Beliefs About Harm to Others and Progress in Psychotherapy

By

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BELIEFS ABOUT HARM TO OTHERS AND PATIENT PROGRESS IN PSYCHOTHERAPY

Introduction

The role of beliefs in the development and maintenance of psychopathology has been elaborated by a number of theorists, such as Beck (1976), Bieber (1980), Freud (1926), Weiss & Sampson (1986). Of particular interest are beliefs based on appraisals of danger. In general the literature has emphasized affects and behaviors based on beliefs of harm to self, such as castration anxiety, separation anxiety, loss of self-esteem, or fear of punishment (Beck, 1976; Bieber, 1980; Freud, 1926). Recently, greater attention has been given to guilt stemming from beliefs about responsibility for harming others (Bush, 1985; DeVos, 1974; Friedman, 1985a,b; Modell, 1963, 1965, 1983; Weiss & Sampson, 1986).

Inspired by the work of Weiss & Sampson (1986), this study will assess the role of beliefs of responsibility for harming others in guiding patient behavior, by examining two adult psychotherapy cases and assessing the impact on patient progress of therapist interpretations that reflect themes of harm to self or harm to others. It is hypothesized that therapist interpretations of harm to others will have a more positive impact on patient progress in psychotherapy than therapist interpretations of harm to self. A brief
review of the literature will provide the background for this hypothesis.

Literature Review

What is a belief? "Although there are disagreements amongst philosophers and psychologists about the meaning of beliefs, there seems to be agreement that beliefs form an important psychological guide to action" (Sigel, 1985, p.346). For purposes of this study, a belief is defined as "a conviction or acceptance that certain things are true or real" (Webster's New World Dictionary, 1980).

Beliefs, conscious or unconscious, have been shown to play a role in the development and maintenance of psychopathology (Beck, 1976; Weiss & Sampson, 1986). Of particular interests are beliefs based on appraisals of danger. Most of the emphasis has been placed on affects and behaviors based on beliefs of harm to self. Most notable has been Freud's work (1926) on castration anxiety based on young males' belief in castration as a punishment for their sexual feelings. Beck et al (1961, 1963, 1970, 1971, 1976) has demonstrated that beliefs based on faulty learning and erroneous premises about harm to self, such as loss of self-esteem, loss of valued objects, separation anxiety, punishment, and physical injury, underlie many emotional disorders. Bieber has given an integral role in psychopathology to beliefs of self-injury, such as rejection, humiliation, and "any event which is considered
to be inimical to one's integrity or best interests" (1980, p.25) in his theory of Cognitive Psychoanalysis.

Recently, greater attention has been given to the role of beliefs about harm to others in the development and maintenance of psychopathology (Weiss & Sampson, 1986). The prominence given to beliefs about responsibility for harming others has largely centered around their distinction from beliefs of harm to self in the conceptualization of guilt. Weiss and Sampson have contended that theorists and clinicians have been guided by Freud's definition of oedipal guilt which is based on beliefs of harm to self, that is, the fear of punishment or loss of love as a consequence of hostile, destructive impulses (Bush, 1985; Freud, 1926; Friedman, 1985b; Weiss & Sampson, 1986). According to Friedman,

"Freud's legacy has obscured an important line of human motivation and placed constraints on what psychoanalysts have been able to observe and have told their patients about their deepest motives... guilt was for Freud, and remains for much of psychoanalytic theory, the fear of an inner policeman, formed by one's experience with a threatening parent, representing, in however distorted a form, the threats of that parent, and fueled by one's own hate" (Friedman, 1985b, p.508).
A growing number of writers have conceptualized guilt, not as a consequence of fear of punishment, but rather as stemming from beliefs of responsibility for harming others (Bush, 1985; DeVos, 1974; Friedman, 1985a,b; Loewald, 1980; Modell, 1963, 1965, 1983; Weiss & Sampson, 1986). In this newer light, guilt has been defined as the "unique human capacity to be aware that one has the power to harm another person" (DeVos, personal communication). As a belief, guilt involves the "appraisal, conscious or unconscious, of one's plans, thoughts, actions, etc. as damaging, through commission or omission, to someone for whom one feels responsible" (Friedman, 1985b, p.529). Fundamental to this conceptualization of guilt is the sense that one has done "something bad, like being disloyal to another person towards whom one feels a special sense of attachment or responsibility, such as a parent, sibling, or child" (Bush, 1985, p.2).

Guilt based on beliefs of harming others does not necessarily arise from hostile impulses as postulated by Freud (Bush, 1985; Friedman, 1985b; Weiss & Sampson, 1986). What has been underestimated, is that guilt can stem from beliefs that pursuing normal developmental goals are injurious or harmful to others, particularly parents (Bush, 1985; Friedman, 1985a,b; Loewald, 1980; Modell, 1963, 1965, 1983; Weiss & Sampson, 1986). The following dramatically illustrates Loewald's view of the oedipal conflict as a normal developmental process of becoming an adult in which
significant emotional ties with the parents are severed,

"The assumption of responsibility for one's own life and its conduct is in psychic reality tantamount to the murder of the parents, and involves dealing with the guilt incurred thereby. Not only is parental authority destroyed by wrestling authority from the parents and taking it over, but the parents, if the process were thoroughly carried out, are being destroyed as libidinal objects as well" (Loewald, 1980, p.389).

According to Loewald, the inevitable harm to one's parent presents a moral dilemma for the child and results in guilt and shame and attempts at atonement. How one faces this guilt largely determines whether psychopathology develops. Loewald has postulated that repressing the guilt is "unconsciously evading the emancipatory murder of the parents and maintaining infantile libidinal dependent ties with them" (Loewald, 1980, p.390). This can lead to the formation of a superego that is rigid, cruel and inflexible and the need for punishment (masochistic behavior). Although Loewald has not explicitly made the distinction between guilt based on beliefs of harm to self or beliefs of harm to others, masochistic behavior (inflicting harm to self), seen
in this light, is secondary to the belief that one has harmed others and becomes a defense against the belief that one has harmed one's parents.

Loewald's viewpoint of pursuing normal developmental goals as harmful to parents is evident in how lay people may also conceptualize guilt. The following excerpt from the autobiography of Richard Rodriguez, first generation Mexican American, is an illustration of his painful journey in becoming a scholar in Renaissance literature and the guilt incurred in breaking the intimate cultural bonds with his immigrant parents. He has written,

"As I grew fluent in English, I no longer could speak Spanish with confidence. I continued to understand spoken Spanish. And in high school, I learned how to read and write Spanish. But for many years I could not pronounce it. A powerful guilt blocked my spoken words; an essential glue was missing whenever I'd try to connect words to form sentences. I would be unable to break a barrier of sound, to speak freely. I would speak, or try to speak, Spanish, and I would manage to utter halting, hiccupsing sounds that betrayed my unease.

When relatives and Spanish-speaking friends of my parents came to the house, my brother and sisters seemed reticent to use Spanish, but at least they managed to say a few necessary words before being
excused. I never managed so gracefully. I was cursed with guilt. Each time I'd hear myself addressed in Spanish, I would be unable to respond with any success. I'd know the words I wanted to say, but I couldn't manage to say them. I would try to speak, but everything I said seemed to me horribly anglicized. My mouth would not form the words right. My jaw would tremble. After a phrase or two, I'd cough up a warm, silvery sound. And stop...for my part, I felt that I had somehow committed a sin of betrayal by learning English. But betrayal against whom? Not against visitors to the house exactly. No, I felt that I had betrayed my immediate family. I knew my parents had encouraged me to learn English. I knew that I had turned to English only with angry reluctance. But once I spoke English with ease, I came to feel guilty. (This guilt defied logic.) I felt that I had shattered the intimate bond that had once held the family close. This original sin against my family told whenever anyone addressed me in Spanish and I responded, confounded" (Rodriguez, 1982, p.28-30).

Rodriguez, as a lay person, has described his guilt more in line with the newer notion of guilt, that is, his guilt appeared to stem from a belief that by pursuing normal developmental goals, such as separating from parents and
learning new skills, he has betrayed his parents' way of life. There was no conscious intent of hostility underlying his guilt. Rather, using the framework of Loewald, Rodriguez's emancipatory murder of his parents was a real psychical threat which caused him intense sadness and loneliness at the loss of his parents. His autobiography can be seen as a mourning process in his rite of passage to becoming an adult.

Unconscious guilt, stemming from beliefs that pursuing normal development goals are harmful to others, has assumed a major role in the development and maintenance of psychopathology in the new psychoanalytic theory proposed by Weiss and Sampson (1986). Weiss has postulated that these pathogenic beliefs are based on a child's compelling need to maintain parental ties. That is, children will go to the extremes of renouncing or distorting their normal developmental goals which they believe threaten their ties to their parents (Weiss, personal communication).

"The child needs his parents to protect him from a variety of dangers, including the danger of their punishing him. He therefore dares not risk the loss of their love. In order to retain it, he develops a powerful wish to obey his parents, be loyal to them, and to be like them...Freud assumed that guilt arises from a particular kind of disruption in the child's relationships to his parents; that is, a disruption
which arises from behavior which the child experiences as provoking punishment or rejection. Perhaps just as important, however, in the production of guilt is the disruption which arises from behavior which the child experiences as worrying, saddening, hindering, draining, or humiliating a parent, or expressing disloyalty to the parent. Indeed, the most profound and powerful feelings of guilt may be rooted in a person's pathogenic belief that he has, in one way or another, hurt a parent" (Weiss & Sampson, 1986, p.47).

Bush (1985), citing studies of abusive child-parent relationships, has further elaborated upon Weiss and Sampson's viewpoint that children may unconsciously be motivated less by a fear of punishment or loss of love and more by a need to protect their parents and a fear of their power to hurt their parents or that they have, in fact, already damaged them and now need to restore them. According to Bush,

"One of the principal ways in which children attempt to protect and restore their parents is by preserving their parents' narcissistically invested illusions about themselves. When parents are in fact defective, sadistic, corrupt, rejecting, or neglectful, but desperately need to see themselves as strong, superior, loving, and virtuous, children will feel an intense
obligation to deny their realistically critical perceptions of their parents. These denials and idealizations are maintained at a great cost to the child in the sense that the child must repress his real anger and distress about being mistreated, must sacrifice some portion of his reality testing in an attempt to convince him/herself that what he/she sees is not true, and must forgo real opportunities for healthier relationships with other adults in order to perpetuate his parents' sacred fictions about themselves...For a variety of reasons children are prone to developing very exaggerated and distorted ideas about how their behavior has hurt or may hurt others" (Bush, 1985, p.2).

Beliefs about responsibility for hurting others may be based on a child's limited understanding of causal relationships and the tendency to be egocentric, omnipotent, and magical in their thinking (Bush, 1985; Friedman, 1985b; Weiss & Sampson, 1986). Furthermore, Bush has suggested that children are not only,

"inclined to blame themselves and feel responsible for anything bad that happens to their parents, their siblings, and themselves, but it is also very difficult for children to attribute malevolent motives to their parents. Thus, they tend to blame themselves for any
mistreatment (justified or unjustified), they experience at the hands of their parents. In developing beliefs about how they hurt others, children will be guided not only by what their parents say, but even more importantly by what they do. For example, if a parent becomes withdrawn and depressed or assaultive and rejecting whenever the child develops a relationship that does not include the parent, the child may come to believe that having a capacity for and an interest in developing relationships with other people is very hurtful to the parent...Moreover, in order to punish themselves and make reparations to the persons they believe they have damaged, children may develop extremely abnormal behavior patterns and become pathologically antisocial, perverse, infantile, or narcissistic" (Bush, 1985, p.5-8).

Although beliefs about harm to others have been presented as typically acquired in childhood, they also have been presented as being acquired at other points in life. Citing Niederland's study of holocaust victims, Modell (1983) has described another type of guilt, survivor guilt, based on the belief that merely living was a sign of disloyalty to those family members that were less fortunate. Tied in with this guilt is the belief that the good things in life were at the expense of others, and thus, one does not deserve any better.
Modell's work points out one of the major difficulties encountered in accepting the idea that guilt is based on beliefs of harm to others, and that is beliefs of harm to self, such as fear of punishment or loss of love, are often a consequence, rather than an antecedent of beliefs of harming others. Feelings that one is not deserving of good things in life has not been typically thought of as stemming from beliefs based on harm to others (Sampson, personal communication).

Self-punishment as a reparative, expiatory act has been argued to be secondary to beliefs of harm to others (Bush, 1985; DeVos, 1974; Friedman, 1985a,b; Loewald, 1980; Modell, 1983; Weiss & Sampson, 1986). DeVos, in his anthropological studies of guilt underlying the achievement drive in Japanese culture, has pointed out "fear of punishment, either by the parents, society, or God, is not truly internalized guilt. Insofar as the punishment is perceived as external in source, the feeling is often fear or anxiety, as distinct from guilt" (DeVos, 1974, p. 141). In Thematic Apperception Test responses, stories about parents dying were viewed as punishment of a child for injuring one's parents by lack of obedience or seriousness of purpose. Emphasis on hard work and success after the death of parents suggested some expiatory meaning. Suicide was thought of not only as self-punishment for hurting parents by failing to meet their expectations, but also as a hostile act to hurt parents (DeVos, 1974).
In his clinical work with anorectic patients, Friedman (1985a) has illustrated how separation anxiety, based on beliefs of impending harm to self, can follow from beliefs of harm to others and thus, becomes more difficult to see that they are different experiences with different causes. Contrary to Masterson's viewpoint that the predominant underlying dynamic conflict of anorectic patients was separation anxiety and abandonment depression, the anorectic patients Friedman saw were "primarily burdened by unconscious guilt over hurting somewhat fragile mothers, by having depleted them and/or by separating from them (Friedman, 1985a, p.36). Acknowledging that patients may experience separation anxiety, he observed whenever his interpretations reflected separation anxiety as a defense against experiencing guilt over hurting others, his patients' symptoms were reduced. He has written,

"I would like to emphasize that anorectic patients often do experience separation anxiety and fears of abandonment, etc. However, the patient's conscious experience often is not a reliable guide to their underlying conflicts. The patient's conscious experience may represent a compliance with parental wishes or expectations; for example, separation anxiety may be a way of protecting the mother by professing intense need for her. Separation anxiety may also result from an identification with the parent the
patient fears she is hurting by her wishes to separate. The patient becomes the victim rather than the offender. Separation anxiety becomes for these patients a defense against separation guilt" (Friedman, 1985a, p. 36).

The reluctance of giving any prominence to beliefs of harm to others, not only in conceptualizing guilt, but also in the development of psychopathology, has been due to the major role given to motives of self-interests (Friedman, 1985b). In an effort to argue that man is not motivated by purely self-interests (i.e., egoistic motives), Friedman (1985), citing research by Hoffman, Mussen and Eisenberg on prosocial behavior, has subscribed to the notion that man has prosocial instincts, that is, the predisposition to respond to another's distress, mediated by empathy, for in the long run it is beneficial to the survival of the species. By doing so, he has provided a plausible argument that man is also motivated by concerns for others (i.e., altruistic motivations), and guilt, stemming from beliefs of harming others, can be an independent and important motivating force in behavior.

Implications at the Clinical Level

How do these theoretical considerations apply at the clinical level? According to Weiss and Sampson (1986), pathogenic beliefs of both harm to self and harm to others are grim and constricting. They may destroy feelings of
self-worth and self-esteem, undermine one's belief in one's good intentions, make one less able to defend oneself in the face of false accusations and unmerited mistreatment. They form the basis of feelings of guilt and may increase a person's vulnerability to being traumatized. Thus, they may motivate a person to set up a plan to defend against these threatening experiences and feelings of guilt, to make restitution and reparation, to incur punishment, and to renounce normal developmental goals. (Bush, 1985; Friedman, 1985a,b; Loewald, 1980; Modell, 1964, 1965, 1983; Weiss & Sampson, 1986).

Weiss and Sampson (1986) have proposed that a person comes to therapy (whether it be psychoanalytic or other forms of psychotherapy) to disconfirm these pathogenic beliefs in relation to the therapist. The therapist must therefore be aware of these pathogenic beliefs. If the therapist does not act as the patient's belief predicts (for example, feeling hurt, traumatized or threatened by the patient's statements), then the belief loosens its hold on the patient, who is more willing to attempt behaviors that were inhibited by obedience to the belief. In an elegant series of research studies, Weiss & Sampson and the Mt. Zion Research Group on Psychotherapy (1986) have provided converging lines of evidence of a psychoanalytic patient's wish to change her pathogenic beliefs and by doing so, overcomes her problems. Their findings have indicated the
kinds of analytic interventions that are likely to help the patient, as well as those that are not.

Bieber (1980) and Beck (1976) also have proposed therapeutic strategies in correcting beliefs underlying psychopathology. In his studies on the role of fantasies in psychotherapy and psychopathology, Beck (1970) found that the visual fantasies of neurotic patients were often derivatives of a distorted conception (his examples were primarily beliefs of harm to self) of reality. Furthermore, his findings suggested that repetition of a fantasy in response to the therapist's instruction appeared to provide mastery over the threatening implications of a stressful situation, that is, as the patient was more able to appraise the fantasy more realistically, the threat and accompanying anxiety were reduced.

To date, no studies have been conducted to examine therapist considerations of beliefs of harm to others and the impact of therapist interpretations of these beliefs on patient progress in psychotherapy. This study is such an attempt. Therapist interpretations that focus on themes of harm to self or harm to others in two adult psychotherapy cases were evaluated in relation to patient progress in psychotherapy.
PILOT STUDY

OVERVIEW

In the Literature Review, it was shown that greater attention has been given to the role of guilt stemming, not from beliefs of harm to self, but rather, from beliefs of responsibility for harming others, especially in the pursuit of normal developmental goals. Because of this reconceptualization of guilt, beliefs of harm to others has assumed a major role in the development of psychopathology.

To translate these important theoretical considerations into clinical application, this pilot study was conceived to look at the relationship of therapist considerations of beliefs of harm to others, as different from beliefs of harm to self, on patient progress in psychotherapy. (As a counterpart, a separate study, conducted by Kohloss (1986), examined the patient's focus on beliefs of harm to others). The selective impact of therapist interpretations of danger to self versus danger to others on patient progress in psychotherapy was examined. Consistent with the new emphasis on harm to others by Weiss and Sampson (1986), it was hypothesized that therapist interpretations of harm to others will have a more positive impact on patient progress than therapist interpretations of danger to self.

Two adult brief psychotherapy cases reported in a previously published study (Silberschatz, Fretter, & Curtis,
1986) on the impact of therapist interventions on treatment process were selected for this study. The Silberschatz et al study (1986) obtained statistically significant correlations supporting the hypothesis that the suitability of therapist interpretations were more predictive of patient immediate progress in therapy than the type of interpretation (transference vs non-transference). The suitability of therapist interpretations referred to interpretations that were compatible with a clinical formulation of the patient's plan and goals for treatment. Patient immediate progress in therapy was measured by the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1970).

The present study utilized raw data collected from the Silberschatz et al study (1986), specifically: 1) therapist interpretations that were identified and rated for accuracy; 2) ratings on the Plan Compatibility of these therapist interpretations; 3) ratings on the Experiencing Scale.

For this study, the interpretations identified in the Silberschatz et al study were rated again for themes of danger to self and danger to others. Then, in a process paralleling that of the Silberschatz et al Study (1986) the impact of these two categories of interpretations on patient progress (as measured by the Experiencing Scale) was examined. Danger to self and danger to others interpretations were also evaluated for plan compatibility.
METHOD

Subjects

Patients

For this study, the two patients originally studied for research on the effect of therapist interpretations on immediate patient progress in therapy (Silberschatz et al, 1986) were randomly selected from a larger sample pool of patients voluntarily participating in a research project on the process and outcome of brief, dynamic psychotherapy, conducted at Mt. Zion Hospital, San Francisco. All patients were screened by an independent clinical evaluator. The minimal acceptance criteria for brief therapy were: 1) a history of positive interpersonal relationships; 2) no evidence of psychosis, organic brain syndrome, or mental deficiency; 3) no evidence of serious substance abuse; and 4) no evidence of suicidal or homicidal potential. Both cases were studied after their therapies had been completed.

Although the two patients under study differed from one another in their problems and backgrounds, both were diagnosed as suffering from chronic, neurotic depression (DSM-III American Psychiatric Association, 1980): dysthmic disorder) (Silberschatz et al, 1986).

Patients gave written, informed consent to have their therapies audio-recorded, which were then transcribed.

Therapists
Patients seen through the Mt. Zion Project, who met the above criteria for brief therapy were referred to a therapist on a random basis. The therapists were all experienced psychologists and psychiatrists with a psychodynamic orientation. All received specialized training in brief psychotherapy. Prior to treatment, the therapists knew nothing about the patients.

Procedures

The research design of this study involved: 1) developing two scales to measure therapist interpretations that focused on themes of danger to the patient (Danger to Self Scale) and danger to people other than the patient (Danger to Others Scale); 2) rating therapist interpretations using these two scales; 3) comparing the relationship of Danger to Self and Danger to Others interpretations on immediate patient progress in psychotherapy (and assessing the hypothesis that Danger to Others interpretations has a greater impact on immediate patient progress than Danger to Self interpretations); 4) studying the relationship between therapist interpretations of Danger to Self and Danger to Others with Plan Compatibility; 5) comparing the relationship between Therapist Interpretations of Danger to Self and Danger to Others with Patient's Statements of Danger to Self and Danger to Others.
Measures

Classification of Therapist Interventions

For the Silberschatz et al study (1986), all therapist interventions were categorized into interpretations and non-interpretations, [based on a typology devised by Malan (1963, 1976)]. Interpretations were further categorized into transference and non-transference. Interpretation was defined as "any intervention in which the therapist suggests or implies an emotional context in the patient over and above what the patient has already said. Transference interpretation was defined as any interpretation directed toward the patient's feelings about the therapist or the therapy. Non-transference interpretations could be directed toward the patient's feelings about themselves, about a significant other in their lives, or about parents or siblings" (Silberschatz et al, 1986).

Three to four judges used to categorize all the therapist interventions from each of the two cases reached a final average agreement of classification of interventions of 93.3 percent. All transference interpretations and the most frequently occurring category of non-transference interpretation in each case were studied.

Plan Compatibility of Therapist Interpretations

This is a measure of the suitability or accuracy of therapist interpretations employed by Silberschatz et al (1986). It is a case-specific measure based on the plan formulation of a case. A plan formulation, based on the
theory of Weiss and Sampson (1986), is "a dynamic case formulation which includes a description of the patient's presenting problems and history as well as the following specific components: 1) the patient's goals for treatment, 2) the inner obstacles (pathogenic beliefs) preventing the attainment of goals, 3) the means by which the patient will work in treatment to disconfirm his/her pathogenic beliefs (tests of the therapist), and 4) the insights that will be helpful to the patient" (Silberschatz et al, 1986).

In the Silberschatz et al study (1986), independent clinical judges applied the Plan Compatibility of Intervention Scale (PCIS) (Caston, 1986) to the interpretations of each case, achieving excellent reliabilities. Case 1 = .89 and Case 2 = .85 coefficient alpha. The PCIS is a 7 point Likert-type scale ranging from -3 (strongly anti-plan) to +3 (strongly pro-plan) with 0 as the mid-point (both pro- and anti-plan aspects).

Immediate Patient Progress

Immediate patient progress was evaluated by three to six judges applying the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1970) to the pre- (baseline) and post- (effect) interpretation segments of patient speech for each case. Then the impact of the interpretation on shifts on the Experiencing Scale (from pre- to post-interpretation was evaluated. The Experiencing Scale is 7-point scale thought to tap such constructs as insights, patient involvement, lack of resistance, and productive free association
(Kiesler, 1973). Interrater reliabilities were: Case 1 = .80 and Case 2 = .86 coefficient alpha.

**Therapist Interpretations of Danger to Self and Danger to Others as related to Patient Statements regarding Danger to Self and Danger to Others**

Data collected from a study conducted by Kohloss (1986) assessing the impact of patient concerns of danger to self or danger to others on plan compatibility and immediate patient progress in therapy, were also used in this study. Kohloss developed scales to measure themes of danger to self and danger to others in patient speech segments. These scales were applied to the pre- and post- interpretation segments isolated in the Silberschatz et al study (1986). Kohloss obtained excellent reliabilities with these scales. (The scales developed by Kohloss served as a prototype for the Danger to Self Interpretations and Danger to Others Interpretations Scales used in the current study.)

**Danger to Self and Danger to Others Interpretations Scales**

These 5-point Likert-type scales were designed to rate the degree to which therapist interpretations focused on themes relating to danger to the patient (Danger to Self Scale) or danger to people other than the patient (Danger to Others Scale). Danger was broadly defined as including, but not necessarily limited to, loss, dysphoric feelings, or physical injury. Therapist interpretations for each case were rated on the Danger to Self and Danger to Others Scales according to specified criteria. (See Appendix I)
Five judges were used for each case. The judges were all involved in the field of mental health (vocational rehabilitation, social work, occupational therapy and clinical psychology). They received two to four hours of individual and group training in the use of the scales.

The judges, working independently, were given all the interpretations isolated from the transcript and presented in random order, a case at a time. They were instructed to rate each interpretation on both the Danger to Self and Danger to Others Scales. The judges were blind to where the interpretations occurred in therapy and also blind to the plan formulation for each case.

Intraclass correlations between judges for Danger to Self and Danger to Others ratings are presented in Table 1. (See Table 1). All subsequent data analyses utilized the means of the judges' ratings.

Results

Danger to Others and Danger to Self Interpretations and Immediate Patient Progress

To assess the relation between danger to self interpretations and danger to others interpretations, and test the hypothesis that danger to others interpretations had a more consistent correlation with patient's immediate progress in psychotherapy than danger to self interpretations, Pearson correlations were calculated between the mean scores from the Danger to Self and the
Table 1

Intraclass Correlations between 5 Judges (J) on Danger to Others and Danger to Self Ratings

Case 1, Gary: Danger to Self Ratings

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Case 1, Gary: Danger to Others Ratings

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Case 2, Myra: Danger to Self Ratings

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Case 2, Myra: Danger to Others Ratings

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<tr>
<td>J5</td>
<td>0.49</td>
<td>0.71</td>
<td>0.75</td>
<td>0.81</td>
</tr>
</tbody>
</table>
Danger to Others Scales and the residualized gain scores from the Experiencing Scale. (See Table 2). The residualized gain scores (Cohen & Cohen, 1975) measure the variance in the post- (effect) segment not predicted by the pre- (baseline) segment (Silberschatz et al, 1986). In both cases, statistically significant correlations were obtained between Danger to Self interpretations and the residualized gain scores on the Experiencing Scale, but not, as predicted, between Danger to Others interpretations and the residualized gain scores on the Experiencing Scale. In other words, when the therapist made interpretations of danger to self the Experiencing scores tended to increase. In case 1, therapist interpretations accounted for about 8% of the variance and in case 2, it accounted for about 11%.

<table>
<thead>
<tr>
<th></th>
<th>Case 1, Gary</th>
<th>Case 2, Myra</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXP</strong></td>
<td><strong>EXP</strong></td>
<td></td>
</tr>
<tr>
<td>SELF</td>
<td>0.27***</td>
<td>0.34****</td>
</tr>
<tr>
<td>OTHER</td>
<td>0.15</td>
<td>0.03</td>
</tr>
<tr>
<td>n=78</td>
<td>n=70</td>
<td></td>
</tr>
<tr>
<td>(**=*p&lt;.02)</td>
<td>(**=*p&lt;.01)</td>
<td></td>
</tr>
</tbody>
</table>
A clearer case can be made for the impact of therapist interpretations if we consider instances of high scores (>+2.4) on the Danger to Self Scale with low scores (<+2.0) on the Danger to Others Scale, and instances with high Danger to Others, low Danger to Self scores. In other words, what would happen to the patient's subsequent level of experiencing when a therapist made interpretations that connected either danger to self or danger to others themes, but not both, with the patient's behavior or feelings?

The only statistically significant correlation obtained was between high Danger to Self, low Danger to Others scores and the residualized gain scores from the Experiencing Scale for case 1 (p<.01), accounting for 38% of the variance in, and further supporting the overall tendency of danger to self interpretations to result in increased patient experiencing. The relationship between interpretations of danger to self and increased patient experiencing was not supported in case 2. (See Table 3a).

Like the correlation between the total danger to others interpretations scores and experiencing scores, there was no statistically significant correlation between high Danger to Others, low Danger to Self scores and the residualized gain scores from the Experiencing Scale in case 1. In case 2 the sample size was too small to do a correlation. (See Table 3b). In general, the small sample size of Danger to Others score could be the problem that statistically significant correlations cannot be obtained.
TABLE 3

a. Correlation between High Danger to Self, Low Danger to Others (HDS/LDO) and the residualized gain scores on the Experiencing Scale (EXP)

<table>
<thead>
<tr>
<th>Case 1, Gary</th>
<th>Case 2, Myra</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXP</td>
<td>EXP</td>
</tr>
<tr>
<td>HDS/LDO</td>
<td>.62****</td>
</tr>
<tr>
<td>n=28</td>
<td>n=31</td>
</tr>
<tr>
<td>(**p&lt;.01)</td>
<td></td>
</tr>
</tbody>
</table>

b. Correlation between High Danger to Others, Low Danger to Self (HDO/LDS) and the residualized gain scores on the Experiencing Scale (EXP)

<table>
<thead>
<tr>
<th>Case 1, Gary</th>
<th>Case 2, Myra</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXP</td>
<td>EXP</td>
</tr>
<tr>
<td>HDO/LDS</td>
<td>.22</td>
</tr>
<tr>
<td>n=8</td>
<td>n=3</td>
</tr>
</tbody>
</table>

The correlation between danger to self interpretations and increased patient experiencing may be explainable by the fact that the Experiencing Scale is biased in terms of themes about self, that is, ratings were given whenever the patient talked about him/herself. The scale did not consistently take into account patient themes concerning other people unless it contained personal elements.
Danger to Self and Danger to Others Interpretations and Plan Compatibility

To assess the relation between danger to self and danger to others interpretations and plan compatibility, Pearson correlations were calculated between the Plan Compatibility of Interventions Scale scores and the Danger to Self Interpretations and Danger to Others Interpretations scores for each case. (See Table 4). In case 1, highly statistically significant correlations were obtained between Danger to Self Interpretations and Plan Compatibility, whereas in case 2, highly statistically significant correlations were obtained between Danger to Others Interpretations and Plan Compatibility. Although these results tended to account for a small variance (the coefficient of determination for case 1 was 7% and about 16% for case 2), they suggest that Plan Compatibility is not necessarily equivalent with interpretations of danger to self or danger to others, but that different patients may be working on different danger issues in treatment.

TABLE 4
Correlations between Danger to Self (SELF) and Danger to Others (OTHER) Scales and Plan Compatibility (PC)

<table>
<thead>
<tr>
<th>Case 1, Gary</th>
<th>Case 2, Myra</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC</td>
<td>PC</td>
</tr>
<tr>
<td>SELF</td>
<td>0.27***</td>
</tr>
</tbody>
</table>
OTHER 0.19* 0.40****
n=78 n=70
*=p<.10 ****=p<.01
***=p<.02

Therapist Interpretations and Patient Statements

To examine whether therapist interpretations of danger to self or danger to others reflected danger issues brought up by the patient and facilitated further patient productions of specific danger issues, Pearson correlations were calculated between the mean scores of Therapist Interpretations of Danger to Self and Danger to Others and the mean scores of Patient Statements of Danger to Self and Danger to Others (pre- and post-interpretation). (See Table 5). In Case 2, statistically significant correlations were obtained when the therapist reflected danger issues initiated by the patient. These accounted for 16% (danger to self issues) and 22% (danger to others issues) of the variance. Although these therapist interpretations were followed by patient production of the same danger issues, no statistically significant correlations were found. In general, there was no consistent evidence that the therapist and patient necessarily followed one another in discussing themes of danger (for example, when the patient talked about danger to self, these statements were followed by therapist
interpretations of danger to others, which were then followed by patient themes about danger to self).

**TABLE 5**

Correlations between Therapist Interpretations of Danger to Self (THSELF) and Danger to Others (THOTHER) and Patient Statements of Danger to Self (PRESELF and POSSELF) and Danger to Others (PREOTHER and POSOTHER)

<table>
<thead>
<tr>
<th></th>
<th>Case 1, Gary (n=78)</th>
<th>Case 2, Myra (n=70)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PRESELF</td>
<td>POSSELF</td>
</tr>
<tr>
<td>THSELF</td>
<td>0.05</td>
<td>0.22**</td>
</tr>
<tr>
<td>THOTHER</td>
<td>0.18</td>
<td>0.17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>PREOTHER</th>
<th>POSTOTHER</th>
<th>PREOTHER</th>
<th>POSTOTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>THSELF</td>
<td>-0.09</td>
<td>-0.16</td>
<td>-0.09</td>
<td>0.22**</td>
</tr>
<tr>
<td>THOTHER</td>
<td>0.16</td>
<td>0.11</td>
<td>0.47***</td>
<td>0.09</td>
</tr>
</tbody>
</table>

* = p<.10  
** = p<.05  
*** = p<.02  
**** = p<.01  

The results do not support the idea of the prominence of danger to others interpretations in patient progress in psychotherapy. However, they also do not consistently support the importance of danger to self interpretations in
patient progress in psychotherapy. Furthermore, the results do not consistently support the importance of therapist focus on themes of danger initiated by the patient or that therapist interpretations facilitated further patient productions of the same danger issues. The results do suggest that different patients may have different danger issues, for example, in the case of Gary, danger to self interpretations were plan compatible, whereas in the case of Myra, danger to others interpretations were plan compatible. Thus, the results suggest that danger to others interpretations may be important and independent of interpretations about danger to self.

Discussion

It is important to bear in mind that this was a pilot study based on two cases. For example, the number of items rated high (> +2.4) on the Danger to Others Scale in both cases was very small. (See Table 6). Therefore, although the hypothesis that Danger to Others interpretations would have a more positive impact on patient progress in psychotherapy was not supported, the results are not conclusive.

The study also presented several conceptual and methodological problems, namely: 1) the operational definition of the phenomenon of beliefs of danger to self
NOTE DESCRIPTIVE STATISTICS ON GARY FOR DANGER SELF/OTHER THERAPIST SCALE.

<table>
<thead>
<tr>
<th></th>
<th>THSELF</th>
<th>THOTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>73</td>
<td>78</td>
</tr>
<tr>
<td>MEAN</td>
<td>1.90</td>
<td>0.659</td>
</tr>
<tr>
<td>MEDIAN</td>
<td>2.00</td>
<td>0.200</td>
</tr>
<tr>
<td>TMEAN</td>
<td>1.89</td>
<td>0.557</td>
</tr>
<tr>
<td>STDEV</td>
<td>1.26</td>
<td>0.977</td>
</tr>
<tr>
<td>SEMIAN</td>
<td>0.14</td>
<td>0.111</td>
</tr>
<tr>
<td>MAX</td>
<td>4.00</td>
<td>3.600</td>
</tr>
<tr>
<td>MIN</td>
<td>0.00</td>
<td>0.000</td>
</tr>
</tbody>
</table>

THSELF

| MIDDLE OF | NUMBER OF OBSERVATIONS |
| INTERVAL  |                      |
| 0.0       | 15                     |
| 0.5       | 3                      |
| 1.0       | 7                      |
| 1.5       | 3                      |
| 2.0       | 22                     |
| 2.5       | 7                      |
| 3.0       | 6                      |
| 3.5       | 8                      |
| 4.0       | 7                      |

THOTHER

| MIDDLE OF | NUMBER OF OBSERVATIONS |
| INTERVAL  |                      |
| 0.0       | 45                     |
| 0.5       | 12                     |
| 1.0       | 3                      |
| 1.5       | 2                      |
| 2.0       | 9                      |
| 2.5       | 3                      |
| 3.0       | 3                      |
| 3.5       | 1                      |

TABLE 6: CASE 1, GARY
NOTE DESCRIPTIVE STATISTICS FOR MYRA ON DANGER SELF/OTHER THERAPIST SCALE.

<table>
<thead>
<tr>
<th></th>
<th>THSELF</th>
<th>THOTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>MEAN</td>
<td>2.14</td>
<td>0.563</td>
</tr>
<tr>
<td>MEDIAN</td>
<td>2.20</td>
<td>0.200</td>
</tr>
<tr>
<td>TMEAN</td>
<td>2.15</td>
<td>0.458</td>
</tr>
<tr>
<td>STDDEV</td>
<td>1.04</td>
<td>0.606</td>
</tr>
<tr>
<td>SEMEAN</td>
<td>0.12</td>
<td>0.097</td>
</tr>
<tr>
<td>MAX</td>
<td>4.00</td>
<td>3.200</td>
</tr>
<tr>
<td>MIN</td>
<td>0.00</td>
<td>0.000</td>
</tr>
</tbody>
</table>

| THSELF |
|--------|-------------------------------|
| MIDDLE OF INTERVAL | NUMBER OF OBSERVATIONS |
| 0.0 | 6 | ***** |
| 0.5 | 4 | *** |
| 1.0 | 2 | ** |
| 1.5 | 11 | *********** |
| 2.0 | 16 | ************ |
| 2.5 | 13 | *********** |
| 3.0 | 5 | **** |
| 3.5 | 7 | ***** |
| 4.0 | 6 | ***** |

| THOTHER |
|--------|--------------------------------|
| MIDDLE OF INTERVAL | NUMBER OF OBSERVATIONS |
| 0.0 | 33 | ***************************************** |
| 0.4 | 14 | *********************************** |
| 0.6 | 7 | ********* |
| 1.2 | 4 | *** |
| 1.6 | 3 | *** |
| 2.0 | 4 | *** |
| 2.4 | 2 | ** |
| 2.8 | 1 | * |
| 3.2 | 2 | ** |

TABLE 6: CASE 2, MYRA
and danger to others may not have tapped this complex phenomenon; 2) the scales developed to measure therapist interpretations of danger to self and danger to others were too simple to pick up this complex phenomenon; 3) the measures used for patient progress in psychotherapy were skewed in favor of themes of danger to self; 4) the type of therapy, Brief Psychotherapy, may not have lent itself to the unraveling of the genetic reasons for the beliefs (especially if these beliefs were unconscious) of danger to self or danger to others, as may be the case in longer term therapy such as psychoanalysis or ongoing psychotherapy. These problems will be briefly discussed.

Beliefs of Harm to Self and Harm to Others is a Complex Phenomenon

As mentioned in the literature review, the focus on beliefs of harm to others have been overshadowed by beliefs of harm to self, making it difficult for theorists as well as therapists (and raters) to be cognizant that different experiences are involved. Often times these two beliefs are intertwined and the affects and behavior generated by one belief may become a defense against another belief (for example, as Friedman pointed out in his work with anorectic patients, separation anxiety may be a defense against survivor guilt [1985]). Furthermore, Friedman (1985) has pointed out the difficulty in ascribing motives primarily
based on concerns for others. The following example from case 1, Gary, illustrates this point. (underlying is mine)

Example 1

(During many previous sessions, patient has been continually asking the therapist to lead the therapy. This session patient is continuing to describe his need for the therapist to point him in a useful direction. The patient says that he cannot see any further direction without guidance from the therapist.)

Therapist/I think that this theme of seeing things, seeing things for yourself, has been an important one that we've talked about from time to time. This issue of seeing. And the theme is something like this—that the seeing goes along with knowing and doing and acting and that kind of thing on the one hand versus not seeing, not knowing, being confused on the other hand. And it seems to me that you do take a lot of pride in seeing things, being independent, being able to see things and work things out for yourself; and you've done that for yourself at various points in your life, and done it well. But it also seems to me that at times you get uncomfortable about doing that or seeing something for your self. It's as if—I don't know, that in seeing something for yourself you're leaving somebody else out, or you're--there's some element of discomfort about--maybe guilt--about seeing something that other people don't see./
Patient/(sigh) I'm not so sure that--I know that what you referred to--/

Therapist/Well I'll give you an example of something I have in mind. Say like when you were younger, and your family moved to Israel. It seemed to me that you as a child, assimilated things fairly quickly, and you could probably pick up certain things and see certain things that your parents maybe didn't see, that other people didn't see. Or could do things or know things that other people couldn't do or didn't know. How, on the one hand you liked that; you liked it a lot. And moved with it and went with it. But at the same time, it seems to me, that maybe at times that you felt uncomfortable or guilty about being able to see things, or do things, or know things that your parents couldn't do and couldn't know. (Pause) And to the extent that that's so, I wonder if there isn't some element of that in what we've been talking about - (that goes on here between you and me)./ 

This item received a high plan compatibility score of +2.75, a Danger to Others Interpretation score of +2.2, and a high Danger to Self Interpretation score of +3.0. Only one out of the five raters scored this item +4.0 on the Danger to Others Interpretation score. The other four raters gave it +1.0, +2.0, +2.0 and +2.0. These same four raters on the Danger to Self Interpretation scale rated this item a +3.0, +4.0, +4.0 and +3.0. Although they recognized
the therapist interpretation contained elements of danger to others, clearly, they perceived danger to self underlying the patient's behavior of being uncomfortable, guilty and confused about seeing and doing things for himself. These raters did not perceive that underlying the patient's guilt about knowing more than his parents, being more capable of doing things than his parents, was a belief that he would be leaving them out, somehow outshining them, and that this may be what is going on between the patient and the therapist. This latter conception was supported in Gary's plan formulation.

Reducing these beliefs into the two broad categories of danger to self and danger to others, in a sense, pitting one against the other, was perhaps too simplistic and did not capture the phenomenon that was intended. Sigel (1985), in his studies on parental beliefs regarding children's cognitive development as a predictor of parental behaviors found that it was difficult to predict a one to one correspondence between global beliefs and behavior. Beliefs that contained clear-cut, direct behavioral expressions were more predictive of an individual's behavior (Sigel, 1985); In this study, when the therapist was explicit about connecting the patient's behavior with interpretations of danger to others, the item not only received a high Danger to Others Interpretation score, but also a high rating in Plan Compatibility as illustrated in Example 2.
Example 2

(Patient is discussing the uneasiness he feels in criticizing the therapist.)

Therapist/It seems to me that the uneasiness is related to what you were talking about last time--that you feel, uhm, that you have to be very cautious about uh--hurting other people's feelings or offending other people because you're afraid of being powerful and what you might be able to do to them.?

This item received a Plan Compatibility score of +2.6, a Danger to Others Interpretation score of +3.0, and a Danger to Self Interpretation score of +2.0.

In addition to the small number of items rated high on the Danger to Others scale, a further complication in the case of Gary, was that there was very little variability in the plan compatibility ratings. Whenever the therapist made an interpretation it tended to be plan compatible, which made it difficult to assess the correlation with danger to others interpretations. (See Histogram 1). However, it is interesting to note that in both cases, danger to others interpretations ratings (>+1.8) tended to be high in plan compatibility (ratings between +1 and +3), whereas danger to self interpretations scores (>1.8) were high and low in plan compatibility. (See Histograms 1 and 2).

Despite the inconclusive results, they do suggest that issues of danger vary from patient to patient and that both
NOTE GARY-PLAN COMPATIBILITY & DANGER TO SELF

PC
3.0+
-  
-  
-  
-  
-  
-  
2.0+
-  
-  
-  
-  
-  
-  
-  
1.0+
-  
-  
-  
-  
-  
-  
-  
0.0+
-  
-  
-  
-  
-  
-  
-  
-1.0+
-  
-  
-  
-  
-  
-  
-  
-2.0+
+--------------------------+--------------------------
  0.0  1.0  2.0  3.0  4.0  5.0

NOTE GARY-PLAN COMPATIBILITY & DANGER TO OTHER

PC
3.0+
-  
-  
-  
-  
-  
-  
2.0+
-  
-  
-  
-  
-  
-  
-  
1.0+
-  
-  
-  
-  
-  
-  
0.0+
-  
-  
-  
-  
-  
-  
-1.0+
-  
-  
-  
-  
-  
-  
-2.0+
+--------------------------+--------------------------
  0.0  1.0  2.0  3.0  4.0  5.0

HISTOGRAM 1, Gary
NOTE PLOT OF PLAN COMPATIBILITY & DANGER TO SELF

PC
3.0+
-  
-  
-  
-  
-  
-  
1.5+
-  
-  
-  
-  
-  
2  
0.0+
-  
-  
-  
-  
-  
-  
-  
-  
-  
-  
-1.5+
-  
-  
-  
-  
-  
-  
-  
-  
-  
-3.0+
-----------------------------------------THESelf
0.0  1.0  2.0  3.0  4.0  5.0

NOTE PLOT OF PLAN COMPATIBILITY & DANGER TO OTHER

PC
3.0+
-  
-  
-  
-  
-  
-  
1.5+
-  
-  
-  
-  
-  
2  
0.0+ 4  
-  
-  
-  
-  
-  
-  
-1.5+  
-  
-  
-  
-  
-  
-3.0+
-----------------------------------------OTHER
0.00  0.90  1.80  2.70  3.60  4.50

HISTOGRAM 2, Myra
types of interpretations, i.e., danger to self and danger to others interpretations must be considered.

Problems with the Danger to Self and Danger to Others Scales

The question remains whether the danger scales were in fact, measuring the phenomenon intended. The following examples of therapist interpretations from case 1, Gary, illustrate the various problems with the design of the scales and the unit of study.

One of the problems with the scales may have been that the dimension of danger may not have captured the phenomenon of beliefs of harm to others. Although danger was broadly defined as including, but not necessarily limited to, loss, dysphoric feelings, or physical injury, it did not pick up undeserving feelings, or placing concerns about other people before one's own interests. Although empathy does not necessarily involve appraisals of danger to others, Friedman has written that empathic distress, i.e., responding to another's distress, is the affective component of guilt stemming from the belief of being responsible for harming others (Friedman, 1985, p.529). The following segment illustrates this point:

Example 3

(Patient said that he feels good and would like to pursue further what they worked on last session. Then patient says he doesn't know what to talk about it. Then
patient asks therapist what the therapist thinks would be worth discussing."

Therapist/What's interesting to me in your raising that now is that it seemed to me that you did have somewhat of an agenda today and that rather than to say your good feelings, or wondering about your undoing and doing, and that rather than sort of following your agenda, your own agenda, you asked me whether I'd like to pursue mine first.?

This item received a high plan compatibility score of +2.7, a Danger to Other Interpretation of score of 0 and a Danger to Self Interpretation score of 0. It is understandable why this item received a rating of 0 on both Danger to Self and Danger to Others Scales. On face value, there is no mention by the therapist of a sense of harm to the patient or other people. However, the therapist is stating that the patient is not pursuing his own agenda, but instead is deferring to the therapist's agenda. Renouncing one's interests in favor of another's interest suggests more concern about others than oneself and was intended to be part of the phenomenon of danger to others that was not being tapped by the scale. This could have been due, in part, to the unit of study, the interpretation segment. Often times, the genetic reasons for the patient's sense of danger was implied in the therapist interpretation and had to be inferred by the raters. However, sometimes the genetic reasons for the patient's sense of danger would be explicit in the therapist
interpretations, but because the therapist interpretations were given in random order, the raters had no way of consistently rating items of similar danger issues that may have been implied in one segment and explicit in another. Perhaps if the raters had read the verbatim transcripts of each case, the raters may have been consistent in rating items where the genetic reasons for the patient's sense of danger had been stated explicitly by the therapist earlier in therapy and then implied, or alluded to later in therapy. Examples 4 and 5 illustrate these points.

Example 4

(Patient has said that it's unpleasant for him to be involved in taking a position of leadership.)

Therapist/Right. I don't think it is pleasant for you either. But it seems to me that what you're more uncomfortable with is being (pause) say, real strong and bold in these situations that you want to be forthright in./

Patient/Would you say it again?/

Therapist/I'm sorry?/

Patient/Can you say it again?/

Therapist/Yeah, that I think what you--one of the reasons that you withhold a lot--you're saying that it could have to do with aggression, and that's why you're into controlling and that kind of thing, and it's my feeling that
aggression is not the major thing--that it is that you're just uncomfortable being in a position where you're seen as being strong, bold, or successful, or whatever--?

Patient/That I'm uncomfortable?
Therapist/Yeah/

This item received a Plan Compatibility rating of +2.6, a Danger to Other Interpretation rating of +.4 and a Danger to Self Interpretation rating of +3.8. This interpretation segment does not explicitly state why the patient is feeling uncomfortable as will be shown in Example 5, instead what is being said by the therapist at face value in this one random segment is that the patient is uncomfortable with being strong, bold, or successful. The raters were not allowed to infer danger to others unless it was supported in the patient statement.

Example 5

Patient/But the other side connected is the uh--kind of protecting myself, being--I told about it, talked about it. Being uh--sure of saying the right thing, for me, so that I won't be uh--hurt by anything that I say or that somebody might say in reaction to me.

Therapist/How would you need to be so sure?
Patient/(pause) (sigh) I don't know. (silence) I'm trying to think, but I'm blocked. And I repeat your
question again and again. I don't know. (3-minute silence)/

Therapist/You were saying earlier that you have these uh--fantasies about your strength when you were younger, and that you were bigger and stronger than the others, than your friends and people around you. I wonder if it could be connected. So you had to watch yourself then, and watch what you did. I wonder if this couldn't be part of the same thing, that you have to watch what you say because it could be so powerful, it could be so--/

This item received a Plan Compatibility score of +2.6, a Danger to Other Interpretation score of +2.6 and a Danger to Self Interpretation Score of +1.8. As in Example 4, the therapist is addressing the patient's concern about being big and strong. However, in this item the therapist is connecting the patients concerns about being bigger and stronger to others, i.e., his friends and the people around him.

Measures in favor of Danger to Self Interpretation scores

As mentioned in the Results, the Experiencing Scale, simply by nature of what it is intended to measure, may have confounded the results in favor or Danger to Self Ratings. The Danger to Others Interpretation Scale may also have skewed the results in favor of Danger to Self Interpretations. Virtually every high Danger to Others score was accompanied by a Danger to Self rating of +2. The
converse was not true for Danger to Self scores. This also points out the methodological difficulty in conceptualizing danger to others without elements of danger to self.

Concluding Remarks

Although the prominence of danger to others interpretations over danger to self interpretations in patient progress in psychotherapy could not be supported by this pilot study, findings have suggested that beliefs of danger to others function differently from beliefs of danger to self and may need to be considered separately by the therapist. For example, in case 1 danger to self interpretations were more compatible with the patient's plan for treatment, whereas in case 2, danger to others interpretations appeared more compatible with the patient's plan for treatment. This finding also seemed to support the notion that a case-specific evaluation of the patient is more important than the diagnostic evaluation. Although both cases were diagnosed as suffering from depression, each patient had different danger issues. Thus, interpretations of danger to others may be viewed by one patient as meaningful for achieving her/his goals in therapy, but may be seen by another patient that maybe he/she should be more worried or concerned about other people.

Taking into consideration the conceptual and methodological problems in carrying out this project, for future research, a better focus of study would be guilt. Since it has been proposed that most therapists are guided
by Freud's definition of guilt in which there is more of an emphasis on beliefs of harm to self (Bush, 1985; Freud, 1926; Friedman, 1985a,b; Weiss & Sampson, 1986), this can be contrasted with guilt as defined in the more recent literature as stemming from beliefs that one's thoughts, feelings, or actions are responsible for harming others (Bush, 1985; DeVos, 1974; Friedman, 1985; Weiss & Sampson, 1986). Case studies, where a greater sample of therapist interpretations concerning guilt or undue responsibility toward other people can be identified, should be obtained. However, this may continue to pose a problem in light of the relative underestimation of guilt as a major issue in the development of psychopathology. Finally, using a measure that reflects an undifferentiated sense of danger, for example, a measure of patient anxiety levels, could be used to measure patient progress in psychotherapy in relation to the danger issues surrounding guilt. Perhaps then, the question of the prominence of interpretations of danger to others over interpretations of danger to self in patient progress in psychotherapy may be answered. Until such conceptual and methodological problems can be worked out, the theoretical questions surrounding the prominence of beliefs of harm to others in patient progress in psychotherapy remains unsettled.
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APPENDIX I

DANGER TO SELF/DANGER TO OTHERS SCALES

This scale is designed to rate the degree to which therapist interventions focus on themes relating to danger to the patient (danger to self) or danger to people other than the patient (danger to others).

The rater's task is to recognize the following 3 components in a therapist's intervention:

1. A sense of danger or harm which may be indicated by, but not necessarily limited to, the following kinds of feelings or behaviors:
   a. loss of love - abandonment, exclusion, isolation, loneliness, criticism, ridicule, rejection, withdrawal of affection
   b. dysphoric emotions - shame, humiliation, embarrassment, depression, anxiety, sense of failure, loss of control, fatigue, jealousy, helplessness, despair, frustration, feeling crazy or stupid or confused, pressure, guilt
   c. physical injury or annihilation - punishment, attack, death, self-injury

2. Identification by the therapist of the object who is affected by the danger or harm. The object of danger or harm is exclusive to:
   a. self - refers to the patient
   b. other(s) - refers to any person(s) other than the patient, e.g. parent, sibling, therapist, spouse, lover, friend, boss, child.

3. Indication by the therapist that the danger to patient/self or danger to other(s) influences the patient's behavior or feelings.
DANGER TO SELF/DANGER TO OTHERS SCALE

The sign indicates self [-] or other(s) [+]. The number represents the degree to which the therapist identifies the object of danger or harm and how danger to the object influences the patient's behavior or feelings.

[+/-] 4 Therapist indicates how the danger to self [-] or danger to other(s) [+] influences the patient's behavior or feelings.

[+/-] 3 This is a midpoint rating to be used when a segment falls between a 4 and a 2.

[+/-] 2 Therapist identifies patient/self [-] or other(s) [+] as the object of danger. However, unlike a 4 rating, the therapist does not indicate how this influences the patient's behavior or feelings.

[+/-] 1 This is a midpoint rating to be used when a segment falls between a 2 and a 0.

[+/-] 0 Therapist does not identify patient/self [-] or other(s) [+] as the object of danger.
DIRECTIONS:

Each dimension of danger is defined by the object of danger (self vs. other) rather than the nature of the feeling or behavior.

Each numbered segment will always receive two [2] ratings, a [-] rating for Danger to Self and a [+] rating for Danger to Other(s).

In most cases it will be clear from the therapist intervention who is being endangered, i.e., self [-] or other(s) [+], and how this influences the patient's behavior or feelings. In some cases, it may be necessary to attend closely to the the patient's statement to make this determination.

For example, the patient may be talking about how her mother humiliated her in front of her friends and the therapist responds, /It was humiliating./ This would be rated a -2 (Danger to Self), since the therapist is reiterating the patient's concern of being humiliated, and humiliation is a dysphoric emotional state.

In some therapist interventions there will be elements of both Danger to Self [-] and Danger to Other(s) [+], and it will be necessary to determine what is more strongly influencing the patient's behavior, i.e., is it Danger to Self [-] or Danger to Other(s) [+]? In these cases, the highest rating will be given in the direction that is most influencing the patient's behavior or feelings.

For example, therapist states: /You are worried about being dependent on your husband, because he may feel overwhelmed./

"You are worried" is a dysphoric emotion for the patient and therefore would receive a -2 (Danger to Self). However, the therapist is also stating that the patient's husband will be overwhelmed by the patient's dependency (Danger to Other) and that this concern over danger to the husband is what is influencing the patient's worry. Therefore this intervention would also receive a +4 (Danger to Other is what is influencing the patient's feeling.)
EXAMPLES:

<table>
<thead>
<tr>
<th>Rating of 4</th>
<th>Danger to Self/Danger to Other(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are worried that if you have an enjoyable conversation with your friend's wife, your friend may exclude you from future social events.</td>
<td>-4 [-] +0 [+]</td>
</tr>
<tr>
<td>You feel guilty about being independent from your husband, because he may leave you.</td>
<td>-4 [-] +0 [+]</td>
</tr>
<tr>
<td>You feel guilty about being independent from your husband, because he may feel rejected.</td>
<td>-2 [-] +4 [+]</td>
</tr>
</tbody>
</table>

**Rating of 3**

This is a midpoint rating to be used when a segment falls between a 4 and a 2.

**Rating of 2**

Feeling guilty. -2 [-] +0 [+]

You are worried about being independent. -2 [-] +0 [+]
Your mother will feel rejected. -0 [-] +2 [+]
Your father is unhappy about your decision to leave home. -0 [-] +2 [+]
You and your mother are unhappy with your father's decision to get a divorce. -2 [-] +2 [+]

**Rating of 1**

This is a midpoint rating to be used when a segment fall between a 2 and a 0.
Rating of 0
So you destroyed your doll.  -0  +0