19	21	B-3	3	21	B-3	3
20	31	B-3	3	31	B-3	3
21	31	B-3	3	31	B-3	3
22	21	B-3	3	21	B-3	3
23	31	B-3	3	31	B-3	3
24	32	B-1	3	32	B-1	3
25	32	B-1	3	32	B-1	3
26	21	B-3	3	21	B-3	3
27	34	B-3	4	34	B-3	4
28	34	B-3	4	34	B-3	4
29	61	---	X	61	---	X

Ratings of Judges 1 and 2 of Therapeutic Hour IX

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	02	A-3	3	02	A-3	3
2	21	A-3	3	21	A-3	3
3	21	A-3	X	21	A-3	X
4	11	B-1	3	11	B-1	3
5	21	A-3	3	21	A-3	3
6	11	B-1	3	11	B-1	3
7	12	B-1	3	12	B-1	3
8	02	A-3	X	02	A-3	X
9	21	B-3	3	21	B-3	3
10	21	B-3	3	21	B-3	4
11	34	B-3	4	34	B-3	4
12	34	B-3	4	34	B-3	4
13	12	B-1	3	12	B-1	4
14	31	B-3	3	34	B-3	4
15	34	B-3	4	34	B-3	4
16	11	B-1	3	11	B-1	3
17	11	B-1	X	11	B-1	3
18	11	B-1	X	11	B-1	3
19	12	B-1	3	12	B-1	4
20	31	B-3	3	31	B-3	4
21	31	B-3	4	31	B-3	4
22	02	A-3	X	02	A-3	X
23	12	B-1	2	12	B-1	3
24	02	A-3	X	02	A-3	X
25	11	A-3	2	12	B-1	3
26	21	B-1	3	12	B-1	3
27	02	A-3	X	02	A-3	X
28	12	B-1	3	12	B-1	3
29	12	B-1	X	12	B-1	3
30	12	B-1	2	12	B-1	3
31	12	B-1	3	34	B-3	4
32	34	B-3	4	31	B-3	3
33	31	B-3	3	21	B-3	3
34	21	B-3	3	21	B-3	3
35	11	B-1	2	11	B-1	2
36	12	B-1	3	12	B-1	3
37	31	B-3	3	31	B-3	3
38	02	A-3	X	02	A-3	X
39	12	B-1	3	12	B-1	3
40	61	---	X	61	---	X
41	61	---	X	61	---	X

Ratings of Judges 1 and 2 of Therapeutic Hour X

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	61	---	X	61	---	X
2	34	B-1	4	34	B-1	4
3	34	B-1	4	34	B-1	4
4	21	B-3	4	21	B-3	4
5	11	B-1	3	12	B-1	3
6	12	B-1	3	12	B-1	3
7	12	B-1	3	12	B-1	3
8	11	B-1	3	11	B-1	3
9	12	B-1	3	12	B-1	3
10	02	A-3	3	02	A-3	3
11	21	A-3	3	21	A-3	3
12	21	A-3	3	21	A-3	3
13	21	B-1	3	21	B-1	3
14	11	B-1	X	11	B-1	X
15	11	B-1	3	11	B-1	3
16	12	B-1	4	34	B-3	4
17	70	---	X	70	---	X
18	70	---	X	70	---	X
19	21	B-3	3	21	B-3	3
20	02	A-3	3	02	A-3	3
21	70	---	X	70	---	X
22	34	B-3	4	34	B-3	4
23	21	B-3	3	12	B-1	3
24	12	B-1	3	12	B-1	3
25	12	B-1	3	12	B-1	3
26	12	B-1	3	12	B-1	3
27	12	B-1	3	12	B-1	3
28	32	B-3	3	32	B-3	3
29	34	B-3	3	34	B-3	3
30	61	---	X	61	---	X

Ratings of Judges 1 and 2 of Therapeutic Hour XI

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	32	B-3	4	32	B-3	4
2	34	B-3	5	34	B-3	4
3	34	B-3	5	34	B-3	5
4	34	B-3	5	34	B-3	5
5	11	B-3	5	12	B-3	5
6	11	B-3	5	12	B-3	5
7	31	B-3	4	31	B-3	4
8	34	B-3	5	34	B-3	5
9	34	B-3	5	34	B-3	5
10	11	B-3	3	11	B-3	3
11	12	B-3	3	12	B-3	3
12	12	B-3	3	12	B-3	4
13	53	B-3	3	53	B-3	3
14	53	B-3	3	53	B-3	3
15	34	B-3	4	34	B-3	5
16	31	B-3	3	31	B-3	4
17	34	B-3	5	34	B-3	5
18	34	B-3	5	34	B-3	5
19	34	B-3	5	34	B-3	5
20	34	B-4	5	34	B-4	5
21	31	B-3	5	31	B-3	4
22	31	B-3	4	31	B-3	4
23	34	B-3	5	34	B-3	5
24	34	B-3	5	34	B-3	5
25	12	B-3	5	12	B-3	5
26	21	A-3	4	21	A-3	4
27	12	B-3	4	12	B-3	5
28	21	A-3	4	21	A-3	4
29	12	B-3	5	12	B-3	5
30	34	B-3	5	34	B-3	5
31	12	B-3	5	12	B-3	5
32	32	B-3	3	32	B-3	3
33	34	B-3	4	34	B-3	4
34	12	A-3	3	11	A-3	2
35	34	B-3	4	34	B-3	4
36	31	B-3	4	31	B-3	4
37	32	B-3	4	32	B-3	4
38	34	B-3	4	34	B-3	5
39	53	B-3	3	53	B-3	4
40	34	B-3	4	34	B-3	5

(Table continued on next page)

Ratings of Hour XI--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
41	12	B-3	5	12	B-3	5
42	34	B-3	5	34	B-3	5
43	41	B-3	4	41	B-3	4
44	34	B-3	5	34	B-3	5
45	34	B-3	5	34	B-3	5
46	54	B-3	4	54	B-3	4
47	34	B-3	5	34	B-3	5
48	34	B-3	5	34	B-3	5
49	21	A-3	4	21	A-3	4
50	34	B-3	4	34	B-3	4
51	34	B-3	5	34	B-3	5
52	34	B-3	5	34	B-3	5
53	12	B-3	3	12	B-3	3
54	21	A-3	4	21	A-3	4
55	12	B-3	4	12	B-3	4
56	12	B-3	4	12	B-3	4
57	34	B-3	5	34	B-3	5
58	34	B-3	5	34	B-3	5
59	12	B-3	3	12	B-3	3
60	54	B-3	4	54	B-3	4
61	21	B-3	4	21	B-3	4
62	31	B-2	3	31	B-2	3
63	31	B-2	3	31	B-2	3
64	34	B-3	4	34	B-3	4
65	34	B-3	4	34	B-3	4
66	34	B-4	5	34	B-4	5
67	11	B-3	4	12	B-3	4
68	11	B-3	4	12	B-3	4
69	12	B-3	4	12	B-3	4
70	12	B-4	4	12	B-4	4
71	34	B-4	4	34	B-4	4
72	34	B-4	4	34	B-4	4
73	34	B-4	4	34	B-4	4
74	34	B-3	4	34	B-3	4
75	34	B-4	5	34	B-4	5
76	34	B-3	5	34	B-3	5
77	34	B-3	5	34	B-3	5
78	34	B-3	5	34	B-3	5
79	34	B-3	5	34	B-3	5
80	34	B-3	5	34	B-3	5

(Table continued on next page)

Ratings of Hour XI--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
81	34	B-3	5	34	B-3	5
82	34	B-4	5	34	B-4	5
83	32	B-4	4	32	B-4	4
84	34	B-3	5	34	B-3	5
85	34	B-4	5	34	B-4	5
86	12	B-3	4	12	B-3	4
87	34	B-4	5	34	B-4	5
88	12	B-3	3	12	B-3	3
89	21	A-3	3	21	A-3	3
90	34	B-3	4	34	B-4	5
91	34	B-4	4	34	B-4	4
92	12	B-3	4	12	B-3	4
93	34	B-4	4	34	B-4	4
94	51	B-3	3	41	B-3	3
95	31	B-3	3	31	B-3	3
96	32	B-3	3	32	B-3	3
97	34	B-4	4	34	B-4	4
98	34	B-3	5	34	B-3	5
99	34	B-3	5	34	B-3	5
100	34	B-4	5	34	B-4	5
101	34	B-3	4	53	B-3	4

Ratings of Judges 1 and 2 of Therapeutic Hour XII

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	34	B-3	4	34	B-3	4
2	12	B-3	4	12	B-3	4
3	34	A-3	4	34	A-3	4
4	11	A-3	3	11	A-3	2
5	11	A-3	3	11	A-3	2
6	41	B-3	3	41	B-3	3
7	11	A-3	3	11	A-3	3
8	12	B-4	3	12	B-4	3
9	12	B-4	3	12	B-4	3
10	12	B-4	3	12	B-4	3
11	12	B-4	4	12	B-4	4
12	11	A-3	3	11	A-3	2
13	11	A-3	3	11	A-3	2
14	12	B-1	3	12	B-1	2
15	12	B-1	4	12	B-1	3
16	34	A-3	3	34	A-3	3

Ratings of Judges 1 and 2 of Therapeutic Hour XIII

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	11	A-3	3	11	A-3	X
2	34	B-3	4	34	B-3	4
3	21	B-3	4	21	B-3	4
4	34	B-3	4	34	B-3	4
5	34	B-3	4	34	B-3	5
6	34	B-3	4	34	B-3	5
7	34	B-3	4	34	B-3	5
8	34	B-3	5	34	B-3	5
9	34	B-3	5	34	B-3	5
10	34	B-3	5	34	B-3	5
11	34	B-3	5	34	B-3	5
12	32	B-3	3	34	B-3	5
13	12	B-3	3	12	B-3	4
14	34	B-3	3	21	B-3	4
15	12	B-3	3	12	B-3	4
16	21	B-3	3	21	B-3	4
17	21	B-3	4	34	B-3	5
18	21	B-3	4	34	B-3	5
19	34	B-3	4	34	B-3	5
20	21	B-3	4	21	B-3	5
21	21	B-3	4	21	B-3	5
22	21	B-3	3	21	B-3	5
23	34	B-3	4	34	B-3	5
24	34	B-4	4	34	B-4	5
25	12	B-3	3	12	B-3	4
26	53	B-4	X	53	B-4	4
27	34	B-3	4	34	B-3	5
28	34	B-3	4	34	B-3	5
29	21	B-3	3	21	B-3	3
30	34	B-3	4	34	B-3	5
31	54	B-4	4	54	B-4	5
32	34	B-4	4	34	B-4	5
33	34	B-4	4	32	B-3	4
34	12	B-3	4	12	B-3	4
35	34	B-4	4	21	B-3	4
36	34	B-4	4	12	B-3	4
37	34	B-3	4	34	B-3	5
38	34	B-4	4	34	B-4	5
39	54	B-4	4	54	B-4	5

Ratings of Judges 1 and 2 of Therapeutic Hour XIV

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	53	B-3	3	53	B-3	3
2	21	B-4	3	21	B-4	3
3	34	B-4	4	34	B-4	4
4	34	B-4	4	34	B-4	4
5	21	B-3	3	21	B-3	3
6	21	B-3	3	21	B-3	3
7	34	B-3	4	12	B-3	4
8	34	B-3	4	34	B-3	4
9	21	B-4	4	21	B-4	4
10	21	B-4	4	21	B-4	4
11	34	B-3	5	34	3-3	4
12	34	B-4	5	34	B-4	5
13	34	B-4	5	34	B-4	5
14	34	B-4	4	34	B-4	5
15	12	B-4	4	12	B-4	5
16	34	B-4	4	12	B-4	5
17	34	B-4	4	34	B-4	4
18	32	B-3	3	32	B-3	3
19	34	B-3	4	34	B-3	4
20	34	B-3	4	34	B-3	4
21	12	B-3	3	12	B-3	4
22	12	B-4	3	12	B-4	4
23	34	B-4	5	34	B-4	4
24	12	B-3	4	12	B-4	4
25	34	B-3	4	34	B-4	4
26	34	B-4	4	34	B-4	4
27	32	B-4	4	32	B-4	4
28	34	B-4	4	34	B-4	4
29	34	B-4	4	34	B-4	4
30	34	B-4	4	34	B-4	4
31	34	B-4	4	34	B-4	4
32	34	B-4	4	34	B-4	4
33	34	B-4	5	34	B-4	3
34	34	B-4	5	34	B-4	4
35	31	B-4	4	12	B-4	4
36	54	B-4	4	54	B-4	4
37	12	B-3	4	12	B-3	3
38	34	B-4	5	34	B-4	3
39	54	B-4	5	54	B-4	3
40	34	B-4	4	34	B-4	2

(Table continued on next page)

Ratings of Hour XIV--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
41	54	B-4	4	54	B-4	5
42	54	B-4	4	54	B-4	5
43	34	B-4	4	34	B-4	4
44	34	B-4	4	41	B-3	4
45	34	B-4	4	34	B-4	4
46	12	B-4	4	12	B-4	3
47	12	B-4	4	12	B-4	3
48	32	B-3	3	53	B-1	3
49	34	B-4	5	34	B-4	4
50	34	B-4	5	34	B-4	4
51	34	B-4	5	34	B-4	5
52	34	B-4	5	34	B-4	5
53	34	B-4	5	34	B-4	5
54	32	B-3	4	21	B-3	5
55	34	B-3	4	34	B-3	5
56	34	B-3	4	21	B-3	5
57	34	B-4	5	34	B-4	5
58	34	B-3	5	34	B-3	5
59	31	B-3	4	31	B-3	4
60	34	B-4	4	34	B-4	4

Ratings of Judges 1 and 2 of Therapeutic Hour XV

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	21	A-3	3	21	A-3	3
2	41	B-1	X	43	B-1	X
3	11	B-1	X	11	B-1	X
4	43	B-1	X	43	B-1	X
5	11	B-1	X	11	B-1	X
6	43	B-1	X	43	B-1	X
7	43	B-1	X	43	B-1	X
8	43	B-1	X	43	B-1	X
9	43	B-1	X	43	B-1	X
10	43	B-1	X	43	B-1	X
11	43	B-1	X	43	B-1	X
12	43	B-1	X	43	B-1	X
13	51	B-1	3	51	B-1	3
14	51	B-1	3	51	B-1	3
15	02	A-3	X	11	B-1	X
16	11	B-1	3	11	B-1	3
17	02	A-2	X	02	A-2	X
18	11	B-1	X	11	B-1	X
19	11	B-1	X	11	B-1	X
20	11	B-1	X	11	B-1	X
21	11	B-1	X	11	B-1	X
22	11	B-1	X	11	B-1	X
23	21	B-3	3	21	B-3	3
24	11	B-1	X	11	B-1	X
25	11	B-1	X	11	B-1	X
26	02	A-2	2	02	A-2	2
27	12	B-1	3	12	B-1	3
28	12	B-1	4	12	B-1	4
29	11	B-1	3	11	B-1	X
30	11	B-1	X	11	B-1	X
31	11	B-1	X	11	B-1	X
32	21	B-1	3	21	B-1	3
33	11	B-1	X	11	B-1	X
34	11	B-1	X	11	B-1	X
35	11	B-1	X	11	B-1	X
36	11	B-1	3	11	B-1	3
37	11	B-1	X	11	B-1	X
38	11	B-1	X	11	B-1	X
39	02	A-3	X	02	A-3	X
40	11	B-1	X	11	B-1	X

(Table continued on next page)

Ratings of Hour XV--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
41	11	B-1	3	21	B-1	3
42	11	B-1	X	11	B-1	X
43	11	B-1	X	11	B-1	X
44	11	B-1	X	11	B-1	X
45	11	B-1	3	11	B-1	3
46	11	B-1	X	11	B-1	X
47	11	B-1	X	11	B-1	X
48	21	B-3	3	21	B-3	3
49	11	B-1	X	11	B-1	X
50	11	B-1	X	11	B-1	X
51	11	B-1	X	11	B-1	X
52	11	B-1	X	11	B-1	X
53	11	B-1	X	12	B-1	X
54	11	B-1	X	11	B-1	X
55	11	B-1	X	11	B-1	X
56	11	B-1	X	11	B-1	X
57	11	B-1	2	11	B-1	X
58	11	B-1	X	11	B-1	X
59	11	B-1	X	11	B-1	X
60	11	B-1	X	11	B-1	X
61	11	B-1	X	11	B-1	X
62	11	B-1	X	11	B-1	X
63	11	B-1	X	11	B-1	X
64	21	B-1	3	21	B-1	4
65	43	B-1	X	43	B-1	X
66	43	B-1	X	43	B-1	X
67	43	B-1	X	43	B-1	X
68	12	B-1	X	12	B-1	X
69	43	B-1	X	43	B-1	X
70	21	A-3	3	32	B-3	3
71	43	B-1	X	43	B-1	X
72	43	B-1	X	43	B-1	X
73	43	B-1	X	43	B-1	X
74	61	---	X	61	---	X

Ratings of Judges 1 and 2 of Therapeutic Hour XVI

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	61	---	X	61	---	X
2	21	B-3	3	21	B-3	3
3	21	B-3	3	21	B-3	3
4	12	B-3	3	12	B-3	3
5	11	B-3	3	12	B-3	3
6	31	B-3	3	31	B-3	4
7	11	B-3	X	11	B-3	X
8	11	B-3	X	11	B-3	X
9	11	B-3	X	11	B-3	X
10	32	B-3	3	32	B-3	3
11	11	B-3	X	11	B-3	X
12	11	B-3	X	11	B-3	X
13	21	B-3	2	21	B-3	2
14	12	B-3	3	12	B-3	3
15	32	B-3	4	32	B-3	3
16	21	B-3	X	12	B-3	X
17	21	B-3	3	21	B-3	3
18	12	B-3	3	11	B-1	3
19	12	B-1	3	12	B-1	3
20	34	B-3	4	34	B-3	4
21	32	B-3	3	32	B-3	2
22	11	B-1	3	11	B-1	3
23	11	B-1	3	11	B-1	3
24	51	B-3	3	51	B-3	3
25	21	B-3	3	21	B-3	4
26	53	B-3	3	53	B-3	3
27	12	B-3	3	12	B-3	3
28	21	B-3	3	21	B-3	3
29	34	B-3	4	34	B-3	4
30	34	B-3	4	34	B-3	5
31	31	B-3	4	34	B-3	4
32	02	B-3	3	02	B-3	4
33	21	B-3	3	21	B-3	3
34	31	B-3	3	34	B-3	4
35	34	B-3	3	34	B-3	4
36	34	B-3	4	34	B-3	4
37	34	B-3	4	34	B-3	4
38	34	B-3	3	34	B-3	4
39	34	B-3	4	34	B-3	4
40	02	A-3	X	02	A-3	3

(Table continued on next page)

Ratings of Hour XVI--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
41	34	B-3	4	34	B-3	4
42	34	B-3	3	34	B-3	5
43	31	B-3	3	31	B-3	3
44	51	B-3	3	31	B-3	4
45	02	A-3	X	31	B-3	4
46	34	B-3	4	34	B-3	5
47	12	B-1	3	12	B-1	4
48	12	B-1	3	12	B-1	4
49	34	B-3	4	34	B-3	5
50	34	B-3	4	34	B-3	4
51	12	B-1	3	12	B-1	3
52	34	B-4	3	34	B-4	3
53	34	B-4	5	34	B-4	4
54	34	B-4	5	34	B-4	5
55	70	---	X	32	B-3	4
56	34	B-4	5	34	B-4	4
57	34	B-4	5	34	B-3	4
58	12	B-3	3	12	B-3	X
59	34	B-4	5	34	B-4	4
60	34	B-4	5	34	B-4	4
61	34	B-4	5	34	B-4	4
62	34	B-4	5	34	B-4	4
63	34	B-4	5	34	B-4	5
64	34	B-4	4	31	B-3	4
65	34	B-4	4	34	B-4	4
66	34	B-3	4	31	B-3	4
67	12	B-3	3	12	B-3	3
68	12	B-3	4	12	B-3	3
69	34	B-3	3	34	B-3	4
70	12	B-3	3	31	B-3	4
71	21	B-3	3	21	B-3	4
72	12	B-3	3	12	B-3	3
73	12	B-3	3	12	B-3	3
74	12	B-3	3	31	B-3	3
75	02	A-3	3	02	A-3	X
76	02	A-3	X	02	A-3	X
77	31	B-3	3	31	B-3	3
78	31	B-3	3	31	B-3	3
79	34	B-4	4	34	B-4	4
80	21	B-1	3	21	B-1	3

(Table continued on next page)

Ratings of Hour XVI--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
81	34	B-1	X	70	---	X
82	31	B-3	3	31	B-3	3
83	34	B-4	5	34	B-4	4
84	34	B-4	4	34	B-4	4
85	34	B-4	4	34	B-4	4
86	11	B-1	3	11	B-1	3
87	12	B-1	3	12	B-1	3
88	34	B-4	5	34	B-4	5
89	34	B-4	5	34	B-4	4
90	11	B-1	3	70	---	X
91	34	B-3	4	11	B-1	3
92	51	B-1	4	51	B-1	4
93	02	A-3	X	02	A-3	X
94	34	B-3	4	21	B-1	3
95	34	B-3	3	34	B-3	4
96	12	B-1	3	12	B-1	3
97	12	B-1	3	12	B-1	3
98	12	B-1	3	12	B-1	4
99	11	B-1	3	11	B-1	3
100	12	B-3	3	34	B-1	4
101	12	B-1	3	12	B-1	3
102	21	B-3	3	21	B-3	4
103	34	B-3	4	34	B-3	4
104	34	B-3	4	34	B-3	5
105	70	---	X	70	---	X
106	54	B-3	3	54	B-3	4
107	34	B-3	3	21	B-3	3
108	34	B-3	3	34	B-3	4
109	34	B-3	4	34	B-3	5
110	21	B-3	3	34	B-3	3
111	32	B-3	3	32	B-3	3
112	34	B-3	4	34	B-3	4
113	34	B-3	4	34	B-3	4
114	34	B-3	4	34	B-3	4
115	34	B-4	4	34	B-4	5
116	34	B-4	4	34	B-4	4
117	34	B-4	3	34	B-4	4
118	34	B-4	4	34	B-4	5
119	12	A-3	3	02	A-3	X
120	21	B-1	2	21	B-1	3
121	61	---	X	61	---	X

Ratings of Judges 1 and 2 of Therapeutic Hour XVII

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	43	---	X	43	---	X
2	43	---	X	43	---	X
3	21	A-2	2	21	A-2	2
4	12	B-1	3	12	B-1	3
5	11	B-1	3	11	B-1	3
6	21	B-4	4	21	B-4	3
7	70	---	X	70	---	X
8	11	A-3	X	11	A-3	X
9	02	A-3	3	02	A-3	3
10	21	B-3	3	21	B-3	3
11	21	B-3	3	21	B-3	3
12	02	A-3	X	02	A-3	X
13	12	B-1	3	12	B-1	3
14	32	B-3	3	21	B-1	3
15	11	B-1	X	11	B-1	X
16	12	B-1	3	12	B-1	3
17	12	B-1	3	12	B-1	3
18	12	B-1	3	12	B-1	3
19	21	B-1	3	12	B-1	3
20	21	B-1	3	12	B-1	3
21	02	A-3	X	02	A-3	X
22	21	B-1	3	21	B-1	3
23	31	B-3	3	31	B-3	3
24	31	B-3	3	31	B-3	3
25	34	B-3	4	34	B-3	4
26	21	B-3	3	21	B-3	3
27	12	B-1	3	12	B-1	3
28	34	B-3	4	34	B-3	3
29	61	---	X	61	---	X

Ratings of Judges 1 and 2 of Therapeutic Hour XVIII

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	11	A-3	3	11	A-3	3
2	11	A-3	3	11	A-3	3
3	21	A-3	3	21	A-3	3
4	31	B-3	3	31	B-3	3
5	11	B-2	2	21	A-3	3
6	34	B-3	4	34	B-3	4
7	34	B-3	3	34	B-3	3
8	34	B-3	3	34	B-3	3
9	21	A-3	3	34	B-3	3
10	34	B-3	4	34	B-3	3
11	12	B-1	3	12	B-1	3
12	31	B-3	3	32	B-3	3
13	31	B-2	3	31	B-2	3
14	31	B-3	3	31	B-3	3
15	34	B-3	3	34	B-3	4
16	34	B-4	4	34	B-4	3
17	31	B-2	4	31	B-2	3
18	34	B-3	5	34	B-3	5
19	12	B-2	3	12	B-2	3
20	31	B-2	3	31	B-2	3
21	32	B-4	2	32	B-4	2
22	32	B-3	2	32	B-3	2
23	31	B-3	3	31	B-3	3
24	32	B-3	3	32	B-3	3
25	32	B-3	3	32	B-3	3
26	34	B-3	4	34	B-3	4
27	34	B-3	4	34	B-3	4
28	32	B-3	4	34	B-3	4
29	34	B-3	4	34	B-3	4
30	34	B-4	4	31	B-4	4
31	34	BT-4	3	34	BT-4	4
32	34	B-4	3	34	B-4	4
33	32	B-3	3	32	B-3	4
34	32	B-4	4	54	B-4	4
35	12	B-3	4	12	B-3	4
36	21	B-3	3	34	B-3	4
37	34	B-3	4	34	B-3	4
38	31	B-3	3	31	B-3	4
39	21	B-3	4	34	B-3	5
40	34	B-3	4	34	B-3	4

(Table continued on next page)

Ratings of Hour XVIII--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
41	34	B-3	4	12	B-1	4
42	32	B-3	3	32	B-3	4
43	34	B-3	3	34	B-3	4
44	34	B-3	5	34	B-3	4
45	12	B-3	3	12	B-3	3
46	34	B-3	4	34	B-3	3
47	54	B-4	4	54	B-4	4
48	31	B-3	4	31	B-3	4
49	21	B-3	4	21	B-3	3
50	34	B-3	4	34	B-3	4
51	34	B-3	4	34	B-3	4
52	34	B-3	4	34	B-3	4
53	34	B-3	4	34	B-3	4
54	34	B-3	4	32	B-3	4
55	32	B-3	3	32	B-3	4
56	31	B-2	3	31	B-2	3
57	31	B-2	3	31	B-2	3
58	34	B-3	4	34	B-3	4
59	12	B-3	3	12	B-3	3
60	32	B-3	3	32	B-3	3
61	31	B-3	3	31	B-3	3
62	34	B-3	3	34	B-3	4
63	34	B-3	4	34	B-3	4
64	34	B-3	4	34	B-3	4
65	32	A-3	4	32	A-3	3
66	31	B-3	4	34	B-3	4
67	12	B-3	4	12	B-3	3
68	12	B-3	4	12	B-3	3
69	32	B-3	3	34	B-3	3
70	12	B-3	3	34	B-3	4
71	34	B-3	4	34	B-3	5
72	34	B-3	4	70	---	X
73	31	B-3	4	31	B-3	4
74	34	B-4	4	34	B-4	4
75	12	B-4	3	12	B-4	4
76	12	B-4	3	12	B-4	3
77	32	B-3	3	32	B-3	3
78	34	B-3	4	34	B-3	5
79	12	B-1	3	12	B-1	3
80	12	B-4	4	12	B-4	3

(Table continued on next page)

Ratings of Hour XVIII--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
81	31	B-2	3	31	B-2	3
82	21	B-3	3	21	B-3	3
83	11	B-1	X	11	B-1	X
84	34	B-3	3	34	B-3	3
85	34	B-3	4	34	B-3	4
86	31	B-3	3	31	B-3	3
87	34	B-3	4	34	B-3	4
88	32	B-3	3	32	B-3	3
89	12	B-3	3	12	B-3	3
90	32	B-3	4	32	B-3	3
91	12	B-3	3	12	B-3	3
92	51	B-3	3	51	B-3	3
93	12	B-3	4	12	B-3	3
94	31	B-3	3	31	B-3	3
95	70	---	X	70	---	X
96	34	B-3	4	34	B-3	5
97	31	B-3	3	31	B-3	4
98	31	B-3	3	31	B-3	4
99	32	B-3	3	32	B-3	X
100	11	B-1	X	11	B-1	X
101	51	B-3	3	51	B-3	4
102	51	B-3	4	51	B-3	3
103	34	B-3	3	34	B-3	4
104	11	B-1	3	11	B-1	3
105	34	B-3	3	34	B-3	4
106	34	B-3	3	34	B-3	3
107	12	B-1	3	34	B-3	4
108	12	B-3	3	12	B-3	3
109	21	B-3	3	21	B-3	3
110	70	---	X	70	---	X
111	21	B-3	3	21	B-3	4
112	70	---	X	70	---	X
113	61	---	X	61	---	X

Ratings of Judges 1 and 2 of Therapeutic Hour XIX

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	61	---	X	61	---	X
2	61	---	X	61	---	X
3	01	A-3	X	01	A-3	X
4	12	B-1	X	12	B-1	X
5	41	B-1	X	41	B-1	X
6	12	B-1	3	12	B-1	3
7	12	B-1	3	12	B-1	3
8	21	B-1	3	21	B-1	3
9	11	B-1	3	11	B-1	3
10	11	B-1	3	11	B-1	3
11	01	A-3	X	01	A-3	X
12	34	B-3	3	34	B-3	3
13	34	B-3	4	34	B-3	4
14	34	B-1	3	70	---	X
15	41	B-4	3	21	B-4	X
16	41	B-1	X	41	B-1	X
17	34	B-4	3	34	B-3	3
18	01	A-3	X	01	A-3	X
19	01	A-3	X	01	A-3	X
20	01	A-3	X	01	A-3	X
21	01	A-3	X	01	A-3	X
22	01	A-3	X	01	A-3	X
23	01	A-3	X	01	A-3	X
24	34	B-3	4	34	B-3	4
25	12	B-1	X	12	B-1	3
26	12	B-1	3	12	B-1	3
27	21	B-1	3	21	B-1	3
28	11	B-1	3	11	B-1	3
29	11	B-1	3	11	B-1	3
30	34	B-3	3	34	B-3	3
31	21	B-1	3	21	B-1	3
32	34	B-4	4	34	B-4	4
33	12	B-1	3	21	B-1	3
34	01	A-3	X	01	A-3	X
35	01	A-3	X	01	A-3	X
36	11	B-1	X	11	B-1	X
37	01	A-3	X	01	A-3	X
38	01	A-3	X	01	A-3	X
39	11	B-1	3	11	B-1	3
40	12	B-3	4	21	B-1	3

(Table continued on next page)

Ratings of Hour XIX--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
41	11	B-1	3	11	B-1	3
42	12	B-1	3	21	B-1	3
43	11	B-1	3	11	B-1	3
44	34	B-3	4	34	B-1	4
45	34	B-3	4	34	B-1	3
46	11	B-1	3	11	B-1	3
47	11	B-1	3	11	B-1	3
48	12	B-1	3	12	B-1	3
49	34	B-3	4	34	B-3	5
50	12	B-1	3	12	B-1	3
51	34	B-3	4	34	B-3	5
52	34	B-3	4	34	B-3	5
53	34	B-3	4	34	B-3	5
54	34	B-3	4	34	B-3	3
55	11	B-1	3	11	B-1	3
56	11	B-1	3	11	B-1	3
57	34	B-3	4	34	B-3	5
58	34	B-3	4	34	B-3	5
59	70	---	X	70	---	X
60	34	B-1	4	34	B-3	5
61	12	B-1	3	12	B-1	3
62	12	B-1	4	12	B-1	3
63	12	B-1	3	12	B-1	3
64	12	B-1	3	12	B-1	3
65	11	B-1	3	12	B-1	3
66	12	B-1	3	12	B-1	3
67	12	B-1	3	12	B-1	3
68	12	B-1	3	12	B-1	3
69	12	B-1	3	12	B-1	3
70	12	B-1	3	12	B-1	3
71	21	B-1	3	21	B-1	3
72	32	B-1	3	32	B-1	3
73	21	B-1	3	21	B-1	3
74	21	B-1	3	21	B-1	3
75	32	B-1	3	32	B-1	3
76	32	B-1	3	32	B-1	3
77	32	B-1	3	32	B-1	3
78	21	B-1	3	21	B-1	3
79	34	B-1	4	34	B-1	3
80	12	B-1	X	12	B-1	3

(Table continued on next page)

Ratings of Hour XIX--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
81	01	A-3	X	01	A-3	X
82	11	B-1	X	11	B-1	3
83	21	B-1	3	21	B-1	3
84	70	---	X	70	---	X
85	34	B-1	3	34	B-3	4
86	34	B-1	3	34	B-1	4
87	01	A-3	X	01	A-3	X
88	21	B-1	X	21	B-1	3
89	21	B-1	X	21	B-1	3
90	21	B-1	X	21	B-1	3
91	34	B-3	4	34	B-3	4
92	34	B-3	4	34	B-3	4
93	34	B-1	4	34	B-1	4
94	34	B-1	4	34	B-1	4
95	21	B-3	4	21	B-3	3
96	21	B-1	3	21	B-1	3
97	12	B-1	3	21	B-1	3
98	21	B-1	3	21	B-1	3
99	34	B-1	4	34	B-1	4
100	34	B-1	4	34	B-1	4
101	34	B-1	4	34	B-1	4
102	34	B-4	4	34	B-4	4
103	34	B-3	4	34	B-3	4
104	34	B-3	4	34	B-3	4
105	34	B-3	4	34	B-3	4
106	01	A-3	X	01	A-3	X
107	34	B-1	4	34	B-1	4
108	34	B-1	3	34	B-1	4
109	01	A-3	X	01	A-3	X
110	61	---	X	61	---	X

Ratings of Judges 1 and 2 of Therapeutic Hour XX

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
1	12	B-1	3	12	B-1	3
2	21	B-1	3	21	B-1	3
3	11	B-1	4	12	B-1	3
4	34	B-3	4	34	B-3	4
5	21	B-3	3	21	B-3	3
6	11	B-1	3	11	B-1	3
7	11	B-1	3	11	B-1	3
8	61	---	X	61	---	X
9	11	B-1	X	11	B-1	3
10	12	B-1	3	12	B-1	3
11	02	A-3	3	02	A-3	3
12	21	B-3	3	21	B-3	3
13	11	B-1	2	11	B-1	2
14	11	B-1	X	11	B-1	X
15	21	B-1	3	21	B-1	3
16	11	A-2	X	11	A-2	X
17	12	B-1	3	12	B-1	3
18	12	B-1	3	12	B-1	3
19	21	A-2	X	21	A-2	3
20	11	B-1	X	11	B-1	X
21	21	A-2	3	21	A-2	3
22	21	A-2	X	11	B-1	X
23	11	B-1	X	11	B-1	X
24	61	---	X	61	---	X
25	11	B-1	X	12	B-1	X
26	11	B-1	X	11	B-1	X
27	11	B-1	X	11	B-1	X
28	02	A-2	X	11	B-1	X
29	11	B-1	X	11	B-1	X
30	12	B-1	X	12	B-1	X
31	11	B-1	X	11	B-1	X
32	11	B-1	X	11	B-1	X
33	11	B-1	X	11	B-1	X
34	21	B-3	3	21	B-3	3
35	11	B-1	3	11	B-1	3
36	12	B-1	3	11	A-2	X
37	32	B-2	3	32	B-2	3
38	21	B-2	3	21	B-2	3
39	12	B-2	3	12	B-2	3
40	21	B-2	3	21	B-2	3

(Table continued on next page)

Ratings of Hour XX--Continued

Unit No.	Judge 1			Judge 2		
	Type	Focus	Responsibility Scale	Type	Focus	Responsibility Scale
41	32	B-1	X	32	B-1	X
42	32	B-1	X	32	B-1	X
43	11	B-1	3	11	B-1	3
44	11	B-1	3	11	B-1	3
45	12	B-1	3	11	B-1	X
46	11	B-1	X	11	B-1	X
47	11	B-1	X	11	B-1	X
48	11	B-1	3	11	B-1	3
49	11	B-1	X	21	B-1	3
50	11	B-1	3	11	B-1	2
51	12	B-1	4	12	B-1	2
52	21	B-1	3	12	B-1	3
53	21	B-3	4	21	B-3	3
54	32	B-3	4	32	B-3	3
55	12	B-1	3	11	B-1	X
56	41	B-1	3	41	B-1	3
57	12	B-1	3	12	B-1	3
58	11	B-1	X	11	B-1	X
59	11	B-1	X	11	B-1	X
60	11	B-1	X	11	B-1	X
61	11	B-1	X	11	B-1	X
62	12	B-1	X	12	B-1	X
63	11	B-1	X	11	B-1	X
64	11	B-1	X	11	B-1	X
65	11	B-1	X	02	B-1	X
66	11	B-1	X	11	B-1	X
67	43	B-1	X	43	B-1	X
68	43	B-1	X	43	B-1	X