ABSTRACT

GETTING WORSE BEFORE GETTING BETTER: USING CONTENT ANALYSIS TO EXAMINE THE CHANGE PROCESS IN A TIME-LIMITED PSYCHODYNAMIC GROUP THERAPY FOR SOCIAL PHOBIA

By Michael Andrew Gray

Research involving the assimilation model of psychotherapeutic change has suggested that psychodynamic therapies, when successful, often involve a degree of “getting worse before getting better.” That is, there is an increase in client distress across early sessions of therapy followed by improvement as treatment progresses. This study examined this pattern in the context of a content analysis of a group therapy for social phobia. Four clients participated in up to 10 sessions of group therapy. Through intensive contact with transcripts of the sessions, investigators constructed a system of content categories for coding client dialogue and its associated emotional valence, which was then applied by independent raters to the transcripts. The results of this procedure suggested that although the reliability of the coding system was not high, there was some support for the “getting worse before getting better” phenomenon as a component of the therapeutic change process.
GETTING WORSE BEFORE GETTING BETTER: USING CONTENT ANALYSIS TO EXAMINE THE CHANGE PROCESS IN A TIME-LIMITED PSYCHODYNAMIC GROUP THERAPY FOR SOCIAL PHOBIA

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“Getting Worse Before Getting Better:” Using Content Analysis to Examine the Change Process in a Time-Limited Psychodynamic Group Therapy for Social Phobia

The purpose of this study was to explore the content of group therapy for social phobia and examine the possible contribution of a getting worse before getting better pattern predicted by the assimilation model of change in psychotherapy, that is, an increase in client distress that may precede client improvement in psychodynamic therapy.

Theories of psychodynamic psychotherapy generally assert that meaningful therapeutic change occurs when problematic experiences, assumed to be unconsciously affecting clients in a negative way, are brought to the client’s awareness, allowing him/her some degree of insight into their cause (Freud, 1920/1966; Konig, 1995). Research involving the assimilation model of change in psychotherapy (Stiles, Elliott, Llewelyn, Firth-Cozens, Margison, Shapiro, & Hardy, 1990), a system for describing the processing of problematic experiences in therapeutic interactions, provides a language for conceptualizing this claim. The assimilation model suggests that psychotherapeutic change occurs as a client’s negative or painful experiences (which are, by definition, unwanted by the client) become integrated among the larger collection of other experiences within the client. Clients, who may be unaware or confused about the roots of their problems, achieve increased clarity and insight into the experiences that caused their distress. This information can come to be used as a resource, as clients learn to take the self-knowledge they have acquired and use it to cope with future stresses.

In this research, a content analysis procedure was employed to explore eight distinct areas of theoretically relevant content as they appeared in the dialogue of four clients who participated in a group therapy for social phobia. The ten (10) sessions of the
therapy were transcribed, and trained raters coded this content (which included references to symptomatology, references to past interpersonal encounters related to social phobia, etc.) and rated the emotional valence associated with this content. These ratings were then examined in light of the postulates of the assimilation model to describe how each member of the group changed in the therapy.

Social Phobia: Background

The DSM-IV (1994) criteria for the diagnosis of social phobia includes a) a marked and persistent fear of one or more social performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others; b) exposure to the feared social situation almost invariably produces anxiety; c) the person recognizes that the fear is excessive and unreasonable; d) social or performance situations are avoided or else endured with intense anxiety and distress; e) the avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person’s normal routine, occupational (academic) functioning, social activities or relationships, or there is marked distress about having the phobia. Individuals with social phobia are plagued by intense fears of humiliation and worry that others will judge them to be weak, crazy, or stupid. Persons with social phobia often experience a vicious cycle or anticipatory anxiety. In these cycles, their excessive fear and self-consciousness concerning social performance elicits from others the aversive social responses they dread, confirming and perpetuating their existing beliefs.

The most popular current treatment for social phobia is cognitive-behavioral therapy (CBT). CBT is generally geared toward modifying the immediate cognitions associated with a social phobic's fears while concurrently exposing the individual to
feared situations and retraining their behavior to be more adaptive in those situations. Research on CBT has shown it to be effective as a treatment for social phobia (see Heimberg & Juster, 1995 for an excellent review), but there is a lack of literature concerning the efficacy of alternative treatments for the disorder.

This paucity is somewhat surprising, as there has been work suggesting social phobia may be more complicated than other phobias. Both Hoffman, Norman, Becker, Taylor, and Roth (1995) and Sloane and Slane (1990) have done work suggesting a significant comorbidity between DSM-IV Axis I anxiety disorders and Axis II personality disorders. Turner, Beidel, and Townsley (1992) indicated that social phobia is often coexistent with avoidant, schizotypal, and borderline personality disorder. These authors suggest that treatment with social phobics with personality disorders would have to address not only the specific aspects of the individual's social fears, but also the underlying personality problems that serve to further complicate those fears. This recommendation—to examine the use of alternative, depth-oriented treatments was a major motivation for this research.

**The Assimilation Model: Background and Theoretical Frame to the Study**

The assimilation model (Stiles, Elliott, Llewelyn, Firth-Cozens, Margison, Shapiro, & Hardy, 1990; Honos-Webb, Surko, Stiles, & Greenberg, 1999) is a general model for describing the process of change in psychotherapy across a variety of therapeutic approaches. Clients are thought to understand their life experiences in a consistent and organized way that helps them to more successfully navigate their world. That is, they generate and continually refine *schemas* based upon their experience. When
they encounter problematic experiences, broadly defined as memories, wishes, feelings, or ideas that are painful and distressing, client’s schemas are challenged by this new, discrepant information and must be reworked in light of the disturbing influence. This reworking, or healing, encompasses the bulk of the time that clients spend in therapy and typically unfolds in a predictable, sequential series of steps. These steps describe the changing relationship between the client's perspective and the problematic experience with which they are struggling.

When a client is without any awareness of the effect of a problematic experience on his or her life, he or she is said to be at the lowest stage of assimilation, stage 0. In this stage, termed warded off/dissociated, the client expresses limited/restricted affect, and the problematic experience may manifest itself as somatic complaints or acting out. In the first stage of actual assimilation, “unwanted thoughts/active avoidance,” the client becomes aware of his/her problematic experience largely through external circumstances, like a therapeutic intervention. The affect associated with this stage is largely negative, and the problematic experience is actively driven from consciousness. Stage two, termed vague awareness/emergence the client is becomes aware of their problematic experience but unable to clearly articulate it. This stage is often associated with the most acute distress, as the problematic experience is present in the client’s overall experience but lacks the boundaries that make it capable of being processed.

Stage three, problem statement/clarification, is marked by the emergence of a clear statement of the problematic experience from the client. In this stage, affect remains negative but less so than at lower levels of assimilation, and by definition, the
client experiences the problem as less confusing and pervasively oppressive than he or she did before.

The next four stages, which explicitly address the relationship to the problematic experience once it has been clearly articulated, are generally characterized by the improvement of the client’s overall condition and are marked by positive increases in client affect. In stage four, **understanding/insight**, the clarified problematic experience becomes is more clearly understood and some sense of the meaning of the experience becomes available to the client. Stage five, **application/working through**, finds clients using the insight that they have gained to begin addressing and understanding their problematic experiences.

**Resourcefulness/problem solution**, the sixth stage of assimilation, features the emergence of new relationship between the client and their problem. The problematic experience is seen less as a problem within the client’s frame of reference and has instead become a new resource for the client to use in solving other problems in his or her life.

The final stage of the assimilation process is called **integration/mastery**. In this stage, the client’s problematic experience becomes fused within the client’s perspective and is experienced as inseparable from it. The client is very quickly able to generate solutions to new problems based on the formerly problematic experience. A summary of the stages of the assimilation model is contained in Table 1.

**Assimilation and Exploration-Oriented Therapies**

Research involving the assimilation model has suggested that exploration-oriented therapy modalities (such as psychodynamic and interpersonal approaches) often manifest
a pattern of an increase in client distress in the initial stages of the therapy process (Stiles, Barkham, et al., 1992; Reynolds, Stiles et al., 1996; Stiles, Shankland et al., 1997).

Exploration-oriented therapy modalities assume that some portion of a client’s problematic experience is unconscious and beyond the client’s immediate awareness. Such therapies are typically focused at the lower stages (0 or 1) of assimilation and often involve challenging and clarifying aspects of a client’s conscious life that are assumed to be indicative of unconscious emotional conflict. Clients are asked to explore painful experiences from the past so that they can be worked on in the therapy relationship. This often comes with some negative consequences for the client, as the work to revisit negative life events and push through ambivalence about them is often painful and exhausting.

In assimilation terms, the client moves from the very near obliviousness of stages 0 and 1 towards a growing awareness and clarification of the scope and breadth of their problematic experience (stages 2 and 3). This movement is often characterized a marked increase in the client’s level of experienced psychological distress. In a sense, the client is moving metaphorically "closer" to his/her problems. As the distance between the client's frame of reference and the problematic experience itself becomes progressively smaller, the client's affect related to the experience becomes progressively more intense.

At the same time, the goal of exploration-oriented therapies is the generation of insight (APES stage 4) and the working through/application of this insight into the daily life of the client (APES stage 5 and beyond) and therefore, a bulk of the time spent in therapy is also directed towards interventions intended to improve the client's quality of life. Once the roots of problematic experiences have been exposed, they can then be
questioned and reexamined. The client is able to move to a position of greater harmony concerning the diverse experiences, both positive and negative, that make up his or her past.

Thus, the assimilation model suggests that one way of viewing psychodynamic therapies is that they involve some degree of getting worse (the distress produced while exploring warded off negative experiences) before getting better (the relief and accomplishment associated with understanding and working thorough one’s problems). Interestingly, there appears to be some convergence in thinking about this process in the writings of psychodynamic thinkers scholars, specifically concerning the concept of resistance.

Resistance is the term used to describe those actions by clients, sometimes conscious but often unconscious, to prevent therapy from uncovering and addressing deeply-rooted intrapsychic conflicts (Freud, 1920/1966; Konig, 1995; Cullari, 1996). According to dynamic theorists, resistance is instinctive and self-protective. It constitutes the work of the ego to protect itself from frightening feelings that accompanied conflicts early in the developmental life of the client (Glick, 1995; Freud 1926/1946).

At the same time, resistance is ultimately self-defeating with respect to therapy. If unconscious conflicts are unable to surface and play out in the transference relationship between the client and therapist, those conflicts will continue to be a source of distress to the client. Thus, resistance must be addressed by the therapist and client, and a tone must be set in the therapy relationship such that the client is guided towards doing insightful if sometimes unpleasant work (Cullari, 1996).
The psychodynamic theoretical account of working against resistance converges conceptually with the assimilation account of the process of exploration-based therapies. From both perspectives, a central part of therapy involves bringing unconscious conflicts into a position of salience. This process that is usually associated with some distress and re-living of negative past experiences. Therapists and clients must push through this discomfort, however, as this work is necessary for bringing about insight, which clients need in order to make lasting positive changes in their lives.

Content Analysis

One useful method for observing the process of assimilation in psychodynamic therapy is through monitoring shifts in the content of client discourse. A similar approach was adopted in an analysis of a cognitive-behavioral group therapy (CBGT) for social phobia by Biran, Simons, and Stiles (2002). The authors note that observing shifts in the content of therapy provides valuable information about the scope of client symptomatology, the integrity of treatment (that the dialogue of the therapy is to some degree confluent with the goals and postulates of treatment), and client maladaptive interpersonal patterns. Examining the transcripts of the completed group, the authors used a recursive procedure, guided by their knowledge and beliefs about both CBGT and social phobia, to generate a set of 20 categories to describe the content of a completed group therapy. An independent group of trained raters then coded written transcripts of the therapy using these categories.

The authors suggested that content coding can be a valuable means of “recontextualizing” (p. 237) meaningful portions of the therapy, i.e. rearranging significant episodes and moments from the whole of treatment to provide an account of
those change processes that occurred within it. Thus, the content analysis functions almost like a literary procedure, with researchers treating the incidence of theoretically-relevant content as indicative of central therapeutic themes in treatment. These themes are then examined and combined to create a meaningful account of the psychological processes at work in the group.

Purpose and Design

The purpose of this study was to explore psychodynamic therapy from an assimilation perspective through the intensive study of a single group therapy for social phobia. Using a procedure similar to that used by Biran, et al. (2002), a content coding system was generated through intensive examination of the transcripts from a completed group therapy conducted in the spring of 2000. Eight (8) theoretically-significant areas of content were identified and independent student raters applied the system to the transcripts of the therapy. Raters were charged with noting both the presence of specific content in the dialogue of the clients as well as the emotional valence that was assumed to accompany the content. It was expected that the emotional tone of the client’s dialogue would follow the “getting worse before getting better” pattern predicted in both the assimilation and psychodynamic literature. That is, the valence of client expressions would show a trend towards negativity at the beginning of therapy and gradually become more positive as the therapy progressed.

Thus, the goals of this project were twofold. The first goal was to assess the reliability and applicability of the coding system to client discourse across sessions of the therapy. Second and related to the first goal is to describe how the significant content and valence of client speech changes throughout the process of therapy, with specific
focus upon how those changes are consistent with the predictions of the assimilation model and the “getting worse before getting better” pattern. To accomplish this, the data from the coding/rating procedure, as well as clinical observations by the author (who participated as therapists in the group), were synthesized together to construct a detailed account of what occurred in the therapy.

Method

Participants
The participants in this study were solicited by advertisement in local college and community newspapers. The respondents were interviewed by the author and inclusion in the study was based on applicant adherence to the DSM-IV criteria for social phobia. Exclusion criteria included major depressive disorder, substance abuse or dependence, and psychosis. All participants gave informed consent to participate in treatment and were made aware both before and during the group that the information they provided would be kept confidential by the therapists and raters.

From the pool of 6 persons who responded to the advertisement and were interviewed, 4 persons were selected for inclusion in the group. Unintentionally, all of the subjects who were included in the study were divorced Caucasian females, with ages that ranged from 29 to 53. All but one client, #2, had previously received some type of mental health care service. The sessions were co-facilitated by a male graduate student in clinical psychology and a licensed female clinical psychologist. The latter had been a practitioner for over 20 years and had extensive experience with psychodynamic group therapy.
Client #1 was a divorced mother of two in her late 30’s. She was a licensed clinical social worker, and had come to the group because of some problems with public speaking. For additional income, this client had facilitated training workshops on clinically relevant issues (such as identifying signs of on-going sexual abuse in preverbal children) for the local police and other public services workers. She had recently completed one of these workshops and had received some negative feedback concerning her performance, which she experienced as a significant blow to her confidence and a questioning of her professional abilities.

Client #2, at 28, was the youngest member of the group. She had no children, and she and her husband of 3 years had recently been through a relatively amicable divorce and she came to the group with concerns related to anxiety triggered by meeting new people and asserting herself socially without her husband.

Client #3 was a self-described “support group junkie,” she was a divorced woman in her early 50’s and she had come to the group with concerns about spending the remainder of her life alone and feeling anxious when attempting to form social relationships with persons who were around her age. She was a teacher at a local junior high and related that she had very few friends on the faculty and little if any contact with anyone who was not one of her students. Client #3 had two children by her former husband; a son that was currently away attending college and a 13-year-old daughter who lived with her in an isolated rural area.

Client #4 was a divorced woman, also in her early 50’s, who worked as a nurse at a local school. She joined the group with concerns about being excessively anxious
around strangers at formal social gatherings, which she attended regularly with her second husband.

*Treatment*

The therapeutic treatment was a variation of Short-Term Restructuring Psychotherapy as detailed by Magnativa (1997), a psychodynamic therapy utilizing Freud’s tripartite structural theory of the mind as a theoretical base. The treatment is focused upon exploring difficulties at the level of defense (maladaptive interpersonal and client/therapist interactions, cognition (inappropriate or distressing thoughts) and affect (painful or overwhelming negative emotions). It is characterized by a strong focus on the client’s core/central disturbances and conflictual issues, a high level of activity by the therapist, the early and frequent use of therapist interpretations, the maintenance of a high level of emotional arousal for the client, an attention to time limitations, a rapid derepression of unconscious conflict, and a focus on deep emotional contributions to psychopathology.

Therapy sessions lasted approximately 90 minutes each. During the first 20 to 30 minutes, the group members engaged in unstructured discussing on topics ranging from general “catching up” to their thoughts about their social fears, their feelings concerning the therapy, and events outside of therapy related to the course of treatment. The therapists had very little interaction with clients during this time-period. After the half-hour mark in each session, the therapists gradually asserted their presence in the group and began more focused interventions with the group members.

Client attendance was mixed. Clients #2 and #3 attended all of the sessions, Client #1 was present at all sessions but one (session 8), and Client #4 attended six sessions.
Client #4 reported experiencing some confusion about the starting date for the group and joined the group three weeks after it had begun.

Each of the ten sessions was transcribed from video and audiotape recordings of the group, with the bulk of the transcribing being completed by the author. In the interest of timeliness, however, some outside aid was used in the transcription process, and research assistants were responsible for completing major portions of sessions 1, 4, 5, and 7.

**Self-Report Measures**

All participants were administered a battery of questionnaires both prior to and immediately following their participation in the group as a means of assessing the general degree of improvement/distress reduction they experienced throughout the treatment process. The measures included the Beck Depression Inventory (BDI: Beck, 1972; Beck and Beamsderfer, 1974), a 27-item questionnaire designed to measure the types and intensity of depressive thoughts, the Symptom Checklist 90 Revised (SCL-90-R: DeRogaitis, 1977), a 90-item checklist designed to measure the severity of client symptomatology in a variety of clinical domains and the Social Anxiety and Distress Scale (Watson & Friend, 1969), a 35-item survey to assess the intensity of client distress in specific relation to DSM criteria for social phobia.

**Coding System Development**

There were many steps involved in the generation of the content categories. First, investigators (including the two co-therapists and four undergraduate researchers who had been responsible for observing and videotaping the therapy) met for several weeks and reviewed the transcript of the first session of the therapy, as well as the content analysis work completed previously by Biran et al. (2002). The investigators were
encouraged to brainstorm and elaborate any potential categories that were logically connected to social phobia and psychotherapy. From these meetings, a rough draft set of 15 content categories was constructed. The categories ranged from mentions of specific behaviors (i.e. avoidance reactions in anxiety producing situations) to general types of utterances (i.e. insight-oriented reactions).

Next, this rough draft of the coding system was distributed to another group of 4 undergraduate research assistants. They were asked to apply the system to selected sections of the therapy transcripts. During this procedure, two important issues were raised. First, the number of content categories (15) was too large. The cognitive load of the rating task made it difficult for raters to concentrate on reaching a consensus concerning how each category appeared in the actual wording of the transcripts. Second, although content from some of the categories—such as references to a need for control in daily life—were distinct and identifiable in client speech, it was difficult to determine how they were related to fundamental aspects of the therapy.

To address these issues, the content categories were once again revised. The number of categories was halved, from 15 to 8, to reduce the cognitive demands of rating. Second, the additional dimension of emotional valence was added to the content category ratings, with the scaling ranging from 1 (extremely negative) to 5 (neutral) to 9 (extremely positive). Thus, raters using the system would now be (1) coding the presence or absence of theoretically significant content and (2) rating the intensity and directionality of the affect associated with the content, when it was present. The final list of content categories, with a breakdown of each categories’ specific component criteria,
are detailed in Appendix B, which contains a copy of the guidelines that were given to raters. An abbreviated list of the categories is listed in Table 2.

**Raters and Rating Procedure**

Three undergraduate psychology majors at Miami University served as raters in this project. Raters were recruited from an advanced course in child psychopathology at the time that the project began in and were in good academic standing.

Raters were trained over a month-long period. Using transcripts from previous group treatments for social phobia, raters were taught to use the coding system with clinical material. Raters also worked together to reach a consensus concerning the use of the valence ratings and together with the author, established guidelines for inferring client affect from the text. Raters participated in several practice sessions (3), during which they coded a small sample of therapy text similar to the text of the group therapy. Reliability analyses were performed on the results of the these practice sessions with raters present, and they were given immediate feedback on how to improve the accuracy of their coding.

The raters coded the content and rated the affect in the session transcripts from the group therapy over a period of 1.5 months, at a rate of roughly 2 therapy sessions per week. Raters were given the full transcript (i.e. the dialogue of both the therapists and the clients was included) of each of the ten therapy sessions, with each client speaking turn individually numbered. On rating sheets, raters (a) coded each speaking turn into one of the content categories and (b) rated the emotional valence (on the 1 to 9 scale) of each turn that was so coded. In all, there were 3,493 potentially ratable client passages in the transcripts of the ten therapy sessions. To avoid confounding order of rating with
session number, raters were presented with the sessions in a random order, however, all raters rated transcripts in the same order. The rating sheet used to collect rater responses is included in Appendix C.

Initial analyses of participant ratings suggested that rater fatigue was a problem. There was a marked decline in rater reliability over time, and the final three sessions presented to the raters (Sessions 2, 8, and 9, respectively) were rated particularly unreliably. It was decided that raters would re-rate these particular sessions following a short break of approximately 3 weeks in duration. When the re-rating procedure began, one of the original three raters was unavailable for continuing the project and at that time, it was decided that this individual’s ratings were incomplete and would not be included in the final data analysis.

Results

Self Report Measures

Each participant had a different pattern of results on the self-report measures (Table 3). Client #1 showed marked improvement all the measures. Her initial BDI score was in the mildly symptomatic range (12) and dropped to 1 at the end of treatment. She had similar large decreases on the SCL-90-R (.80 initial to .20 at treatment end) and on the SADS, which dropped from 5, a score indicative of very mild social anxiety symptoms, to 0, suggesting improvement in that domain of functioning.

Client #2, on the other hand, showed little improvement on the measures. Her initial score on the BDI was in the very mildly symptomatic range (7) and had in fact increased at the conclusion of therapy, albeit only by a single point. Her SCL-90-R score dropped from .64 to .43 at posttreatment, suggesting some general improvement, but she
had little change in her SADS scores (26 to 22 at the end of the group) and remained in
the range considered symptomatic of severe social anxiety.

Client #3's differed from both Client #1 and #2. She scored in the very mild
range on the BDI (a score of 9), and had an identical score at the end of the group. Her
SCL-90-R score dropped from .98 to .45, and her scores on the SADS showed little
change and remained in the highly symptomatic range at posttreatment (26 to 22).

Client #4, in contrast to Clients #2 and #3, had scoring profile like that of Client
#1 and improved on all measures. Her BDI score dropped from 12 to 2, her SCL-90-R
score from .50 to .12, and her SADS from 10 to 4. She, like Client #1, appeared to
receive some relief as a result of participating in the group.

Coding System Reliability

Kappa coefficients and Interclass Correlation Coefficients (ICC) were calculated
to assess the reliability of rater responses in applying the coding system to the transcripts
of the therapy. Kappa values index the agreement between coders concerning the content
in each speaking turn. ICC values (I used the ICC designated ICC (3, 2) by Shrout &
Fleiss, 1979, which treats rater variation as a fixed effect), measured of the agreement
between raters in the frequency of each code used by each client in each session across
the ten sessions. Thus, the reliability analysis examined rater agreement on each
category using two different units: the individual speaking turn (Kappa values) and
frequency of use per session (ICC values).

Judgments concerning the strength of rater agreement were guided by the work of
Landis and Koch (1977) and Fleiss (1981). Landis and Koch suggested the following
standards for determining the strength of kappa values: .2 to .4 is considered fair, .4 to .6
is considered moderate, and .6 to .8 is considered a substantial degree of agreement. Fleiss, concerning the significance of ICC values, suggested the following guidelines: <.40 is poor, .40 to .59 is fair, .60 to .74 is good, and .75 or higher is excellent.

Raters noted the presence of codable content in 658 passages of client speech, which represented approximately 18.8% of the total 3,493 passages of client discourse in the therapy. Raters were most reliable identifying content related to references to assertive, approach behaviors in response to feared situations and to medications/medical consultations. As shown in Table 4, the highest kappa value generated for any of the individual content categories was .75 for category 1 (approach) and .75 for category 7 (medical). Kappa coefficients were in the moderate range for all of the other coding categories, excepting code 6b (emotional symptoms), code 5b (significant interpersonal encounters, past), code 8a (personality/self statements), and code 4b (experiences with social phobia, past), which had coefficients that were in the fair to poor range.

The Kappa coefficients were almost always higher than the ICC values for each content category (Table 4). Only one category, code 6d (avoidance reactions), had an ICC coefficient that was near the excellent range and the ICC associated with nearly all the other categories fell within the moderate to poor range. The difference in the Kappa and ICC scores suggests greater agreement between raters concerning the presence of codable content in individual speaking turns than across each of the sessions. It is possible, however, that these differences are simply an artifact of the low usage of several of the codes (such as 1, 2, and 4b). That is, they could be less attributable to a lack of agreement between raters, but more so to limitations in the utility of the content categories themselves, and issue that is discussed further in the Discussion section.
Content Analysis

The content that was most frequently identified by raters was symptomatology, as codes 6a through 6d were identified in 212 of the 658 coded passages (32.2 %). Code 3 (references to the group) was also used extensively and appeared 154 times (23.4 % of total) in the ratings, as was code 5a (significant interpersonal interactions, current), which appeared 118 times (17.9 % of total). The least frequently identified content involved code 5b (significant interpersonal encounters, past), code 4b (experiences with the phobia, past), code 2 (insight reactions), and code 1 (approach/mastery behaviors). These categories were each identified in fewer than 10 (1.5 %) of the passages coded.

Codable content was identified far more often in the first half of the therapy than in the second half (Table 5). Of the 658 passages determined to contain significant content by the raters, 477 (72.4 %) were in the first 5 sessions of the therapy. The codes that most often appeared during the first half of the therapy were references to the group (code 3) and symptomatology, particularly emotional symptoms (code 6b). Emotional symptomatology was the most prominent type of content identified in the last 5 sessions of therapy, with the next most often identified type of content being references to significant current interpersonal experiences (code 5a).

Valence Ratings

The ICC comparing each of the trained raters valence judgments was .50, which, according to standards set by Fleiss (1981), suggests that raters were moderately reliable in their valence ratings. As shown in table 3, the categories with the two highest mean valence were approach behaviors (code 1) and insight-oriented statements, which are both types of content associated with improvement and decreased distress in therapy and
should have theoretically received the highest valence ratings. Not surprisingly, the mean valence ratings for the different types of symptomatology (code 6 a-d) were very low, suggesting that raters believed that content of this kind to be associated with negative affect and distress. The mean valence ratings for codes 4 and 5 were also well below neutral, whereas codes 3, 7, and 8 all had mean valence scores that were very close to 5, the value associated with neutral affect.

Each client produced different patterns of valence ratings across the sessions of treatment. As shown in Figure 1, Client #1’s ratings started at just below neutral at the beginning of treatment, dipped substantially across sessions 3 (M=3.56) and 4 (M=3.50), and then gradually climbed back up to slightly above neutral at the end of the 10th session (M=5.63) of treatment. This pattern of affect is consistent with the “getting worse before getting better” pattern predicted by the assimilation model of psychotherapeutic change, as the client’s discourse in therapy showed an increase in distress that preceded an improvement.

Client #2’s valence scores were different. Her valence scores were consistently just below neutral for the first five sessions of therapy. The mean valence then dipped sharply and became very negative in the 6th session (M=3.21) before it rose to nearly neutral for sessions 7 (M=5.42) and 8 (M=4.75). In the final two sessions, however, the mean valence dropped sharply again, and the client had mean valence of 3.50 at the end of treatment.

Clients #3 and #4 had similar valence profiles, both of which are different than those for Clients #1 and #2. Both of these clients had mean valence scores that were at or
above neutral at the beginning of therapy but which steadily declined ($M=2.0$ for Client #3 for the final session; $M=3.20$ for Client #4) across the ten sessions of the therapy.

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Discussion

The goals of this project were twofold. The first goal was to assess the reliability of the new coding system. The second goal was to describe how the codable content and the valence of client speech changed across the ten sessions of the group therapy, making specific note of how these changes were theoretically relevant to the assimilation model and the “getting worse before getting better” phenomenon.

With respect to the first goal, the results of the reliability analysis of the coding system were mixed. The raters were most adept at identifying code 7 (content related to consultations with medical professionals), code 8b (statements of worldview, code 1 (approach behaviors in response to feared situations), and code 6a (physical symptoms of anxiety). Categories associated with these types of content received relatively high reliabilities. The majority of the content categories were rated in the moderate to fair range, excepting code 4b (past experiences in connection to social phobia), which was noted only once by either of the coders and yielded a very poor reliability rating.

The reliability for the valence ratings was in the “fair” range, again suggesting that there was not a substantial amount of agreement amongst raters concerning the affect associated with codable content in the therapy transcripts. As a whole, the reliability of both the content and valence ratings were mediocre, suggesting the coding system in its present form is in need of revision. The system seemed more useful for describing the
first five sessions of the therapy than the latter five, and thus needs reworking to more effectively account for diverse therapeutic content.

The majority (nearly 75%) of the content identified by raters appeared in the first five sessions of therapy, the bulk of which concerned client’s reactions to the group (code 3), their symptomatology (codes 6a-d), and significant past interpersonal events. The second half of therapy featured the presence of far less content, and the majority of what was coded concerned code 6b, the emotional symptomatology of social phobia. The implications of this finding (i.e. that the coding system was perhaps more problem- than solution-focused) is discussed later, in the Methodological Improvements/Future Directions section.

With respect to the valence of client affect throughout therapy, only one client--#1--displayed a pattern that seemed to conform to the “getting-worse-before-getting-better-pattern” as described by the assimilation model (Stiles et al., 1992; Stiles et al., 1997). Client #1 entered therapy at a moderate level of distress, which dramatically at sessions 3 and 4, and then made progressive improvement until the end of therapy. Client #2, appeared to become more distressed as a result of therapy and left treatment with a mean valence that was nearly a half point lower than when she began coming to therapy. Clients #3 and #4 showed little change across treatment and like Client #2, appeared to leave therapy with a level of distress that was markedly worse than at the outset of therapy.

It is important to note, however, that the observed pattern of outcomes for Clients #2, #3, and #4 may be more of a function of the therapy being unsuccessful than a lack of support for the change process as predicted by the assimilation model. The assimilation
model provides an account of the change process in therapy that is successful, and when the therapeutic experiences of these three clients are examined more closely (as will be done in the next section), it appears that this may not have been the case. The therapy may not have been as long or intensive as it needed to be to facilitate significant change with these clients, an issue that is addressed further in Methodological Improvements/Future Directions section.

In light of the problems with the content coding, it seems useful to provide a more clinically-oriented account of what happened in the therapy. This type of analysis, using passages from each of the clients with the observations of the author (who also participated as a co-therapist in the group therapy), is presented in the next section. Qualitative/Clinical Observations

In this section, qualitative and clinical observations concerning each of the participants will be brought together with the information from the content coding to provide a more rich account of the processes that shaped the clients' outcomes.

Client #1 generally responded favorably to treatment. As she was an experienced practitioner of therapy, she was verbally adept and able to talk openly and lucidly concerning her problems. At times, however, she tended to slip into the role of therapist and would interpret statements by other group members, often seemingly in an attempt to avoid speaking at length about her own concerns and anxieties. She was also often critical of the open-ended and non-directive format of the group, frequently expressing her displeasure with statements like the following:

Client #1: I’m angry because I hate this talking in circles. That’s not, you know, the type of therapy that I give. You know, I don’t reflect it all back. It’s not my style. So I feel that when I ask a question and it’s all talked around, I see the
game and hate it. Give me a frank, solid something. Don’t try to connect it back to me. (Session #4, passage 201)

After some heated discussion of this in the fourth session, it became clearer that client #1’s difficulties with the style of treatment stemmed from her belief that because they did not offer advice, the co-therapists were less able or willing to hear her distress and attend to her central concern: an incident of sexual abuse that she suffered at the hands of an uncle when she was a very young girl. This incident profoundly impacted the client and left her with intense feelings of awkwardness and worthlessness, which she carried with her into her adolescence and adulthood. Compounding these negative feelings further were reactions of isolation and rejection from her parents, who were disbelieving and invalidating of her experience of the abuse and withdrew affection from her upon her insistence that it truly occurred. As she describes it:

Client #1: And so everything in your life, I think when that happens to you, is defined in terms of one damn event. Everything. What everybody says ... how everybody looks at you … Everything. How your relatives treat you, and don’t-- it’s because of that. (Session #4, passage 277)

Client #1 was able to articulate that her central concern was that as a result of this violation, something was terribly wrong with her and that her family, acquaintances, and even strangers were able to very readily perceive this about her. This fear, in turn, left Client #1 extremely uneasy in social and professional settings where she would be seen and evaluated by others. Over time in the group, however, Client #1 was able to become more accepting of herself, working through some of her very hurt feelings concerning the abuse and her family’s reaction to it.

From the perspective of the assimilation model (see Table 1), Client #1’s progress in therapy represented a move from stages 1 to 5. She entered treatment with a host of
undifferentiated but significant concerns related to social anxiety (stage 1) and had a central problem--sexual abuse--emerge (stage 2) under great duress in the fourth session of treatment. In turn, this problem was unpacked and clarified in its scope and implications (stage 3) and this knowledge enabled Client #1 to gain insight into how the problem affected her life in the present (stage 4). This insight paved the way for the client to do some substantial working through of the problem with the help of the therapists and other clients (stage 5), which appeared, on the basis of her outcome measure scores, to bring with it a significant reduction in her anxiety.

Just as the content of this client’s movement in therapy followed the predicted course for successful therapies by the assimilation model, her mean valence ratings followed the "getting worse before getting better" pattern. The client came into therapy with a moderate level of distress that “worsened” as her warded off conflicts emerged in therapy and were clarified. As the client gained insight into her problem and began working through it, however, her valence ratings improved considerably.

Throughout the first several sessions of the therapy, Client #2, the youngest member of the group, appeared uneasy with the emotionally charged nature of therapy and the amount of intimate disclosing that was being done by the other members of the group. She indicated that she had no specific traumatic experiences in her past like Client #1, that she had a generally positive and supportive relationship with her parents, and that she was a very happy person a majority of the time. She continued to have regular contact with ex-husband, whom she referred to as her “best friend,” and often expressed confusion that the group was not specifically focused upon more pragmatic matters like
building social skills and developing coping strategies for dealing with the stress of especially challenging social situations.

Client #2 seemed confused about how talking about negative experiences from the past would truly beneficial to anyone, as she believed that this lead to “thinking too much” and “dwelling” on hurtful things that would best be forgotten. As she indicated in an exchange in the second session:

Client #2: How many things should you actually let out, though? How many things that actually bother you should you actually express? You know what I’m saying? You know, like, things that you’re carrying around with you, things that you’re upset about or that are upsetting to you--why should you express that?

Interviewer #2: Why should you express that [negative experiences]?

Client #2: Yeah, like how much should you really express? Why should you always have to get it out in the open? (passages 153-154)

As therapy progressed, Client #2’s became more comfortable bringing internal conflicts to the group and was more disclosing about the aspects of her life that she found troubling. In the final two sessions of the group, she revealed that her relationship with her former husband was not as comfortable as she had originally indicated and that she had recently had an intense desire to become romantically re-involved with him. This longing for reconnection brought forth with it a powerful surge of complicated thoughts and feelings concerning a variety of topics, including fears about being alone and longstanding difficulties with emotional openness and vulnerability. Client #2 begun to feel overwhelmed, as she realized that she could no longer avoid reflecting on difficult questions about the direction of her life and what, if anything, would give her satisfaction. As she related in one particularly charged exchange in session 10:

Client #2: And it’s been very hard for me. And I feel like I am more sad now than I have been in years! And I don’t know if it’s because--I mean, I’m not
saying it’s this group, I’m just saying there are a lot of factors in my life and this one of them. But I’ve just been very—thinking a lot about my past and things I’ve done and things I’m going to be doing, where I’m going to be going, and it’s like—I just can’t explain it. I mean, I was at work yesterday and I just started crying! At my freaking monitor! And I was like, “What am I doing?” “Why am I crying?” You know? And I never do that, but I’ve done it a lot recently in the past 2 days. And I feel so lonely, so alone. (passage 91)

Client #2 was having a therapeutic breakthrough, as those parts of her experience that she regarded as unsavory—but were nevertheless centrally important to her quality of life—began to come forth into active expression. In terms of the assimilation model, Client #2’s movement in therapy seemed to represent a shift from stage 0 (warded off) to stage 2 (emergence). When she came into therapy, Client #2 was not yet ready or able to acknowledge the problems that she was facing, and only had the feeling that something in her life was not as it should be. As the therapy progressed, however, Client #2 became more comfortable with the format of the treatment and more trusting of the co-therapists and other clients, and this atmosphere of greater comfort made it easier for her to examine her thoughts and feelings. This introspection was very trying for Client #2, however, and it brought with it the painful emergence of many of the core conflicts she had previously been only partially able to acknowledge.

From an assimilation model perspective, by the end of the therapy, Client #2 had only reached the “getting worse” portion of the “getting worse before getting better” phenomenon. As reflected in her scores on the self-report outcome measures (Table 1) and in the mean valence ratings associated with her dialogue in therapy (Figure 1), her level of distress had not appreciably decreased in treatment and in some instances (most notably her score on the BDI), had actually increased. This data is intriguing in light of
Client #2’s clinical presentation, however, as her expressions of distress in group seemed to be genuinely connected to growing insight and self-awareness.

Client #2 likely needed to continue therapeutic work, to aid her in working through some of her problems that had come out in the group, and to help her to deal with them in a tolerable way. At the conclusion of the group, she was given referral information for additional therapy services and was strongly advised to continue building upon the work that she had already completed with another therapist. A particularly rich summary of Client #2’s growth in therapy occurred between she and Clients #1 and #3 in the final session of the therapy:

**Client #1:** It’s like when you break your arm and it heals wrong and you can’t even hold anything. The doctor says he can fix that arm, but it’s going to hurt to straighten out and untwist it. It’s gonna hurt like hell.

**Client #2:** I know.

**Client #1:** It hurts to get fixed.

**Client #2:** Yeah, it does.

**Client #3:** But you’re already on the way.

As therapy proceeded, it became clear that Client #3, the schoolteacher struggling with issues related to middle age, had a characteristic pattern of what she called “dumping” her feelings. “Dumping” consisted of engaging in episodes of rumination and intense emotional revelation--during which she would become overwhelmed to the point of near uncontrolled crying--concerning a specific topic of difficulty to her. Client #3 had longstanding problems with her ex-husband, who had been unfaithful to her during their marriage and had married his mistress, with her parents, whom she indicated were emotionally abusive and demanding of her until their deaths a few years prior, and with
her children--particularly her daughter--with whom she frequently fought. Client #3 was frequently overwhelmed by the stresses in her life, as she revealed in passages such as this one:

**Client #3**: My parents were sick for years with cancers. So it was homemaking and teaching and grading papers and raising kids and taking care of sick people. And you are spinning. I used to feel like I was spinning plates on sticks like the Ed Sullivan show. I don’t know if you know the analogy, but just too much too handle and just skimming the surface and doing the best you can with all these horrible loads you’re carrying. Then, arriving naked more or less at this point in life and wanting to fix things. (Session 1, passage 139)

Client #3, true to her description as a “support group junkie,” relied on the group as more of a source of emotional aid and appeared less able or interested in delving into the roots of the problems with which she constantly struggled. She was generally resistant to overtures by the therapists and other group members to take a more active role in confronting those things that bothered her. Additionally, she would sometimes engage in other activities while the group was going on, such as grading papers or crocheting, to disengage and avoid adding anything to lines of discussion that she found too upsetting or uncomfortable.

As the group concluded, Client #3 began to express serious concerns about the prospect of being on her own and without the support of the group. She indicated that she was thinking of taking up breeding dogs as a way of coping with the emptiness that she was anticipating feeling, and had brought a puppy to the group to sit with her on her lap as she met with everyone for the final time. In one particularly heated moment, Client #3’s feelings about the group ending surfaced intensely:

**Client #3**: But, (crying heavily) it just the way that it happens--school’s ending, the group’s ending and people die. It’s just the way it is.
Using the language of the assimilation model, Client #3 appeared to progress somewhere in between stage 1 (unwanted thoughts/active avoidance) and stage 2 (emergence) in therapy. The problematic feelings that she harbored--about her marriage, her parents, and her children--would surface in discrete and powerful bursts, but never for a period of time long enough to have them clearly delineated and identified. She could use the group as a source of comfort during painful moments of reflection, but as the prospect of separating from the group became salient in the last few sessions of treatment, she became increasingly agitated in anticipation of the emotional toll that parting would take.

By the end of treatment, Client #3 had only begun to experience the “getting worse” that comes before getting better, a trend that was reflected in both her scores on the outcome measures (she showed virtually no improvement) and the mean valence ratings for her speaking turns, which appeared to get progressively worse throughout the therapy. Therapy appeared to be unsuccessful in helping this client manage the level of distress in her life.

Client #4’s attendance was not consistent, as she missed four (including the first three) sessions of the group and would frequently leave early from the sessions to which she came. A school nurse in her 50’s, she did very little disclosing about her life and her past, but did indicate that she came from a large Catholic family in New York with a history of serious mental illness and that she had an older sister that committed suicide when Client #4 was in her twenties.

Client #4’s interpersonal style in the group was very animated and confrontational, and she would frequently challenge the other clients if something they
said or did struck her as “dysfunctional.” In the following exchange, from session 5, she became very adamant that Client #2’s father is a major cause for her anxieties and that she should in fact be very angry with him:

Client #2: I think that’s a good point, because I always felt like I had to be perfect. I feel like I-

Client #4: Hate your father!

Client #2: I feel like...

Client #4: I was upset with your father last week. And I felt like when I criticized your father, it was like you were really right there to defend him and I thought-

Client #2: Yeah, it pissed me off

Client #4: I know it did. I know, I know.

Client #2: I mean, no, I just ... nobody had ever like-

Client #4: Oh, you’re going to defend him.

Client #2: Well, don’t you understand why I defend him? He’s my dad.

(passages 350-360)

These types of exchanges were typical of Client #4, as she would often offer interpretations and advice to the other clients based on limited knowledge of their life circumstances. At times, it seemed that Client #4 adopted this style as a defense, a means of diverting group attention away from her own conflicts and problems onto some aspects of one of the other client’s lives, in spite of how appropriate or inappropriate her shifting of the focus may have been.

Before session 9, Client #4 indicated out of session that she had been receiving individual therapy through a private practitioner in town and that she saw that as the space where she did the more depth-focused work that resembled what other members of the group had been doing. After consultation with this therapist, it was decided that it
would not be a conflict of interest for Client #4 to attend the final session of the group. At this time, it also became clear that Client #4 was never truly engaged by the group and had volitionally withheld discussing serious personal problematic experiences in session. In light of this information, it is very difficult to speculate what effect that participating in the group had on Client #4. While is likely that the group was a consistent and supportive environment for her to share in, it is clear that Client #4 did not make a serious effort to engage in the process of therapy and thus, it is probable that she experienced very little progress as a result of her participation.

Methodological Improvements/Future Directions

My experience of conducting this study and analyzing the results has suggested several methodological revisions that would have improved this study and would improve studies like it in the future.

First, in the procedure used to design the coding system, only the first few sessions (sessions 1 through 3) of the group therapy were studied intensively. It was assumed that content that appeared consistently in these sessions would likely continue to appear across the remaining sessions of the therapy. As the content ratings indicated, this assumption was not accurate. Nearly 75% of the passages that were coded as containing significant content appeared in the first five sessions of the therapy. Apparently, the content of the later sessions of the therapy did not match the first, and the results from the content analysis were less informative about what specific changes in the content of client discourse occurred in the last five sessions of therapy.

In the future, it would seem wise to incorporate all of the sessions of the therapy into the process of deriving of the coding system. Time pressure was a factor in the
design of this study and the decision was made to begin training coders to use the coding system before the focus groups had considered the data from all 10 sessions. This decision was necessary, but ultimately costly to the quality of the system.

A second issue concerns the content categories themselves, many of which should undergo revision before being used in subsequent research. A number of the categories (codes 4 and 5, in particular) were very broadly defined and were consequently very difficult for the trained raters to reliability identify in the transcripts. Additionally, some of the categories (such as code 2—insight oriented reactions) concerned very complex, internal psychological processes that were difficult for raters to infer on the basis of reading transcripts. Before this coding system is again used, it would be advisable to clarify and narrow the scope of these categories.

An additional problem with the coding procedure involved how often the valence ratings were given by the trained raters. In this study, raters gave valence ratings only to passages that had been assigned a content code. The number of passages identified as containing content from the categories by raters represented only about one fifth of the discourse in therapy, so in effect, four fifths of the dialogue in therapy was not used in reaching conclusions about patterns of client affect.

To address this, future research could separate valence ratings from content ratings altogether. This would allow raters to use a substantially greater amount of the data from the sessions in making inferences about the valence of client discourse and not make valence ratings dependent upon the additional appearance of codable content.

On the other hand, valence ratings, done by outside raters, may not solely be the best way to assess the valence of client affect in therapy. A brief self-report measure,
surveying the client’s feelings and level of distress could be completed immediately following a session. This would be a useful additional way of cross-validating the construct of valence. Multiple sources of data, considering both client and observer perspectives on the emotional tone of the therapy, would be valuable for making clearer conclusions about the valence of client speech.

A third area of improvement with this study concerns the choice of treatment itself. In this study, the participants received ten, 90-minute sessions of group therapy, which may have not been sufficient to address the needs of the clients involved. Several of the participants had very involved and longstanding problems, and the brevity of treatment appeared to reduce opportunities to observe how they each changed in response to intervention. Specifically, Clients #2 and #3 would seemed to have benefited from longer, more intensive treatment as some of the problems that they were struggling with were just beginning their emergence in the final session of the group.

In light of this, future research would likely be improved by increasing the duration of treatment. While this would of course make therapy and the rating procedure more involved and time-consuming than it is currently, it would likely significantly enhance the quality of the project. Added time in treatment would give clients more opportunities to work on complicated and pervasive problems, which would likely both (1) increase the chances of therapy being successful and relatedly, (2) make content related to therapeutic change more readily detectable in client speech.

Although there were some difficulties in interpreting the results, the changes observed in several of the individual clients appeared to follow at least parts of the “getting worse before getting better” pattern predicted by the assimilation model of
change in psychotherapy. That being said, additional research, taking into consideration
the limitations of the methodology employed here, is still needed to continue to more
comprehensively examine how social phobia sufferers benefit from psychodynamic
therapy.
Reference


Stiles, W. B. & Angus, L. (2000) Qualitative research on client’s assimilation of problematic experiences in psychotherapy. In J. Frommer & D. L. Rennie (Eds.), *Qualitative Psychotherapy Research - Methods and Methodology*.

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This project is dedicated to them.
Table 1

Assimilation of Problematic Experiences Scale (APES)

0. Warded off/dissociated. Client seems unaware of the problem; the problematic voice is silent or dissociated. Affect may be minimal, reflecting successful avoidance. Alternatively, problem may appear as somatic symptoms, acting out, or state switches.

1. Unwanted thoughts/active avoidance. Client prefers not to think about the experience. Problematic voices emerge in response to therapist interventions or external circumstances and are suppressed or actively avoided. Affect involves unfocused negative feelings; their connection with the content may be unclear.

2. Vague awareness/emergence. Client is aware of the problem but cannot formulate it clearly--can express it but cannot reflect on it. Affect includes intense psychological pain--fear, sadness, anger, disgust--associated with the problematic experience.

3. Problem statement/clarification. Content includes a clear statement of a problem--something that can be worked on. Opposing voices are differentiated and can talk about each other. Affect is negative but manageable, not panicky.

4. Understanding/insight. The problematic experience is formulated and understood in some way. Voices reach an understanding with each other (a meaning bridge). Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.

5. Application/working through. The understanding is used to work on a problem. Voices work together to address problems of living. Affective tone is positive, optimistic.

6. Resourcefulness/problem solution. The formerly problematic experience has become a resource, used for solving problems. Voices can be used flexibly. Affect is positive, satisfied.

7. Integration/mastery. Client automatically generalizes solutions; voices are fully integrated, serving as resources in new situations. Affect is positive or neutral (i.e., this is no longer something to get excited about).
Table 2

Final List of Content Categories

1. Approach behaviors and mastery in social situations
These include references to: the performance of social activities previously avoided due to the phobia, attempts to master the social interaction situation and to initiate/maintain social competency, instances of responding assertively to other.

2. Insight-oriented reactions
Expressions that indicate awareness of the origins of the social phobia, connect past experiences with the current problem, and demonstrate a general sense of self-awareness.

3. References to the therapists or the group
References to the therapist’s demeanor, the attributes of the other group members, or feelings about the group as a whole.

4. Significant interpersonal encounters in connection to the social phobia
References to past or present events that impact the course of the social phobia
a) Past
b) Current

5. Significant interpersonal encounters in the lives of client
References to profound interpersonal occurrences or relationships that are of psychological importance to the lives of clients.
a) Past
b) Current

6. Symptomatology
   a) Physiological reactions--references bodily reactions/nervous gestures such as sweating, heart racing, dry mouth, choking, limbs shaking.
   b) Emotional reactions—descriptions of subjective internal states experienced in connection to the phobic situation such fright or shame.
   c) Cognitive preoccupations—expression of concerns about negative evaluation, performance failure, or negative social feedback.
   d) Avoidance reactions—reports of avoiding situations (parties, classes, conferences, etc.) because of the phobia.

7. References to other professional consultation/medication usage
Discussions involving previous/additional consultation with a mental health care professional, psychiatric evaluation, or the use of psychotropic medications.

8. References to the self
Utterances made by the client concerning:
a) his/her personality or disposition.
b) his/her world view
Table 3
Pre- and Post Treatment Scores on Self-Reported Outcome Measures

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Table 4

Mean Valence, Kappa, and ICC Ratings by Code

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Note. Values concern mean ratings for each content category across all ratable passages for both raters. Kappa values are meant to be an index of rater agreement concerning the presence of significant content in each passage of transcripts, whereas ICC values are an index of rater agreement about the frequency with which each type of content appeared across each of the sessions of the therapy.
Table 5

Average Frequency of Content Codes by Session

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Note. Values represent average of usage of content by clients, as coded by raters.
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**Average Frequency of Content Codes by Session**

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Figure 1. Mean valence ratings for all of the 4 client’s passages in each of the ten sessions of psychodynamic group therapy.
Appendix A
Training Manual for Raters Including Descriptions of All Content Categories

I. The Content Categories w/ Examples

1) Approach behaviors and mastery in social situations
These include references to: the performance of social activities previously avoided due to the phobia, attempts to master the social interaction situation and to initiate/maintain social competency, instances of responding assertively to others, narratives that bespeak a growing sense of confidence and social competency within the client.

Example:

“I minored in speech at Miami. I get the pre-jitters, but if I know what I’m going to do [with respect to her speech], I’m fine.” (Client #3)

2) Insight-oriented reactions
Expressions that indicate awareness of the origins of the social phobia, connect past experiences with the current problem, and demonstrate a general sense of self-awareness.

Example:

 “[After hearing another about Client 3’s history] Yeah, I truly, truly feel, I mean I relate to her so well. So many things that you’re talking about are things that hit me, starting around 26 I guess, and it probably hit me again when I go out of my marriage, thank god, ten years of it.” (Client #1)

3) References to the therapists or the group
References to the therapist’s demeanor, the attributes of the other group members, or feelings about the group as a whole.

Example:

“[to Interviewer #1] See, I keep thinking that this is your group and we’re helping you because this is your project, you know. What is it you’re wanting to do?” (Client #1)

4) Significant interpersonal encounters in connection to the social phobia
References to past or present events that impact the course of the social phobia
a) Past
b) Current

Example:

“[Recounting an incident from elementary school] I remember, I might have talked to you about this, like the kids are sitting in the classroom and you know they’re saying ‘Now little Johnny you read one paragraph and Susie you read the next paragraph.’ And
I can remember thinking to myself … I didn’t know when a paragraph … just when somebody shut up I assumed my turn, and if I lost them, buddy I was in trouble. Yeah, just freaking for that to come around to me. I didn’t understand what a paragraph was and I felt ignorant. But I can remember that, and I know it happened more than once, probably that whole darn year. (Client #1)

5) Significant interpersonal encounters in the lives of client
References to profound interpersonal occurrences or relationships that are of psychological importance to the lives of clients.
a) Past
b) Current

Example:

“One time my dad accused me of looking like a hooker, and I was going out after that. I was mortified. And to find out, he just thought we were hob-gobbling it [trick or treating]. But I lived for years thinking that he said that to me.” (Client #3)

6) Symptomatology
a) Physiological reactions--references bodily reactions/nervous gestures such as sweating, heart racing, dry mouth, choking, limbs shaking.
b) Emotional reactions—descriptions of subjective internal states experienced in connection to the phobic situation such fright or shame.
c) Cognitive preoccupations—expression of concerns about negative evaluation, performance failure, or negative social feedback.
d) Avoidance reactions—reports of avoiding situations (parties, classes, conferences, etc.) because of the phobia.

Examples:

“Well, my heart is starting to pound a little bit.” (Client #1)

“I just feel like I’m more of an introvert and just basically scared about getting out there and meeting people.” (Client #2)

“I think it was really hard for me to admit that I have this problem because I think people associate social disorder with someone who has no confidence in themselves.” (Client #2)

“For me, I don’t like talking in front of people I don’t know and large groups of people that I’m unfamiliar with. Therefore, I’ve chose something to do with my life where I would not be put in that situation.” (Client #2)

7) References to other professional consultation/medication usage
Discussions involving previous/additional consultation with a mental health care professional, psychiatric evaluation, or the use of psychotropic medications.

*Example:*

“There is depression, it runs on my father’s side of the family and I am on medication and I am handling it the best that I can, and I’m exercising, which is very helpful.” (Client #3)

**8) References to the self**
Utterances made by the client concerning:

- a) his/her personality.
- b) his/her world view and/or beliefs about the character of larger political and spiritual forces at work in the life of the client.

*Examples:*

“I would have to describe myself normally as painfully shy.” (Client #1)

“In today’s society, honestly, people get so...people are too freaking sensitive sometimes, you know?” (Client #2)

**II. Valence Ratings**

Valence ratings are designed to measure the intensity and directionality (i.e. how negative or how positive) of a client’s feelings related to the content of their speech. These ratings represent *inferences* about how the client is feeling and thus, they require a careful reading of the context in which a client makes a content statement. The valence ratings are scaled in the following way:

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## Appendix B

### Data Sheet Used for Ratings

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