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THE RELATIONSHIP OF CHILD THERAPIST'S A-B SCALE SCORES TO CERTAIN VARIABLES OF THERAPEUTIC ACTIVITY

A DISSERTATION

SUBMITTED TO THE GRADUATE FACULTY

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degree of

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BY

MELVYN HYMAN

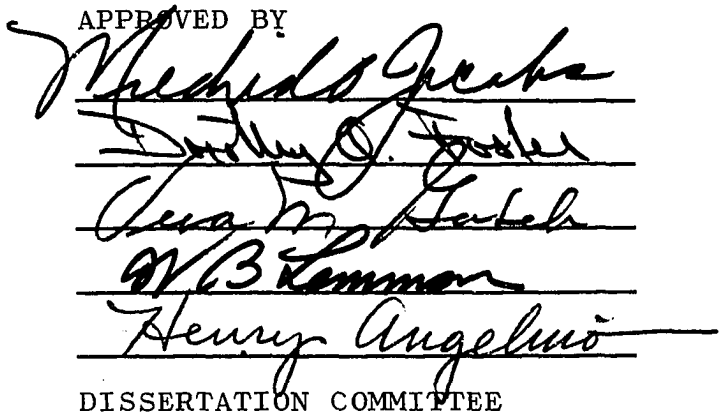
Norman, Oklahoma

1968

THE RELATIONSHIP OF CHILD THERAPIST'S A-B SCALE SCORES

TO CERTAIN VARIABLES OF THERAPEUTIC ACTIVITY

APPROVED BY



DISSERTATION COMMITTEE

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CHAPTER I

INTRODUCTION

It is the purpose of this study to determine how certain characteristics of a child therapist's verbal behavior are associated with his scores on the Whitehorn-Betz A-B Scale, an instrument which has been shown to be related to therapeutic effectiveness.

The field of psychotherapy has been characterized by rising enthusiasm for a variety of treatment forms, the effectiveness of which has been difficult to demonstrate objectively. The assertion that psychotherapeutic approaches are ineffective in helping either the disturbed child or the neurotic adult has been made by a great many studies. Statistical studies of the effectiveness of psychotherapy have failed to show that any form of psychotherapy is followed by significantly more improvement than would occur with the mere passage of an equivalent period of time.

Teuber and Powers (1953) conducted the single largest controlled study of the effects of counseling, guidance or psychotherapy. The study involved 600 delinquency-prone boys. Initially, 650 boys were paired on such variables as age, intelligence, school grades, delinquency ratings and socio-economic background. One member of the pair was assigned randomly to the treatment group, the other to the control group. Much of the treatment was supportive therapy in which the individual counselor attempted to develop a friendly and supportive relationship with the boys. Both psychoanalytically-oriented and client-centered counselors participated in the treatment program. Analysis of the data indicated that the control group showed equivalent positive changes as compared to the treatment group. In fact, the evidence suggested a slight difference in outcome favoring the control group; the treatment group had six per cent to zero percent more offenses during treatment than did the control group. These results occurred contrary to the data showing that a majority of the boys in the treatment group personally reported their belief in the value of the counseling, guidance and psychotherapy, and that the counselors themselves considered their therapeutic relationships highly effective.

Brill and Beebe (1955) also attempted to analyze statistically the effects of psychotherapy. Specifically,

they studied the results of treatment of war neurosis occurring during World War II. Comparisons were made between large numbers of neurotic soldiers receiving individual therapy and similar large numbers of neurotic soldiers receiving routine hospital care, rest and sedation, or no treatment. The group whose patients received only rest and sedation showed slightly greater proportion of improvement than those receiving either individual therapy or no treatment.

Barron and Leary (1955) found similar results. Of 150 neurotic patients who had applied and been accepted for treatment in a psychiatric clinic, 23 were placed on a waiting list and this served as a control during the six-month period of observation. Eighty-five were assigned to group therapy and 42 were assigned to individual therapy. All patients in treatment received a minimum of three months of therapy. All subjects were tested on the MMPI (Minnesota Multiphasic Personality Inventory) initially and after treatment. The Barron and Leary study is one of the few studies using professionally qualified therapists; the psychiatrists, psychologists, and social workers involved had at least three years of post-doctoral or postgraduate training and experience. The therapists described their orientations as dynamic and neopsychoanalytic. Both experimental and control groups were similar as to such characteristics as age, sex and educational level. At the outset,

all three groups compared closely in diagnosis, prognosis, severity of initial illness. As expected, the results indicated a reduction in major pathology in both of the treatment groups, individual and group therapy. However, overall findings indicated no significant differences on any of the measures between the control group and treatment groups.

There have been several other smaller studies (Anker and Walsh, 1961; Broedel, Ohlsen, Proff and Southard, 1960; Cartwright and Vogel, 1960; Frank, Gliedman, Imber, Stone and Nash, 1959; Gerard, Saenger and Wile, 1962; Gliedman, Nash, Imbers, Stone and Frank, 1958; Goodstein and Crites, 1961; James, 1962; Levitt, Beiser and Robertson, 1959; May and Terman, 1964; Mink and Isaacson, 1959; Poser, 1966) which have shown findings similar to those mentioned above.

The ineffectiveness of counseling and psychotherapy was reviewed by Eysenck (1960) and by Levitt (1957) who summarized reported improvement rates in patients receiving psychotherapy and counseling. Eysenck's conclusions, based on 7,000 cases treated by eclectic or psychoanalytic approaches to psychotherapy, were that the resultant 64 per cent improvement rate tends to be somewhat poorer than the estimates of spontaneous recovery rates in non-treated neurotics -- an average improvement rate of 66 to 72 per cent. The percentage improvement rate for counseling and

psychotherapy with children as reported by Levitt indicated that psychotherapy resulted in a 67 per cent improvement rate at termination of therapy in 3,399 reported cases and in 78 per cent improvement at a five-year follow-up on 4,219 cases. Since the five-year follow-up for spontaneous recovery rates suggests that at least 80 per cent show remissions of symptoms, these data also raise question as to the effectiveness of counseling and psychotherapy.

In spite of the mass of evidence that the therapist is not significantly helpful in producing improvement beyond that observed in patients receiving no treatment, specific studies involving specific therapists have demonstrated positive effects of counseling or psychotherapy. These studies suggest that one cannot approach this issue in a molar fashion; rather we must ferret out the significant factors which contribute to success and failure.

Shlien, Mosak, and Dreikurs (1962) studied time limited client-centered and Adlerian psychotherapy. Their results indicated statistically significant positive changes in self-concept for patients receiving counseling or psychotherapy, but no changes in a control group of untreated neurotics.

Williamson and Bordin (1940) studied the effects of counseling on achievement levels in college students. They used a matched treatment and control sample. Their findings indicated that the counseled students showed slightly

superior college achievement. As a group, they had a grade point average of 2.18, which was significantly above the grade point average of 1.97 for the control students. Campbell (1965) undertook a follow-up study of the groups used by Williamson and Bordin. Campbell examined the functioning of individuals in both the therapy and the control groups 25 years after counseling. An analysis of the 123 pairs of males indicated that in a measure of "contribution to society," the counseled group showed a statistically significant superiority over the control group.

Several other recent studies (Baymurr and Patterson, 1960; Draspa, 1959; Graham, 1960; Shouksmith and Taylor, 1964; Spielberger, Weitz and Denny, 1962) have also shown statistically significant results indicating positive gains resulting from psychotherapy.

Truax and Carkhuff (1967) interpret the current situation as follows:

> Inasmuch as the available evidence indicates that the average ineffectiveness of psychotherapy and counseling, as currently practiced, is due to the presence of large numbers of practitioners who have negative effects offsetting the equally large numbers of those who have positive effects, it would seem sensible for professional organizations, clinics, schools, hospitals and other interested agencies to attempt to identify the effectiveness of individual practitioners. In that way, and in that way only, can the patient's welfare and the public good be best served. Unfortunately, this has almost never been done.

Carson (1967) appears to be of the same opinion as Truax and Carkhuff:

> Thus, the critical issue concerns an understanding of the conditions under which psychotherapy is likely to succeed or fail, where the 'conditions' refer among other things, to definable characteristics of the participants.

Carson (1967) and Truax and Carkhuff (1967) indicate that research should focus on the role of the therapist in the therapeutic process.

Research into the effectiveness of the therapist in relation to therapeutic outcome has grown out of the pioneering work of Whitehorn and Betz at the John Hopkins Hospital (Betz, 1963a, 1963b; Whitehorn, 1964; Whitehorn and Betz, 1954). Their classic contribution was a retrospective study of seven psychiatrists whose schizophrenic patients had an improvement rate of 75 per cent, as contrasted with seven other psychiatrists of similar training who had an improvement rate of only 27 per cent. Their evidence indicated that the patients seen by the two sets of therapists did not differ in any systematic way that favored one group over the other, and yet they showed this striking contrast in success rates. Further analysis of the two groups of psychiatrists showed that the success of the patients appeared to be greatly dependent on some qualitative differences in the therapists themselves. The initial data presented by Whitehorn and Betz is in strong agreement with the recently emerging evidence that suggests

that psychotherapy can indeed be "for better or for worse"; many therapists and counselors are indeed helpful but many are also harmful (Truax, 1963).

It was discovered from further study of the therapists constituting these two groups, that they could be differentiated on the basis of their responses to twenty-three items from the *Strong Vocational Interest Blank*. These twenty-three items have come to be known as the Whitehorn-Betz A-B Scale. Whitehorn and Betz using these differentiated responses were able to predict therapeutic effectiveness prior to the therapist's actual contact with patients. They succeeded in replicating and cross-validating their findings (Betz, 1962).

The following conditions, as cited by Segal (1967), prevailed in their investigation: (1) prediction of effectiveness prior to therapists' contact with patients based on past improvement rates with a similar sample; (2) relative homogeniety among the therapists with regard to training, theoretic orientation, and experience; and (3) no significant clinical and demographical differences between the patients of A's and B's. Thus, one may conclude that the A-B Scale measures some aspects of the therapist's personality which, in turn, relate to success in treating schizophrenic patients. The A-B Scale represents, then, the first personality measure which seems to be predictive of therapeutic success (Truax and Carkhuff, 1967; Segal,

1967). Research in psychotherapy has been hampered by the lack of such a measure. The scale appears to have potential to fill this void.

As stated by Segal (1967), Whitehorn and Betz concluded from their study of chart notes of A and B therapists, that the more successful therapists (A's) could be characterized as: (1) having a better understanding of the meaning and motivation of the patient's behavior; (2) tending to be more perceptive of the inner experience of the patient; (3) regarding the patient as an individual whose solutions to his problems are obtained through collaboratory efforts; and (4) being able to "expect and respect spontaniety," and to "evoke self-respectful social participation" more successfully than therapists in Group B. In contrast, the less successful therapists (B's) were described by Whitehorn and Betz as placing greater emphasis on "regulatory or coercive" efforts and focusing on symptom reduction and encouragement of "better socialization." These findings were interpreted by Whitehorn and Betz to mean that in the treatment of schizophrenic patients, those therapists who are more successful succeeded in establishing a personal relationship characterized by trust and confidence, and that they are more "active" in helping the patient to reorient himself in his personal relationships.

TABLE 1

Strong Vocational Interest Blank Items (Form M) which Discriminated between A and B Therapists

SVIB Number	Description of Item
17	Building Contractor. (D, I)[a]
19	Carpenter. (D, I)
59	Marine Engineer. (D)
60	Mechanical Engineer. (D)
68	Photoengraver. (D)
87	Ship Officer. (D, I)
90	Speciality Salesman. (D)
94	Toolmaker. (D)
121	Manual Training. (D, I)
122	Mechanical Training. (D, I)
151	Drilling in a company. (L, I)
185	Making a radio set. (D)
187	Adjusting a carburetor. (D, I)
189	Cabinet making. (D, I)
216	Entertaining others. (D, I)
218	Looking at shop windows. (D, I)
290	Interested public in a new machine through public address. (L, I)
311	President of a society or club. (L)
365	Having many women friends.
367	I can accept just criticism without getting sore. (Yes)
368	I have mechanical ingenuity. (No)
375	I can correct others without giving offense. (Yes)
381	I can follow up subordinates effectively. (?, Yes)

[a]Responses of A therapists are indicated in parenthesis following each item: L = like, I = indifferent, D = dislike. Where two choices are indicated, A's responded by selecting either "D" or "I." From Whitehorn and Betz, 1960.

The A-B Scale has subsequently been used in a variety of investigations to confirm its predictive power and seek its personality correlates. McNair, et al. (1962) attempted to replicate Whitehorn and Betz' findings with a sample of therapists treating non-schizophrenic patients. In this study, A and B therapists treated neurotic out-patients at Veterans Administration clinics. At the beginning of treatment, patients of A and B therapists could not be discriminated on the basis of severity of disorder and a variety of associated measures. At the end of four months, and again at one year following initiation of therapy, the two patient groups diverged significantly on a number of outcome variables. However, it was the patients of B therapists who clearly showed the greater improvement, in direct contradiction to the earlier studies by Whitehorn and Betz. In attempting to explain their results, the authors suggest that outcome was determined by some form of interaction between the A-B therapist variable and the differential characteristics of the two classes of patients studied. Carson (1967) states that this appears likely in that the relatively unsuccessful therapists in both cases, Whitehorn and Betz's B therapists and McNair, Callahan and Lorr's A's, appeared at the outset to evidence less psychological understanding of their particular patients' problems than did their more successful counterparts. In view of the findings of these two studies, McNair, et al. (1962)

and Segal (1967) tentatively conclude that A-type therapists are more effective with schizophrenic patients than with non-schizophrenic patients, while the converse holds for B-type therapists.

The relationship described by McNair, et al. has been confirmed in further studies. Kemp (1963) attempted to determine if persons classified as A's or B's would respond differently to subjects behaving in accordance with "experimentally standardized personality characteristics." His subject-patients were characterized by having symptomatology which was predominantly either "turning-against-self" (Neurotic) or "avoidance-of-others" (schizoid). The results indicated a significant "therapist-type" by "patient-type" interaction regarding the level of discomfort and ease in responding to these two types of patients. The A's were less comfortable and had greater difficulty in responding to the schizoid-type subjects, while B's were less comfortable with neurotic patients. These findings support previous findings that A's and B's are individuals who are in some way differentially sensitive to differing forms of behavior pathology.

Carson, et al. (1964), in following up the implications of Kemp's investigations, have reported two experiments whose results also show that A's and B's respond differently to persons portraying differing forms of behavior pathology. In the first of these experiments, A's and B's

responded to letters purported to have been written by patients in a local mental hospital. These letters were composed in such a way as to be written by patients characterized by either one of the three following syndromes: (1) avoiding-others (Ao), (2) turning-against-self (As) and (3) turning-against-others (To). It was found that A therapists were more likely than B's to respond to patients with either Ao or To symptoms by "interpreting more deeply and directly," while B's tended to respond to As patients with a greater degree of "depth directedness" than A's (Segal, 1967).

In a second study reported by Carson, et al. (1964), A and B subjects were required to interview students who were induced to maintain a particular "set" toward their interviewer. This set was established by prewarning some of the respondents that they could expect a "cagey," "cunning" interviewer who would resort to "trickery," and by telling other interviewees that their interviewer would be a "direct and sincere" type of individual who would take a "real interest in people." As was predicted, A interviewers tended to get relatively more information from subjects "set" for distrustful interviewers and B's from respondents "set" for a trusting interviewer. Carson, et al., presented the following tentative conclusions:

> A's in relation to persons exhibiting distrustful-extrapunitive behavior, and B's in relation to persons exhibiting trusting-intropunitive behavior

> are (relative to the opposite conditions) more sensitized and alerted to, and at the same time more capable of understanding and formulating what the other person is saying and doing; given these circumstances they are prompted to assume a relatively more leading, assertive role when the structural nature of the relationship permits that form of adaptation (pp. 432-433).

By extending the study of Carson, et al. (1964), Carson and Hardin (1964) attempted to focus on the actual behavior of A- and B-type therapists in the interview situation. The results between A's and B's yielded no significant differences pertaining to their kinds of "interpersonal behavior" which Segal (1967) states may be due to low rater reliability. But the results indicated that A's in relation to the distrustful, hostile, expectancy of harm (schizoid) interviewees tended to be more broadly ranging in their exploratory activity and to perceive their partners as more flexible, and to be perceived by their partners as favoring a more dominant role. B's related to the trustful, friendly, expectancy of help (neurotic) interviewees exactly as the A's had to their respective interviewees.

Carson and Klein (1965) recently attempted to clarify and further explore the suggestion from previous studies that A and B persons are in some way tuned to respond differently "to a component variable of a role partner's behavior" (p. 2). An interaction was found between A- and B-type persons and interviewees portraying different symptoms. Regarding this interaction, Carson and Klein report that A's, in relation to the avoiding-others (Ao) type of

subject, and that B's, in relation to turning-against-self (As) behavior, attributed to the interviewees, in a relative sense: (a) less cooperativeness, (b) more cruelness, meanness, (c) more imaginativeness, (d) more laziness, (e) less likeableness, (f) less reserve or dignity, and (g) less of a sense of humor. Thus, B's tended to see the As subject, and the A's the Ao subject, in relatively negative terms. Results similar to those of Carson and Klein are reported by Kemp and Sherman (1965). Their results indicated that A's, in evaluating schizoid patients, and B's in evaluating neurotic patients: (1) were less interested in treating the patient; (2) had less confidence in the outcome of treatment; (3) perceived the patient as being less like their concept of an ideal patient; and (4) believed that it would be more difficult to discover the etiology of the patient's illness.

Segal (1967) used 20 graduate students training in a clinical psychology program in interaction with one of their respective clients as subjects. Segal's findings indicated that there was a relationship between A-B Scale scores of therapists and therapeutic activity. Specifically, it was found that: (1) B-type therapists tended to make fewer negative-type comments than A-therapists; (2) B-therapists were more facilitative, that is encouraging of self exploration; (3) A-therapists tended to be more interpretative; and (4) B-therapists tended to place less emphasis

than A-therapists on having clients respond to specific questions or ideas. Segal's findings confirmed previous research with the A-B Scale which suggested that there is a relationship between A-B personality characteristics and the therapist's behavior in psychotherapy.

In summarizing the research using the A-B Scale, it is apparent that A and B individuals are reacting differently to people with or portraying differing forms of behavior pathology. Specifically, A's have been shown to respond to "schizoid" symptoms and B's to "neurotic" symptoms, with negative attitudes or reactions, yet with apparent greater effectiveness. Thus, the A-B Scale is a measure of personality attributes, which are related to performance in psychotherapy. Earlier studies of the A-B Scale have dealt with adult neurotics or schizophrenics. Further, except for the original studies by Whitehorn and Betz (1954; 1960), and the studies by McNair, et al. (1962), and Segal (1967), no other research with the A-B Scale has been conducted in actual clinical situations. Instead, the majority of work made use of therapeutic analogues or quasi-therapeutic situations, using untrained individuals as subject-therapists. Additional investigation is needed to gain an understanding of the fundamental differences between A and B kinds of therapists and to determine how they may behave differentially in a therapeutic relationship. This study is concerned with the latter issue as related to child therapy.

Levitt (1957) and Teuber and Powers (1953) have reported low success rates in children receiving therapy. Therefore, it appears fruitful to attempt to extend the findings related to A-B research to the area of child therapy. For, as mentioned above, research in child therapy has not been immune to the findings that while success can occasionally be demonstrated statistically in some studies, a great many studies have demonstrated that various therapy approaches were ineffective in helping disturbed children.

It would seem that further exploration of the A-B Scale might be potentially fruitful to help identify therapeutic compatibility between therapist and child, and to gain more insight into the relationship between A-B Scale scores and certain aspects of therapeutic behavior.

CHAPTER II

STATEMENT OF THE PROBLEM

The A-B Scale permits prediction of behavior in a variety of contexts which have direct implication for the psychotherapeutic process (Carson, 1966; Segal, 1967). No research has been done regarding how A-B personality correlates are related to the therapists' behavior in child therapy. Therefore, the basic question remains: Do A's and B's differ in their practice of child therapy?

It was expected that the therapeutic behavior of A- and B- child therapists would vary sufficiently to permit reliable differentiation of their respective therapeutic activities. When given appropriate criteria for measurement of therapist activity, then the various activities of child therapists can be compared as to kinds of therapeutic interaction. This investigation focused on the child therapist's verbal communications and attempted to place these into categories in order for therapeutic activity between A and B therapists to be compared.

The hypothesis of this research was that there is a relationship between child therapists' scores on the A-B Scale and their therapeutic behavior, as defined by three content analysis systems. Specifically, this investigation has attempted to determine if there are differences in therapeutic activity between A and B therapists regarding: (1) attitude toward children, as manifested by their verbalizations; (2) type of therapeutic activity; questioning, interpretative statements, playing; and (3) specificity of statements, the degree to which the child therapist's comments set limits on the range of possible alternatives from which the child may select his reply.

CHAPTER III

METHOD

SUBJECTS

The subjects for this investigation are sixteen male child therapists, all of whom describe themselves as "eclectic," that is, they do not strongly affiliate themselves with any one particular theory of child therapy. These therapists range in age from 21 years to 47 years, with a median age of 33 years. Their mean experience in psychotherapy is 3.6 years, with a range of 1 to 16 years. Group A included: one intern in clinical psychology; one clinical psychologist; two post-interns in clinical; and four clinical psychology trainees. Group B included: two interns in clinical psychology; two clinical psychologists; two psychiatric residents; one social worker; and one clinical psychology trainee. Experience of the groups did not differ, averaging 3-4 years for both. The A-B scores obtained from these therapists ranged from 7 to 19, with a median score of 13.5. These A-B scores were derived from their responses to the original 23 items on the Strong

Vocational Interest Blank, on which the therapists in Whitehorn and Betz' (1954) initial study were found to differ (see Table 1). The designation of therapists as A or B was accomplished by the same system used by Whitehorn and Betz. Assigned was a score of one for the items checked which are consistent with the ones found representative of A's and a zero for the items checked representative of B's, to a high of 23, the A-end of the continuum. Designation of A and B groups was obtained by splitting the scores at the median. Using this method of categorizing therapists, there were eight therapists in each group.

The child population consisted of 16 males, who varied in duration of treatment from one month to three years with a mean average time in treatment of 1.6 years. The ages of the children ranged from 6.5 years to 12 years, with a mean age of 9.5 years. Selection of child-therapist dyads was made on the basis of how each child was described by his therapist on the Symptomatic Behavior Inventory Rating Scale. This measure was derived from the classification scheme used by Phillips and Rabinovitch (1958), to determine whether a person's primary mode of functioning is characterized by a neurotic (turning-against-self) or schizoid (turning-against-others) type of adjustments (see Appendix A for a copy of this scale). This scale is the measure used in previous A-B studies to characterize client behavior. After evaluating the Behavior Inventory for each

of the children being seen in therapy by all child therapists in this study, the child who most closely resembled or presented symptoms congruent with neurotic or turning-against-self behavior was selected as the other member of the therapeutic dyad, and this relationship was the one studied.

PROCEDURE

The procedure follows that developed by Segal (1967). Each therapist completed the A-B Scale, and also filled out the Symptomatic Behavior Inventory for each child he was seeing in a therapeutic relationship. Two tape recordings of the selected therapeutic relationship, with a minimum of two weeks between recordings, were obtained from each of the therapists. Tape recordings are routinely used by the therapists in this study for purposes of supervision or consultation with a control. Therefore, the obtaining of these two recordings should not have presented any atypical circumstances. The child therapists were unaware as to the purpose for which the tapes were requested. It was decided to evaluate two therapeutic interactions in order to obtain a greater representation of therapist activity. A typed transcript was made of the therapist's verbalizations for both of the two therapy hours. These transcripts were the source of the data evaluated in this study.

EVALUATION OF THERAPIST VERBALIZATIONS: CONTENT ANALYSIS SYSTEM

Four content analysis systems were applied to these data: (1) The Interaction Process Categories (Bales, 1950); (2) Therapist Directiveness, a measure adapted from Strupp's (1960) Measures for Analyzing Psychotherapeutic Interactions; (3) Therapist Specificity, adapted from Lennard and Bernstein's (1960) Categories for Evaluating Psychotherapy; and (4) Segal's (1968) P Factor Scheme for analyzing verbalizations related to play-oriented tasks. Content analysis studies of psychotherapy have been used with apparent success by Strupp (1955; 1960); Cutler (1958); Holzman and Forman (1966); and Lennard and Bernstein (1960) among others.

These first three scales have been used extensively in research in psychotherapy and have been shown to be reliable measures, capable of yielding optimally meaningful and usable ratings (Lennard, 1962; Strupp, 1955; 1960; 1962). The Bales measure was selected because it is particularly useful in quantification of therapist's responses in that it: (1) provides a general purpose framework for describing social interaction; (2) it is theoretically neutral with respect to different conceptual approaches to psychotherapy; and (3) it provides a means of describing the attitudes and/or style of behavior by

therapists toward clients. The Bales Categories are presented in Table 2. For this analysis, a modification of the Bales Scheme by Noble, Ohlsen and Proff (1961) was used. This is a 12-category scheme for rating therapists' behavior with three categories in each of four general areas: positive reactions; gives orientation; asks for orientation; and negative reactions.

TABLE 2

Interaction Process Categories[a]

Category Number	Interaction Process Category	Psychotherapeutic Definition[b]
1	Shows solidarity, raises other's status, gives help, reward.	Gives reassurance, encouragement, shows compassion, empathy.
2	Shows tension release, jokes, laughs, shows satisfaction.	Expression of cheerfulness, buoyance, satisfaction, gratification, or any positive response conveying tension reduction.
3	Agrees, shows passive acceptance, understands, concurs, complies.	Shows passive acceptance, understanding, is permissive.
4	Gives suggestion, direction, implying autonomy for others.	Proposes course of action, defines (structures) situation.
5	Gives orientation, evaluation, analysis, expression of feelings or wishes.	Interprets, analyze behavior patterns, inferential reasoning, confrontations.
6	Gives orientation, information, repeats, clarifies, confirms.	Restates, clarifies, reflects.

Interaction Process Categories--Continued

Category Number	Interaction Process Category	Psychotherapeutic Definition[b]
7	Asks for orientation, information, repetition, confirmation.	Asks factual questions, expresses lack of knowledge, uncertainty.
8	Asks for opinion, evaluation, analysis, expression of feeling.	Explores, asks for elaboration or expression of feeling.
9	Asks for suggestion, direction, possible way of action.	Seeks solution through action of other as to how to proceed, etc.
10	Disagrees, shows passive rejection, formality, withholds help.	Shows passive rejection, disbelief, ignores request or complaints.
11	Shows tension, asks for help, withdraws out of field.	Expression of personal discomfort.
12	Shows antagonism, deflates other's status, defends or asserts self.	Shows antagonism, aggression, sarcasm, irony, cynicism.

[a]Based on a scale developed by Bales (1950).

[b]This column gives examples of kinds of responses by therapists included in the categories.

The measures derived from Strupp's procedure, Type of Therapist Activity, was selected because it is well suited for assessing the degree to which therapists take responsibility for directing clients verbalizations (Strupp, 1960). This system is also particularly valid for comparisons between therapists of varying experience levels, degrees and kinds of training, backgrounds, and so on

(Strupp, 1960). By use of this scale, an attempt was made to assess in what kinds of therapeutic activity the therapist typically engages. Does he primarily ask questions, offer interpretive statements, give authoritative statements, give authoritative opinions, or rely on inferential operations? Thus, the attribute identified by this Scale (see Table 3) is referred to as directiveness.

The content-analysis measure based on Lennard and Bernstein's work was designed to investigate the extent to which the therapist places limits upon the array of verbal responses from which the patient may choose a reply. The attribute, therefore, measured by this Scale (see Table 4) is identified by the term specificity, and is primarily associated with attempting to discover if therapists differ in how they may elicit information from their clients.

The P Factor System (Segal, 1968) was used because it is designed to deal with those verbalizations which relate to the play-oriented tasks in which therapist and child become involved. Statements directed at the play activities are not scorable by any of the other three systems. Specifically, those verbalizations which focused solely on play, a medium commonly used in child therapy, were scored "P."

TABLE 3

Type of Therapist Activity[a]

Category	Type of Activity	Psychotherapeutic Definition
1	Facilitation	Acceptance or acknowledgment of child's communication (e.g., "um...go on...I see...").
2	Exploration-Clarification	1) Simple questioning. Asking for further information, clarification, examples, elaboration; simple probes, broad case history questions (e.g., "What do you mean...?" "For example?" "I don't understand." "Say that again."). 2) Reflection of feeling. 3) Restatement for clarification (e.g., "Did you mean that...?" "By that you meant...").
3	Moderately inferential and/ or Moderately interpretative	Questioning to stimulate child's curiosity and to stimulate self-exploration; suggestive summaries; pointing out inconsistencies (e.g., "What do you make of that?" "Is there a connection between...?" "That is why you are sad...").
4	Direct Interpretation	Direct interpretation (analysis of defenses; establishing connections, identifying wishes or problem areas, direct confrontation).
5	Guidance	Guidance or direct instruction, either in reference to therapy or to situations outside of therapy (e.g., "Why don't you...").

[a]Adapted from Strupp (1960).

TABLE 4

Specificity of Therapist Interventions[a]

Category	Type of Intervention	Psychotherapeutic Definition
1	Encouragement to talk.	Passive or active encouragement to talk, without providing a subject matter or other limiting of child's choice of response (e.g., "Um hum," "go on," "Yes, I see.")
2	Limits to subject matter.	Child is limited to one subject area, but within that area can select from a wide range of information and frame of references. For example, "How do you feel about... (subject matter is provided or specific mention of subject is offered). "Tell me about..." Statements usually beginning with "Why," "How," and "What," when a specific subject matter follows, are usually scored in this category.
3	Limits to proposition or to specific idea.	Differs from #2 in referring to a specific idea or frame of reference to which the child must address himself. Hypotheses, interpretations, confrontation, and the like, are included in this category. For example, "How come you find school work too hard?" is scored in this category. "How do you feel about your school work?" is scored in category 2. Statements of an interpretative nature ("You are afraid to go to school.") are included in category two.

Specificity of Therapist Interventions--Continued

Category	Type of Intervention	Psychotherapeutic Definition
4	Introduction of a new idea or proposition.	Differs from #3 in that statements in this category reflect the therapist taking initiative in introducing a new idea. Therapist attempts to stimulate child to react to new idea. Therapist offers alternative to child (e.g., "You sound sad"... "Maybe it's because..." "Look at it this way...").
5	Direct Interpretation (A sequence of new propositions.)	Therapist actively reorganizes informational propositions already conveyed, recombining them in a new way or different manner to attempt to redirect the child's way of perceiving, or to redirect the flow of subsequent information. A long sequence is usually offered, which usually distinguishes it from #3 (e.g., "I think that because you...you came to think of this as scary and wanted to run away...").
6	Limits to specific answer.	Content of expected answer is clear to child. Questions of fact. "Yes - No" questions. Therapist attempts to solicit a particular item of information.
7	Excludes discussion.	Therapist directs child's communications into a different channel and/or excludes a specific topic or communication (e.g., "We

Specificity of Therapist Interventions--Continued

Category	Type of Intervention	Psychotherapeutic Definition
		don't need to go into that now..." "That's not important.).

[a]Adapted from Lennard and Bernstein (1960).

[b]A proposition is defined as a verbalization containing a subject and predicate either expressed or implied. It is the verbal expression of a single idea.

JUDGES

Two judges were selected for this study, both of whom hold Ph. D. degrees in clinical psychology, to assign all scorable therapist verbalizations into the various categories of the four scales. These judges had established, over the past 18 months, with prior A-B Scale related research, an overall agreement of over 82 per cent in judging 2,647 therapist interventions on three of the four scales used in this investigation. (The criteria for scoring therapist interventions is described in Appendix B.)

ANALYSIS OF DATA

The initial data were in the form of frequency scores in the various categories on the four scales. These frequency scores were converted to percentiles, which

represent the proportion out of the total number of statements offered for each therapist, of interventions in a given category. In order to determine the extent to which the distribution of therapists' verbalization scores within each category was related to the therapist's A-B Scale scores, a rank order correlation was computed between A-B scores and each of the categories on the four scales.

CHAPTER IV

RESULTS

RATER AGREEMENT

The two judges were in agreement for 80% of the statements (Type of Therapist Activity, 88%; Specificity of Therapist Interventions, 72%; Interaction Process Categories, 79%; P Factor, 86%). These figures represent a relatively high degree of consistency in scoring of therapist statements. The judges' past performance was described in Chapter III.

AMOUNT OF THERAPIST ACTIVITY

A total of 6,917 therapist interventions were obtained from the two therapy hours of each of the therapists from which 5,811 were scorable (see Appendix B for scoring criteria).

THERAPIST ATTITUDE

The Bales Social Interaction Process Categories (Table 2) was used to attempt to measure the relative

proportion of therapist statements which were positive or negative reactions. According to Bales (1950) and Noble, Ohlsen and Proff (1961), the twelve separate categories which constitute the scale can be combined to form four sub-scales, each representing a different form of interaction. Categories 1-3 group together to identify positive reactions; categories 4-6 identify behavior described as giving orientation; categories 7-9 describe behavior which asks for orientation; and items 10-12 describe negative reactions. It is the first and last sub-categories in which therapist attitude has its operational referents. The procedure followed was to code each therapist's statements into one of the 12 categories, collapse the scale into the four sub-groups, and convert the distribution of statements for each therapist into percentage indices. Each percentage figure represented then, the proportion out of the total number of statements offered for each therapist, of interventions in a given category. (This conversion to percentage indices was also applied to the data for the other scales.) Table 5 shows the proportion of each therapist's scorable verbal output that falls under each of the four sub-scales described above, together with their A-B Scale scores. The A and B groups were constituted by a median split of the A-B Scale scores (median = 13.5).

In order to determine the extent to which the distribution of scores within each category is related to

TABLE 5

A-B Scores and Proportion of Therapist Interventions in Each of Four Sub-Scales of the Interaction Process Category Scale*

Therapist	A-B Score	Positive Reaction	Gives Orientation	Asks for Orientation	Negative Reaction
A	7	.25	.56	.02	.17
B	8	.10	.62	.28	.00
C	10	.15	.39	.10	.37
D	10	.06	.22	.00	.72
E	10	.12	.28	.07	.53
F	11	.35	.44	.02	.19
G	12	.15	.29	.02	.54
H	12	.25	.40	.07	.28
I	15	.20	.53	.23	.05
J	16	.06	.19	.00	.75
K	16	.31	.66	.03	.00
L	17	.09	.18	.00	.72
M	17	.09	.86	.01	.03
N	17	.10	.42	.04	.44
O	19	.12	.12	.03	.73
P	19	.10	.11	.02	.76

*Appendix C (Table 11) contains the observed frequencies in each category.

therapist's A-B Scale scores, a rank order correlation was computed between A-B scores and each of the four categories. Table 6 presents the results of this analysis in Spearman's rank order correlation coefficients and in t values. The t values were determined according to Ferguson's (1959) test for significance of Spearman's p using t. This procedure was used to obtain t values for all subsequent coefficients.

TABLE 6

Rank Order Correlations Between A-B Scores and Interaction Process Categories

	Category			
	Positive Reaction	Gives Orientation	Asks for Orientation	Negative Reaction
p	- .29	- .36	- .29	.40
t	-1.13	-1.45	-1.14	1.67

The findings indicate: (1) no significant correlation between the Positive Reaction category and A-B Scale scores, (2) no significant correlation between Gives Orientation type of statements and A-B scores, (3) no significant correlation between Asks for Orientation type of interventions and A-B Scale scores, and (4) no significant correlation between statements categorized as Negative Reactions and A-B Scale scores.

TYPE OF THERAPIST ACTIVITY

Strupp's (1960) scheme for determining type of therapist activity was combined, according to Segal's (1968) modification, to form three subscales. Category 1 represented Facilitation; Categories 2 and 3 identified behavior described as Asking For; Categories 4 and 5 identified behavior described as Giving To. In addition, Segal's (1968) P Scheme was added to represent a fourth category identifying behavior relating to play-oriented tasks in which therapist and child became involved. Table 7 shows the distribution of therapists' statements in the four categories of response.

In order to determine if there was a relationship between the proportion of statements made by A and B therapists within each category and A-B Scale scores, rank order correlations were derived between A-B scores and proportions of interventions within the four categories. Table 8 presents the results of this analysis.

The correlations for the four categories indicate that little or no relationship exists between these types of activities and A-B Scale scores.

THERAPIST SPECIFICITY

Table 9 shows the percentage of each therapist's verbal output that falls into each category of informational stimulus value.

TABLE 7

A-B Scores and Type of Therapeutic Activity: Proportion of Therapist Interventions in Each of Four Categories[a]

Therapist	A-B Score	Categories* 1	2	3	4
A	7	.52	.24	.22	.02
B	8	.23	.30	.39	.08
C	10	.30	.20	.35	.14
D	10	.59	.18	.18	.06
E	10	.48	.27	.23	.03
F	11	.63	.10	.20	.06
G	12	.57	.19	.23	.00
H	12	.71	.17	.11	.00
I	15	.35	.16	.25	.24
J	16	.52	.32	.16	.00
K	16	.47	.23	.25	.05
L	17	.54	.25	.19	.02
M	17	.15	.47	.31	.06
N	17	.38	.31	.24	.06
O	19	.75	.11	.08	.06
P	19	.64	.20	.16	.01

*1 - Facilitation
2 - Asking For
3 - Giving To
4 - Playing

[a]Appendix C (Table 12) contains the observed frequencies within each category.

TABLE 8

Rank Order Correlations Between A-B Scores and Type of Therapist Activity

	Categories			
	Facilitation	Asking For	Giving To	Playing
p	.23	.05	- .34	- .16
t	.89	.20	-1.38	- .63

TABLE 9

A-B Scores and Therapist Specificity: Proportion of Therapist Interventions in Each of Seven Categories[a]

Therapist	A-B Score	Categories* 1	2	3	4	5	6	7
A	7	.00	.27	.00	.19	.06	.46	.00
B	8	.06	.18	.00	.12	.28	.33	.02
C	10	.02	.21	.00	.21	.22	.32	.02
D	10	.00	.29	.00	.27	.07	.37	.00
E	10	.00	.18	.01	.24	.19	.31	.07
F	11	.00	.19	.00	.40	.16	.25	.00
G	12	.00	.20	.00	.27	.19	.32	.02
H	12	.00	.26	.00	.27	.09	.37	.01
I	15	.09	.12	.02	.21	.37	.15	.03
J	16	.00	.28	.00	.27	.09	.37	.00
K	16	.00	.21	.00	.26	.15	.37	.00
L	17	.00	.23	.00	.30	.08	.38	.00
M	17	.00	.29	.00	.09	.12	.50	.00
N	17	.00	.22	.00	.16	.18	.41	.02
O	19	.02	.17	.00	.36	.15	.26	.03
P	19	.00	.13	.00	.40	.14	.30	.03

*1 - Encouragement to talk.
2 - Limits to subject matter.
3 - Limits to proposition or to specific idea.
4 - Introduction of a new idea or proposition.
5 - Direct interpretation.
6 - Limits to specific answer.
7 - Excludes discussion.

[a]Appendix C (Table 13) contains the observed frequencies in each category.

Rank order correlations between each of the specificity categories are presented in Table 10.

The findings reveal no significant relationship between the categories in the Therapist Specificity Scale and A-B Scale scores.

TABLE 10

Rank Order Correlations Between A-B Scores and Specificity of Therapist Statements

	Categories*						
	1	2	3	4	5	6	7
p	-.12	-.13	-.15	.34	.12	-.001	.11
t	-.48	-.49	-.57	1.39	.47	-.005	.45

*1 - Encouragement to talk.
2 - Limits to subject matter.
3 - Limits to preposition or to specific idea.
4 - Introduction of a new idea or proposition.
5 - Direct interpretation.
6 - Limits to specific answer.
7 - Excludes discussion.

CHAPTER V

DISCUSSION

This research evolved from the author's interest in the literature pertaining to the A-B Scale as being a very indirect, although perhaps highly correlated, measure of whatever personality variables underlie the differential interpersonal behaviors of A- and B-type therapists. Much evidence has been presented which indicates that the A-B Scale is a useful instrument for approaching the task of studying characteristics of therapists (Carson, 1967; Kemp, 1963; McNair et al., 1962; Segal, 1967; Truax and Carkhuff, 1967; Whitehorn and Betz, 1954; 1960).

The basic hypothesis of this research was that there is a relationship between child therapists' scores on the A-B Scale and their therapeutic behavior, as defined by three systems of content analysis (Bales, 1950; Lennard and Bernstein, 1960; Strupp, 1960).

This hypothesis was in no way supported; A- and B-type child therapists did not differ significantly in verbal behavior as categorized by the various schemes used in this investigation.

This research has not demonstrated that the verbalizations of child therapists have any relationship to their respective A-B Scale scores. As stated in Chapter 1, previous research has reported positive correlations between A- and B-type therapists and their verbal behavior (Betz, 1962; 1963a; 1963b; Carson and Hardin, 1964; Carson et al., 1964; Kemp, 1963; Segal, 1967; Whitehorn, 1964; Whitehorn and Betz, 1954; 1960).

Since this present study evidenced no significant relationship between A-B Scale scores and the verbal behavior of child therapists, a question is raised as to the reasons for this outcome. Initially, one can postulate that there is no relationship between a child therapist's A-B scores and his therapeutic activity. However, past findings with adult populations necessitate that some discussion be devoted to possible reasons for the inability to find a significant correlation between A-B scores and therapists' verbalizations as categorized by the schemes used in this study.

A question can be raised as to how the therapists in this study compare to the subjects used in previous studies. The studies of Carson and Hardin (1964); Carson, et al. (1964); Carson and Klein (1965); Kemp (1966); Kemp and Sherman (1965) used mostly undergraduate male students having obtained extreme (excluding at least the middle 50 per cent) scores on a modified form of the A-B Scale. A

and B subjects were placed into dyadic encounters with other "persons," real or fictitious, whose characteristics were experimentally varied so as to simulate "schizoid" or "neurotic" types of adjustment. Certain of these studies used various means to provide subjects with descriptive material on a patient, where the subject was not led to believe that he was engaged in a reciprocally contingent form of interaction with the other person. These procedures differ greatly from those used in this study.

The procedures used by McNair, et al. (1962) and Segal (1967) are similar to those used in this study. McNair, et al. used a sample of therapists whose backgrounds compared favorably to those used by this author. In addition, the method of determining A- and B-type therapists was similar to that used in this study, and the experience level of 5-6 years was similar to that used in this study, which was 3-4 years. Segal (1967) reports using a group of therapists with an experience level of 2.7, which also compares favorably with the experience level of subjects used in this study. Segal (1967) selected his A- and B-type therapists identically to the procedure used in this study. Since all of the above cited studies found significant results, it is this author's conclusion, and also that of Carson (1967), that wide variation in types of therapist subject characteristics is not a crucial variable effecting the results of A-B studies. Hence, variation in the

characteristics of therapists used by this author cannot be used to explain the lack of significant results found in this study.

Carson summarized the conceptual implications of A-B research as follows:

> ...there can be little doubt that behavioral manifestations of the A-B variable are markedly and differentially dependent upon the interpersonal context, and this conclusion is rendered all the more salient by a relative dearth of main effect differences between A's and B's across differing stimulus persons. Moreover, since the sex and social status of the "persons" with whom A and B subjects interacted were essentially held constant in these experiments, the results tend to be disconfirming of the suggestion that these are the critical variables in explaining the findings of the psychotherapy outcome studies, as described above. It seems rather more likely, in view of the data reviewed here, that the A and B psychotherapists in these studies were predominantly responding in their characteristic and differential ways to a component variable in their patients' behaviors which happens to be correlated with diagnosis. Carson, Harden and Shows (1964) have tentatively conceived this presumed dimension as one involving a distrustful-extrapunitive (schizoid) versus a trusting-intropunitive (neurotic) interpersonal orientation. It remains to be seen whether this categorization is sufficiently precise to account adequately for the phenomena as further data become available (1967, p. 51).

In viewing Carson's statement, it is possible that in a relationship with a child, the therapist moved into a different framework from which he normally uses to relate to adults. Possibly, in working with children, the therapists in this study did not visualize the schizoid-neurotic dimension which was used to categorize the children by this researcher. One can further speculate that if the schizoid-

neurotic dimension is not a useful concept to child therapists, perhaps there are other differences. For example, the crucial relationship may be evidenced in non-verbal behavior. One could speculate that a great deal of the pertinent communication between child and therapist cannot be retrieved from transcriptions of verbalizations.

Riese, in discussing the child and his psychotherapist, states:

> Between any two people who try to reach each other by the spoken word stands the history and experience of their whole lives. The imagery, the atmosphere, the meaning associated with each word is tinged with the reminiscences of the past. Every spoken word has a very different connotation for each partner to a conversation who can understand the other only by means of his own associations, thoughts, and feelings. This is the only way by which we can assimilate impressions coming from without and preserve the units of our personality. The necessity to be self-defining, indispensable for the continuity of our identity, limits us to our own boundaries -- rich and vast as a man's territory might be. Understanding between two people can only succeed by way of translating the languages spoken in the two 'countries.'
>
> What is it that causes the feeling that through words there is a meeting of minds? All of us are familiar with the assistance to communication offered by the more general, the public conveyence of gestures and mimicry. But in language itself there are nuances of voice, of tone, of accent and tuning, acceleration or retardation of speed, scanning of rhythm, great varieties of articulation and their opposite, to mention but a few that help the listener catch the exact meaning conveyed by the speaker when he talks.
>
> The richer the past experience, the more potentialities it holds for the attuning of the nuances and the meanings of the two 'languages'

> spoken by two people, the more 'conveyances' will be at hand for traveling back and forth between the two 'countries.' Actually the two people will share more than the mere 'conveyance' of language, imposing as it may be, because both will travel together for some duration through the same 'scenery,' in the milieu that presently surrounds them and generates their responses to it.
>
> When, therefore, a child in therapy speaks of his family and home concretely, or of the deep and meaningful recollections that arise from the vague and remote past, the therapist who has traveled with him for a while has gained some comprehension of the experiences that underlie the words. The miracle remains that an apparently satisfactory understanding results when none of the imagery girding the most fundamental words can be alike for both, though empathy and time may diminish their strangeness. That the child usually does not have a differentiated knowledge of the therapist with whom he communicates is not only of minor importance but a factor that favors the transference. It is less relevant that the child does not understand the psychotherapist's words in their specific vocabulary, since his understanding of the world is still gained more extensively by ultra-verbal channels, the more so, the younger he is or the younger he has remained in his morbid isolation. Properly timed silence, interruptions, or pauses may count much in the impact made on the child. The voice and the rhythm that chant to him or comfort him are what he responds to, rather than words and sentences as such. (1962, 329-330)

Bettelheim also views the essence of communication between adult and child as going beyond the spoken word:

> If picked up, the child increases the closeness to the mother on his own, through his clinging. But when the response to him is positive he learns that reaching out to gain closeness increases his well-being. He learns also that whether this happens or not depends on the response of another person, and that his own actions could and did evoke that response. Here the essence of what is communicated is the value of combined action, where one's solitary action might fail.

> Later on, communication through spoken language and even more so in silent thought is how we normally grasp and make contact with reality. (1967, p. 27)

Taft, in discussing her views of child therapy, appears to place little emphasis on the therapist's verbalizations or on the schizoid-neurotic dimension used in this study.

> The relationship between us was taken simply and immediately for itself and developed according to what the child found in it and did to it of her own will both positively and negatively, under the pressure of the deprivations and frustrations imposed by the time limits, the reality situation, and the lack of projection on my part. The interviews, or rather the contacts, for there was much more action than verbalization, were carried through, as far as I was humanly able, in terms of the child as she actually was at the moment, and my recognition of her immediate will, feeling or meaning. Everything centered in her, was oriented with regard to her. This does not mean that there were no checks but that when my response was a prohibition, it was also a seeing of her, never a denial of the nature of her impulse or her right to have it. Where my own curiosity as to her behavior symptoms or my interest in bringing out certain material got the better of me, as it did occasionally, I abandoned it, as soon as I became conscious of my folly. This was to be her situation, not mine, and I held to that even when I felt that nothing interesting therapeutically or psychologically could come of it. Interpretation there was none, except a verbalization on my part of what the child seemed to be feeling and doing, a comparatively spontaneous response to her words or action which should clarify or make more conscious the self of the moment whatever it might be. (1933, pp. 27-28)

Since it has previously been established empirically that A and B therapists do differ significantly in their therapeutic behavior, significant results using child therapists might be achieved by devising both a

different system for categorizing therapeutic behavior and by re-evaluating the procedures used to classify clients in past A-B research. For example, categories might be based on verbal and non-verbal interactions. Following Taft's views, we might reject the rigid classification of children along systems such as those presented by Phillips and Rabinovitch (1958). It is possible that further investigation will reveal similar findings to this study.

In conclusion, differences between the verbalizations of child therapists do not seem to be useful as a predictor of whether a child therapist is an A- or B-type. The research has demonstrated a need for more involved schemes for categorizing therapist-child interactions. The lack of significance found, and the need for new schemes, warrants the suggestion for further study in this area.

CHAPTER VI

SUMMARY

The purpose of this research was to explore the possible relationship between child therapists' A-B Scale scores and certain aspects of their verbalizations. A review of the literature suggests that A-B Scale scores relate to verbal behavior of therapists. The need for further investigation of the behavioral correlates of the A-B Scale was presented. Consequently, this research attempted to investigate whether A-B Scale scores were significantly correlated with verbal behavior of child therapists.

The subjects for this study were 16 child therapists and their respective clients. Two therapy hours were transcribed for each therapist. The therapists' verbalizations were rated on twenty-five categories, representing four scales: The Interaction Process Categories; Therapist Directiveness; Therapist Specificity; and the P Factor Scheme. It was predicted that therapists' verbal behavior, as categorized by the above scales, would correlate

significantly with their respective A-B Scale scores. This prediction was not supported and the conclusion from this research was that A-B Scale scores are not related to child therapists' verbal behavior.

Clearly, a different approach toward evaluating the therapeutic activities of child therapists is needed. Possibly ratings made from direct observation of the therapeutic interaction might prove rewarding in terms of a significant relationship to A-B Scale scores.

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Appendix A

Client's Symptomatic Behavior Inventory

CLIENT'S SYMPTOMATIC BEHAVIOR INVENTORY

Name of Patient_____ Sex _____ Age _____

Time of Treatment_____ Education_____

Therapist _____

INSTRUCTIONS: This inventory consists of a number of symptoms often manifested in emotional disorders. Read each and decide if it applies to your client or not. Indicate so by circling the true (T) or not true (NT) column by each item. Please answer every item. Thank you for your cooperation.

1.	Patient is nervous most of the time	T	NT
2.	Expresses bizarre ideas	T	NT
3.	Has loss of appetite	T	NT
4.	Has difficulty sleeping - complains of insomnia	T	NT
5.	Has made a suicidal attempt	T	NT
6.	Is withdrawn.	T	NT
7.	Complains of headaches.	T	NT
8.	Is depressed.	T	NT
9.	Talks of suicide.	T	NT
10.	Feels perverted	T	NT
11.	Has hallucinations.	T	NT
12.	Is perplexed most of the time	T	NT
13.	Is tense most of the time	T	NT
14.	Has a tendency toward compulsions	T	NT
15.	Makes self-deprecating statements	T	NT
16.	Is suspicious	T	NT
17.	Is apathetic.	T	NT
18.	Is sexually preoccupied	T	NT
19.	Expresses bodily complaints	T	NT

Appendix B

Criteria for Scoring Therapist Interventions

CRITERIA FOR SCORING THERAPIST INTERVENTIONS

Method for Assessment of Therapist's Verbalizations

Described below is Segal's (1967) framework for categorization of therapist's verbalizations used in this study. It is based principally on the rules established by Lennard and Bernstein (1960) in their study. The same rules or procedures have been used by both Bales and Strupp in their investigation. Therefore, the system described below pertains to all the scales used in this study.

Proposition

A proposition is defined as a verbalization containing a subject and a predicate either expressed or implied. It is the verbal expression of a single idea. The following are rules for arriving at a proposition: (A) A proposition, in this study, will consist of an independent clause together with one or more dependent clauses. When a single subject is followed by a series of predicates, a separate score is not to be given for each predicate. Instead, the entire verbalization will be scored as one unit. For example, the statement, "It sounds like your father is angry with you, and that this scares you very much," although containing a dependent clause, is to be counted as a single proposition -- the assumption being that the whole meaning conveys more than the dependent

clause standing alone. When a series of uninterrupted propositions, referred to as a therapist's statement, is offered, the statement in its entirety, and not the individual propositions, will be scored. For example, the statement, "It seems that you find it nice. It wasn't always like that." is to be treated as one unit and scored for its total meaning. This procedure differs from that established by Lennard and Bernstein. The assumption underlying this approach is that the individual propositions are not unrelated, and that the total communication is to what the child is most likely to respond. (B) "Uh-huh," "Yes," "Mm-hm," etc. are counted as single propositions. (C) False starts do not count as separate units. The following sentence contains a single proposition: "I went, I went downtown yesterday." (D) Phrases like "You know," "I guess," "Well," "Huh," and "Isn't it," when added on to a sentence, are not considered separate units. For example, "Well, you know, it may hurt you, huh?" The addition of "huh" apparently serves to form a question, rather than to leave the statement as a declarative remark.

Verbalizations

A therapist's verbalization is defined as a statement made by him immediately after a child's statement. Anything expressed by the therapist in response to child's verbalization is regarded as a message to his client, and categorized as its possible therapeutic import.

Incomplete Propositions

Utterances lacking some essential feature of a complete sentence because of an interruption by the child or a lapsing into silence are considered separate units whenever the meaning is clear. When not enough is said to make the meaning clear, what is said is not considered to be scorable.

Appendix C

Observed Frequencies within Categories on Each of the Three Measures of Therapeutic Intervention

TABLE 11

A-B Scores and Frequency of Therapist Interventions in Each of Four Sub-Scales of the Interaction Process Category Scale

Therapist	A-B Score	Positive Reaction	Gives Orientation	Asks for Orientation	Negative Reaction
A	7	60	19	141	2
B	8	41	100	118	8
C	10	98	104	150	8
D	10	25	6	34	0
E	10	74	60	95	21
F	11	245	95	152	0
G	12	78	56	93	5
H	12	120	40	160	5
I	15	50	87	36	6
J	16	52	18	72	0
K	16	78	45	111	3
L	17	46	12	58	1
M	17	34	49	198	0
N	17	67	72	167	10
O	19	48	20	34	4
P	19	71	25	54	5

TABLE 12

A-B Scores and Type of Therapeutic Activity: Frequency of Therapist Interventions in Each of Four Categories

Therapist	A-B Score	Categories* 1	2	3	4
A	7	70	155	5	48
B	8	29	182	81	2
C	10	59	156	38	146
D	10	9	34	1	112
E	10	55	124	32	238
F	11	233	289	12	125
G	12	63	118	8	224
H	12	104	170	28	118
I	15	38	102	45	9
J	16	26	80	2	320
K	16	73	152	7	0
L	17	32	62	3	245
M	17	26	241	4	9
N	17	56	244	24	258
O	19	44	46	10	270
P	19	62	68	13	464

*1 - Facilitation
2 - Asking For
3 - Giving To
4 - Playing

TABLE 13

A-B Scores and Therapist Specificity: Frequency of Therapist Interventions in Each of Seven Categories

Therapist	A-B Score	Categories* 1	2	3	4	5	6	7
A	7	66	30	28	3	2	84	0
B	8	28	36	48	10	22	64	0
C	10	53	35	61	25	8	100	0
D	10	10	3	3	1	0	26	0
E	10	52	29	25	3	0	56	4
F	11	230	37	73	23	1	118	0
G	12	68	23	27	1	0	58	0
H	12	103	25	16	1	0	113	0
I	15	38	18	28	26	22	28	4
J	16	26	16	8	0	0	54	0
K	16	75	36	39	8	2	62	0
L	17	31	14	11	1	0	34	0
M	17	20	62	41	8	1	114	0
N	17	55	44	35	9	2	91	0
O	19	54	8	6	4	3	23	0
P	19	61	19	15	1	0	23	0

*1 - Encouragement to talk.
2 - Limits to subject matter.
3 - Limits to proposition or to specific idea.
4 - Introduction of a new idea or proposition.
5 - Direct Interpretation.
6 - Limits to specific answer.
7 - Excludes discussion.