Improving Interpersonal Perceptual Accuracy and Psychological Adjustment through Brief Perception Therapy with a Substance Abuse Population

B. Gerald Hartman

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IMPROVING INTERPERSONAL PERCEPTUAL ACCURACY AND PSYCHOLOGICAL
ADJUSTMENT THROUGH BRIEF PERCEPTION THERAPY
WITH A SUBSTANCE ABUSE POPULATION

by

B. Gerald Hartman

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
Department of Counseling and Personnel

Western Michigan University
Kalamazoo, Michigan
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This study's purpose was to determine if a type of cognitive therapy, Brief Perception Therapy, (Bullmer, 1980) could improve interpersonal perceptual accuracy and psychological adjustment in a substance abuse population. Thirty-five patients seeking inpatient treatment were randomly assigned to a treatment and a comparison group. Twenty-five patients completed the three week program, 13 in the treatment group and 12 in the comparison group. The treatment group received Group Brief Perception Therapy (GBPT) and the comparison group received Regular Group Therapy (RP). Therapists were experienced master's level psychologists and social workers trained in group treatment. GBPT groups used a programmed text, The Art of Empathy (Bullmer, 1975) as a guide and followed a structured group format.

The Affective Sensitivity Scale (ASS) was chosen for the study to measure interpersonal perception accuracy. The profile of Mood States (POMS), the Minnesota Multiphasic Personality Inventory (MMPI) and the Tennessee Self Concept Scale (TSCS) were used to measure psychological adjustment. A t test (two tailed) was used to determine significant differences between pretreatment and posttreatment mean scores for both groups and posttreatment mean scores.
scores for each group with significance set at <.05.

No significant differences were found between pretreatment and posttreatment responses to measures of interpersonal perception accuracy for both groups. Two factors on the POMS, Tension-Anxiety and Depression-Rejection showed significant differences for the treatment group. No significant differences appeared in responses to posttest comparisons of the GBPT and RP groups on measures of interpersonal perception accuracy and psychological adjustment. Some trends toward significant differences were observed between pretest and posttest measures of psychological adjustment for the GBPT group. Trends toward significant differences between posttest measures of psychological adjustment for the GBPT and RP groups were noted.

The conclusions drawn from conducting this study suggest that a more structured approach to group therapy (GBPT) may be as effective as more traditional psychotherapy (RP) in improving psychological adjustment in a substance abuse population. Recommendations for further research included extending the length of the treatment beyond the three week period to allow more time for the patients to internalize the concepts and at the same time allow more time for the therapists to make stringent evaluations and more accurately assess the conceptions of the patients.
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IMPROVING INTERPERSONAL PERCEPTUAL ACCURACY AND
PSYCHOLOGICAL ADJUSTMENT THROUGH BRIEF PERCEPTION THERAPY
WITH A SUBSTANCE ABUSE POPULATION

Western Michigan University

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First of all, I wish to dedicate this dissertation to my wife, Ruth, and our children Dan and Marty, David and Vicki, Dale and Donna. Each of them in their own way gave special supportive encouragement which made it possible for me to complete this project.

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B. Gerald Hartman
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CHAPTER I

THE PROBLEM AND ITS BACKGROUND

Background of the Problem

Interpersonal relationships form a large part of our lives. Tagiuri (Tagiuri and Petruillo, 1958) suggests that one person in a relatively smooth day-to-day interaction is in some degree aware of what another person is doing, is feeling, is wanting or is about to do. To be able to evaluate other persons seems to come naturally and we tend to give it very little thought. Asch (1952) suggests:

To act in the social field requires a knowledge of social facts of persons and groups. To take our place with others we must perceive each other's existence and reach a measure of comprehension of one another's needs, emotions and thoughts (p. 139).

This interaction has been variously identified as social perception, interpersonal perception, or person perception to name a few of the descriptive phrases used. The terms person perception or interpersonal perception may be inadequate to describe the interaction between two or more persons. Tagiuri (1958) suggests a double interaction. For purposes of this study interpersonal refers primarily to observations of intentions, attitudes, emotions, ideas, abilities and purposes, which are more accurately described as being inside the person.

Allport (1961), Asch (1952), Blake and Ramsey (1951), Dember (1960) and Heider (1958) made outstanding contributions to the body of early theory and research in interpersonal perception. Likewise,
in the field of counseling and psychotherapy, personality theorists such as Ellis (1962), Maslow (1954), Rogers (1951), Sullivan (1953) and more recently Beck (1976), have concluded that effective interpersonal relationships are a critical element in psychological adjustment.

There is evidence which supports a significant relationship between personality variables and accuracy of interpersonal perception. Literature produced during the past several decades has supported these concepts (Ansbacher, 1937; Atzet, 1968; Carde, 1977; Jorgensen, 1968; Knower, 1945; Pfaff, 1954; Soskin and Kaufman, 1961; Sprouse, 1977; Stephens, 1936; and Wyman, 1978). Personality theorists from different orientations (Ellis, 1962, 1976; Lewin, 1935; Maslow, 1954; and Rogers, 1951) have studied accurate perception as it relates to psychological adjustment or maladjustment. It appears that the individual's psychological well-being is dependent on his ability to perceive accurately.

Maultsby (Goodman and Maultsby, 1978) states:

People tend to confuse their beliefs with their perceptions. They start out with a thought and let it color their perception of external reality. The result is a delusion. Attitudes, beliefs, and perceptions reinforce each other, and persons tend to define one in terms of another (p. 50).

Cognitive theories have been receiving more attention during the past few years. For example, Beck (1976), Ellis (1962), Goldfried and Goldfried (1975), Mahoney (1974) and Meichenbaum (1977), have described their successful applications of cognitive therapies.
Many of the current systems of therapy focus on the cognitive perceptual process of the patient. These systems focus on reducing the patients' perceptual distortions so that they may learn to see themselves and others more accurately and function better on the cognitive level. Ellis (1962, 1976) refers to irrational thinking as promoting psychological disfunction. He also suggests that improving the emotional state will decrease irrational thinking. Beck (1976, 1979), discusses helping patients restructure their thinking and behavior and guiding them toward a transformation of distorted thinking patterns. This cognitive approach to therapy demonstrates that the patients' behaviors are a consequence of their mental set.

Interpersonal perceptual accuracy as it relates to psychological adjustment was investigated by Bullmer (1980) using a new treatment modality which was called Brief Perception Therapy. This new therapy might be described as a cognitive approach to helping patients deal with distorted and irrational thinking. The results of Bullmer's case study research suggest that the new modality was effective in improving interpersonal perceptual accuracy and psychological adjustment. Isaac and Michael (1971) suggest that case study research does provide valuable background material for planning empirical studies.

Statement of the Problem

Bullmer (1970) demonstrated that accuracy in interpersonal could be improved through direct teaching methods. Bullmer (1970,
1972, 1975) programmed material on interpersonal perception skills which as been used successfully in counselor training classes. Since that time others have documented the results achieved initially (Barsaloux, 1977; Bullmer, 1980; Dambach, 1978; Edwards, 1976; Hale, 1979; and Park, 1976).

Recent studies of interpersonal perception in substance abuse populations suggest that serious social and psychological maladjustments interact with problems of interpersonal perception accuracy (Carde, 1977; DuHamel, 1970; Fehr, 1971; Mules, Hague and Dudley, 1977; Pushkash and Quereshi, 1980; Qereshi and Soat, 1976; and Ward, 1975). There is a need to better understand and clarify the relationship between improving interpersonal perception accuracy and improvement in psychological adjustment. Carkhuff (1969) suggested that good interpersonal relations are closely related to accurate interpersonal perceptions. He also suggested that training in human relations does improve psychological adjustment. Training in interpersonal perception, he states, is done most effectively and efficiently carried out through the group process.

The purposes of this study are:

1. To determine if Group Brief Perception Therapy (GBPT) in a substance abuse population improves interpersonal perceptual accuracy.

2. To determine if GBPT in a substance abuse population improves psychological adjustment.

3. To determine if GBPT is more effective than Regular...
Psychotherapy (RP) in improving interpersonal perceptual accuracy in a substance abuse population.

4. To determine if GBPT is more effective than RP in improving psychological adjustment in a substance abuse population.

Significance of the Study

The problem this study addresses is important for a number of reasons. First, the study is a test of Brief Perception Therapy as a method of improving interpersonal perceptual accuracy in groups. Second, it is one of the first empirical studies using the Brief Perception Therapy model in a psychiatric population. Third, the study is designed to provide new information which may suggest improved methods of treating psychological maladjustment in a substance abuse population. The literature suggests that there is a relationship between interpersonal perception accuracy and a state of psychological adjustment in certain populations. BPT has been used in recent case study research (Bullmer, 1980). The results appear to confirm that this treatment approach not only improves interpersonal perceptual accuracy, but psychological adjustment as well. This study is intended to expand the scope of the previous case study research by conducting experimental research using BPT with a different population in small groups.

Research Questions

Bullmer (1980) used BPT with psychiatric outpatients with
positive results. Since interpersonal perception and psychological problems characterize substance abuse populations the following research question were proposed.

1. Does GBPT improve the interpersonal perceptual accuracy of substance abuse patients?

2. Does GBPT improve psychological adjustment in substance abuse patients?

3. Is GBPT more effective than Regular Psychotherapy (RP) in improving interpersonal perceptual accuracy of substance abuse patients?

4. Is GBPT more effective than RP in improving psychological adjustment of substance abuse patients?

Overview of the Study

In Chapter I the importance of interpersonal perceptual accuracy to psychological adjustment has been discussed. It has been proposed that GBPT does improve interpersonal perceptual accuracy in a substance abuse population. It has also been proposed that GBPT improves psychological adjustment.

A selected review of the literature on the interpersonal perception construct and how interpersonal perceptual accuracy relates to psychological adjustment is presented in Chapter II. The sample, the methods and the rationale used to organize the study are described in Chapter III. Also, described in Chapter III are the methods and rationale used in data collection, and the statistical
techniques used in analyzing the results. Research findings are presented in Chapter IV. Chapter V, includes a summary of the study, a discussion of the research results and implications for future research.
CHAPTER II

REVIEW OF THE LITERATURE

The literature and research related to this study is concerned with three areas: the interpersonal perception construct and process; the relationship of interpersonal perceptual accuracy and personality variables; and psychological adjustment as it relates to interpersonal perceptual accuracy.

The Interpersonal Perception Construct and Process

In discussing the meaning of perception, Dember (1979) suggests that the word perceiving more accurately connotes activity or process with which we are concerned. For most people, being consciously aware of the environment is not a startling fact. The process of perceiving involves attaching meaning to the external world and internalizing the information. Gibson (1959) describes perception as a "function of stimulation" (p. 459). He continues the association by stating, "and stimulation is a function of the environment" (p. 459). The perceiver plays a very active role in the process, both in the selection of cues that are attended and responded to, and in the organization of those cues into a personally meaningful form.

Perception, as Forgus (1966) explained, may be very simply defined as the process of extracting information from the environment. It is, however, really no simple process because of the interdependence between perception, learning, and thinking. Bullmer (1970) stated "perception is the core process which influences and is influenced by
learning and thinking" (p. 7). In the cognitive development of a person, attitudes, beliefs and values are incorporated into the process of perception.

Bullmer (1970) summarizes very clearly the importance of the perceiver in the process of perception:

The directing force behind the perceptual operations of attention and organization is some kind of perceptual-cognitive structure within the perceiver; a structure which is a unique combination of previous learnings and thought processes and which is influenced by the perceivers beliefs, attitudes, and values. The perceptual cognitive structure of the perceiver determines which cues shall be emphasized and which shall be inhibited, and dictates what dimensions shall be utilized in ordering the selected cues into a configuration which is useful and meaningful to the perceiver. (pp. 9-10)

Some theorists make distinctions between the concept of perception and the concept of response. Epstein (1967) describes perception as an intervening construct relating to the inferred processes that intervene between measurable stimulus conditions and measurable overt responses. He concludes that the observable overt response has importance in the study of perception only as it serves as a basis for inferences concerning the perceptual process. Ellis (1962) states, "perception biases response and then response tends to bias subsequent perception" (p. 44). With improved perceptual ability there would be carry over effects on future perceptions which would modify the entire perceptual process.

Perceiving another person or interpersonal perception occurs when the stimulus to be perceived is another person. A variety of factors are involved in this process. As already suggested in
describing the process of perception, these factors are the person's attitudes, beliefs, motives and values which are products of their past learning experiences and thinking processes. Heider (1958) suggests that interpersonal perception may be "described as a process between the center of one person and the center of another person, from life space to life space" (p. 33). Persons perceive psychological processes in other persons through their own expectations, wishes and sentiments. Asch (1952) enlarges on this construct:

The paramount fact about human interactions is that they are happenings that are psychologically represented in each of the participants. In our relation to an object, perceiving, thinking and feeling take place on one side, whereas in relations between persons these processes take place on both sides and in dependence upon one another...We interact with each other not as the paramecium does by altering the surrounding medium chemically, nor as the ants do by smell, but via emotions and thoughts that are capable of taking into account the emotions and thoughts of others. (p. 142)

These psychological processes, including motives, intentions and sentiments, are expressed in overt behavior which is interpreted by the perceiver. It is necessary to make inferences concerning the meaning of the behavior. Allport (1961) questions the accuracy of the term, interpersonal perception, since many of these properties are internal and inferred rather than external. He suggests instead, that individuals are known or judged, rather than perceived. Other theorists, including Rogers and Truax (1966) and Tagiuri and Petrullo (1958), support the concept that person perception includes these internal properties so that an individual becomes aware of another
individual's thoughts and experiences.

Sarbin, Taft and Bailey (1960) have examined extensively the process of clinical inference as it relates to interpersonal perception. They have divided clinical inference into six phases: a postulate-system; a major premise; observation; instantiation; inferential product; and prediction. An analysis of each phase uses logic to systematically present this cognitive theory of clinical inference in its interaction with interpersonal perception.

Other theorists have developed models with cognition and thinking as their foundation in explaining and understanding the interpersonal perceptual process. Lang, Phillipson and Lee (1966) called their model the Interpersonal Perception Method. It was designed primarily to be used within the dyadic experience. Stotland and Canon (1972) described interpersonal perception in terms of schemas which use inference to understand not only observable behavior but other behaviors including feelings, thoughts, motives and intentions. These schemas are formed in such a way as to influence future behavior. As individuals experience new interactions with others, their perceptions will influence existing schemas. There is also an interaction effect between new perceptions and the schemas. These concepts support the importance of developing accurate interpersonal perceptions in order to have constructive interpersonal relationships.

Selective perception, as suggested by McCall and Simmons (1966) may bias the schema resulting in limited processing of information.
which in turn may lead to misinformation such as prejudice and stereotyping. Ellis (1962) and Beck (1976) agree with these concepts that responses bias subsequent perceptions.

During the past decade there has been a growing interest in developing cognitive behavioral theories. Bandura (1969) saw the trend in this direction when he summarized the literature beginning to deal with cognitive-symbolic mediation. Mahoney (1974) is one, among others, who has been dealing with the importance of inference in studying interpersonal relationships. Mahoney suggests that "Inferences are expediencies. They are involved only when the exigencies of the situation demand" (p. 31). The cognitive approach to understanding interpersonal perception as a process is an area of theory and research which appears to be growing today. The psychological characteristics of the perceiver are an important part of interpersonal behavior. The accuracy of perception will be effected by personality variables.

The Relationship of Interpersonal Perceptual Accuracy and Personality Variables

Selected literature related to the interpersonal perception construct and process has been hereto considered. The literature which demonstrates the effect of different personality variables on perceptual accuracy is the focus of this section.

Allport (1961) lists nine different personality characteristics that may identify the good person perceiver. Allport's work is basic
in defining and analyzing these personality variables. These personality variables are: experience; social skills; good adjustment; superior intelligence; cognitive complexity; self-insight; detachment; interceptiveness; and esthetic attitude. Bullmer (1970) analyzed these personality variables and concluded that there were three major areas of possible error in person representation. These major areas are: "errors caused by perceptual distortion; errors caused by inadequate intelligence; and errors caused by the use of implicit personality theory" (p. 17). Hale (1979), in a study of personality in characteristics associated with accuracy in person perception, found that the most accurate judges in person perception had the following personality description: they had higher I.Q.'s; were more extroverted; more psychologically minded; more cognitively complex/flexible; and more empathic. Hale's research seems to support Allport's (1961) conclusions.

Closely related to intelligence in interpersonal perception accuracy is style of cognitive functioning. The cognitive inference model as outlined by Sarbin, Taft and Bailey (1960) uses a logical system of arranging new events in order to understand interpersonal behaviors. More cognitively complex individuals appear to have more skill in accurately perceiving the behavior of others. Hale (1979), Mayo and Crockett (1964) and Bieri (1955) in their research on cognitive complexity, achieved results which generally support this variable as correlating with accurate interpersonal perception in different settings.
Those who have the ability to think in abstractions seem to have more accurate interpersonal perception ability. Harvey, Hunt and Schroder (1964) found in their research that concreteness is related to low discriminatory ability to analyze and develop more accurate impressions of people.

Considerable research has been done in examining the authoritarian variables. Smithers and Lobley (1978) found results in their research which supported Rokeach's (1960) findings that a dogmatism scale measures authoritarianism on the left as well as the right. Vacchiano (1977) found in his research that those who score low in dogmatism were more accurate in their interpersonal perceptions. Burke (1966) and Jacoby (1969) also found similar results in their studies of dogmatism.

Ridgeway (1977), Karp (1977), and Shrauger and Altrocchi (1964) in separate investigations of field-dependence/field-independence, found that their results support other researchers' findings that field-independent persons are better person perceivers than those who are perceptually field-dependent. Fehr (1971) studied perceptual field-dependence and inconsistency of interpersonal perceptions in alcoholics. It was found that field-dependent alcoholics tended to be associated with inconsistency in interpersonal perceptions, while field-independent alcoholics perform comparably to field-independent controls.

Another variable which has been successfully studied is the locus of control construct which was derived from Rotter's Social
Learning Theory (Rotter, 1966). Locus of control has two dimensions: internality, the degree to which individuals perceive that they have control over their behaviors; and externality, the degree to which individuals perceive their behaviors as being controlled by powerful others, luck, chance or fate, or beyond their control (Lefcourt, 1976). Scalese (1978) did research on locus of control as it relates to accuracy of interpersonal perception and found that individuals with internal locus of control are more accurate in their perceptions than those with external locus of control. In their study Phares and Wilson (1972) found that individuals tended to project their control orientation onto individuals identified as stimuli. Phares, Richie and Davis (1968) observed that externals were more defensive in interpersonal relationships than internals. The locus of control variable appears to have potential for additional evaluation as it relates to interpersonal perception accuracy.

The literature surveyed documents a definite relationship between interpersonal perceptual accuracy and many different personality variables. The research indicates that those who experienced better psychological adjustment also had more accurate interpersonal perception skills. It seems logical to assume that improving interpersonal perception accuracy should also improve psychological adjustment in the perceiver. Personality characteristics of the individual are made up of a variety of variables which are related to the psychological adjustment of the individual. It should follow then that interpersonal perception
accuracy will be related positively to psychological adjustment.

Psychological Adjustment as it Relates to Interpersonal Perceptual Accuracy

Few researchers have directly examined the relationship between interpersonal perceptual accuracy and psychological adjustment. The term psychological adjustment has been generally accepted as referring to the psychological state of well-being in a person. Psychological adjustment may be defined as the degree of homeostasis in the mental state of an individual which results in appropriate or inappropriate responses to the environment.

Tucker (1970) suggests that the biological state of individuals may have a strong influence on behavior as it relates to adjustment. He states that the biological mechanisms "mediate his perceptions and his interactions with the environment, and it sets certain limits to his experimental and behavioral possibilities" (p. 23). This suggests that maintaining a homoestatic physiological state will have an effect on the accuracy of perceptions and the degree of adjustment individuals have in their environments.

Studies of the relationship between psychological adjustment and interpersonal perception have sometimes focused on effects of psychopathology in interpersonal perception. Rogers and Stevens (1967) confirmed the hypothesis that schizophrenic patients were unable to accurately perceive the core conditions of a therapeutic relationship. Papson and Hamersma (1974) found that schizophrenic male self-perceptions and their perceptions of maternal figures
varied significantly from the perceptions of normal males. Widom (1976) and Smith (1975) studied the interpersonal and personal construct systems of diagnosed psychopathic individuals. Smith (1975) hypothesized that since the psychopath is a very manipulative person he should have special skills in person perception. The results indicated that antisocial males were not more accurate person perceivers, even when motivation was given by offering a reward for accuracy. These studies demonstrate the problem of maladjustment as they relate to poor interpersonal perception.

Allport (1961) suggested that accurate perception is essential to the development of a healthy personality. Leimkuhler and Ziegler (1978) concluded from their research that more well-adjusted individuals can more objectively perceive other persons. This supports Allport's (1961) description of good person perceivers.

Personality theorists such as Maslow (1957, 1962) and Rogers (1951) view well-adjusted persons as self-actualizing individuals who have the capacity to be objective and active person perceivers. They are able to accept and trust their own perceptions, feelings and judgements.

Bach (1973) and Matkom (1963) studied their subjects at different levels of adjustment as it related to person perceptual accuracy. They found that maladjusted subjects had serious problems in accurately perceiving persons. It appeared that they tended to rely on their own subjective feelings rather than on objective cues from the situation itself. Hjelle (1968) attempted to improve on a
study by Vingoe and Antonoff (1968) by replicating their work. Hjelle hypothesized that good judges compared to poor judges would score significantly higher on the California Psychological Inventory scales of (1) Flexibility, (2) Good Impression, (3) Psychological-mindedness, (4) Social Presence, (5) Tolerance, and (6) Well-Being. The results indicated the good judges scored significantly higher on the Psychological Mindedness, Tolerance and Well-Being scales. The other three scales were short of significance but were in the direction predicted by the hypothesis. Hjelle (1968) concluded that "good judges are responsive to subtle social attitudes structure, and are free of excessive complaints, worries and self-doubts" (p. 580).

Dambach (1978) in a study of the relationship of interpersonal perception and psychological adjustment concluded that improvement in interpersonal perceptual accuracy can produce improvement of the cognitive component of psychological adjustment in the sense of responsibility for self, sensitivity to others and flexibility in thinking.

In summary, research does indicate a tentative relationship between interpersonal perception accuracy and psychological adjustment. Personality theories and experimental results support the conclusion that improving interpersonal perception accuracy will also improve psychological adjustment.
CHAPTER III

METHODOLOGY

Population and Sample

The reference population used in this study was substance abuse patients seeking treatment for their alcohol and drug problems at a Veterans Administration (V.A.) Medical Center, substance abuse treatment unit. These patients were males who served in the military services during the Korean conflict era, Vietnam conflict era or post Vietnam era. They were between the ages of twenty-one and fifty-seven, and they were mainly unemployed men from middle to lower socio-economic levels.

Those subjects having at least a ninth grade reading level as determined by a reading test (Burns and Roe, 1980), were invited to participate in this study. This level of reading ability was important because of the bibliotherapy aspects of the treatment model used in this investigation. (See Table 1 for a detailed demographic description of the sample.)

A sample of 35 subjects were invited to participate in this study. Eighteen subjects were assigned to the treatment group (GBPT) and 17 subjects were assigned to the regular psychotherapy treatment group (RP). All subjects in both the experimental group and the RP group were randomly assigned to small groups of four to seven as a function of their enrollment at the time of referral for group therapy. Assignment of treatment to the GBPT and RP groups in this
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<td>21 - 30 Years</td>
<td>7 28%</td>
</tr>
<tr>
<td>31 - 40 Years</td>
<td>13 52%</td>
</tr>
<tr>
<td>41 - 50 Years</td>
<td>1 4%</td>
</tr>
<tr>
<td>50 - 57 Years</td>
<td>4 16%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>Some College</td>
<td>9 36%</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>14 56%</td>
</tr>
<tr>
<td>Less than High School</td>
<td>2 8%</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>2 8%</td>
</tr>
<tr>
<td>Divorced</td>
<td>12 48%</td>
</tr>
<tr>
<td>Single</td>
<td>8 32%</td>
</tr>
<tr>
<td>Separated</td>
<td>2 8%</td>
</tr>
<tr>
<td>Widowed</td>
<td>1 4%</td>
</tr>
<tr>
<td><strong>Number of Treatments</strong></td>
<td></td>
</tr>
<tr>
<td>Prior to this Treatment</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>8 32%</td>
</tr>
<tr>
<td>1</td>
<td>11 44%</td>
</tr>
<tr>
<td>2 - 4</td>
<td>1 4%</td>
</tr>
<tr>
<td>5 or more</td>
<td>5 20%</td>
</tr>
<tr>
<td><strong>Substance Abused</strong></td>
<td></td>
</tr>
<tr>
<td>Alcohol Only</td>
<td>15 60%</td>
</tr>
<tr>
<td>Drugs Only</td>
<td>2 8%</td>
</tr>
<tr>
<td>Multiple, Including Alcohol</td>
<td>8 32%</td>
</tr>
<tr>
<td><strong>Probation Status or Have Legal Problems Pending</strong></td>
<td>12 48%</td>
</tr>
<tr>
<td><strong>Type of Community in Which Patients Live</strong></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>14 56%</td>
</tr>
<tr>
<td>Rural</td>
<td>11 44%</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>21 84%</td>
</tr>
<tr>
<td>Employed</td>
<td>2 8%</td>
</tr>
<tr>
<td>Disabled</td>
<td>1 4%</td>
</tr>
<tr>
<td>Retired</td>
<td>1 4%</td>
</tr>
<tr>
<td><strong>Admitted Experiencing Blackouts and Shakes</strong></td>
<td>22 88%</td>
</tr>
<tr>
<td><strong>Number of Years of Substance Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>2 - 4 Years</td>
<td>9 36%</td>
</tr>
<tr>
<td>5 - 12 Years</td>
<td>8 32%</td>
</tr>
<tr>
<td>13 Years or More</td>
<td>8 32%</td>
</tr>
</tbody>
</table>

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manner, was accomplished by using a table of random numbers (Wert, Nejdt and Ahmann, 1966).

A total of 5 members from each treatment group did not complete the program. Thirteen members of GBPT and 12 members of RP groups completed the program.

Brief Perception Therapy, developed by Bullmer (1980), is a model of therapy using cognitive-didactic methods to improve the subject's psychological adjustment by improving interpersonal perceptual accuracy. This therapeutic approach provides an opportunity for each patient to relate his own problem areas to the concepts of interpersonal perceptual accuracy. Each patient received a programmed text, *The Art of Empathy* (Bullmer, 1975). Twelve sessions of GBPT were used to cover the six units of the text. Each session was ninety minutes long and was structured into three major sections: (1) the topic; (2) a personalization exercise and (3) discussion. GBPT was a growth group or a socio-process group as defined by Betz (1977). Homework assignments were given during each session and an opportunity was provided for reporting on the assignment from the preceding session. In addition to the twelve regular sessions of GBPT, eight one-hour enrichment and review sessions were held to make sure the members of each group learned the material in the programmed text. The proficiency tests provided in the text were used as a measure of the level of comprehension each patient could demonstrate in his understanding of the concepts of improving interpersonal perception. An achievement level of eighty
percent was the goal toward which the patients worked. When this goal was not reached additional review was assigned until a better understanding of the material was achieved. Those who desired individual help and counseling scheduled private sessions with the therapist. A manual was developed by the GBPT therapist (see Appendix C) to give structure to his leadership of the sessions and to insure that each small group received the material in a systematic order.

The RP group also received twelve sessions of treatment. This treatment was the psychotherapy offered in the substance abuse treatment program. Each patient had the opportunity to discuss his feelings and problems in the small group setting and deal with relationships which had been complicated by substance abuse. Eight additional sessions were scheduled for RP groups also. In these sessions the patients worked on the practical aspects of dealing with their self-defeating behaviors using an outline developed by Cudney (1978) on eliminating self-defeating behaviors. These self-defeating behavior sessions were a regular part of the psychotherapy treatment. Individual therapy was also made available for those who requested private sessions.

All therapists working with subjects in both GBPT and RP groups completed self-ratings on a Therapist Orientation Sheet consisting of five point scales in twenty-four areas and twenty specific therapeutic techniques. These instruments were adapted by Paul (1966) who derived them from Sundland and Barker (1962). The
therapists were masters level psychologists and social workers working in the Substance Abuse Treatment Program in the V.A. Medical Center. In addition to completing the Therapist Orientation Sheet, each therapist was asked to list the three authors who have been most influential in shaping their attitudes toward therapy and the school or schools of psychotherapy to which he feels most related. They reported the number of years each had worked as therapists.

Five therapists participated in this study. The GBPT therapist was a masters level psychologist. Two of the RP therapists were masters level social workers and two were masters level psychologists. They each had from 10 to 14 years of experience as therapists. Theoretical orientation ranged from cognitive to psychodynamic. On the Orientation Sheet scales, the therapists differed by responding at opposite ends of the scales on 9 of the 24 areas covered: No. 3, activity-structure; No. 5, relationship-structure; No. 7, relationship-therapist actions; No. 9, goals-source; No. 15, therapeutic gains-emotional understanding (affective awareness); Nos. 20 and 21, focus of therapeutically significant topics; No. 23, theory of motivation; and No. 24, curative aspect of the therapist. There were wide differences in attitudinal orientation in some areas. On the other hand in 13 different areas out of the 24, the responses were clustered in one or two sections of the scale. A similar pattern of responses was reported on the use of 20 specific techniques in therapy. (See Appendix B for summary tables on therapist orientation).
Data Collection

This study was designed to compare changes within groups over time and treatment, and between groups after treatment. The independent variables were the two types of group therapy. The dependent variables were the patient's performance on the pre- and post-test battery of test measurements. Pre-treatment and post-treatment instruments administered included the Affective Sensitivity Scale, the Minnesota Multiphasic Personality Inventory, the Profile of Mood States and the Tennessee Self Concept Scale. See procedural flow chart (Appendix C) for the schedule followed during the research.

Description of the Instrumentation

Four scales were used in the study. The descriptions of these scales follow.

Affective Sensitivity Scale (ASS)

This instrument was developed by Kagan and Krathwohl (1967) at Michigan State University. The scale is designed to measure subjects' sensitivity to the affective states of other individuals. A series of video taped excerpts from actual counseling interviews were viewed by the subjects. They were then asked to respond by selecting from three possible choices a response which best represented their perception of the "feelings" expressed by the patients during the final moments of the scene. In this study the
scale was used to evaluate the accuracy of the subjects' perception of the affective meaning of others.

Form B of the scale was used in the study. This form consists of sixty-six multiple choice questions. Over a two-week period, the reliability of the instrument was reported as .70 to .80. Validity is rated at .75 (Campbell, Kagan and Krathwohl, 1971; Danish and Kagan, 1971).

This scale has been found to be responsive to experiences designed to increase interpersonal perceptual skills (Bullmer, 1970, 1972). Mean scores for untreated subjects have been reported by Bullmer (1970), Damback (1979) and Scalese (1978). These data (N = 279) indicate mean score norms for undergraduate college students to be 31.86 with a standard deviation of 5.81.

Profile of Mood States (POMS)

This instrument was developed by McNair, Lorr and Droppleman (1971) to measure six identifiable moods, or affective states: (1) tension-anxiety; (2) depression-dejection; (3) anger-hostility; (4) vigor-activity; (5) fatigue-inertia; and (6) confusion-bewilderment. The POMS is a five-point adjective rating scale consisting of sixty-five factor-analyzed items designed primarily as a method of measuring mood states and assessing changes in psychiatric outpatients. The internal consistency of the instrument was reported to be high (McNair, Lorr, and Droppleman, 1971) with the reliability coefficient ranging from .84 to .95. Although test-retest
reliability coefficients are lower than those expected for relatively stable personality traits, they are consistent with what might be expected for an instrument measuring less stable mood swings. Six independent factor analytic replications were conducted in the development of the POMS and support the factorial validity of the six mood factors.

Brief psychotherapy studies have given supportive evidence for the predictive and constructive validity of the POMS (Lorr, McNair, Weinstein, Michaux and Raskin, 1961; Lorr, McNair and Weinstein, 1964; Haskell, Pugatch and McNair, 1969). In these studies, one or more of the factor scores have proven to be sensitive to change associated with psychotherapy. Content validity of the factor scores was also substantiated for separate items defining each mood scale.

**Minnesota Multiphasic Personality Inventory (MMPI)**

The Minnesota Multiphasic Personality Inventory, a 550 item instrument, was developed by Hathaway and McKinley (1967) "to provide an objective assessment of some of the major personality characteristics that effect personal and social adjustment" (p. 7). The MMPI has been the most widely used personality inventory since its development about forty years ago (Anastasi, 1976; Dahlstrom and Dahlstrom, 1980). There are ten clinical scales and four validity scales which provide for differential diagnosis and evaluation in twenty-five different categories (Hathaway and McKinley, 1967).

The reliability of the individual scales on the basis of
test-retest procedures, ranges from .50 to .90 (Kleinmuntz, 1967). The uniqueness of this instrument is its power to discriminate and make broad nosological distinctions. In terms of validity, Hathaway and McKinley (1967) found that a high score on a scale tended to positively predict or estimate the corresponding clinical assessment in more than sixty percent of new psychiatric patients.

**Tennessee Self Concept Scale (TSCS)**

This instrument is comprised of one hundred statements to be rated on a five-point scale. It was developed by Fitts (1965) to provide a description of the self concept which is "simple for the subject, widely applicable, well standardized and multi-dimensional" (p. 1). The TSCS has been used in a broad spectrum of populations in measuring psychological adjustment. The Clinical Research Form was used for this study.

Reliability studies suggest that the test-retest correlations on all scales range between .60 and .92. Forty-eight different scores can be obtained from the test, and of these only three had reliabilities less than .65.

The validity of the scale was assured by several procedures. Items were judged by seven psychologists as to the three by five dimensional scheme and as to whether they were positive or negative. Only items on which perfect agreement was obtained were kept. In another procedure the test differentiated psychiatric patients from norm groups at $p < .001$ on almost all scales. Studies (Congdon,
1959; Wayne, 1963) of this kind have all indicated highly significant differences between patients and nonpatients.

The Tennessee Self Concept Scale has been correlated with the Minnesota Multiphasic Personality Inventory, the Edwards Personal Preference Schedule, the Taylor Anxiety Scale and the California F Scale (McGee, 1960; Berman, 1974; Hall, 1964; Wayne, 1963).

Criteria Measurement

All subjects received pre-treatment and post-treatment administrations of the Affective Sensitivity Scale, the Minnesota Multiphasic Personality Inventory, the Profile of Mood States and the Tennessee Self Concept Scale. Baseline data were collected from both the GBPT group and the RP group by four additional administrations of the POMS during treatment.

Operational Definitions as Used in This Study

Perception is a process of deriving information from the environment and elaborating and interpreting the information so as to yield organization and meaning (Dember, 1979). Interpersonal perception is a process by which an individual makes inferences concerning the internal as well as the external properties of another person.

Interpersonal perceptual accuracy was operationally defined as the scores achieved on the Affective Sensitivity Scale.

For purposes of this study, psychological scales were used as a
measure of psychological adjustment. These measures of psychological adjustment included the Minnesota Multiphasic Personality Inventory, the Profile of Mood States, and the Tennessee Self-Concept Scale.

Cognitive Therapy, in its broadest sense, consists of approaches which alleviate psychological distress and improves psychological adjustment through the medium of correcting faulty conceptions and perceptions.

Operational Hypotheses Developed for This Study

With the research questions in mind, the following operational hypotheses have been developed.

Hypothesis 1. For substance abuse patients receiving GBPT there will be a statistically significant improvement between the pretreatment and the posttreatment scores on the Affective Sensitivity Scale in the measurement of interpersonal perceptual accuracy.

Hypothesis 2. For substance abuse patients receiving GBPT there will be a statistically significant improvement between the pretreatment and the posttreatment scores on the Minnesota Multiphasic Personality Inventory, the Profile of Mood States, and the Tennessee Self-Concept Scale in measurements of psychological adjustment.

Hypothesis 3. Substance abuse patients receiving GBPT compared to substance abuse patients receiving Regular Therapy (RP) will report a statistically significant improvement between the pretreatment and the posttreatment scores on the Affective Sensitivity Scale in the measurement of interpersonal perceptual accuracy.
**Hypothesis 4.** Substance abuse patients receiving GBPT compared to substance abuse patients receiving RP will report a statistically significant improvement between the pretreatment and posttreatment scores on the Minnesota Multiphasic Personality Inventory, the Profile of Mood States, and the Tennessee Self-Concept Scale in measurement of psychological adjustment.

**Data Analysis**

Analysis of the data in this study was confined primarily to the $t$ test of a difference between two means. Group means were computed for all pretreatment and posttreatment scores on the Affective Sensitivity Scale, the Minnesota Multiphasic Personality Inventory, the Profile of Mood States and the Tennessee Self Concept Scale for both the Brief Perception Therapy group and the Regular Psychotherapy group. The $t$ tests (two tailed) were used to determine significant differences between the pretreatment mean scores and the posttreatment mean scores for both groups. The same procedure was used to determine significant differences between the posttreatment mean scores of each group (Hayes, 1963).

For the purposes of this investigation, the .05 level of significance was established. Probability values equal to or less than .05 were considered to be representative of significant differences between the test results of the two therapy groups.
Summary

A sample of twenty-five subjects in a Substance Abuse Treatment Program were divided into two groups. One group of twelve subjects received the usual psychotherapy treatment (RP) offered in the program. The other group of thirteen subjects received the Brief Perception Therapy (GBPT). All subjects received the treatment in small groups of five to seven members. A design based on pre- and posttreatment measures was used to study the effectiveness of the two kinds of treatment in improving interpersonal perception accuracy and psychological adjustment. Interpersonal perception accuracy was measured by the affective sensitivity scale and psychological adjustment was measured by the Minnesota Multiphasic Personality Inventory, the Tennessee Self Concept Scale, and the Profile of Mood States. The data were then subjected to statistical analysis using the t test to determine differences between pretreatment and posttreatment mean scores for each group.
CHAPTER IV

ANALYSIS OF THE DATA

Introduction

Some studies have presented evidence that there is a relationship between interpersonal perception accuracy and psychological adjustment. Results of other studies have suggested that in substance abuse populations serious social and psychological problems interact with problems of interpersonal perception accuracy. The purpose of this study was to determine whether Group Brief Perception Therapy (GBPT) in a substance abuse population would improve interpersonal perception accuracy and psychological adjustment. A GBPT group was compared with a Regular Therapy (RP) group to determine if GBPT was more effective than RP in improving interpersonal perception accuracy and psychological adjustment in a substance abuse population.

In Chapter Four an analysis of the data is presented. Results are reported comparing the two groups in the following sequence: (1) findings are reported comparing groups prior to group therapy (2) findings are reported comparing differences within the experimental group (GBPT) over time and treatment (3) findings are reported comparing differences between the experimental (GBPT) groups and comparison (RP) groups after treatment. (4) Mood affect levels for each group during treatment are also reported.
Sample Data

The final research sample consisted of twenty-five subjects who were patients seeking help for their substance abuse problems in a substance abuse treatment program. Thirteen of these subjects received Group Brief Perception Therapy (GBPT) in small groups while twelve of these subjects received the Regular Psychotherapy (RP) treatment in small groups. The subjects were randomly assigned to each group as a function of their enrollment at the time of referral to group therapy.

Comparison of Groups Before Therapy

It was assumed that the two sample groups represented a single homogeneous normally distributed population. To establish that the two groups comprising the research sample were indeed the result of random sampling from a single homogeneous population, a two tailed $t$ test was used to determine any significant differences in the pretest mean scores.

In Table 2 summary data is presented on pretest mean differences on the Affective Sensitivity Scale for the GBPT and RP groups.
TABLE 2

A Comparison of GBPT and RP Pretest Differences on the Affective Sensitivity Scale

<table>
<thead>
<tr>
<th>GBPT MEAN</th>
<th>STANDARD DEVIATION</th>
<th>RP MEAN</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.15</td>
<td>3.287</td>
<td>27.50</td>
<td>4.602</td>
<td>1.040</td>
</tr>
</tbody>
</table>

*p .05 t 23 = + 2.069

As evidenced in Table 2 there was no significant difference in the mean scores on the pretest administration of the Affective Sensitivity Scale to the GBPT and the RP groups.

In tables 3, 4, and 5 summary data is presented on pretest mean differences on the Minnesota Multiphasic Personality Inventory (MMPI), the Tennessee Self Concept Scale (TSCS) and the Profile of Mood States (POMS) for the GBPT and RP groups.
TABLE 3

A Comparison of GBPT and RP Pretest Differences on the MMPI

<table>
<thead>
<tr>
<th>SCALE</th>
<th>GBPT MEANS</th>
<th>STANDARD DEVIATION</th>
<th>RP MEANS</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>46.92</td>
<td>5.545</td>
<td>46.08</td>
<td>6.156</td>
<td>.3589</td>
</tr>
<tr>
<td>F</td>
<td>65.77</td>
<td>18.290</td>
<td>64.25</td>
<td>12.240</td>
<td>.2419</td>
</tr>
<tr>
<td>K</td>
<td>48.62</td>
<td>8.569</td>
<td>50.75</td>
<td>8.346</td>
<td>.6301</td>
</tr>
<tr>
<td>Hs</td>
<td>61.15</td>
<td>15.910</td>
<td>62.08</td>
<td>15.590</td>
<td>.1474</td>
</tr>
<tr>
<td>D</td>
<td>67.92</td>
<td>14.760</td>
<td>71.50</td>
<td>17.820</td>
<td>.5482</td>
</tr>
<tr>
<td>Hy</td>
<td>62.31</td>
<td>12.130</td>
<td>66.58</td>
<td>10.040</td>
<td>.9552</td>
</tr>
<tr>
<td>Pd</td>
<td>76.92</td>
<td>13.670</td>
<td>78.17</td>
<td>9.571</td>
<td>.2613</td>
</tr>
<tr>
<td>Mf</td>
<td>63.85</td>
<td>10.370</td>
<td>60.92</td>
<td>8.273</td>
<td>.7765</td>
</tr>
<tr>
<td>Pa</td>
<td>63.46</td>
<td>16.250</td>
<td>68.83</td>
<td>13.230</td>
<td>.9018</td>
</tr>
<tr>
<td>Pt</td>
<td>67.00</td>
<td>12.570</td>
<td>70.42</td>
<td>11.710</td>
<td>.7015</td>
</tr>
<tr>
<td>Sc</td>
<td>74.85</td>
<td>21.370</td>
<td>76.58</td>
<td>20.630</td>
<td>.2065</td>
</tr>
<tr>
<td>Ma</td>
<td>69.54</td>
<td>10.060</td>
<td>71.08</td>
<td>16.220</td>
<td>.2888</td>
</tr>
<tr>
<td>Si</td>
<td>53.62</td>
<td>10.440</td>
<td>52.83</td>
<td>11.930</td>
<td>.1748</td>
</tr>
</tbody>
</table>

*p = .05 \( t_{23} = \pm 2.069 \)

Evidence in Table 3, indicates no significant difference in the mean scores on the subscales of the pretest administration of the MMPI to the GBPT and RP groups.
### TABLE 4

A Comparison of GBPT and RP Pretest Differences on the TSCS

<table>
<thead>
<tr>
<th>SCALE</th>
<th>GBPT MEANS</th>
<th>STANDARD DEVIATION</th>
<th>RP MEANS</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Criticism</td>
<td>38.310</td>
<td>4.768</td>
<td>37.170</td>
<td>3.857</td>
<td>.6543</td>
</tr>
<tr>
<td>T/F</td>
<td>1.307</td>
<td>.564</td>
<td>1.159</td>
<td>.231</td>
<td>.8421</td>
</tr>
<tr>
<td>Net Conflict</td>
<td>9.769</td>
<td>16.860</td>
<td>2.583</td>
<td>8.174</td>
<td>1.3370</td>
</tr>
<tr>
<td>Total Conflict</td>
<td>35.460</td>
<td>10.190</td>
<td>29.580</td>
<td>8.447</td>
<td>1.5630</td>
</tr>
<tr>
<td>Total Positive</td>
<td>298.700</td>
<td>34.490</td>
<td>292.400</td>
<td>36.120</td>
<td>.4443</td>
</tr>
<tr>
<td>Row 1</td>
<td>111.800</td>
<td>10.800</td>
<td>110.800</td>
<td>13.680</td>
<td>.2064</td>
</tr>
<tr>
<td>Row 2</td>
<td>87.770</td>
<td>16.610</td>
<td>83.580</td>
<td>13.160</td>
<td>.6944</td>
</tr>
<tr>
<td>Row 3</td>
<td>99.080</td>
<td>11.420</td>
<td>98.000</td>
<td>15.360</td>
<td>.2001</td>
</tr>
<tr>
<td>Column A</td>
<td>61.080</td>
<td>8.261</td>
<td>57.170</td>
<td>11.660</td>
<td>.9737</td>
</tr>
<tr>
<td>Column B</td>
<td>58.230</td>
<td>9.373</td>
<td>57.830</td>
<td>7.837</td>
<td>.1145</td>
</tr>
<tr>
<td>Column C</td>
<td>56.460</td>
<td>8.657</td>
<td>55.580</td>
<td>9.876</td>
<td>.2369</td>
</tr>
<tr>
<td>Column D</td>
<td>60.310</td>
<td>8.138</td>
<td>55.170</td>
<td>11.400</td>
<td>1.3060</td>
</tr>
<tr>
<td>Column E</td>
<td>63.310</td>
<td>6.872</td>
<td>62.500</td>
<td>5.729</td>
<td>.3177</td>
</tr>
<tr>
<td>Variability Total</td>
<td>49.540</td>
<td>11.930</td>
<td>54.500</td>
<td>15.990</td>
<td>.8841</td>
</tr>
<tr>
<td>V. Column</td>
<td>30.920</td>
<td>9.041</td>
<td>32.830</td>
<td>12.320</td>
<td>.4445</td>
</tr>
<tr>
<td>V. Row</td>
<td>18.620</td>
<td>6.252</td>
<td>21.670</td>
<td>5.959</td>
<td>1.2470</td>
</tr>
</tbody>
</table>

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TABLE 4 (Continued)

A Comparison of GBPT and RP Pretest Differences on the TSCS

<table>
<thead>
<tr>
<th>SCALE</th>
<th>GBPT MEANS</th>
<th>STANDARD DEVIATION</th>
<th>RP MEANS</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>D 5</td>
<td>15.380</td>
<td>12.760</td>
<td>12.000</td>
<td>13.300</td>
<td>.9796</td>
</tr>
<tr>
<td>D 4</td>
<td>25.620</td>
<td>10.130</td>
<td>30.580</td>
<td>9.558</td>
<td>1.2590</td>
</tr>
<tr>
<td>D 3</td>
<td>28.620</td>
<td>7.309</td>
<td>23.750</td>
<td>9.564</td>
<td>1.4360</td>
</tr>
<tr>
<td>D 2</td>
<td>20.620</td>
<td>9.251</td>
<td>22.500</td>
<td>5.036</td>
<td>.6247</td>
</tr>
<tr>
<td>D 1</td>
<td>9.769</td>
<td>6.954</td>
<td>11.170</td>
<td>7.234</td>
<td>.4924</td>
</tr>
<tr>
<td>Defensive Positive</td>
<td>48.000</td>
<td>11.520</td>
<td>45.830</td>
<td>12.120</td>
<td>.4583</td>
</tr>
<tr>
<td>General Maladjustment</td>
<td>83.620</td>
<td>10.200</td>
<td>82.500</td>
<td>10.610</td>
<td>.2679</td>
</tr>
<tr>
<td>Psychosis</td>
<td>49.770</td>
<td>4.867</td>
<td>49.250</td>
<td>4.330</td>
<td>.2808</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>57.150</td>
<td>12.580</td>
<td>56.170</td>
<td>10.310</td>
<td>.2135</td>
</tr>
<tr>
<td>Neurosis</td>
<td>69.850</td>
<td>11.930</td>
<td>70.080</td>
<td>13.300</td>
<td>.0470</td>
</tr>
<tr>
<td>Personality Integration</td>
<td>8.231</td>
<td>3.919</td>
<td>9.167</td>
<td>4.282</td>
<td>.5707</td>
</tr>
</tbody>
</table>

*p .05 t 23 = ± 2.069

Evidence in Table 4, indicates no significant difference in the mean scores on the subscales of the pretest administration of the TSCS to the GBPT and RP groups.
TABLE 5

A Comparison of GBPT and RP Pretest Differences on the POMS

<table>
<thead>
<tr>
<th></th>
<th>GBPT MEANS</th>
<th>STANDARD DEVIATION</th>
<th>RP MEANS</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tension-Anxiety</td>
<td>43.69</td>
<td>6.250</td>
<td>47.08</td>
<td>7.879</td>
<td>1.1970</td>
</tr>
<tr>
<td>Depression-Rejection</td>
<td>46.92</td>
<td>8.119</td>
<td>48.75</td>
<td>4.845</td>
<td>.6757</td>
</tr>
<tr>
<td>Anger-Hostility</td>
<td>43.23</td>
<td>4.935</td>
<td>46.58</td>
<td>7.562</td>
<td>1.2900</td>
</tr>
<tr>
<td>Vigor-Activity</td>
<td>57.23</td>
<td>11.080</td>
<td>57.33</td>
<td>7.390</td>
<td>.0270</td>
</tr>
<tr>
<td>Fatigue-Inertia</td>
<td>47.15</td>
<td>8.112</td>
<td>49.83</td>
<td>5.654</td>
<td>.9502</td>
</tr>
<tr>
<td>Confusion-Bewilderment</td>
<td>44.00</td>
<td>5.986</td>
<td>45.25</td>
<td>5.545</td>
<td>.5403</td>
</tr>
</tbody>
</table>

*p .05 t 23 = ± 2.069

The data in Table 5 indicates no significant differences in the mean subscores on the pretest administration of the POMS to the GBPT and RP groups.

It was concluded therefore, from the summary data presented in Table 2 – 5 that the GBPT and RP groups met the requirement of random assignment from a homogeneous population. There were no significant differences between the mean scores on pretest measurements of interpersonal perception accuracy and psychological adjustment.
Research Findings

The research findings are presented in the following manner:

1) the null hypotheses are stated, (2) the data are presented, and (3) the findings are discussed.

H01: There will be no difference between the results of pretest and posttest responses of the GBPT group on measures of interpersonal perception accuracy.

<table>
<thead>
<tr>
<th>TABLE 6</th>
<th>Comparison of GBPT Pre-Posttest Differences on the Affective Sensitivity Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PRETEST MEAN</td>
</tr>
<tr>
<td>---------</td>
<td>---------------</td>
</tr>
<tr>
<td></td>
<td>29.15</td>
</tr>
</tbody>
</table>

*p .05 t 24 = ± 2.064

As evidenced in Table 6 there were no significant differences between pretest and posttest responses of the GBPT group on measures of interpersonal perception accuracy. Therefore, the results of this analysis do support the Null Hypothesis stating that no difference will be found between results of pretest and posttest responses of the GBPT group on measures of interpersonal perception.
There will be no difference between the results of the pretest and posttest responses of the GBPT group on measures of psychological adjustment.

**TABLE 7**

Comparison of GBPT Pre-Posttest Differences on the MMPI

<table>
<thead>
<tr>
<th>SCALE</th>
<th>PRETEST MEANS</th>
<th>STANDARD DEVIATION</th>
<th>POSTTEST MEANS</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>46.92</td>
<td>5.545</td>
<td>44.62</td>
<td>3.070</td>
<td>-1.313</td>
</tr>
<tr>
<td>F</td>
<td>65.77</td>
<td>18.290</td>
<td>62.54</td>
<td>14.870</td>
<td>-0.4943</td>
</tr>
<tr>
<td>K</td>
<td>48.62</td>
<td>8.569</td>
<td>49.54</td>
<td>10.810</td>
<td>0.2413</td>
</tr>
<tr>
<td>Hs</td>
<td>61.15</td>
<td>15.910</td>
<td>55.15</td>
<td>15.030</td>
<td>-0.9887</td>
</tr>
<tr>
<td>D</td>
<td>67.92</td>
<td>14.760</td>
<td>61.77</td>
<td>10.700</td>
<td>-1.217</td>
</tr>
<tr>
<td>Hy</td>
<td>62.31</td>
<td>12.130</td>
<td>57.15</td>
<td>14.190</td>
<td>-0.9951</td>
</tr>
<tr>
<td>Pd</td>
<td>76.92</td>
<td>13.670</td>
<td>75.00</td>
<td>14.710</td>
<td>-0.3453</td>
</tr>
<tr>
<td>Mf</td>
<td>63.85</td>
<td>10.370</td>
<td>61.54</td>
<td>8.412</td>
<td>-0.6232</td>
</tr>
<tr>
<td>Pa</td>
<td>63.46</td>
<td>16.250</td>
<td>60.31</td>
<td>16.600</td>
<td>-0.4896</td>
</tr>
<tr>
<td>Pt</td>
<td>67.00</td>
<td>12.570</td>
<td>64.31</td>
<td>13.750</td>
<td>-0.5211</td>
</tr>
<tr>
<td>Sc</td>
<td>74.85</td>
<td>21.370</td>
<td>68.08</td>
<td>22.230</td>
<td>-0.7916</td>
</tr>
<tr>
<td>Ma</td>
<td>69.54</td>
<td>10.060</td>
<td>70.15</td>
<td>9.072</td>
<td>0.1638</td>
</tr>
<tr>
<td>Si</td>
<td>53.62</td>
<td>10.440</td>
<td>51.69</td>
<td>8.779</td>
<td>-0.5084</td>
</tr>
</tbody>
</table>

*p = .05 \( t_{24} = +2.064 \)
A Comparison of GBPT Pre-Posttest Differences on the TSCS

<table>
<thead>
<tr>
<th>SCALE</th>
<th>PRETEST MEANS</th>
<th>STANDARD DEVIATION</th>
<th>POSTTEST MEANS</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Criticism</td>
<td>38.310</td>
<td>4.768</td>
<td>37.230</td>
<td>4.086</td>
<td>- .6184</td>
</tr>
<tr>
<td>T/F</td>
<td>1.307</td>
<td>.564</td>
<td>1.216</td>
<td>.544</td>
<td>- .4199</td>
</tr>
<tr>
<td>Total Conflict</td>
<td>35.460</td>
<td>10.190</td>
<td>30.000</td>
<td>7.916</td>
<td>-1.5260</td>
</tr>
<tr>
<td>Total Positive</td>
<td>298.700</td>
<td>34.490</td>
<td>323.200</td>
<td>38.560</td>
<td>1.7100</td>
</tr>
<tr>
<td>Row 1</td>
<td>111.800</td>
<td>10.800</td>
<td>119.800</td>
<td>12.470</td>
<td>1.5970</td>
</tr>
<tr>
<td>Row 2</td>
<td>87.770</td>
<td>16.610</td>
<td>96.150</td>
<td>15.230</td>
<td>1.3420</td>
</tr>
<tr>
<td>Row 3</td>
<td>99.080</td>
<td>11.420</td>
<td>107.900</td>
<td>13.300</td>
<td>1.8190</td>
</tr>
<tr>
<td>Column A</td>
<td>61.080</td>
<td>8.261</td>
<td>66.380</td>
<td>10.350</td>
<td>1.4450</td>
</tr>
<tr>
<td>Column B</td>
<td>58.080</td>
<td>9.373</td>
<td>64.460</td>
<td>8.242</td>
<td>1.8000</td>
</tr>
<tr>
<td>Column C</td>
<td>56.460</td>
<td>8.657</td>
<td>61.920</td>
<td>8.674</td>
<td>1.6070</td>
</tr>
<tr>
<td>Column D</td>
<td>60.310</td>
<td>8.138</td>
<td>63.380</td>
<td>9.811</td>
<td>.8703</td>
</tr>
<tr>
<td>Column E</td>
<td>63.310</td>
<td>6.872</td>
<td>67.080</td>
<td>7.522</td>
<td>1.3340</td>
</tr>
<tr>
<td>Variability Total</td>
<td>49.540</td>
<td>11.930</td>
<td>44.690</td>
<td>11.610</td>
<td>-1.0500</td>
</tr>
</tbody>
</table>

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TABLE 8 (Continued)

A Comparison of GBPT Pre-Posttest Differences on the TSCS

<table>
<thead>
<tr>
<th>SCALE</th>
<th>PRETEST MEANS</th>
<th>STANDARD DEVIATION</th>
<th>POSTTEST MEANS</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>V. Column</td>
<td>30.920</td>
<td>9.041</td>
<td>32.830</td>
<td>12.320</td>
<td>.8958</td>
</tr>
<tr>
<td>V. Row</td>
<td>18.620</td>
<td>6.252</td>
<td>16.690</td>
<td>5.879</td>
<td>-.8079</td>
</tr>
<tr>
<td>Distribution</td>
<td>96.540</td>
<td>24.240</td>
<td>95.080</td>
<td>36.120</td>
<td>-.1211</td>
</tr>
<tr>
<td>D 5</td>
<td>15.380</td>
<td>12.760</td>
<td>11.950</td>
<td>13.700</td>
<td>-.6665</td>
</tr>
<tr>
<td>D 4</td>
<td>25.620</td>
<td>10.130</td>
<td>27.770</td>
<td>12.320</td>
<td>.4870</td>
</tr>
<tr>
<td>D 3</td>
<td>28.620</td>
<td>7.309</td>
<td>29.080</td>
<td>14.750</td>
<td>.1071</td>
</tr>
<tr>
<td>D 2</td>
<td>20.620</td>
<td>9.251</td>
<td>19.000</td>
<td>10.760</td>
<td>-.4104</td>
</tr>
<tr>
<td>D 1</td>
<td>9.769</td>
<td>6.954</td>
<td>12.230</td>
<td>11.880</td>
<td>.6449</td>
</tr>
<tr>
<td>Defensive Positive</td>
<td>48.000</td>
<td>11.520</td>
<td>51.310</td>
<td>10.560</td>
<td>.7631</td>
</tr>
<tr>
<td>General Maladjustment</td>
<td>83.620</td>
<td>10.200</td>
<td>91.000</td>
<td>12.800</td>
<td>1.6270</td>
</tr>
<tr>
<td>Psychosis</td>
<td>49.770</td>
<td>4.867</td>
<td>50.310</td>
<td>6.395</td>
<td>.2416</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>57.150</td>
<td>12.580</td>
<td>65.150</td>
<td>9.590</td>
<td>1.8240</td>
</tr>
<tr>
<td>Neurosis</td>
<td>69.850</td>
<td>11.930</td>
<td>76.770</td>
<td>11.500</td>
<td>1.5070</td>
</tr>
<tr>
<td>Personality Integration</td>
<td>8.231</td>
<td>3.919</td>
<td>8.769</td>
<td>4.622</td>
<td>.3204</td>
</tr>
</tbody>
</table>

*p .05 ± 24 = ± 2.064
### TABLE 9

A Comparison of GBPT Pre-Posttest Differences on the POMS

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>PRETEST MEANS</th>
<th>STANDARD DEVIATION</th>
<th>POSTTEST MEANS</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tension-Anxiety</td>
<td>43.69</td>
<td>6.250</td>
<td>37.00</td>
<td>6.028</td>
<td>-2.779*</td>
</tr>
<tr>
<td>Depression-Dejection</td>
<td>46.92</td>
<td>8.119</td>
<td>41.15</td>
<td>5.444</td>
<td>-2.128*</td>
</tr>
<tr>
<td>Anger-Hostility</td>
<td>43.23</td>
<td>4.935</td>
<td>41.54</td>
<td>7.849</td>
<td>-.6581</td>
</tr>
<tr>
<td>Vigor-Activity</td>
<td>57.23</td>
<td>11.080</td>
<td>62.92</td>
<td>8.864</td>
<td>1.4470</td>
</tr>
<tr>
<td>Fatigue-Inertia</td>
<td>47.15</td>
<td>8.112</td>
<td>42.31</td>
<td>10.310</td>
<td>-1.3320</td>
</tr>
<tr>
<td>Confusion-Bewilderment</td>
<td>44.00</td>
<td>5.986</td>
<td>39.77</td>
<td>6.247</td>
<td>-1.7630</td>
</tr>
</tbody>
</table>

*p < .05 t 24 = ± 2.064

Data relevant to the evaluation of Ho2 is found in Tables 7, 8, and 9. As indicated in the report of this data; no significant differences were found between pretest and posttest responses of the GBPT group on the MMPI and TSCS measures of psychological adjustment in Table 7 and 8.

As indicated on Table 9 there were significant differences on two factors of the POMS. The patients in GBPT group reported significant improvement in the level of Tension-Anxiety and Depression-Dejection over time and treatment.

Significant differences indicating improvement in psychological adjustment were found in two factors out of the six on the POMS. The Null Hypotheses Ho2 of no difference was therefore rejected. The data gives some support to the Alternative Hypothesis H2 which states that groups receiving GBPT will experience improved psychological adjustment.

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Ho3 There will be no difference between the results of the posttest responses of the GBPT group and the RP group on measures of interpersonal perception accuracy.

TABLE 10
Comparison of GBPT and RP Posttest Differences on the Affective Sensitivity Scale

<table>
<thead>
<tr>
<th>GBPT MEAN</th>
<th>STANDARD DEVIATION</th>
<th>RP MEAN</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.69</td>
<td>4.767</td>
<td>28.75</td>
<td>4.750</td>
<td>1.019</td>
</tr>
</tbody>
</table>

As evidenced in Table 10 there were no significant differences between the posttest responses of the GBPT group and RP group on measures of interpersonal perception accuracy. Therefore, the Null Hypothesis of no difference cannot be rejected. It is concluded then that the GBPT groups did not differ from RP groups in response to therapy as reported by the measures of interpersonal perception.

Ho4 There will be no difference between the results of posttest responses of the GBPT group and the RP group on measures of psychological adjustment.
### TABLE 11

A Comparison of GBPT and RP Posttest Differences on the MMPI

<table>
<thead>
<tr>
<th>SCALE</th>
<th>POSTTEST MEANS GBPT</th>
<th>STANDARD DEVIATION</th>
<th>POSTTEST MEANS RP</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>44.62</td>
<td>3.070</td>
<td>47.58</td>
<td>6.127</td>
<td>1.5500</td>
</tr>
<tr>
<td>F</td>
<td>62.54</td>
<td>14.870</td>
<td>66.50</td>
<td>16.500</td>
<td>0.6316</td>
</tr>
<tr>
<td>K</td>
<td>49.54</td>
<td>10.810</td>
<td>51.17</td>
<td>10.910</td>
<td>0.3746</td>
</tr>
<tr>
<td>Hs</td>
<td>55.15</td>
<td>15.030</td>
<td>60.08</td>
<td>15.770</td>
<td>0.8003</td>
</tr>
<tr>
<td>D</td>
<td>61.77</td>
<td>10.700</td>
<td>64.25</td>
<td>20.040</td>
<td>0.3906</td>
</tr>
<tr>
<td>Hy</td>
<td>57.15</td>
<td>14.190</td>
<td>62.50</td>
<td>11.930</td>
<td>1.0150</td>
</tr>
<tr>
<td>Pd</td>
<td>75.00</td>
<td>14.710</td>
<td>75.50</td>
<td>14.350</td>
<td>0.0860</td>
</tr>
<tr>
<td>Mf</td>
<td>61.54</td>
<td>8.412</td>
<td>63.00</td>
<td>6.782</td>
<td>0.4756</td>
</tr>
<tr>
<td>Pa</td>
<td>60.31</td>
<td>16.600</td>
<td>67.33</td>
<td>9.355</td>
<td>1.2880</td>
</tr>
<tr>
<td>Pt</td>
<td>64.31</td>
<td>13.750</td>
<td>66.42</td>
<td>16.860</td>
<td>0.3440</td>
</tr>
<tr>
<td>Sc</td>
<td>68.08</td>
<td>22.230</td>
<td>70.67</td>
<td>17.620</td>
<td>0.3210</td>
</tr>
<tr>
<td>Ma</td>
<td>70.15</td>
<td>9.072</td>
<td>72.50</td>
<td>13.940</td>
<td>0.5028</td>
</tr>
<tr>
<td>Si</td>
<td>51.69</td>
<td>8.779</td>
<td>52.42</td>
<td>10.680</td>
<td>0.1859</td>
</tr>
</tbody>
</table>

*p .05 t 23 = ± 2.069

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TABLE 12

A Comparison of GBPT and RP Posttest Differences on the TSCS

<table>
<thead>
<tr>
<th>SCALE</th>
<th>POSTTEST MEANS</th>
<th>STANDARD DEVIATION</th>
<th>POSTTEST MEANS</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Criticism</td>
<td>37.2300</td>
<td>4.086</td>
<td>36.330</td>
<td>5.331</td>
<td>.4747</td>
</tr>
<tr>
<td>T/F</td>
<td>1.2160</td>
<td>.544</td>
<td>1.202</td>
<td>.199</td>
<td>.0816</td>
</tr>
<tr>
<td>Net Conflict</td>
<td>.9231</td>
<td>12.840</td>
<td>2.917</td>
<td>9.774</td>
<td>.4340</td>
</tr>
<tr>
<td>Total Conflict</td>
<td>30.0000</td>
<td>7.916</td>
<td>32.580</td>
<td>8.989</td>
<td>.7640</td>
</tr>
<tr>
<td>Total Positive</td>
<td>323.2000</td>
<td>38.560</td>
<td>309.900</td>
<td>29.480</td>
<td>.9636</td>
</tr>
<tr>
<td>Row 1</td>
<td>119.8000</td>
<td>12.470</td>
<td>118.300</td>
<td>11.080</td>
<td>.1733</td>
</tr>
<tr>
<td>Row 2</td>
<td>96.1500</td>
<td>15.230</td>
<td>90.330</td>
<td>11.940</td>
<td>1.0570</td>
</tr>
<tr>
<td>Row 3</td>
<td>107.9000</td>
<td>13.300</td>
<td>101.300</td>
<td>12.970</td>
<td>1.2680</td>
</tr>
<tr>
<td>Column A</td>
<td>66.3800</td>
<td>10.350</td>
<td>65.250</td>
<td>7.806</td>
<td>.3074</td>
</tr>
<tr>
<td>Column B</td>
<td>64.4600</td>
<td>8.242</td>
<td>61.920</td>
<td>5.143</td>
<td>.9169</td>
</tr>
<tr>
<td>Column C</td>
<td>61.9200</td>
<td>8.674</td>
<td>62.080</td>
<td>7.858</td>
<td>.0482</td>
</tr>
<tr>
<td>Column D</td>
<td>63.3800</td>
<td>9.811</td>
<td>58.420</td>
<td>9.501</td>
<td>1.2840</td>
</tr>
<tr>
<td>Column E</td>
<td>67.0800</td>
<td>7.522</td>
<td>62.250</td>
<td>8.281</td>
<td>1.5270</td>
</tr>
<tr>
<td>Variability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>44.6900</td>
<td>11.610</td>
<td>48.420</td>
<td>11.160</td>
<td>.8163</td>
</tr>
</tbody>
</table>

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A Comparison of GBPT and RP Posttest Differences on the TSCS

<table>
<thead>
<tr>
<th>SCALE</th>
<th>POSTTEST MEANS GBPT</th>
<th>STANDARD DEVIATION</th>
<th>POSTTEST MEANS RP</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>V. Column</td>
<td>32.830</td>
<td>12.320</td>
<td>31.420</td>
<td>10.920</td>
<td>.9173</td>
</tr>
<tr>
<td>V. Row</td>
<td>16.690</td>
<td>5.879</td>
<td>17.000</td>
<td>4.045</td>
<td>.1511</td>
</tr>
<tr>
<td>Distribution</td>
<td>95.080</td>
<td>36.120</td>
<td>96.920</td>
<td>17.440</td>
<td>.1599</td>
</tr>
<tr>
<td>D 5</td>
<td>11.950</td>
<td>13.700</td>
<td>9.417</td>
<td>5.791</td>
<td>.5864</td>
</tr>
<tr>
<td>D 4</td>
<td>27.770</td>
<td>12.320</td>
<td>33.330</td>
<td>8.305</td>
<td>1.3130</td>
</tr>
<tr>
<td>D 3</td>
<td>29.080</td>
<td>14.750</td>
<td>24.830</td>
<td>10.910</td>
<td>.8119</td>
</tr>
<tr>
<td>D 2</td>
<td>19.000</td>
<td>10.760</td>
<td>20.080</td>
<td>6.142</td>
<td>.3055</td>
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<tr>
<td>D 1</td>
<td>12.230</td>
<td>11.880</td>
<td>12.330</td>
<td>7.024</td>
<td>.0260</td>
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<tr>
<td>Defensive Positive</td>
<td>51.310</td>
<td>10.560</td>
<td>48.250</td>
<td>10.370</td>
<td>.7295</td>
</tr>
<tr>
<td>General Maladjustment</td>
<td>91.000</td>
<td>12.800</td>
<td>87.420</td>
<td>9.605</td>
<td>.7863</td>
</tr>
<tr>
<td>Psychosis</td>
<td>50.310</td>
<td>6.395</td>
<td>48.420</td>
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<td>Personality Disorders</td>
<td>65.150</td>
<td>9.590</td>
<td>59.830</td>
<td>8.483</td>
<td>1.4640</td>
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<tr>
<td>Neurosis</td>
<td>76.770</td>
<td>11.500</td>
<td>75.580</td>
<td>11.240</td>
<td>.2684</td>
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<tr>
<td>Personality Integration</td>
<td>8.769</td>
<td>4.622</td>
<td>9.250</td>
<td>3.108</td>
<td>.3025</td>
</tr>
</tbody>
</table>

*p .05 t 23 = ± 2.069
TABLE 13

A Comparison of GBPT and RP Posttest Differences on the POMS

<table>
<thead>
<tr>
<th>SCALE</th>
<th>POST GBPT MEANS</th>
<th>STANDARD DEVIATION</th>
<th>POST RP MEANS</th>
<th>STANDARD DEVIATION</th>
<th>t VALUE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tension-Anxiety</td>
<td>37.00</td>
<td>6.028</td>
<td>37.33</td>
<td>5.836</td>
<td>.1403</td>
</tr>
<tr>
<td>Depression-Dejection</td>
<td>41.15</td>
<td>5.444</td>
<td>40.67</td>
<td>5.140</td>
<td>.2296</td>
</tr>
<tr>
<td>Anger-Hostility</td>
<td>41.54</td>
<td>7.849</td>
<td>42.75</td>
<td>6.717</td>
<td>.4129</td>
</tr>
<tr>
<td>Vigor-Activity</td>
<td>62.92</td>
<td>8.864</td>
<td>63.33</td>
<td>4.793</td>
<td>.1421</td>
</tr>
<tr>
<td>Fatigue-Inertia</td>
<td>42.31</td>
<td>10.310</td>
<td>42.00</td>
<td>5.452</td>
<td>.0671</td>
</tr>
<tr>
<td>Confusion-Bewilderment</td>
<td>39.77</td>
<td>6.247</td>
<td>38.58</td>
<td>6.543</td>
<td>.4636</td>
</tr>
</tbody>
</table>

*p < .05 \( t_{23} = \pm 2.069 \)

Data relevant to the evaluation of Ho4 is found in Tables 11, 12 and 13. The report of this data indicates that no significant differences were found between posttest responses of the GBPT group and the RP group on the MMPI, the TSCS and the POMS measures of psychological adjustment. Therefore, the Hypothesis of no differences cannot be rejected. It is concluded then that the GBPT group did not differ from the RP group in their responses to measures of psychological adjustment after treatment.
Tables 14 and 15 report the mean scores on the six administrations of the POMS to each group. These results show a steady or slow decline in the levels on Tension-Anxiety, Depression-Rejection, Anger-Hostility, Fatigue-Inertia and Confusion-Bewilderment in both groups throughout the three weeks of therapy. Some variability in the level of Vigor-Activity is reported by both groups, however the trend is toward increased levels in this factor.

**TABLE 14**

Profile of Mood States Results For GBPT As a Function of Time in Therapy During Treatment

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tension-Anxiety</td>
<td>43.69</td>
<td>41.92</td>
<td>38.46</td>
<td>39.00</td>
<td>38.38</td>
<td>37.29</td>
</tr>
<tr>
<td>Depression-Rejection</td>
<td>46.92</td>
<td>46.85</td>
<td>44.00</td>
<td>42.91</td>
<td>42.00</td>
<td>41.15</td>
</tr>
<tr>
<td>Anger-Hostility</td>
<td>43.23</td>
<td>43.54</td>
<td>42.46</td>
<td>42.91</td>
<td>42.00</td>
<td>41.54</td>
</tr>
<tr>
<td>Vigor-Activity</td>
<td>57.23</td>
<td>60.77</td>
<td>64.38</td>
<td>62.91</td>
<td>61.69</td>
<td>62.92</td>
</tr>
<tr>
<td>Fatigue-Inertia</td>
<td>47.15</td>
<td>46.77</td>
<td>44.38</td>
<td>41.85</td>
<td>42.69</td>
<td>40.08</td>
</tr>
<tr>
<td>Confusion-Bewilderment</td>
<td>44.00</td>
<td>43.46</td>
<td>42.38</td>
<td>40.77</td>
<td>40.08</td>
<td>39.77</td>
</tr>
</tbody>
</table>
TABLE 15

Profile of Moods States Results For RP Group As a Function of Time in Therapy During Treatment

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tension-Anxiety</td>
<td>47.08</td>
<td>41.92</td>
<td>38.75</td>
<td>38.42</td>
<td>37.42</td>
<td>37.33</td>
</tr>
<tr>
<td>Depression-Rejection</td>
<td>48.75</td>
<td>44.50</td>
<td>42.08</td>
<td>43.83</td>
<td>41.08</td>
<td>40.67</td>
</tr>
<tr>
<td>Anger-Hostility</td>
<td>46.50</td>
<td>44.50</td>
<td>39.50</td>
<td>42.75</td>
<td>43.00</td>
<td>42.75</td>
</tr>
<tr>
<td>Vigor-Activity</td>
<td>57.33</td>
<td>61.25</td>
<td>63.58</td>
<td>62.00</td>
<td>61.75</td>
<td>63.33</td>
</tr>
<tr>
<td>Fatigue-Inertia</td>
<td>49.83</td>
<td>46.25</td>
<td>43.25</td>
<td>43.00</td>
<td>42.92</td>
<td>42.08</td>
</tr>
<tr>
<td>Confusion-Bewilderment</td>
<td>45.25</td>
<td>41.50</td>
<td>40.17</td>
<td>40.33</td>
<td>40.00</td>
<td>38.33</td>
</tr>
</tbody>
</table>

Summary of Results

The results of this research failed to demonstrate that Group Brief Perception Therapy could significantly improve interpersonal perception accuracy in a substance abuse population during a three week program. Within the limits of this study some evidence of improved psychological adjustment was reported as a result of GBPT in the population studied. GBPT subject responses to measures of psychological adjustment did not differ significantly from responses given by subjects in a comparison group who received Regular Psychotherapy.
CHAPTER V

SUMMARY, DISCUSSION, LIMITATIONS AND IMPLICATIONS
FOR FUTURE RESEARCH

Summary

The purpose of this research was to examine the concept of improving interpersonal perceptual accuracy and psychological adjustment using Group Brief Perception Therapy. Bullmer (1980) in her research developed what she called Brief Perception Therapy. Her study suggested the need for further research in using BPT therapy as a method for not only improving interpersonal perception accuracy, but also in improving psychological adjustment. The literature on interpersonal perception in substance abuse populations has suggested that social and psychological maladjustments interact with problems of interpersonal perception accuracy (Pushkash and Quereshi, 1980; Quereshi and Soat, 1976 and Ward, 1975). Brief Perception Therapy in groups was developed for this study using the programmed text, The Art of Empathy (Bullmer, 1975) as a study guide for group members, and structured group format.

The sample for the study consisted of 25 male patients who had requested treatment for their substance abuse problems in a Veterans Administration Medical Center Substance Abuse Treatment Program. They were randomly assigned to two treatment groups, Group Brief Perception Therapy (GBPT) and Regular Psychotherapy (RP) as a function of their enrollment at the time of referral to group
therapy. Twelve sessions of therapy were received by each group over a period of three weeks. GBPT groups used a cognitive-didactic approach. Each patient was given an opportunity to discuss his problems as they related to interpersonal perception accuracy. Each session was ninety minutes long and was structured into three major sections. These sections included a short lecture, a personalization exercise and discussion. Homework assignments were made during each session. An opportunity was given during the following session to report on the assignment. Eight one hour enrichment and review sessions were provided to help group members learn the material in the programmed text. Additional private sessions were provided for those who desired individual help.

The RP groups also received twelve therapy sessions and eight enrichment sessions. This treatment was the psychotherapy offered in the Substance Abuse Treatment Program. Members of the RP group also had the opportunity for individual sessions if they requested personal help.

Pretreatment and posttreatment measures of interpersonal perception accuracy and psychological adjustment were analyzed for both groups. The Affective Sensitivity Scale (Kagan and Krathwohl, 1967) was used to measure interpersonal perception accuracy. The Profile of Mood States (POMS), the Minnesota Multiphasic Personality Inventory (MMPI) and the Tennessee Self Concept Scale (TSCS) were used to measure psychological adjustment. Pretreatment and
posttreatment responses to measures of interpersonal perception accuracy by the GBPT group showed no significant differences. Pretreatment and posttreatment responses to the three measures of psychological adjustment by the GBPT group indicated that there were significant differences on two factors of the POMS. The two factors of Tension-Anxiety and Depression-Rejection on the POMS revealed significant reductions in these mood affect levels. No significant differences appeared in responses to pretest and posttest measures of psychological adjustment on the MMPI and the TSCS for the GBPT group. There were, however, some trends toward significant differences on some dimensions of psychological adjustment which will be discussed in the following section.

Posttest comparisons of the responses of the GBPT and RP groups to measures of interpersonal perception accuracy on the Affective Sensitivity Scale revealed no significant differences. There were no significant differences to be reported between posttest measures of psychological adjustment on the POMS, the MMPI and the TSCS. Trends toward significant differences between the GBPT and RP responses to measures of psychological adjustment as measured by the MMPI and the TSCS were observed.

Discussion

In discussing the results of research done in any environment it is extremely important to recognize the limitations of the study. Generalizations to be made from this study must take into
consideration that it is an "invivo" study. The research was implemented in the midst of an ongoing Substance Abuse Treatment Program. All therapists who participated in the study were well trained masters level psychologists and social workers with 10 to 14 years of experience as group therapists. Therapist orientation and techniques used are reported in responses to the Therapist Orientation Sheet (See Appendix B). Therapists working with RP groups followed the usual procedure in conducting their group sessions using the orientation and techniques described in the Therapist Orientation Sheet. The GBPT therapist adapted his orientation to follow the manual for Group Brief Perception Therapy (See Appendix D).

All group members in both groups participated in all other segments of the program to which they were assigned. These activities included physical fitness, patient education, recreation, occupational therapy, hobby clinics and all necessary contacts with medical and administrative staff.

Patients in both groups responded positively to personal involvement in therapy. Members of GBPT groups verbalized strong interest in the content of the programmed text, The Art of Empathy (Bullmer, 1975). There appeared to be strong motivation to gain a better understanding of interpersonal perception accuracy as it related to their own problems. Several in each small group expressed some frustration that the length of the program was too short and that they would have liked more time to internalize the concepts...
The null hypothesis which stated that there would be no difference between the pretest and posttest responses of GBPT groups on measures of interpersonal perception was accepted. There may be several possible reasons for the failure of the GBPT group to show a significant gain in interpersonal perception accuracy. The following are suggested possible explanations for a lack of significant gain in interpersonal perception accuracy:

1. The overall length of the program was too short to allow for indepth adoption of the concepts presented.

2. The educational level of the subjects was too limited to grasp and internalize the concepts. Bullmer (1970) summarized Allport's (1961) list of nine characteristics of the good person perceiver by suggesting that there are only three major areas of error in person perception accuracy. One of the areas is inadequate intelligence. Perhaps a ninth grade reading level is not an adequate screening instrument to determine intellectual ability.

3. The question might be asked whether the instrument used to measure interpersonal perceptual accuracy was too sophisticated for a substance abuse population to understand. The Affective Sensitivity Scale (Kagan and Krothwohl, 1967) was initially developed at Michigan State University as an instrument to be used in training counselors in their professional development. Perhaps
another instrument could have measured more accurately what
the subjects had learned.

Additional research is necessary to clarify some of the
questions suggested by this study.

The second null hypothesis stated that there would be no
difference between the results of pretest and posttest responses of
the GBPT group on measures of psychological adjustment. These
measures included the POMS, the MMPI and the TSCS. Significant
differences were found on the POMS indicating that levels of
Tension-Anxiety and Depression-Dejection were lowered over time and
treatment. Therefore, the null hypothesis stating that there would
be no difference between the results of pretest and posttest
responses of the GBPT group on measures of psychological adjustment
was rejected. Other factors of this instrument suggested trends
toward a significant increase in Vigor-Activity and a reduction in
Confusion-Bewilderment. Anger-Hostility and Fatigue-Inertia
responses indicated a slight trend in the direction of reduced levels
in these affective states (See Appendix J).

No significant changes were obtained on the subscales on the
MMPI. There appeared to be a trend toward lowering of the depression
level as reported on Scale 2 (See Appendix H). This trend is
supportive of the significant responses observed in the lower
Depression-Dejection factor score of the POMS. There was also some
evidence of a trend toward reduced levels of concern for physical
symptoms of illness as obtained on Scale 1. On Scale 8, the lower
posttest response suggests a trend toward more reality oriented thinking and less need to respond to impulses which may cause problems in interpersonal relationships (Lachar, 1978). The lowered response on Scale 8 of the MMPI supports the trend on factor 6 of the POMS which indicates somewhat lowered levels of Confusion-Bewilderment.

Clopton (1978) in a review of literature on alcoholism and the MMPI reported that most studies show that treatment tends to lower physical discomfort as well as the depression levels. He found also that the length of stay in treatment was a common variable studied. These findings suggest that there may be an optimum length for a treatment program for some substance abusers. Many studies seem to support the finding that substance abuse personality patterns are relatively stable. Clopton (1978) also reported that studies using the MMPI have often found pre- to post- treatment changes lower than statistical significance.

The MMPI profile configuration for the population of this study shows the expected high Scale 4 score which is common in substance abusers. High score Scale 4 individuals tend to be seen as angry, resentful and non-conforming. They may also be seen as immature and unable to profit from their experiences (Duckworth, 1980; and Lachar, 1974). The elevated Scale 4 scores along with a somewhat elevated Scale 9 score increases the probability of behavioral acting out. Lachar (1974) suggests, however, that some more intelligent, more disciplined high energy individuals may be constructively productive. The configuration of scores on the Validity Scales (L, F, and K)
indicates that in general the GBPT groups were able to admit emotional difficulties and seemed to be seeking help. This typical profile reflects the L and K scores below a T-score of 50, and the F score above a T-score of 60 (Duckworth, 1980). The scores forming the configuration of the MMPI profile using Lachar's (1974) version of the Welsh Extended Code are shown for the GBPT groups:

Pretest Code: 4 8' 9 2 7 5 6 3 1 - 0/ L:F-K:
Posttest Code: 4 9' 8 7 2 5 6 - 3 1 0/ L:F-K:

The TSCS responses for the GBPT groups show a number of strong trends toward significant changes. Probably the most important of these trends is reflected in the Total Positive Score which measures the broad concept of self esteem. On the pretest response the score was below the deviant level. The manual suggests that disturbed persons may obtain extreme scores at either end of the continuum, thus appropriate cut-off points for each score on the scale were established to identify those needing special help (Fitts, 1965). Those with low scores see themselves as unhappy, depressed and anxious and may feel that they have little worth. The posttest score was above the deviant cut-off point at a T-score level of 42 (See Appendix I). Positive subscore responses which measure different facets of self concept, also registered comparable improvement. The areas of change included scores reflecting trends toward improved perceptions of Self Identity, Self Satisfaction, Self Behavior, Physical Self, Moral and Ethical Self, Personal Self, Family Self and Social Self.
A strong trend toward significance was shown in the Total Conflict Score on the TSCS. This score, when excessively high, indicates confusion, contradiction and general conflict in self perception. The GBPT group reduced this score from a relatively elevated position to the midpoint on the scale. Three of the Empirical Scales resulted in scores which indicated trends toward significant change. The General Maladjustment Scale score reflected enough improvement to bring it within the cut-off point for identifying disturbed individuals. The difference between pretest and posttest scores on the Personality Disorder Scale and the Neurosis Scale reflect similar trends toward significant improvement. The trends toward significant improvement on these three Empirical Scales suggests reductions in general pathological characteristics, personality defects and neurotic tendencies in the GBPT group over time and treatment.

The pretest profile of the TSCS for the GBPT groups indicated nine scores were deviant. On the posttest profile the number of scores beyond the deviant cut-off point was reduced to one. These results according to Fitts (1965) suggest that the GBPT group members were less emotionally disturbed at the conclusion of their treatment than they were at the beginning of treatment.

The third null hypothesis stated that there would be no difference between the posttest responses of the GBPT and the RP groups on measures of interpersonal perception accuracy. The null hypothesis of no difference was accepted. Several possible reasons
may be suggested for the failure of the GBPT groups to show significantly greater improvement in interpersonal perception accuracy than the RP groups:

1. There was inadequate time to incorporate the concepts of interpersonal perception accuracy into the behavior patterns of the GBPT groups because of the shortness of the length of treatment.

2. It may be that the ninth grade reading level was not an adequate screening instrument to determine the intellectual ability necessary to internalize the concepts of improving interpersonal perception accuracy.

3. Perhaps the instrument used to measure interpersonal perception accuracy was too sophisticated for this population to understand. It may be that another instrument designed more specifically for this population could have more adequately evaluated what the subjects had learned.

The fourth null hypothesis stated that there would be no difference between the posttest responses of the GBPT and RP groups on measures of psychological adjustment. No significant differences were reported on any of the measures. Therefore, the null hypothesis stating that there would be no difference between posttest responses of the GBPT and RP groups on measures of psychological adjustment was accepted.

Scores obtained on most MMPI subscales did not indicate significance nor were they of such magnitude as to disclose
significant trends. The response scores that approached becoming a
trend were obtained on Scale 6. This offers the suggestion that the
lower scores reported by the GBPT group may reflect less rigidity,
distrust and resentfulness over real or imagined wrongs (See Appendix
K). The posttest configuration of the MMPI profile using Lachar's
(1974) version of the Welsch Extended Code are shown for the GBPT and
RP groups:

Posttest GBPT Code: 4 9' 8 7 2 5 6 - 3 1 0/ L:F-K:
Posttest RP Code: 4 9 8' 6 7 2 5 3 1 - 0/ L:F-K:

No major trends toward significant differences on the subscale
scores were observed on the TSCS measures of posttest responses for
the two groups (See Appendix L). Some modest trends were observed on
three of the positive subscores suggesting that the GBPT groups
posttest responses were somewhat higher than the RP group on measures
of perceptions of improved Self Behavior, the Family Self and the
Social Self. The results of scores on the Empirical Scale for
identifying Personality Disorders suggests a modest trend toward
lower levels of responses by the GBPT group. The posttest profiles
of the TSCS for the GBPT group produced only one score beyond the
deviant cut off point. The posttest scores beyond the deviant cut
off point for the RP were three. Fitts (1965) suggests that the cut
off point for deviant scores identifies disturbed persons with
considerable accuracy.

The posttest responses for the GBPT and RP groups on the POMS
are almost identical (See Appendix M). Bullmer (1980) in her
research indicated that she obtained on the POMS the most consistent improvement results for each of the patients in her study. The posttest scores on the POMS in the present study suggest that both groups reported very similar low levels of Tension-Anxiety, Depression-Dejection, Anger-Hostility, Fatigue-Inertia and Confusion-Bewilderment. Both groups also reported high levels of Vigor-Activity. Posttest responses on Scale 9 of the MMPI for both groups is supportive of the high Vigor-Activity response obtained on the POMS.

The baseline POMS scores recorded during the treatment period including the pretest and posttest scores, reflected a basically stable mood and affect throughout therapy. A gradual lessening of the mood of Tension-Anxiety, Depression-Rejection, Fatigue-Inertia, and Confusion-Bewilderment and a gradual increase in the mood of Vigor-Activity was obtained and reported for both groups.

In summary, it appears GBPT and RP as studied in this research are essentially equal in improving interpersonal perception accuracy and psychological adjustment as measured by responses on the Affective Sensitivity Scale, the Minnesota Multiphasic Personality Inventory, the Tennessee Self Concept Scale and the Profile of Mood States in a substance abuse population.

Observations made during this study agree with findings in a literature review by Nathan and Lansky (1978) which states "there is clearly not a single route to alcohol or drug dependence" (p. 714). Understanding personality patterns as they relate to psychological
adjustment in the substance abuser appear to involve more than merely studying the mechanism of dependence, or the etiological process, or even the personality structure alone. A more sophisticated view has emerged. This view involves the recognition that substance abuse problems are related to a complex individual system which is constantly interacting with personal history and environmental factors. Clearly, this type of study is a very difficult task. The difficulty of the task, however, should not deter continued serious research involving studies in the relationship of psychological adjustment to interpersonal perception accuracy in a substance abuse population.

During this study it became more clear that certain rigid behavioral patterns had become a part of the subjects' life style. Even though they were able to verbalize an understanding of their problem with interpersonal relationships, they seemed to find it extremely difficult to internalize new concepts and actually make behavioral changes. There seemed to be a hidden agenda, which was not verbalized. This hidden agenda seemed to be reflecting a strong tendency toward manipulation of other people in interpersonal relationships. Nearly all members of the GBPT groups expressed eagerness to improve interpersonal perception accuracy. However, the motivation toward this overtly positive goal, appeared to be overwhelmed by what Bullmer (1975) calls errors of implicit personality theory. In other words, the covert motivation seemed to be anchored to the basic concept of understanding another person in
order to use that person for self centered purposes. This evaluation
can sound rather harsh, on the other hand, it agrees with the results
of the MMPI configuration showing elevated Scale 4 and Scale 9 scores
as well as somewhat elevated scores for Scales 8 and 7.
Traditionally, patients with these general MMPI configurations have
not been considered to be the best candidates for traditional
psychotherapy treatment (Gilberstadt and Duker, 1965; Duckworth,
1980).

This study was supportive of the findings of McCourt and Glantz
(1980) in their research using cognitive behavior therapy in groups
for alcoholics. They found that some of their patients accepted the
cognitive approach to therapy while others resisted because they felt
it was too abstract. Others appeared to resist because acceptance of
the approach would involve accepting responsibility for their own
thoughts, feelings, actions and problems. They concluded, however,
that their cognitive behavior approach, which in some ways, is
similar to Brief Perception Therapy, was a potentially effective
modality needing further development and research. More stringent
evaluations of the therapy and better assessments of the conceptions
of the patients are needed for continued improvement of methods of
therapy such as GBPT. A more multimodal approach to therapy such as
that recommended by Beck (1976) and Meichenbaum (1977) could be
incorporated into the GBPT model.

The improved mood and affect of the patients in the study was
clearly reflected in the significant results obtained on the POMS, a
measure of psychological adjustment. It would be expected, however, that these overt responses would characterize any group receiving attention from a treatment team offering help for medical, social, recreational and psychological needs. Indeed, both groups did make significant improvements in several areas. This improvement, however, should not be discredited because it seems that this type of psychological adjustment must precede more fundamental enduring changes. The strong trends toward significant positive changes in self concept and self esteem as observed on the TSCS measure of psychological adjustment suggests that the subjects were beginning to take valid steps toward deeper more enduring changes. It seems reasonable to expect that progress toward a better understanding and respect for ones self should help lead to a more mature understanding and respect for others.

There was no evidence of significant improvement in interpersonal perception accuracy as measured by the Affective Sensitivity Scale. However, the trends toward change as observed on the other measures of psychological adjustment do suggest a need for additional research.

Limitations

Studies conducted in natural or field settings encounter difficulties which make the experiment less than ideal. The present study was no exception. A number of limitations, some anticipated and others not, occurred during the course of the study and may have
influenced its outcome. While there is no way to know the extent of the influence, limitations must now be recognized. First, the time period allowed for group therapy was controlled by the setting's program and may have been too short to adequately result in desired change.

Second, it is recognized that the small sample size in this study limited the probability of securing significant results. Third, although a reading level screening test was used to assure a minimum reading ability for the subjects in this study, the measure of interpersonal perceptual accuracy may have been too sophisticated for this substance abuse population. The Affective Sensitivity Scale was first used to assist in training professional counselors. These limitations should be considered in making generalizations from this study to other populations.

Implications for Further Research

Throughout this study it became increasingly evident that problems with interpersonal perception accuracy are strongly related to psychological adjustment in a substance abuse population. There are difficulties and limitations associated with conducting research in a treatment setting. This should not, however, limit continued efforts to seek answers to complex questions in less than ideal field research environments. Current concerns in our society for the problems of substance abuse are having some positive effects in giving more credibility to this type of research. Numerous
possibilities for further research in the field of substance abuse treatment are apparent to professionals who work with these populations.

This research revealed a number of trends toward improved psychological adjustment in the substance abuse population studied. It was concluded that GBPT was helpful in improving psychological adjustment by reducing levels of tension-anxiety and depression-dejection. Strong trends toward improved self concept were also noted. It would appear that changing some procedures and expanding and enlarging the scope of the study in future research might increase the possibility of more significant levels of improvement in both interpersonal perception accuracy and psychological adjustment.

It was observed in this study that some patients did improve interpersonal perception accuracy. Some patients showed marked improvement in psychological adjustment. This study could be refined to include an analysis of the correlation between increased interpersonal perception accuracy and the degree of improvement in psychological adjustment. At the same time the length of the therapy program should be extended beyond the limit of three weeks. This extension of the length of treatment would allow more time for the patients to internalize the new concepts learned in therapy. It would also give the therapist more opportunities to make stringent evaluations and more accurately assess the conceptions of the patients.
The longer time in therapy would also allow more intense group involvement in applying the new behaviors to daily living experiences. Expanding the in-session experiences would help the patients develop their own monitoring skills. Extending the length of the time in therapy would give more time to develop better assessments of the patient's conceptualizations and encourage assimilation of new ideas experientially. Group Brief Perception Therapy appears to be a constructive mode of therapy in a substance abuse population. Further refinement and improvement are needed using a more multimodal approach in the context of a structured group interaction.

A further refinement to this research might include comparing responses of different age groupings within the population of the study. Do younger patients respond differently to Brief Perception Therapy than more mature patients? Another variable which should be explored in a study of GBPT results is the effect of educational background on the substance abuser's response to therapy. Will the more highly educated patient respond more positively? According to Allport's (1961) analysis of good person perceivers, it might be expected that educational background would be a major variable in predicting success for Brief Perception Therapy. Other researchers give support to the idea that education may be one variable which will predict better therapy results (Bieri, 1955; Bullmer, 1970; Hale, 1979; Mayo and Crockett, 1964; and Sarbin, Taft and Bailey, 1960).
There appears to be a need to investigate the response of different substance abuse populations to GBPT. Researching GBPT in a population of socially and economically advantaged substance abusers should not be overlooked. Sources for these populations would include Alcoholics Anonymous groups, private hospital settings or other private treatment programs. Since different treatment and self help programs attract patients from different socioeconomic and demographic backgrounds (Cronkite and Moos, 1978; and Nathan and Lansky, 1978), it seems that comparing results of therapy with patients in these programs would contribute to a more complete understanding of the relationship of interpersonal perceptual accuracy and psychological adjustment in substance abuse populations. Still another approach to researching a substance abuse population should include individual therapy effectiveness as compared to group therapy results in improving interpersonal perception accuracy and psychological adjustment.

In summary, the results of this study suggest that GBPT may be a useful treatment modality for use in a substance abuse population. In the short period of time allowed for the therapy process involved in this research, improvement in mood and affect were noted. Trends toward significant improvement in the self concept of the patients were observed. These results along with other positive trends toward improvement in psychological adjustment as shown in this study seem to suggest the need for additional research to further define the benefits of this treatment procedure with substance abuse populations.
APPENDIX A

Informed Consent Forms
INFORMED CONSENT

Information about the Research Study:

IMPROVING INTERPERSONAL PERCEPTUAL ACCURACY
AND PSYCHOLOGICAL ADJUSTMENT THROUGH BRIEF PERCEPTION
THERAPY WITH A SUBSTANCE ABUSE POPULATION

This study is being conducted to determine the benefits of Group Brief Perception Therapy and Group Psychotherapy in improving participants' understanding of other people and developing a better adjustment to life. Other studies have suggested that improving one's understanding of other people may be helpful in dealing with the problems of substance abuse and the interpersonal problems often associated with alcoholism or drug abuse.

Participants in this study will be assigned to one of two groups: a Psychotherapy Group or a Brief Perception Therapy Group. Members of these groups will have the opportunity to discuss their problems. Each group will be led by an experienced staff member of the Substance Abuse Treatment Unit. Paper and pencil tests will be given to help measure progress in developing awareness of other people and understanding of oneself and others. These tests will be given before the series of group therapy sessions begin and at the conclusion of therapy. Over the three-week period of therapy, one test will be repeated four times. Other studies have shown that training in human relations may be beneficial in finding a better life adjustment. One of the groups will also use a self-help manual for improving interpersonal perception.

The results of your participation in this study will be confidential in that special code numbers will be used in recording data. The tests will not become a part of your V.A. record. The project is considered to be of minimal risk with the probability of harm no greater than that ordinarily encountered in daily life. If you do not choose to participate in this study, another treatment group will be provided for you. The primary researchers in this project is B. Gerald Hartman, a Psychology Technician in the Substance Abuse Treatment Unit of the Battle Creek Veterans Administration Medical Center and an Ed.D. candidate in the Department of Counseling and Personnel at Western Michigan University. If you have any questions, he may be contacted at his office in Building 13, Room 209-D.

Participation in this study is voluntary. Refusal to participate will involve no penalty or loss of benefits to which you as a veteran are otherwise entitled. You may discontinue participation at any time without penalty or loss of benefits.

If you are willing to participate in this research effort, please sign below with the understanding that you may withdraw at any time and this will not effect your care, consideration or treatment.

Signature of Subject

Signature of Witness

Signature of Investigator

Date
Part I - Agreement to Participate in Research

By or under the direction of the Veterans Administration

1. I voluntarily consent to participate as a subject

in the investigation entitled

[Type or print subject's name]

[Date of study]

2. I have signed one or more information sheets with this title to show that I have read the description including the purpose and nature of the investigation, the procedures to be used, the risks, inconveniences, side effects and benefits to be expected, as well as other matters of action open to me and my right to withdraw from the investigation at any time. Each of these items has been explained to me by the investigator in the presence of a witness.

The investigator has answered my questions concerning the investigation and I believe I understand what is involved.

3. I understand that no guarantees or assurances have been given me since the results and risks of an investigation are not always known beforehand. I have been told that the investigation has been carefully planned, that the plan has been reviewed by knowledgeable people, and that every reasonable precaution will be taken to prevent my wellbeing.

4. In the event I sustain physical injury as a result of participation in this investigation, if I am eligible for medical care as a veteran, all necessary and appropriate care will be provided. If I am not eligible for medical care as a veteran, necessary emergency care will nevertheless be provided.

5. I realize I have not released this instrument for liability for negligence. Compensation may or may not be payable, in the event of physical injury arising from each research, under applicable federal laws.

6. I understand that all information obtained about me during the course of the study will be made available only to doctors who are taking care of me and to qualified investigators and their associates whose access to the information is approved and authorized. They will be bound by the same requirements to maintain my privacy and confidentiality as apply to all medical personnel within the Veterans Administration.

7. I further understand that, where required by law, the appropriate federal officer or agency will have free access to information obtained in this study which it becomes necessary. Consent I may elect the same respect for my privacy and confidentiality from these agencies as is afforded by the Veterans Administration and its employees. The provisions of the Privacy Act apply to all agencies.

8. In the event that research in which I participate involves certain new drugs, information concerning my response to the drug(s) will be supplied to the sponsoring pharmaceutical companies that make the drug(s) available. This information will be given to them in such a way that I cannot be identified.

NAME OF VOLUNTEER:

H ave read this consent form. All my questions have been answered. I freely and voluntarily choose to participate. I understand that my rights and privacy will be maintained. I agree to participate as a volunteer in this program.

9. Nevertheless, I wish to limit my participation in the investigation as follows:

[Signature]

[Date]

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[Date]
# AGREEMENT BY SUBJECT'S REPRESENTATIVE TO ALLOW SUBJECT TO PARTICIPATE IN RESEARCH BY OR UNDER THE DIRECTION OF VETERANS ADMINISTRATION

## PART II

### L. —

(Please print or type, initial only)

1. I , by virtue of (Type or print name of subject's representative)

2. I, (Type or print subject's name) , hereby consent for this person to participate as a subject in the investigation entitled (Type of study)

3. I, (Type or print name of study)

4. The investigator has assured me the results and risks of an investigation are not always known beforehand. I have been told that this investigation has been carefully planned, that the plan has been reviewed by knowledgeable people, and that every reasonable precaution will be taken to prevent the well-being of the subject.

5. I realize I have not released this institution from liability for negligence. Compensation may or may not be payable, in the event of physical injury arising from such research, under applicable federal laws.

6. I understand that all information obtained about the subject during the course of this study will be made available only to doctors who are taking care of this subject and to qualified investigators and other persons where their work is directly associated with this institution. They will be bound by the same requirement of maintaining the subject's privacy and anonymity as apply to all medical research conducted at this institution.

7. I further understand that, where required by law, the appropriate federal officer or agency will have access to information obtained in this study should it become necessary. Generally, I may expect the same respect for the subject's privacy and anonymity from these agencies as is afforded by the Veterans Administration and its employees. The provisions of the Privacy Act apply to all agencies.

8. In the event that research in which the subject participates involves certain new drugs, information concerning the subject's response to the drug(s) will be adopted by the agencies conducting the research (Pharmaceutical licensees that make the drug(s) available). This information will be given to them in such a way that the subject cannot be identified.

### NAME OF SUBJECT'S REPRESENTATIVE

I have read this consent form. All my questions have been answered, and I freely and voluntarily agree that the subject participate. I understand that the subject's rights and privacy will be maintained. I agree to the subject's participation as a volunteer in this program.

9. Nevertheless, my consent for the subject's participation in the investigation is limited as follows:

<table>
<thead>
<tr>
<th>Name of Subjects Representative</th>
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<table>
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<th>Investigator's Name</th>
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<th>Subjects I.D. No.</th>
<th>Age</th>
<th>Hand</th>
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</table>
APPENDIX B

Experience and General Orientation of Participating Therapists and Therapist Orientation Sheet
<table>
<thead>
<tr>
<th>Therapist</th>
<th>Most Influential Authors</th>
<th>School of Therapy Orientation</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Beck, Ellis, Rogers</td>
<td>Cognitive Eclectic</td>
<td>12 Years</td>
</tr>
<tr>
<td>2b</td>
<td>Berne, Branden, Ellis</td>
<td>Transactional Analysis Rational Emotive Therapy</td>
<td>14 Years</td>
</tr>
<tr>
<td>3b</td>
<td>Haley, Minuchin, Hollis</td>
<td>Eclectic</td>
<td>10 Years</td>
</tr>
<tr>
<td>4b</td>
<td>Erickson, Haley, Minuchin</td>
<td>Cognitive Systems</td>
<td>10 Years</td>
</tr>
<tr>
<td>5b</td>
<td>Freud, Perls, Berne</td>
<td>Psychodynamic</td>
<td>14 Years</td>
</tr>
</tbody>
</table>

* a GBPT therapist
* b RP therapists

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THERAPIST ORIENTATION SHEET

The following pages contain a number of areas in which psychotherapists have been found to differ. Please indicate your position with regard to each area by placing a checkmark on the scale accompanying each area.

For example: 1. Activity-frequency.

If you feel that with most clients you are usually active (talkative), or usually passive, you would place the checkmark as follows:

Active ...... | .... | .... | .... | .... | Passive, or Active ...... | .... | .... | .... | .... | Passive

If you feel you are more often active than passive, or more often passive than active, you would check as follows:

Active ...... | .... | .... | .... | .... | Passive, or Active ...... | .... | .... | .... | .... | Passive

If you feel you are about equally active and passive with most clients, or active with as many clients as passive, you would check the middle space:

Active ...... | .... | .... | .... | Passive

1. Activity-frequency:

   Active ...... | 12345 | .... | .... | Passive
   (Talkative)   (MONTalkative)

2. Activity-type:

   Directive ...... | 1.3.2.5 | .... | Nondirective

3. Activity-structure:

   Informal ...... | 3.1.4.2 | .... | Formal

4. Relationship-tenor:

   Personal ...... | 1234 | .... | Impersonal
   (Involved)     (Detached)

5. Relationship-structure:

   Unstructured ...... | 2.5 | .... | 1.4 | 3. Structured

6. Relationship-atmosphere:

   Permissive ...... | .... | 123.5 | .... | Nonpermissive
7. Relationship-therapist actions:
   Planned.....| 3..| 1..| 4..| 2..| 5..| Spontaneous

8. Relationship-client dynamics:
   Nonconceptualized.....| 12..| 345 Conceptualized

9. Goals-source:
   Therapist.....| 2..| 3..| 4..| 5..| Client

10. Goals-formalization:
    Planned...| 3..| 12..| 4..| 5..| Unplanned
    (Formalized) (Unformalized)

11. Therapist Comfort and Security:
    Always Secure.....| 2..| 3..| 4..| 5..| Never Secure
    (Comfortable) (Uncomfortable)

12. Client Comfort and Security:
    Never Secure.....| 1..| 3..| 4..| 2..| Always Secure
    (Uncomfortable) (Comfortable)

13. Client Personal Growth:
    Non Inherent.....| 4..| 1..| 3..| 5..| Inherent

14. Therapeutic Gains-self-understanding (cognitive insight):
    Important.....| 1..| 3..| 4..| 2..| Unimportant

15. Therapeutic Gains-emotional understanding (affective awareness):
    Unimportant.....| 4..| 1..| 3..| 5..| Important

16. Therapeutic Gains-"symptom" reduction:
    Important.....| 2..| 3..| 4..| 1..| Unimportant

17. Therapeutic Gains-social adjustment:
    Unimportant.....| 12..| 345 Important

18. Therapeutic Gains-confidence in effecting change:
    Confident.....| 3..| 4..| 12..| 3..| Unconfident

19. Learning Process in Therapy:
    Verbal-Conceptual.....| 23..| 1..| 4..| Nonverbal-Affective
20. Therapeutically Significant Topics:
   Client Centered ... | 1..4.| ...3.| ...2..5| ...Theory Centered
21. Therapeutically Significant Topics:
   Historical ... | ...5| ...3.| ...12.| ...4.Current
22. Therapeutically Significant Topics:
   Ego Functions ... | ...5| 1234.| ...Superego, Id
23. Theory of Motivation:
   Unconscious ... | ...2.| ...345| 1...| ...Conscious
24. Curative Aspect of Therapist:
   Personality ... | ...3.| ...2.45| 1...| ...Training
The following items refer to the use of specific techniques in psychotherapy. Please check to indicate whether you use each technique: almost always, usually, about half the time, only occasionally, never.

<table>
<thead>
<tr>
<th>Item</th>
<th>Almost Always</th>
<th>50/50</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Reflection and Clarification of Feelings:</td>
<td>123.4.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Reflection and Clarification of Content:</td>
<td>123.4.5</td>
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<td></td>
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<tr>
<td>27. Reflection and Clarification of Behavior:</td>
<td>123.4.5</td>
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<tr>
<td>28. Questioning of Feelings:</td>
<td>123.4.5</td>
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<td>29. Questioning of Content:</td>
<td>123.4.5</td>
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<tr>
<td>30. Questioning of Behavior:</td>
<td>123.4.5</td>
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<tr>
<td>31. Interpretation of Feelings:</td>
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<tr>
<td>32. Interpretation of Content:</td>
<td>123.4.5</td>
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<tr>
<td>33. Interpretation of Behavior:</td>
<td>123.4.5</td>
<td></td>
<td></td>
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<tr>
<td>34. Suggestion (not hypnosis):</td>
<td>123.4.5</td>
<td></td>
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<tr>
<td>35. Reassurance:</td>
<td>123.4.5</td>
<td></td>
<td></td>
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<tr>
<td>36. Information and Advice Giving:</td>
<td>123.4.5</td>
<td></td>
<td></td>
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<tr>
<td>37. Attentive Listening:</td>
<td>123.4.5</td>
<td></td>
<td></td>
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<tr>
<td>38. Modeling Techniques (examples):</td>
<td>123.4.5</td>
<td></td>
<td></td>
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<tr>
<td>39. Positive Attitude, Confidence:</td>
<td>123.4.5</td>
<td></td>
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<tr>
<td>40. Warmth and Understanding:</td>
<td>123.4.5</td>
<td></td>
<td></td>
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<tr>
<td>41. Reinforcement (approval-disapproval):</td>
<td>123.4.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. Conditioning, Counterconditioning:</td>
<td>123.4.5</td>
<td></td>
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<tr>
<td>43. Free Association:</td>
<td>123.4.5</td>
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<tr>
<td>44. Auxiliary Techniques (hypnosis, medication):</td>
<td>123.4.5</td>
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<tr>
<td>45. Other (please specify):</td>
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1 is the GGT therapist, 2,3,4, and 5 are RP therapists.
Procedural Flow Chart
APPENDIX D
Therapist's Manual for Group Brief Perception Therapy

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First Session - Introduction to GBPT and the programmed text

I. Provide an opportunity for the members of the group to become better acquainted. Use the coat-of-arms structured exercise to help implement this.

II. Instructions will be given by the therapist explaining the format of the sessions. Rules for group interaction will be formulated by group agreement. The therapist will also survey the material to be covered and offer suggestions on how to use the programmed text, *Art of Empathy*.

Assignment:

A. Read the Introduction to the book and the Introduction to Unit I.

B. Study pages 3-17.
Second Session - Unit I, Interpersonal Perception

I. Introduction to Understanding Interpersonal Perception.

A. How we extract information from our environment and from people.

B. Internal properties—emotions, motives, attitudes and abilities.
   1. How we infer what is happening in another person.
   2. How we use judgments when we do not understand other people. These judgments are often biased.

C. How we develop perceptions.
   1. Past experiences.
   2. Thinking processes.
   3. Choosing the stimuli.
   4. Our "set" or expectations.

D. How we understand other people.
   1. A very individual matter.
   2. Each perceives his environment in a different manner (examples).

E. People often act differently than they feel, giving a false impression.
   1. Respond differently in different situations.
   2. Some develop behavior for specific situations.

F. Our very own "implicit personality theory."
   1. Our beliefs, attitudes, values, biases, and habits.
2. Affects our percepts and judgments.

3. Error is often the result.

G. Response behavior—how we perceive others affects interpersonal relating.

H. Implicit personality theory made explicit by self analysis.

Personalization Exercise: Empathy diagrams and exercises.

Discussion:

Assignment:

A. Read Introduction to Unit II, Sources of Error in Interpersonal Perception.

B. Study pages 20-30.
Sources of Error in Interpersonal Perception.

A. Distortion.

1. A result of selecting stimuli to fit the needs of perceiver.
   a. Defensiveness when perceiver feels threatened (example).
   b. We perceive in others what we choose to perceive (examples, friends, mate, etc.).

2. Individual differences in perceptions.

B. Limited natural ability of perceiver may hinder the organization of incoming stimulus information.

C. Implicit personality theory.

1. Stereotyping.
   a. Attributing the same characteristics to any member of a group or class.
   b. An attitude or bias that is rigidly fixed.

2. Trait attribution.
   a. Assuming that one trait or behavior follows from the presence of another trait or behavior.
   b. Perceiver tends to put emphasis on traits he values highly.
   c. A process of inferring inner traits from observable traits.
3. Assumed similarity.
   a. Attributing to others the characteristics one sees himself possessing.

II. Self Analysis is a way of dealing with implicit personality theory.
   A. Making implicit personality theory explicit.
   B. Improving your interpersonal perceptual skills.

Personalization Exercises: Brainstorming the understanding of implicit personality theory.

A. Stereotypes:
   1. Old people
   2. Women
   3. Blacks
   4. Hippies
   5. Alcoholics
   6. Politicians
   7. Priests or Pastors
   8. Grandmothers
   9. Used cars
   10. Republicans

B. Trait Attribution:
   1. Redheads (temper)
   2. Blondes (dumb)
   3. Fat people (jolly, happy)
   4. People who swear (coarse, immoral)
5. Divorced women (lewd, immoral)
6. Unemployed (lazy)
7. Athletic men (dumb)
8. Feminine men (homosexual)

C. Assumed similarities.
   1. Motivation
   2. Selfishness/unselfishness
   3. Trustworthiness

D. Perceptual distortion.
   Give examples

Discussion:

Assignment:

A. Be prepared to identify ways you use your implicit personality theory through:
   a. Sterotyping
   b. Trait attribution
   c. Assumed similarity

B. Continue self-analysis of your own implicit personality theory.
   a. How can you change it to make it more explicit?
   b. How can you become more aware of your inner beliefs about people?
   c. Make a list of ways you can do this.

C. Review Units I and II.
Fourth Session - Review of Units I and II

I. The goal of this session will be directed toward helping patients share their implicit personality theories.
   A. Share examples of the development of an implicit personality theory.
   B. Explain how past learning influences these theories.
   C. Review ways of making implicit personality theory explicit.
   D. Describe how error is expressed in stereotyping, trait attribution and assumed similarity.

II. Encourage patients to identify ways they have practiced:
   A. Stereotyping.
   B. Assumed similarity.
   C. Trait attribution.

III. Discuss difficulties in making implicit personality theory explicit.

Personalization Exercise: Person perception: feedback exercise.

Discussion:

Assignment:
   A. Read pages 33-34 and do the exercises on pages 35-42.
   B. Be prepared to describe the differences between physical needs and learned needs.
   C. How are emotions and motives related to human needs and desires?
   D. Read page 43 and do the exercises on pages 44-50.
Fifth Session - Unit III, Identifying Emotions, Sections 1 and 2.

I. Needs, desires, motives and emotions.

A. Needs.

1. A definition: A strong feeling in a person to want to change or remove his perception or understanding of physiological discomfort.

2. Everyone is in a continual state of need. What we do is goal directed for satisfaction of needs.

3. Are either biological or learned.
   a. Examples of learned needs are money, achievement and prestige.
   b. Learned needs may be stronger than biological needs. Examples of biological needs are waiting to go to the bathroom, dieting, delaying sexual gratification.

B. Motives.

1. Being in a state of need produces an inner response called a motive.

2. Usually results in overt behavior which seeks to change the environment to alter the need state.

C. Desires.

1. Are also a source of motives and behavior.
   a. Unlike needs which produce motives to avoid discomfort.
b. Desires produce motives directed toward pleasure.

2. Both needs and desires produce goal directed behavior.

D. Emotions.

1. Closely related with motives in that they are associated with human needs.

2. An individual's subjective feelings associated with the same internal responses as are motives.

3. An example is that the person experiencing the emotion of anxiety may be motivated to seek relief.

II. Specific Emotions.

A. A great variety of human emotions.

1. Subjective feelings of pleasantness or unpleasantness.

2. Each emotional experience is unique to the individual experiencing it.

a. Different experiences of the same emotion may have similar characteristics (example: fear).

b. An emotion should be described in the context of a situation.
B. Primary Emotions.
1. Fear - accompanies dangerous or threatening situations.
2. Joy - associated with reaching desired goal.
3. Anger - associated with having goal attainment blocked.

C. Emotions determined by the individual's perception of his behavior as good or bad.
1. Feeling of guilt - a perception of behavior as being wrong or immoral.
2. Feeling of shame - a perception of oneself as unable to succeed because of being bad.
3. Feeling of pride - a perception of oneself as good because behavior meets expectations.
4. Feeling of success or failure - a perception of the quality of his performance as compared to his expectations.

D. Emotions directed toward other people.
1. Love - a person is drawn or desires to be drawn to the other person.
2. Hate - intense dislike with a desire to destroy the hated person or object.
3. Jealousy - a person's perception of a loved one giving affection to someone else.
4. Envy - evoked when a person perceives another person possessing something he wants for himself.

**Personalization Exercise:**

A. Give group members selected statements from text. See if they can give correct responses.

B. Give proficiency tests on Units I and II.

**Discussion:**

**Assignment:**


B. Read the Introduction to Section 3 of Unit III, on page 51, and do the exercises on pages 52-60.

C. Be prepared to discuss the role of emotions in your substance abuse problems.

D. How are needs and motives a part of the way these problems interact in your life?
Sixth Session - Unit III, Identifying Emotions, Section 3

I. Utilize the reports on the assignment from the last session to review the first two sections of Unit II.

II. Identifying emotions in others.

A. Necessary to infer specific needs and desires a person is experiencing.

B. Difficulties in inferring motives and emotions in others.

C. Verbal behavior is usually a good source of information.

D. Make inferences about another person's emotions cautiously.

Personalization Exercises: Practice identifying emotions.

A. Place names of emotions written on small cards in a container.

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<thead>
<tr>
<th>Container 1</th>
<th>Container 2</th>
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<tbody>
<tr>
<td>1. Hate</td>
<td>1. Pride</td>
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<td>2. Anger</td>
<td>2. Guilt</td>
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<td>3. Frustration</td>
<td>3. Jealousy</td>
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<td>6. Anxiety-Excitement</td>
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<td>7. Fear</td>
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<td>8. Love</td>
<td>8. Anger-Fear</td>
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<td>9. Shame</td>
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</table>
B. Let each member of the group select an emotion from the container and non-verbally express it. Ask other members of the group to hypothesize until they correctly identify the emotion.

C. Do the same using verbal expressions of emotions.

D. Discuss difficulties in identifying emotions.
   a. A person may experience multiple needs at the same time.
   b. A person may be unwilling to share needs and desires.
   c. A person may be unaware of his own needs, motives and emotions.

Discussion:

Assignment:

A. Continue to practice identifying emotions in yourself and others.

B. Write down in your notebook the emotions which you find most easy to express to others. Try to determine why some emotions may be easier to express than others.

C. What emotions are most difficult for you to express?

D. Read the Introduction to Unit IV, Identifying Hidden Meaning, page 63, and do the exercises on pages 64-86.
Seventh Session - Unit IV, Identifying Hidden Meaning

I. Hidden Meaning.

A. "Laughing on the outside and crying on the inside."

B. To perceive or understand another person we must interpret the hidden emotions. (Those emotions not expressed verbally or by body reactions.)

II. Anxiety; the most common "hidden" emotion.

A. An unpleasant emotion related to fear from an unidentified source.

B. An uneasiness or apprehension felt consciously but the person is not aware of the source.

C. There may be a strong motivation to reduce the unpleasant state of anxiety.

1. Instrumental responses.
   a. Eliminating the cause of conflict or frustration.
   b. Examples: leave the movie, avoid heights, stop driving the car.

   a. Reducing anxiety not by eliminating conflict or frustration but by denying, falsifying or distorting the reality of the unpleasant situation.
   b. Changing the perception of the situation.
III. Defense Mechanisms.

A. Another name for non-instrumental responses used to deny, falsify or distort reality in order to reduce anxiety.

B. Anxiety controlled by non-instrumental responses is called latent anxiety.

C. Individuals usually learn how to keep anxiety level low.

D. Specific defenses.

1. Rationalization - a method of giving an acceptable motive for activities or behavior that past training has made to appear unacceptable. Good sounding, convincing reasons may be given for behavior which is motivated by unconscious impulses.

2. Compensation - a person accepts a substitute goal or activity because he is unable to achieve direct satisfaction of a motive or achievement. Behavior in accepting a substitute goal may be exaggerated.

3. Identification - giving to one's self qualities or characteristics belonging to another person or object; acting as if he shares the traits or prestige.
4. Projection - attributing to others one's own feelings or motives that he actually believes are undesirable. The other person is often blamed for having unethical traits or desires which are a projection of his self-perception.

5. Reaction Formation - Distorting reality so one's feelings and motives may be seen as the opposite of what they really are. "He protesteth too much."

Personalization Exercise:

A. Have patients verbalize statements and encourage others to identify the mechanism operating.

B. Give defensive statements and have the patients translate into the real meaning as if the person were really telling you what he was feeling and thinking.

1. "The only reason I lied to him was because everyone else did."

2. "All people have problems with their sexual behavior."

3. "I wouldn't have a drinking problem if my wife didn't nag me so much."

4. "Death has never been a problem to me."

5. "I can't believe that anyone would read the garbage in that sick magazine."
6. "I love everybody."

7. "With all these people in here, you can be sure someone will steal something."

8. "Everyone is trying to cheat in one way or another."

Discussion:

Assignment:

A. Practice listening for and identifying defense mechanism statements. Limit your observations to the five basic defense mechanisms listed in the study guide.

B. Record in your notes the defense mechanisms you use most often.

1. When do you use them?

2. Why do you use them?

C. Do you find a pattern in your defensive behavior?

D. Review the material covered to date.
Eighth Session - Unit IV, Identifying Hidden Meaning, continued

I. How people use unacceptable perceptions.
   A. To remove anxiety - use rationalization, identification, projection, and reaction-formation (examples).
   B. To reduce guilt - use projection, rationalization and reaction-formation (examples).
   C. To reduce grief - use denial (examples).
   D. To increase joy - use identification and compensation (examples).

II. Have patients respond with report on assignment from last session.
   A. Share defensive statements they have heard.
   B. Share how they use defenses, etc.

Personalization Exercise: Games Substance Abusers Play - A structured response to a tape by Dr. Richard Bates based on Eric Berne's book, Games People Play.
   A. Can you identify the defense mechanisms used?
   B. Which defense mechanisms have you used in dealing with problems of substance abuse?
   C. Etc.

Discussion:

Assignment:
   A. Read the Introduction to Unit V, The Perceptual Approach to Understanding Others, on page 90, and do the exercises on pages 91-107.
B. Continue listening for and recording defensive statements you hear others make or catch yourself making.

C. How can one learn to see another person from that person's frame of reference?

D. How is understanding another person from his or her frame of reference different from evaluating or judging that person by your own needs, motives and emotions?

E. Bring examples from your own experiences.
Ninth Session - Unit V, The Perceptual Approach to Understanding Others

I. Listening with understanding.

A. Two ways to understand the meaning of the other person.
   1. Explaining the other person in your own frame of reference.
   2. To perceive things in terms of how the other person perceives them.

B. It is natural to agree or disagree—approve or disapprove. Judgment removes ambiguity!!

C. Learning to disregard one's own emotions helps a person to perceive the other person's expressed idea from his frame of reference.

D. If the other person's perceptions are understood his behavior will be easier to understand.

E. It requires courage to enter the perceptual world of another person because you risk being changed.

F. Perceptual approach requires practice.

II. Practice delaying response to another person until you have first restated the ideas and emotions he has expressed.

Personalization Exercise: Meanings are in people: Perception checking exercise.

Discussion:
Assignment:

A. Read Unit IV Introduction summary on page 110. Do the review exercises on pages 111-135.

B. Try to determine how the affective intent of what a person may say is different than the verbal content.

C. Come to group discussion prepared to share how you are trying to understand more accurately some of the important people in your life from their frame of reference.
Tenth Session - Unit VI, Practicing Interpersonal Perception

I. Have you become aware of how you have used implicit personality theory?

A. How have you used **stereotyping**?

B. **Trait attribution** is used to place an emphasis on the traits or behavior you value highly. Can you give examples of belief about others that illustrate this perception of people?

C. Distortions in our perceptions of others may result in cases of **assumed similarity**. This happens when we perceive others as having the same values, motives and goals that we have. Can you give examples?

II. Share list of emotions and review their characteristics.

A. Have a name of an emotion placed on cards:

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<tr>
<th>Emotion</th>
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Give each member of the group an emotion to non-verbally express and have the group hypothesize until they identify the emotion.
B. Now ask group members to identify verbal communications of emotion.

C. Give assignments with suggested situational context—let the group again hypothesize until correct.

D. Have the group share examples of how they are trying to perceive a situation from the other person's frame of reference.

Discussion:

Assignment:

A. What perceptions of others have you changed or would like to change?

B. What situations in your life produce for you an environment in which it is difficult to listen with understanding?

C. How do defense mechanisms work in your life? What part does anxiety have in developing these behaviors?

D. How does drinking alcohol or using drugs contribute to the development of defense mechanisms?
Eleventh Session - Unit VI, Practicing Interpersonal Perception, continued

I. Review defense mechanisms and enlarge on questions from the last assignment.
   A. How does the unpleasant emotion of anxiety lead to the development of a defense mechanism?
   B. What is the purpose of a defense mechanism?

II. Review what it means to listen with understanding.
   A. How does one see another person's point of view from that person's frame of reference?
   B. What are some sources of error in interpersonal perception?

Personalization Exercise: Use proficiency tests on Units I and V as a way of reviewing the major defense mechanisms and the perceptual approach to understanding others.

Discussion:

Assignment:
   A. Bring some examples of ways you have tried to listen to someone with understanding. What feelings did you experience? Did you find it difficult to keep from judging or evaluating?
   B. Be prepared to share sources of error you have identified as problems in your interpersonal perceptions of others.
   C. Review the exercises on pages 130-135.
Twelfth Session - Summary

I. This session will be structured to give the group members an opportunity to share positive feedback with each other.

II. A brief summary statement should be made by the therapist outlining the progress the group has made during the past three weeks.

Personalization Exercise: The strength bombardment exercise adapted to support improved self concept and interpersonal perception accuracy. (From Herbert A. Otto’s Human Potentialities Research Project, University of Utah, Salt Lake City, Utah.)
APPENDIX E

Profile of MMPI Pretest Differences for GBPT and RP Groups
The Minnesota Multiphasic Personality Inventory

Stark R. Hathaway and J. Chamley McKinley

Male

Score's Initials ____________________________

M M P I Pretest Differences for GBPT and RP Groups

GBPT ____________________________ RP ____________________________

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TSCS Pretest Differences for GBPT and RP Groups
APPENDIX G

Profile for POMS Pretest Differences for GBPT and RP Groups
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GBPT  
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POMS Pretest Differences for GBPT and RP Groups

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APPENDIX H

Profile of MMPI Pre-Posttest Differences for GBPT Groups
The Minnesota Multiphasic Personality Inventory
Starke R. Hathaway and J. Charnley McKinley

Scores's Initials

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Pretreatment          Posttreatment

MMPI Pre-posttest Differences for GBPT Groups

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APPENDIX I

Profile of TSCS Pre-Posttest Differences for GBPT Groups
TSCS Pre-posttest Differences for GBPT Groups
APPENDIX J

Profile of POMS Pre-Posttest Differences
for GBPT Groups
**POMS PROFILE SHEET**

**MALE (OM)**

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Pretreatment ____________________ Posttreatment ____________________

**POMS Pre-posttest Differences for GBPT Groups**

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APPENDIX K

Profile of MMPI Posttest Differences for GBPT and RP Groups

121
The Minnesota Multiphasic Personality Inventory

Stark R. Hathaway and J. Charnley McKinley

Scorer's Initials

Male

MMPI Posttest Differences for GBPT and RP Groups

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APPENDIX L

Profile of TSCS Posttest Differences for GBPT and RP Groups

123
APPENDIX M

Profile of POMS Posttest Differences for GBPT and RP Groups
### POMS Profile Sheet

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