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SCORING PARENTAL RESPONSES TO AN APPLICATION
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GUIDANCE CLINIC.

The University of Oklahoma, Ph.D., 1975
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THE UNIVERSITY OF OKLAHOMA
GRADUATE SCHOOL

SCORING PARENTAL RESPONSES TO AN APPLICATION FORM AS A
METHOD TO DISCRIMINATE UNILATERAL FROM BILATERAL
TERMINATIONS AT A CHILD GUIDANCE CLINIC

A DISSERTATION
SUBMITTED TO THE GRADUATE OFFICE
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degree of
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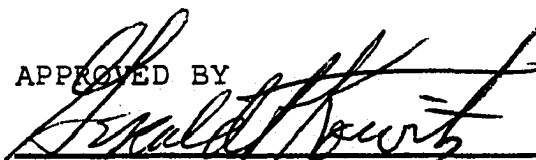
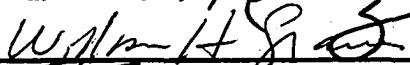
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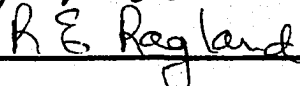
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1975

SCORING PARENTAL RESPONSES TO AN APPLICATION FORM AS A
METHOD TO DISCRIMINATE UNILATERAL FROM BILATERAL
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APPROVED BY



DISSERTATION COMMITTEE

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Chapter

Structural Variables

Correlations

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Number of Positive Adjectives

Number of Negative Adjectives

Number of First Person Pronouns

Number of Third Person Pronouns

First Name

Discriminating Variables

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CHAPTER I

INTRODUCTION

Psychological techniques, often selected as treatment approaches for persons experiencing emotional difficulties, have not always yielded productive results (Levitt, 1971). That certain clients do not continue in therapy until they reach a successful outcome has long been a clinical concern. In fact, clinicians over a period of years have attempted to identify reasons for therapeutic losses in order to modify treatment programs in a way that will circumvent client defection. To date, they have not found answers and the question remains: why do certain clients continue to a successful completion while too many others prematurely conclude treatment?

Equal to the unsatisfactory conclusion of therapy for the clientele is the fact that premature terminators also represent a major inefficiency in mental health service. For example, in child guidance clinics, dropout rates exceeding 30 percent have been reported (Levitt, 1958; Ross & Lacey, 1961). Such findings further indicate the difficulty clinicians experience in making case management decisions that increase the likelihood of success with certain clients.

A growing emphasis on cost accounting for health care services has resulted in an increased interest in the general area of program effectiveness in addition to a focus on specific areas such as early defection of clients. National attention was called to the problem of treatment inefficiencies by the Joint Commission in Mental Health of Children in its final report in 1970. The report re-emphasized the need for an increase in research in the whole field of child mental health and gave high priority to the need for evaluating the effectiveness of various intervention programs. Specifically, program effectiveness and the related issue of personnel shortages were seen as focal issues for further study.

Additional interest in treatment effectiveness is evidenced by recent operational changes in certain state agencies. For example, certain regulations have been introduced by the Kansas Department of Social and Rehabilitative Services. "Utilization Review" is mandatory for welfare clients and highly recommended for other clients receiving mental health service. The review is an evaluation conducted by professionals after a designated number of treatment sessions, as determined by each center. Two or more mental health professionals study the particular treatment program instituted by the therapist and make recommendations deemed necessary to facilitate client improvement. Reports of these reviews are then made a permanent part of the case file.

Clients who prematurely terminate therapy are neither new nor unique to a clinic. Current emphasis on accountability and allocation of funds force therapists to become more aware of the efficacy of clinical assumptions and decisions.

In child guidance clinics, more referrals are often received than can be processed at any one time. Moreover, a considerable amount of staff time is consumed in initial processing which may include intake interviews, diagnostic evaluations, and staff conferences regarding disposition of cases. Unfortunately, much of this expenditure of staff time and energy is dissipated when therapy is prematurely concluded.

Unlike therapy offered at adult clinics, treatment in child guidance centers usually involves related individuals in addition to the identified patient. While the mother is usually the person who receives attention, both parents sometimes participate in the treatment process. In all cases, however, an adult initiates referral and usually decides when to terminate treatment. Consequently, a parent's perception of the child's problem may influence the decision to continue or terminate the child's therapy. Parent attitudes toward the child's therapy may be, therefore, an important factor to clinicians in case management decisions.

Conceptual Framework

Since parents are intimately involved in the child's difficulties, many clinics make an effort to directly include them in the therapy. This general practice is derived from the psychotherapist's belief that the parents' action and influence plays a key role in the treatment of emotionally disturbed or handicapped youngsters. According to Kessler (1966, p. 410), of all the causative factors of emotional disturbances (e.g., organic, constitutional sensitivities, fortuitous events, and genetic influences), the parental influences seem most susceptible to change.

Depending on the particular clinic and case, parent involvement in treatment may vary from periodic sessions with the child's therapist to treatment by a separate therapist. Regardless of the arrangement, the underlying assumption in this process is that a favorable prognosis for the child generally includes a parental desire to make changes in the child's relationship with the parent and the family. Theoretically, parents who assume responsibility for their part in the creation of the child's problem are more amenable to therapeutic intervention. Furthermore, these parents are thought to sustain and stimulate the child's emotional growth in treatment by reassessing and reorganizing their own attitudes and behaviors.

Even though there has been an increase in professional involvement with children who experience emotional difficulties,

a large portion of the responsibility for successful intervention and future adjustment rests with the family. This is an assumption that is common to various clinical theories (Levitt, 1971). Psychodynamic approaches, for instance, focus on how conflict in the child has been fostered and developed by the parent (Wolberg, 1967). One aspect of social learning programs emphasize modeling, a process whereby the parents control the child's undesirable activities by reinforcement (Patterson, 1971). Systems approaches look at the child's deviant behavior as having maintenance value for the particular family structure designed by the parents (Tiffany, Cohen, Ogburn, & Robinson, 1972). Therefore, the concept that treatment success is associated with parent involvement does have wide recognition.

Clinical Procedure

In many children's clinics, each new applicant usually participates in several assessment procedures before therapy is actually begun. As a matter of routine, each new client is assessed in an effort to formulate realistic therapeutic goals and to predict the likelihood of his continuance in treatment to a favorable outcome (Cobb, 1972; Levitt, 1971). In order to make prognostic decisions concerning therapeutic goals, information is collected from application forms, various interviews, and formal testing procedures.

Information from application forms has been widely used in child guidance clinics. Specifically, the forms have

served as supplements to intake interviews, as substitutes for interviews, and as aids in making case assignment decisions. Although the nature of application blanks varies, the structure of the form reflects the needs of the clinic. In some clinics, record keeping is of primary importance, so application questions are designed to elicit demographic information. In other clinics, application forms are viewed as important sources of information to be used in making case management decisions. The particular questions asked reflect the staff's view of what is important to know about a person before a disposition can be made.

At the Wichita Guidance Center (WGC) the application form serves as a substitute for an initial interview. Parents making application in person or by phone are informed that when the questionnaire is completed and returned, the case will be reviewed and assigned. In addition to the completion of the application form, other intake information deemed relevant by the intake worker may be provided (i.e., which parent called for help, how severe he or she believe the child's problem to be). This information is gathered for presentation at a staff conference. The data is read aloud at the staffing and one of the therapists elects to accept the case. A therapist's decision to take a particular case is based on several considerations which may include his current case load, prognosis for improvement, and the estimated treatment period. Thus the application form

carries much weight and provides most of the information in the assignment of a case.

The application form used at the WGC includes two basic sections: the first is devoted to identifying the client by demographic data and the particular problem for which assistance is desired, and the second and main section of the form, (Appendix A), consists of eight open-ended items.

Item one asks the parent to state whether the child's problem behavior(s) is present in one specific situation or whether it has been generalized to various situations. The issue is whether the child exhibits certain behavior in the presence of the parent only, in certain other situations, or across several stimuli situations.

Items two and three were originally combined into one question. Since each of the parts seemed to be eliciting different information, the question was divided into two separate items for the purpose of this study. As revised, item two concerns a time interval. It seeks to obtain information concerning what time period elapsed between the initial appearance of the child's problem and the request for professional assistance. Item three deals with the manner in which the parent became cognizant of the child's difficulty. This question elicits information concerning whether the parent alone recognized the problem or whether it was brought to the parent's attention by some other person.

In item four, the parent is asked to be aware of causative factors which resulted in the child exhibiting emotional or behavioral difficulties. The parent is requested to be aware of cause and effect relationships with respect to why the child behaves as he does.

Item five is concerned with efforts of those closely and intimately associated with the child to change his behavior. The item seeks to determine a parent's understanding of the relationship between parental behavior and that exhibited by the child. In addition, it deals with the degree to which the parent has changed his own behavior in order to reduce problems in the child.

The sixth question asks whether the child is cognizant of his problem(s). Imbedded in this question is the issue of communication and agreement between parent and child.

Items seven and eight concern parent agreement and prior assistance respectively. Information to be elicited involves parental communication and whether they have come to an agreement regarding the nature of the youngster's problems. The parent is then asked if they have sought outside help before and if so from what agencies. Underlying this question is the issue of whether or not the parent has actively sought assistance and, if so, what particular strategy was used in the search for help.

The questions just summarized are logically interrelated and provide information deemed necessary in making case

management decisions. The application form reflects the philosophy that the parental role is very important in the child's therapy. Parental attitudes toward the problem situation and the seeking of assistance are considered to be of paramount importance since it is the adult who initiates clinic contact and decides when to terminate. At the WGC, as in many child guidance clinics, effort is made to involve the accompanying adult in therapy. The parents' responses to the application questions initially serve to aid the clinician in the establishment of a prognostic formulation and treatment plan.

When treatment is contingent upon the completion of an application form, a socioeconomic factor may be influential. As indicated by Hollingshead and Redlich (1958), persons from higher socioeconomic levels are often better educated and more sophisticated in responding to psychotherapy. Thus they may achieve higher rates of success in treatment. Additionally, it might be assumed that parents from higher socioeconomic levels would be better able to provide more complete responses to application questions. This may lead the clinician to perceive them as more likely to benefit from therapy than families coming from the lower socioeconomic levels.

Parent variables, such as parent responsibility and socioeconomic position, may be important factors which relate to the conditions of termination. Since many parent

variables do not lend themselves to experimental manipulation, the researcher is limited to an ex post facto approach. However, the inability to manipulate variables does not preclude a controlled inquiry of the problem when using an after the fact design.

One method of evaluating the accuracy of clinical decision making is to review success and failure cases. Such a review will be conducted in this study by using the ex post facto research design. With the utilization of case file information, the present researcher will explore certain clinical assumptions and test their validity. Case file information is available and provides the researcher an opportunity to follow the client from initial application through termination. Additionally, such information yields a medium for studying variables which already exist and cannot be manipulated.

Limitations

Of course certain limitations exist with any ex post facto study. Kerlinger (1973, p. 190) has discussed three basic weaknesses. He begins by reminding researchers that there is no control of independent variables and second, that there is a lack of power to randomize. To state the problem specifically, the variables under study cannot be introduced as experimental conditions. Groups are selected on the basis of presence or absence of the particular variables under study. The third weakness is the risk of

improper and erroneous interpretations since many plausible explanations can be given for complex events that cannot be submitted to experimental analysis.

Despite these limitations, Kerlinger (1973, p. 391) further suggests that at least one step can be taken to lend more credibility to the results of ex post facto investigations. This step amounts to using hypotheses as a basis for investigation rather than merely collecting quantities of data and then making interpretations. Preferably, in addition to the main hypothesis, alternate hypotheses (plausible explanations) should be routinely tested. Using this guideline, more confidence can be given to positive results obtained with the main hypothesis if the alternative hypotheses can be disconfirmed.

Statement of the Problem

Completed application forms are required of parents during the initial phase of seeking clinic assistance at the WGC because information provided in written responses to application questions plays an important part in case management decisions. Therefore, one of an investigator's major areas of concern should be to test the clinical assumption regarding parent responsibility to determine how it relates to termination. This effort will subject clinical lore to controlled inquiry.

The use of a controlled inquiry of a clinical assumption represents an attempt to validate subjective aspects of case

management decision making. Additionally, subjective assumptions regarding prediction have a greater chance of being useful if they are based on data that have been firmly validated. Parent socioeconomic status may, however, in fact be more important than parent responsibility and may be the variable that can account for the success or failure of various clients. This variable will be examined.

Early identification of premature terminators will also be of considerable value. If a relation does exist between parental responses and treatment success or failure, then further research into alternate treatment approaches would be appropriate. Should application responses and termination relate to any significant extent, there would be two practical implications. First, information regarding the probability of early termination would be of value to clinicians who are frequently overloaded with cases. For example, such information might aid in the modification of intake procedures, in the establishment of priority lists during peak periods, and in the sorting of cases for long and short term treatment. Second, if the techniques of analyzing application responses used in this study are valid, they could be adapted for use in other clinics.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

Research presented in this chapter is organized into three inter-related areas. The first area is concerned with the relation of the parental role to the therapeutic outcome. Research reviewed in this section will focus on relationships between parent factors and the conditions of termination. In the second area, a discussion of clinical and statistical prediction will be presented. The focus will be on what the literature indicates regarding the accuracy of these two methods for the prediction of human behavior. The final section relates to therapeutic effectiveness. Two issues will be pursued: the first issue concerns the reliability among clinicians in their judgments about clients and the second issue concerns the validity of clinical estimations of client success or failure.

Parental Role

Studies presented in this section concern parental involvement and therapeutic outcome. One focus of research has been to study the relation between certain parental characteristics and the conditions under which they terminated their child's therapy. The investigators were usually

interested in identifying parent variables which might be correlated with early termination. A second focus has been in the use of parents as active behavioral co-therapists. In these studies the parent was responsible for changing the child's behavior.

One approach to the study of variables and early terminations consisted of application interviews rated by judges. Lake and Levinger (1960) studied parent interviews in terms of the following dimensions:

1. The degree to which the parent recognized the existence of a problem;
2. The parent's desires to see changes in themselves;
3. The degree of cooperation between parent and therapist;
4. The degree to which parents agreed with the therapist's evaluation of the core problem.

When statements made during the application interviews were examined and rated by the judges, Lake and Levinger found that parents who continued their child in therapy were rated higher on these four dimensions than those who did not continue in treatment.

An earlier investigation did not support this result. Levitt (1958), who was also concerned with the relation of termination and parental motivation, examined judges' reviews of material from cases previously closed. He did not find that the ratings of parental motivation significantly related

to the conditions of termination. The disparity in findings might be attributed to the precision and restriction of boundaries from which the parent interviews were examined in the Lake and Levinger study.

Cole and Magnussen (1967) and Ross and Lacey (1961) utilized file information of male children to analyze parental involvement in connection with termination. Both teams of investigators compared two groups of boys classified on the basis of the number of treatment sessions attended and the clinician's agreement with the parental decision to terminate or the absence of mutual agreement. In both studies, unsuccessful cases were defined as ones in which a child attended less than four treatment sessions and in which the parent terminated of his own volition without the clinician's opinion. On the other hand, cases in which a child attended four or more sessions and the parent's decision to terminate was in agreement with the clinician were regarded as successful treatment cases.

Both investigations found that when cases were terminated early that usually only the mother was receiving therapy in addition to the child. Inferred from this data was the hypothesis that a father who did not participate in therapy was actually undermining treatment or reducing therapeutic effectiveness by not supporting the mother and child. The inference seems rather arbitrary. That the father's absence at the treatment center creates a situation of maternal

support and intentional paternal destruction of therapeutic efforts should be questioned. Instead of an either-or situation, it is possible to speculate that the father's role in therapy might be better assessed on a continuum from support through neutrality to resistance, regardless of whether or not the father was receiving therapy. Secondly, the father's presence or absence might be attributed to other factors (i.e., to whether or not he could get away from his work), rather than to an indication of resistance. In other words, the father's attitudes concerning therapy for his child and whether or not he personally attended sessions may be independent factors.

Still another attempt to determine an existing parental variable related to termination was conducted by Ross and Lacey (1961). These investigators found a higher rate of divorce and separation among parents whose child successfully completed therapy than among cases classified as unsuccessful. No data, however, were presented to indicate whether the marital disharmony existed prior to clinic assistance or whether it was created by therapeutic intervention.

Cole and Magnussen (1967) found that the time between the initial application and the receipt of clinical service was much shorter for unsuccessful cases. The time factor in this study, however, may have been an artifact of the clinic selection process of children rather than a valid

correlation between waiting time and successful treatment. Apparently, cases in which children had symptoms that were less severe and of more recent onset received more immediate attention by the clinic. Additionally, Cole and Magnussen found that parents receiving immediate attention were less motivated than parents of children having chronic difficulties who were placed on waiting lists. Although the clinic's stated philosophy was to involve parents, it gave priority in practice to children with less severe difficulties regardless of parental motivation.

Richardson and Cohen (1968) studied a group of parents who discontinued their child's therapy without therapist agreement. After interviewing these parents, the researchers concluded that they tended to feel minimal responsibility for the occurrence of their child's problem. These parents perceived the child's symptoms to be the result of forces outside the family.

The few studies thus far reviewed contained a rather minimal amount of empirical evidence regarding a causal relation between parental motivation and successful psychotherapy with children. Results based on such a deficiency have doubtful generality. Therefore, it is necessary to review a related area of research in which parents function as active behavioral co-therapists. The reasons for selecting the particular family member(s) as co-therapist(s) in the following studies were not explored by the researchers.

Although the following studies do not explicitly measure parent responsibility, two basic assumptions exist. One, the child's behavior is primarily under the control of reinforcing contingencies supplied by significant others. Two, the training of parents by professionals in the application of operant approaches can lead to a substantial change in the child's behavior.

De Leon and Mandell (1966) trained parents in the use of an electronic respondent device with their functionally enuretic children. The parents kept records of the child's bedwetting in addition to being instructed in the daily use of an apparatus that contained a sleeping pad and alarm device activated by moisture. The child was awakened by the mother when the alarm sounded. The aim was to condition children to awake on full bladder cues. The results were that the frequency and severity of bedwetting were more effectively and quickly reduced with the conditioning device (86% reached the criterion of 13 dry nights) than with those children receiving psychotherapy or no treatment (both reached 11% criterion). The group conditioned by the device did significantly better than the other two groups. Even in cases of relapses, the symptoms were less severe and re-training was more rapid than with the psychotherapy and control groups.

Clement (1970, 1974) discussed the use of mothers as therapists. In one particular case, a mother was trained

to eliminate sleepwalking in her seven year old boy. The boy had nightmares about a "black bug" which resulted in sleepwalking. The mother was trained to awaken her child during sleepwalking and have him tear up pictures of the black bug that had been drawn previously. Additionally, the mother was also encouraged to reinforce the boy for verbal expression of his feelings during waking hours. The nightmare became the conditioned stimulus for waking, and thus, lost its stimulus control of sleepwalking. The sleepwalking behavior was significantly reduced during therapy and for a one year follow-up period.

In another study, the mother of a preschool child was trained in the home to reduce his aggressive and disobedient behaviors (Zeilberger, Samper, & Sloane, 1968). Training in differential reinforcement was given which included ignoring maladaptive behavior, time out (isolation), and social rewards paired with food or special toys. Evidence of the mother's successful modification of her "bossy son" included an increase in percentage of instructions followed by the child and a decrease in latency of responding to instructions. In order to indicate that the behavior was under the mother's control, a reinstatement of baseline conditions (how she originally responded to the child) resulted in an increase in maladaptive behaviors. Following a reinstatement of the experimental conditions, the maladaptive behavior subsided.

Another application of behavior therapy in the home was done by Hawkins, Peterson, Schweid and Bijou (1966). The mother of a four-year-old boy was trained to observe specific problem behaviors (aggressive and oppositional) and to immediately and appropriately provide verbal instructions, time out, or attention, praise, and physical contact. Positive correlations existed between the deviant behavior and the mother's response during baseline periods and a negative correlation during treatment periods; the correlations were significantly different from each other. Inter-rater agreement for the deviant behaviors and the mother's response varied between .70 and 1.00. Again, reinstatement of baseline procedures resulted in an increase in deviant behaviors which were substantially reduced following a reinstatement of experimental conditions.

Wahler, Wenkel, Peterson, and Morrison (1965) and Wahler (1969) discussed boys whose severe oppositional behavior was appreciably modified. The basic approach was to shift the mother's attention to the child's cooperative behavior. In addition, she was trained to use a variety of social and other positive rewards combined with time out procedures to decrease oppositional behavior and increase cooperative behavior. Training took place in the clinic. A light system was used to train the mother to respond to the child and later to reinforce the mother if she responded appropriately. When observer agreement regarding the child

and mother's responses reached 90%, baseline sessions were begun. During baseline, measurements were made of the strength and rate of deviant behaviors, incompatible behaviors, and the frequency of the mother's response. The experimental situation was next introduced, followed by reinstatement to baseline, and finally, by a second experimental period. Substantial improvements were noted in each case.

Patterson and Brodsky (1966) worked with the mother of a five-year-old child with multiple behavior problems. The mother was trained to reinforce behaviors which competed with the occurrence of problem behaviors. Additionally, an attempt was made to reprogram the entire family. The aim was to make the parents and child mutually reinforcing. A dramatic reduction in deviant behaviors was reported with the first ten days, producing the greatest reduction in problem behaviors.

A rather extensive approach to training groups of families in operant procedures was reported by Patterson, Cobb, and Ray (1970). A sequential program was used in which parents had to earn additional involvement by successfully completing assignments. Phase one consisted of the collection of baseline data by parents. Baseline data was collected for a period of two weeks. If successfully completed, a second stage was entered. During the second stage, parents were responsible for progressing through a programmed

text outlining social learning theory. During a third phase, a professional spent one hour to help the parents pinpoint one or two problem behaviors and to set up a schedule for parents to observe the behavior. Finally, if several days of consistently good data were collected, the parents were allowed to attend a small parents group. The group activities involved each parent describing his program with his child. The parents also presented data indicating the effectiveness of their particular approach. When needed, the other group members assisted particular parents in outlining new management techniques. The researchers reported improvements in families whose parent continued in the program and became involved in the parent groups. Significant decreases in deviant behaviors, generalization across non-target response classes, improvement in sibling behavior, and improvements in parents global descriptions of children were reported. The validity of these findings was supported by high inter-rater agreement regarding the occurrence of certain behaviors during follow-up studies six months later.

In the aforementioned group of studies, the focus was on modifying the dispensers of reinforcement (usually mothers) in order to alter contingencies of reinforcement that maintained problem behaviors. However, as noted by Patterson (1971) and Patterson, Cobb, and Ray (1970), involvement of the parent in producing changes is not equal in all cases. Some parents do not become involved because they are forced

(i.e., by the court) to attend training sessions in which they have no investment in producing change. Additionally, some parents have such little involvement with the child that alterations in the child's behavior are not significantly reinforcing to the parents.

As previously mentioned, various therapeutic and training programs operate from the assumption that parents are responsible agents in direct control of the child's natural environment. However, some parents have little investment in changing themselves or their children. Thus, one obvious problem faced by professionals is the need to develop predictive measures of parental involvement and success in therapy. These measures would be of importance to all professionals, whatever their therapeutic program.

One might assume that parent socioeconomic position could be related to therapeutic success. The assumption would be that parents who have higher social achievements would be better suited to foster their child's emotional growth. The ability to achieve socially, (i.e., change and elevate one's life style) may be positively related to the ability to benefit from therapy. This hypothesis does gain support from research conducted in adult out-patient clinics. Luborsky, Chandler, Auerbach, Cohen, and Richardson (1972), in their rather extensive review of 166 adult out-patient studies, found that clients with higher social achievements were better suited for psychotherapy. Various social achieve-

ments that have been examined include occupation, education, income, and type of housing. Reportedly, persons having higher occupational and educational levels seem to benefit more from psychotherapy. Persons capable of achieving in spheres requiring social skills also did well in therapy.

Parents from the higher socioeconomic levels might be expected to be moderately well educated and hence sophisticated regarding psychotherapy. Thus they would be more cooperative. Truckman and Lavell (1959) and Williams and Pollack (1964) used the occupational class of the principal family wage earner as an indicator of parent socioeconomic status. In both studies, socioeconomic position was not found to be significantly associated with the conditions of termination.

Levinger (1960) and Cobb (1972) reviewed research concerning child-guidance terminations but neither review contained information specifying how parent socioeconomic level was determined. Both writers made reference to Hollingshead and Redlich's (1958) two-factor formula (comprised of education and occupation) as an index for determining parent socioeconomic position. However, no statements were made regarding which of the articles reviewed used this system. Both researchers reported that low socioeconomic status could not be related significantly to early termination.

Weiss and Dlugokinski (1973) also used Hollingshead and Redlich's two factor formula. The data indicated that as parental social level increased, the child was seen for a greater number of clinic sessions. No data, however, were presented regarding the positive or negative results of longer treatment periods.

In the literature reviewed, socioeconomic position did not differentiate between successful and unsuccessful treatment outcomes in children's clinics although it was a factor in adult clinics. Sufficient ambiguity existed in the children's studies with regard to composition and homogeneity of the samples to lead one to question the adequacy of data analysis.

Clinical and Statistical Predictions

The research presented in this section relates to two modes of prediction: clinical and statistical. The aim is to explore how clinical prediction may be improved by the addition of statistical data. Special emphasis will be put on predictions based on application information. Specific examples of the development of scoreable application blanks will also be provided.

Responding to a challenge by Meehl (1954), a large number of studies have been conducted involving the complex process of prediction. One area given particular attention has been the comparison of the accuracy of clinical judgments

with actuarial methods of prediction. With few exceptions, clinical predictions were not superior to quantitative actuarial methods of prediction. With few exceptions, clinical predictions were not superior to quantitative actuarial predictions (Lindzey, 1965).

One problem has been that the clinician has seldom been given the opportunity to incorporate actuarial information in formulating a final decision (Holt, 1958). However, the addition of objective data to clinical decision making has resulted in an increase in the accuracy of clinical judgments (Sawyer, 1966) while the addition of clinical information does not always result in a definite improvement in the clinician's predictive accuracy (Sawyer, 1966; Moxley, 1973).

Shagoury and Satz (1969) studied the effects of three levels of quantitative information on judgmental accuracy in differentiating between brain damaged and normal individuals. The judges were given increments of information including composite scores and differential error rates, base rates, and conditional probabilities. With increments in statistical information, the judges' accuracy improved. Specifically, the accuracy of judgments increased substantially over a discriminant functions analysis of quantitative information. And confidence in the accuracy of the decisions also increased.

Mosley (1973) studied the relation between three levels of clinical experience and four levels of information.

Again, there was a linear increase in accuracy and appropriateness of ratings. The judges were able to improve substantially decision accuracy with increments in statistical information while nonstatistical information was not helpful. The decision accuracy of judges surpassed that of a discriminant functions equation. More confidence in judgments was associated with higher rates of accuracy.

Lewinshon, Nichols, Pulos, Lomant, Nickel, and Siskind (1963) used judges to develop a rating scale for quantifying judgments from psychological tests. The judges first were given experience with the scale and then rated 100 blind protocols. Clinical judgment was found to be more reliable and valid under conditions where the judges worked with familiar instruments they helped develop. The rating procedures were highly structured, the population was well-known and the judges were familiar with the criteria they were predicting.

It appears that clinical prediction can be improved and, in some cases, can surpass actuarial methods when the clinician is given the opportunity to incorporate statistical data. The clinician then has not only objective material but also the benefit of cues not available in actuarial tables. In addition to clinical decisions becoming more accurate, there is also an increase in confidence associated with the decision.

Clinical decision making was the focus of the present study. One purpose was to determine if clinical prediction could be sharpened by applying statistical techniques to application form responses. Since research on this topic is virtually non-existent in children's clinics, the subsequent discussion will discuss information from other sources, e.g., industry and adult clinics.

Industrial firms have used techniques similar to those of guidance clinics to predict an applicant's future job success. The techniques have included analyzing application blanks, interviewing, and formal testing. The underlying logic of these techniques has been to obtain a brief sampling of behavior that is relevant to a particular job.

The development of scoring systems for use with application blanks has been based on several considerations. Application forms are a quick and easy method for learning about a person's past performance since past behavior seems to be one of the best ways to gauge future performance (Albright, Glennan, & Smith, 1963, p. 129; Clement, 1974, p. 82; Guion, 1965, p. 380). Application items are purported to be less subject to faking than personality tests, possibly because the items are presented in the context of other items that do require responses of a factual nature (Naylor & Vincent, 1959, p. 81; Smith, Albright, Glennon, & Owens, 1961, p. 62). In addition, the results of sampling behavior are more reliable when the observations are standard as opposed

to interview situations which are subject to much error variance from both applicant and interviewer.

In general, there are four steps to the development of a scorable application blank (Albright et al., 1963; Guion, 1965). First, items that are valid predictors of specific criteria are identified. Second, differential weights are established for response items according to their power to discriminate. When the application blank is in use, the response weights are totaled so that each applicant receives a composite score. Finally, the scale is cross validated with a second group of employees.

Weighted application blanks or personal history inventories have been developed for many different occupations with many different criteria. Naylor and Vincent (1959) were interested in being able to predict absenteeism among clerical workers. The high absentee group was absent four or more days in a six-month period while the low group was absent less than four days. The researchers found that the number of dependents listed on the application form was significantly and positively related to absenteeism; more frequent absenteeism was associated with having a larger number of dependents.

Productivity and turnover rate with seasonal employees were explored by Dunnette and Maltzold (1955). Variable weights were assigned to application items according to the percentage of "good" and "poor" employees (as rated by

supervisors) answering the items. The purpose of the scoring system was to eliminate the maximum number of undesirable candidates and a minimum number of potentially stable employees. The results of the initial and cross validation groups indicated that the scoring system was quite accurate in predicting the criterion.

Mosel and Wade (1951) explored the relationship between application responses and turnover rate. The particular company needed an employee to remain six months in order to repay the company's training investment. Employment duration of one year was needed for the company to earn a profit from the employee. A differentially weighted application scoring system was developed to predict short tenure (six months or less). Kirchner and Dunnette (1957) also studied employee turnover but with clerical workers. A scoring system was developed for short term (less than nine months) and long term (over 16 months) employees. The scale was adequate for predicting tenure for a variety of office positions.

A variety of civil service clerical positions were studied by Walther (1961). A multiple choice instrument given to all employees was used to compare two groups of persons employed at least three years. The high group had consistently earned high production ratings by supervisors. The low group earned consistently low ratings. The scoring key that was developed worked best for predicting performance

of the secretarial employees as opposed to other office positions.

Scollay (1951) examined personal history items for three groups of district managers engaged in promotional activities. Excellent, average, and poor managers were classified according to ratings given by supervisors. Both variable and unit weighting systems were developed with each system significantly differentiating groups.

Smith, Albright, Glennon, and Owens (1961) attempted to predict the productivity of research scientists. The three criteria selected for study were overall job performance and creativity as determined by supervisors' ratings and the number of patent disclosures. A personal history questionnaire was developed and a variable weighted scoring system applied. The weighted application blank was found to yield validity scores that were significant predictors for all three criteria.

In addition to use for hiring, scoreable application blanks have been used for job placement (Albright et al., 1963; Guion, 1965; Lipsett, Rodgers, & Kentner, 1964; Stone & Kendall, 1956). Decisions sometimes need to be made about placement on jobs requiring long training periods versus placement where employees become productive more quickly. For example, the Personnel Division of the United States Air Force (Levine & Zachert, 1951) was interested in making a more efficient utilization of the available pool of recruits.

A scoring system based on a biographical inventory was developed for a number of different occupational specialties. Training school grades were used as criteria of success and failure. The biographical scoring system was quite a valid predictor of success and failure contributing much to the differential classification and placement beyond other predictive measures.

In summary, industrial firms have bolstered selection and placement procedures by developing scoring systems for application blanks. The decision to accept or reject an applicant or to place a person in a particular job requires prediction made by employment personnel. This prediction is based on a mixture of information and speculation. However, systematic research can serve to help improve clinical prediction. Properly used, systematic selection or placement techniques can sharpen the accuracy of predictions by increasing the proportion of relevant information that has been validated (Albright et al., 1973; Holt, 1969).

Several studies (Heilbrun, 1962, 1964, 1965, 1973; Heilbrun & Sullivan, 1962) have focused on evaluating the relation between counseling readiness and early termination with adult clients. The latter study employed the Adjective Checklist (Gough, 1960) which was collected by therapy applicants to develop a Counseling Readiness (CR) scale. An empirical procedure was used to construct scales for males and females. Those adjectives for which there was a different

rate of endorsement for "stays" (attended more than five interviews) and "drops" (attended less than five interviews) were determined by a chi-square analysis. Those items more frequently endorsed by stays were given a plus credit and those for drops were given a minus credit. A T-score conversion table was then constructed using 400 subjects. The CR was cross validated on a new group of clients (Heilbrun, 1964). It was found that the scale was most effectively employed if used to identify high counseling readiness females, ones who would make use of clinic services.

Further research on the CR scale (Heilbrun, 1965, 1973) was performed with non-client males and females. Both males and females who scored low in counseling readiness were found to be more sensitive to social behavior cues and social reinforcement. The author concluded that defection from therapy was one form of a more general class of avoidance responses.

In summary, particular studies reviewed approached the problem of predicting success by empirical methods. The basic approach was to determine which variables differentiated groups and then to apply a scoring system to these variables. The results were that information routinely collected during clinic and job application and subjected to statistical methods did yield valid predictions.

Parent responsibility, a variable considered important in successful therapy with children, was discussed in section

one. Clinicians often perceive a positive correlation between higher degrees of this variable and client improvement. Application information serves to aid the clinician in forming prognostic estimations. In section two application information was shown to be a valuable source of data with which to predict success. It therefore seems reasonable to assume that a scoring system based on parent responsibility can be developed and tested using parent responses to an application form.

Therapeutic Effectiveness

This section will deal with two therapeutic issues. The first concerns the reliability of clinical judgments while the second focus is on the meaningfulness of criteria used in appraising therapeutic effectiveness.

One important factor in the reliability of clinical ratings is the use of clear operational definitions. A "prothetic continuum," a quantification or intensity basis for judgmental formulations, was used to scale functional psychoses (Stone, 1968; Stone & Skurdal, 1968) and a dimension of psychological health (Sennett & Stone, 1970). Inter-judge reliabilities were quite high ranging from .76 to .91. The general conclusion was that judges were able to make reliable ratings when the stimuli were exactly defined and the rules for judging clearly specified. Lewinshorn et al. (1963) also attributed high inter-rater agreement to scoring dimensions that were objectively defined. In addition they

found that high reliability was associated with greater confidence of judges in their ratings.

Two additional factors in high reliability are experience level of the raters and familiarity with the population of subjects being rated (Lewinshorn et al., 1963). Kendell (1973) presented five-minute diagnostic interviews to experienced psychiatrists. Inter-rater agreement on diagnosis was over 75 percent. Jackson and Thompson (1972) found that experienced counselors were in high agreement in rating certain personality dimensions of counselor trainees from responses to case episodes. Accheti, Ornstan, and Taubin (1968) found significant agreement among experienced clinicians who observed videotapes and rated therapists on experience level.

The ratings most frequently employed by clinicians in evaluating client progress are global estimates (Luborsky, 1972). It has been suggested by Leve (1974) that evaluation of behavior change depends on the observer's perceptions, i.e., client, therapist and supervisor. Agreement and disagreement among observers may be important data to be used as part of any evaluation of psychotherapy. Horenstein, Houston, and Holmes (1973) found that the client evaluations were unrelated to their therapist's evaluations and attributed this to the lack of experience and training of the therapists. However, they did find that client and supervisor evaluations correlated quite highly.

Howard, Howard, Coui, Park, Lipman, and Uhlenhuth (1970) studied the differential reliability of experienced psychiatrists in ratings of global improvement. There was significant agreement on ratings of global improvement among therapists and patients (.65) and patients and independent observers (.66). The writers felt global ratings were in high agreement because the data were concrete. The client and his behavior were the criteria for rating. Psychiatrists compared present behavior with past behavior in addition to the client's statements.

Garfield, Bergin, and Prager (1972) used global ratings and objective test scores to evaluate outcome in psychotherapy. While a low correlation existed between the various measures, a moderate but significant correlation (.35 to .44) existed among the global ratings of clients, therapists, and supervisors. When Luborsky (1972) rotated the factor matrix used by Garfield, Bergin, and Prager (1972), he found that client's, therapist's, and supervisor's rating of change loaded on the same factor.

Global estimates given by therapists generally yield a more positive picture of therapeutic outcome than do measures of the difference scores (Garfield, Prager, & Bergin, 1972). Difference scores also show low intercorrelations as compared to global ratings made by supervisors, clients, and therapists (Luborsky, 1972). The benefit of global ratings is that the therapist and client usually have an

intimate knowledge of the specific areas which need change in relation to areas which did change. Not only are specific changes considered in their ratings, but the worth of the change to the patient and the quality of improvement as estimated by the therapist are also considered (Luborsky, 1972). Additionally, global ratings will reflect changes not tapped by objective tests.

There are several liabilities in the use of global ratings (Mintz, 1973). The ratings might be biased by the involvement of the raters in the process of therapy. Secondly, the participants may need to justify their efforts and thereby give higher ratings. A third problem is that therapist and client may forget the initial level of functioning and inflate the improvement to present a more impressive outcome.

The results of the studies presented seem to indicate that global ratings are one reliable and valid method with which to evaluate therapeutic gains. However, there are two important conditions to consider. One, experienced therapists should be the judges making the ratings. Two, if only a small pool of therapists are available for use in a study, care should be taken to eliminate or match data from therapists who have termination rates excessively skewed toward successful or unsuccessful terminations. This precaution would control for possible biasing effects due to a small sample size.

In childrens' clinics, therapeutic success or failure is often viewed as a function of the conditions under which the parents terminate the child's therapy. A parent-initiated decision to terminate is usually equated with failure as opposed to a decision to terminate in which clinician and parents agree that the child had made sufficient progress. In order to lend more validity to defining success and failure by types of parent decisions, unilateral terminations made by a child or clinician could be operationally excluded from study.

Summary

Two problems were stated in Chapter I. The first problem was to determine if a clinical assumption regarding parent responsibility was related to termination. The second problem was to determine if parent socioeconomic position might differentiate success and failure cases.

The review of literature has shed some additional light on the problems stated in Chapter I. No clear relationship has been shown to exist between parent socioeconomic position and termination in childrens's clinics. However, parent involvement does appear to be an important factor in therapeutic success. Estimates of parent responsibility can be made from intake information in the form of responses to application forms. Furthermore, scoring systems can be devised for application responses which may then be used to

test the postulated relationship between increased levels of parent responsibility and successful termination. Finally, global ratings can be one method for gauging success or failure. Agreement and disagreement between client and therapist regarding termination can be a valid method with which to measure treatment effectiveness, as long as controls exist for therapist bias.

Definition of Terms

For ease in exposition, four key terms need to be defined. The focus of the study was the relationship between the variables parent responsibility and parent socioeconomic position and the criteria of unilateral and bilateral terminations.

Parent responsibility was defined as a measure of the degree to which parent statements were rated as reflecting assumed self-involvement for helping create the problem situation. The measure resulted from quantifying written responses to questions on an application form.

Parent socioeconomic position was defined by the father's occupational status. Skill level and prestige value, based on Warner, Meeker, and Eells Occupation Scale (1949), were used to differentiate the status level of occupations.

Unilateral termination refers to a parent-initiated decision to terminate the child's therapy without the agreement of the clinician. Unilateral terminations made by a

child or clinician were not included since the focus of the study was to determine the relation between initial parent responses and parent decisions regarding termination.

Bilateral termination refers to the decision to terminate when the clinician and parent agree that a child had made sufficient progress.

General Hypotheses

Hypothesis 1.--Parents who unilaterally terminate their child's therapy do not make the same kinds of responses to application questions as those who terminate bilaterally. The ratings of parent responses were expected to be higher for bilateral terminators than unilateral terminators.

Hypothesis 2.--Parents who unilaterally or bilaterally terminate their child's therapy do not come from the same socioeconomic levels. Socioeconomic position was expected to be higher for bilateral terminators than unilateral terminators.

Null Hypotheses

Hypothesis 1.--The mean scores of unilateral and bilateral groups will not differ more than the degree expected by the operations of chance.

Hypothesis 2.--The occupational ratings of unilateral and bilateral groups will not differ more than the degree expected by the operations of chance.

CHAPTER III

METHODOLOGY

Subjects

The subjects for this study were drawn from the children who had received psychological services at the Wichita Guidance Center. The Wichita Guidance Center provides treatment services for families with children to age 16 who are experiencing emotional difficulties.

The center is supported financially by the United Fund and serves all of Sedgwick County, Kansas. Sliding scale fees are charged with gross annual income and number of dependents used to determine the cost for treatment.

The Wichita Guidance Center is also a training facility. Its clinical psychology internship program has been approved by the American Psychological Association.

Male and female children, aged five through ten, were selected for this study. Preschool children were not included since they rarely received service at the center and adolescents were eliminated in order to confine the focus of the study to one developmental period. Only children who resided with both parents were selected; single parent families were eliminated from the study as a further refinement. In all cases selected, the parent or child had participated

in at least one therapeutic interview with a WGC therapist. In order to control for possible biasing effects resulting from previous clinic contact, the subjects had not received other therapeutic assistance prior to their current application.

Prior to sample selection, a frequency count was made of the number of unilateral and bilateral terminations between July, 1972 and January, 1973 for each WGC therapist. Table 1 contains the frequency distribution of cases for ten therapists employed by the center. The purpose of this step was to establish control for biasing (error) factors resulting from the small pool of therapists available. Four of the original ten therapists (and their case data) were eliminated from this study since over 75 percent of their terminations were either unilateral or bilateral. The figure of 75 percent was arbitrarily used as the cut off point indicating that the termination rate was sufficiently skewed to warrant elimination of the therapist's data.

Sample One was selected from cases that were terminated from July, 1972 through January, 1973. Twenty-five cases per group were selected from all the unilateral and bilateral terminators. A code number recorded on each termination sheet was used to indicate the condition of termination and to sort cases into categories. The sample was then selected using the last two digits of case file numbers and a table of random numbers. Of the cases selected, 36 were male

TABLE 1
NUMBER OF BILATERAL AND UNILATERAL TERMINATION CASES FOR
EACH WICHITA GUIDANCE CENTER STAFF MEMBER
FROM JULY, 1972, TO JANUARY, 1973

Termination	Counselor									
	J.W.	M.T.	B.C.	D.S.	T.F.*	L.F.	A.H.	T.R.*	A.C.*	H.J.*
Bilateral	4	9	4	9	0	5	3	0	8	3
Unilateral	3	7	3	6	3	3	4	4	1	0

*Therapists eliminated from the study.

children and 14 were female children. From this sample a rating manual was to be constructed.

Sample Two was also selected using case numbers and a table of random numbers. Twenty-five cases per group were selected from unilateral and bilateral termination cases from February through June, 1973. Of the cases selected, 34 were male children and 16 were female children. This sample was used to cross validate the rating manual developed with sample number one.

Instrumentation

Six WGC therapists were used as judges in the development of the rating manual for parent responsibility using data from sample number one. Each therapist had been employed by the center for at least two years.

Experienced clinicians were selected for two reasons. The review of research indicated that judgments made by experienced clinicians are more reliable. Secondly, as indicated by Stone (1968, p. 31), clinical assessments of some phenomenon have meaning only in terms of subjective norms which themselves reflect previous observations over some range of behavior. Therefore, experienced clinicians would be expected to make more valid judgments than novices. Additionally, judgmental categorizations by experienced clinicians would extend over a wider range on a continuum while novices would be more inclined to make judgmental errors (e.g., central tendency, leniency, extreme ratings).

The Wichita Guidance Center Application Form (Appendix A) consisted of seven questions. Question number two, as previously discussed, was divided into two separate questions because the original question appeared to be eliciting two different types of information. There were 50 items to be classified for each of the eight variables. With only a small number of judges, a scaling method was needed that would yield reliable values that extended over all levels of the scale.

The questions were highly interdependent with regard to the information elicited. Therefore, a scaling method that could present values on individual items as well as a total scale score was needed. This method would permit the application of statistical techniques designed to minimize chance factors by eliminating covariance. The scaling method selected combined aspects of two approaches: (a) equal-appearing intervals, and (b) summated ratings (Edwards, 1957; Maranell, 1974).

The equal-appearing interval method was applied to develop a scoring manual which contained scale values that were independent of the judges' attitudes. In the development of the manual, a judging group of six raters was used to determine scale values which would be used to score a second group of subjects.

The summated ratings method was applied to provide a relative ordering of responses in an efficient manner. A

five-point, Likert-type scoring system was applied to each item individually rather than sorting a large group of items into categories as was done with the equal-appearing interval method. A second reason for the summated approach was that the subject's scores on individual items is totaled to yield a composite score. This rating permitted the use of a multivariate statistical approach that will be described in the procedure section.

Each judge was presented a list of parents' written responses to the eight questions on the application form. Each judge assigned a response value of one through five to all responses. Higher numbers were assigned to responses perceived to reflect a feeling of greater responsibility. Each judge rated twenty-five sets of parent responses for each question.

Each parent response received six ratings which were then averaged for a mean rating score. This was followed by assigning standard deviations to each of the parent responses. Justification for these operations include the fact that the arithmetic mean is an appropriate measure of central location for interval variables and provides a better estimate of population parameters than any other measures of central tendency. Standard deviations were used to select responses with the highest degree of rater agreement.

The final part of the scaling process involved an item analysis in order to select scoring examples (parent

responses) that were similar within a particular weight but different between weights. The fifty items, mean response scores, were rank-ordered from low to high. The fifty ranked scores for each question were divided into five groups with each group containing ten mean values. The two responses at the beginning and end of each group interval were eliminated. This procedure created a buffer zone that prevented responses with quite similar mean values from being used to separate groups. Each group of six responses was assigned a response weight of one through five. From the remaining six responses in each group, the three with the lowest standard deviation were selected as scoring examples for a particular weight.

The final form of the rating manual consisted of each question having individual weights on one through five. Each weight contained three scoring examples. It was not possible to obtain three scoring examples for each weight on variables seven and eight. These variables contained a high frequency of cases in which parents did not respond to the questions or gave a simple "yes" or "no" answer. With little variety in responses, it was not possible to obtain more than one scoring example for several weights.

The second instrument used in this study was a one-factor index that yielded parent socioeconomic position. The Revised Scale for Rating Occupations, developed by Warner, Meek and Eells (1949), provided a comparatively

objective means of determining socioeconomic position. The definitions for each of the seven levels were rather precise and eliminated much subjective judgment (Miller, 1970, p. 195).

The scale contains seven occupational levels with one as the highest level of occupational status and level seven the lowest. The categories of occupations are distributed among the seven levels according to the degree of skill required and the prestige value attached to a job. Therefore, any category of occupation is not limited to a single rating but could potentially be given a higher or lower rating depending on the skill required and status accorded. While the scale measures one status characteristic, it does correlate highly with social class. Miller (1970, p. 196) reported the Occupation Scale as correlating highly ($r = .91$) with the evaluative participative method of social class position. Since this scale correlated highly with social class, was precise, and eliminated much subjective judgment, it was selected as an efficient method to examine the influence of socioeconomic status.

Procedure

For discussion of the procedures used, each step is presented separately. The presentation includes training of a new group of judges in the use of the rating manual, the validation of the scoring manual, and the evaluation of the

relationship between parent socioeconomic status and the conditions of termination.

Rater Training.--In order to permit an independent appraisal of the rating manual, three judges, none of the original six, were trained in the use of the instrument. Each judge was enrolled in a doctoral program in clinical psychology. Two of the judges had completed a one-year internship at the WGC, while the third had just begun the internship.

The training consisted of having the judges rate parent responses using the manual as a guide. Each judge rated a list of parent responses taken from ten unilateral and ten bilateral cases. These cases were selected from those not used in samples one and two. The judges did not know which cases were unilateral or bilateral terminators.

Inter-Rater Reliability.--Ratings were made on cases selected from sample number two. The three judges rated a list of fifty responses for each of the eight questions. The three ratings for each item were then averaged to yield a mean rating score. Correlation coefficients were computed between each of the raters for each of the eight questions. The correlations were computed to examine inter-rater reliability for each of the eight criteria. It was important to examine inter-rater agreement for individual questions in order to determine if the total scores for each group were a reflection of high agreement. Additionally, some judgmental

consensus is needed if the individual estimates (across judges) are to be averaged. A directional, one-tailed test was used to examine the degree of inter-rater reliability.

Hypothesis 1.--The first hypothesis dealt with the measurement of parent responsibility. Two groups, unilateral and bilateral terminators, were used to test the first hypothesis. The hypothesis in the null form stated that the mean parent responsibility scores for unilateral and bilateral groups would not differ more than the degree expected by the operations of chance.

A multivariate test, the Hotelling's T^2 , was computed to test the difference between groups. The Hotelling's T^2 was computed using computer program CCIP-6 (1973), which was the Wichita State University number for the U.C.L.A. Biomedical Computer Program BMD-5M (Dixon, 1973). This particular program converts a multivariate U-statistic to an approximate F-statistic.

The scale was a unidimensional scale with each of the eight criteria measuring different aspects. As noted earlier, it was necessary to use a multivariate technique since the criteria variables were logically interrelated and the researcher did not want to capitalize on chance. Individual t tests would not have accounted for any interaction or correlation present between the various measures.

Since each variable elicited information that was not exclusive from that obtained from other variables, an analytic

method was used that would account for redundancy. In short, the T^2 was comparable to a univariate t which might have been computed for each separate pair of variables (Overall & Klett, 1972, p. 308). An additional reason for using the T^2 concerned the small sample size. Ender and Wetzel (1973) reported findings that the T^2 was very robust to error variance created by small sample sizes as long as the samples contained an equal number of subjects.

A probability level of less than .10 was used as a critical point to determine statistical significance. The selection of the significance level was based on the relation between sample size to power. Since the population variance was not known, it had to be estimated by gathering preliminary data from the standardization sample (sample number one). A formula reported by Glass and Stanley (1970, p. 375) was used to compute a mean difference and a ϕ value.

With the small sample size used in this study, the probability of obtaining a mean difference of 0.91 would have been 0.30. There would have been only three chances in ten of detecting a significant difference between unilateral and bilateral groups if a difference of 0.91 actually existed in the population. Therefore, the significance level was lowered to .10 to raise the power of the T^2 to 0.48. The rationale for this procedure was to increase the likelihood of finding a relation by compensating for the reduction in probability caused by using a small sample size.

In the absence of significant findings an analysis of the structure of the scale was planned. While it was assumed that the scale was unidimensional, the possibility existed that it really was comprised of a number of components. A factor analysis was applied to identify sources of common variance among the variables. Wichita State University computer program CCIP-6 (1973) adopted from the U.C.L.A. Biomedical Computer Program BMD-8M (Dison, 1973) was used. The program uses the Guttman (1954) criterion for deciding how many factors to define. The variance accounted for by each factor (sum of the squared loadings on each factor) exceeds 1.0.

Hypothesis 2.--The importance of parent socioeconomic position as related to termination was examined in Hypothesis 2. The hypothesis in the null form stated that the occupational ratings of unilateral and bilateral groups would not differ more than the degree expected by the operations of chance.

All the unilateral and bilateral cases from July, 1972 through June, 1973 were examined, and a list of the fathers' occupations was made. Then an independent judge (not used as a rater) gave each occupation a one to seven rating. A Chi-square test with a .05 level of significance was used to test the hypothesis.

Structural Variables.--An additional statistical analysis was planned in the event that the use of the rating manual produced significant reliability but low validity.

Two questions were to be explored. If rater agreement was high and parent responsibility was not a discriminating variable, what was affecting the raters' judgments? Perhaps the raters were responding to certain structural elements of the written responses. Examination of the structural elements would provide a clearer understanding of what elements of the responses the judges were using to make their ratings. Secondly, would examination of the structural elements yield factors which would discriminate between groups?

The written responses to each question would be examined and tallies made of the following (a total of 40 variables); (a.) number of words in each answer, (b.) number of positive adjectives, (c.) number of negative adjectives, (d.) number of first person pronouns (singular and plural combined), and (e.) number of third person pronouns (singular and plural combined). An additional variable included the total number of times the child's first name was written across the eight questions.

A total of 50 variables were collected for each case. The variables included the eight mean rating scores, parent socioeconomic position (high or low), and the 41 structural elements previously mentioned. The 50 variables were entered into a discriminant functions analysis. Wichita State University computer program CCIP-27 adopted from the U.C.L.A. Biomedical Computer Program BMD-4M (Dixon, 1973) was used to compute the analysis.

The directional hypotheses implicit in these exploratory analyses were as follows:

Hypothesis 1.--The more words a parent uses to answer a question indicates greater parent involvement. Bilateral terminators will write longer answers to each question than unilateral terminators.

Hypothesis 2.--The more the positive adjectives written in a response the greater is the parent involvement. Bilateral terminators will write answers to each question that will contain a higher number of positive adjectives than responses of unilateral terminators.

Hypothesis 3.--The more the negative adjectives written in a response the less is the parent involvement. Unilateral terminators will write answers to each question that will contain a higher number of negative adjectives than responses of bilateral terminators.

Hypothesis 4.--The more first person pronouns in a response the greater the parent involvement. Bilateral terminators will write answers to each question that will contain a higher number of first person pronouns than responses of unilateral terminators.

Hypothesis 5.--The more third person pronouns written in a response the less is the parent involvement. Unilateral terminators will write answers to each question that will contain a higher number of third person pronouns than responses of bilateral terminators.

Hypothesis 6.--The more times a parent writes the child's first name is indicative of higher parent involvement. The total number of times the child's first name is written will be higher for bilateral terminators than unilateral terminators.

The null hypotheses implicit in these exploratory analyses were as follows:

Hypothesis 1.--The number of words in parent responses of unilateral and bilateral terminators will not differ more than the degree expected by the operations of chance.

Hypothesis 2.--The number of positive adjectives in parent responses of unilateral and bilateral terminators will not differ more than the degree expected by the operations of chance.

Hypothesis 3.--The number of negative adjectives in parent responses of unilateral and bilateral terminators will not differ more than the degree expected by the operations of chance.

Hypothesis 4.--The number of first person pronouns in parent responses of unilateral and bilateral terminators will not differ more than the degree expected by the operations of chance.

Hypothesis 5.--The number of third person pronouns in parent responses of unilateral and bilateral terminators will not differ more than the degree expected by the operations of chance.

Hypothesis 6.--The total number of times the child's first name is written in parent responses of unilateral and bilateral terminators will not differ more than the degree expected by the operations of chance.

CHAPTER IV

RESULTS AND DISCUSSION

Inter-rater Reliability

Table 2 presents the correlation coefficients for paired raters on each of the eight variables. Using a one-tailed test with an N of 50 ($df=48$), all coefficients except two were significant beyond the .01 level. Of the remaining two coefficients, one was significant at the .05 level. The results indicate a generally high agreement between judges on their ratings of each of the eight variables.

Parent Responsibility and Termination

The first hypothesis stated in the null form that the mean scores of unilateral and bilateral terminators on the measure of parent responsibility would not differ more than the degree expected by chance. A .10 level was used to determine statistical significance.

Table 3 contains the means and standard deviations for the two groups for each of the eight variables. Only on variables one and eight are the means of the bilateral group lower than the unilateral group.

Table 4 contains the approximate F-statistic computed for the mean difference between the unilateral and bilateral

TABLE 2
INTER-RATER RELIABILITY FOR EACH OF THE
EIGHT VARIABLES

Variables	Raters		
	1 and 2	1 and 3	2 and 3
1	.58**	.72**	.57**
2	.48**	.13	.34**
3	.56**	.59**	.79**
4	.79**	.84**	.79**
5	.80**	.82**	.76**
6	.61**	.31*	.47**
7	.64**	.62**	.85**
8	.83**	.92**	.92**

df = 48

* $p < .05$

** $p < .01$

TABLE 3
MEANS AND STANDARD DEVIATIONS FOR UNILATERAL AND
BILATERAL GROUPS ON EIGHT VARIABLES

Variables	Unilateral		Bilateral	
	$\bar{X}$	S.D.	$\bar{X}$	S.D.
1	3.09	1.32	2.77	1.28
2	2.49	1.18	2.93	0.91
3	2.67	1.27	2.92	1.23
4	3.20	1.41	3.24	1.49
5	2.59	1.29	3.08	1.38
6	2.35	1.15	2.79	1.00
7	2.38	0.88	2.63	0.86
8	2.68	1.39	2.64	1.19

Note. Each group contains 25 subjects.

groups. The F-statistic of 1.03 failed to reach significance at the .10 level. Thus the null hypothesis was not rejected. The parent responsibility mean scores of unilateral and bilateral terminators were not shown to be significantly different.

TABLE 4
HOTELLING'S T^2 OF MEAN DIFFERENCE BETWEEN
UNILATERAL AND BILATERAL GROUPS ON
EIGHT PARENT VARIABLES

Source	df	Approximate F Statistic	Critical F Value at .10 Level
Group	8	1.03	1.83
Error	41		

A factor analysis was computed on 50 cases with eight variables. Using the Guttman (1954) criterion, two factors with eigenvalues (1.51 and 1.01 respectively) were extracted. The two factors accounted for 32 percent of the variance extracted. While the common variance amounted to 76 percent, the total variance accounted for was quite small.

Table 5 presents the 8x8 correlation matrix for the combined unilateral and bilateral groups. The commonality estimates in the diagonals indicate how each variable is defined by the rest of the scale. The low commonality estimates

TABLE 5
THE 8 X 8 CORRELATION MATRIX FOR THE COMBINED UNILATERAL
AND BILATERAL GROUPS WITH COMMONALITY ESTIMATES
IN THE DIAGONALS

Variables	Variables							
	1	2	3	4	5	6	7	8
1	0.10							
2	0.09	0.56						
3	0.07	0.74	0.59					
4	0.15	0.19	0.27	0.23				
5	0.11	0.03	0.10	0.28	0.31			
6	0.06	0.14	0.11	0.09	-0.14	0.42		
7	0.14	-0.13	-0.21	-0.13	0.20	0.49	0.51	
8	-0.17	0.02	-0.06	-0.05	-0.12	0.04	0.21	0.14

for variables one and eight indicate that these variables were probably not measuring the same universe of variance as items two through seven. The results of this table seem to deny the fundamental assumption of a unidimensional scale.

Table 6 presents the factor loadings for each variable after a Varimax rotation. The numbers represent the strength of the factor loadings on each variable. In order to be conservative, 0.50 was used as the criterion for significant factor loadings.

TABLE 6
ROTATED FACTOR MATRIX

Variables	Factors	
	1	2
1	0.17	0.11
2	0.77	-0.09
3	0.80	-0.18
4	0.37	-0.05
5	0.16	0.06
6	0.24	0.60
7	-0.06	0.77
8	-0.06	0.18

Two factors emerge from the analysis. Responses to questions two and three load high on factor one. The content covered by the two questions were, "when and in what way did the problem come to the parents' attention?" Essentially, the questions sought parent awareness of the child's difficulties. "Parent awareness" was used as the construct to explain the commonality measured.

Responses to questions six and seven concerned the degree to which the child was aware he had a problem (as perceived by the parent) and the degree of agreement between parents that a problem existed. The common element involved the degree of agreement among family members (according to the perception of the applicant) that a problem existed. The construct used to explain the commonality was "family agreement."

The high inter-rater agreement in addition to the low commonality estimates for items one and eight suggest that something other than responsibility was measured. The factor analysis extracted two common sources of variance. It therefore seems plausible to postulate that the scale was possibly measuring four dimensions, two common and two unique, instead of one.

It seems logical to postulate that the operational definition of responsibility was too broad. Perhaps each variable required a more specific definition. In other words, the defining task may not be the same for all eight items.

Parent Socioeconomic Status and Termination

Table 7 presents the frequencies of families in high and low occupational levels. The original seven levels were collapsed to form the two groups with the common property being either high or low socioeconomic level. It was necessary to form collapsed groups due to low expected frequencies in many of the original seven levels (Siegel, 1956). Levels one through four formed the high group and five through seven the low group.

TABLE 7
OBSERVED FREQUENCIES OF UNILATERAL AND BILATERAL
TERMINATORS BY HIGH AND LOW OCCUPATIONAL LEVEL

Occupational Level	Unilateral	Bilateral	df	χ^2
High	12	27	1	4.63*
Low	51	49		

*p .05

The hypothesis that there was no relationship between socioeconomic status and type of termination was rejected. The results support the relationship between parent socioeconomic status and the conditions of termination. This relationship results from the large percentage of bilateral terminators being classified in the high socioeconomic position. The conclusion was that parent socioeconomic level is related to the type of termination.

Structural Variables

The results presented in this section are divided into eight parts. The first section is devoted to presenting the correlations between the structural variables and mean rating scores. The next six divisions contain results related to each hypothesis. In the final section, the results of the discriminant analysis are presented.

Correlations.--The question to be explored was if by examining the relationship between structural variables and mean rating scores, one could better understand to what elements of the responses the judges were responding when making their ratings. Table 8 presents the Pearson correlations of the structural variables with each item on the application form. Only correlations with a significance level of .05 or better are reported.

The mean rating scores on item one are correlated most highly with the number of words contained in answers to that item. While other variables are related, the number of words in the parent written statements is the variable most highly correlated with judges' ratings of the responses.

In items two and three, the number of words appears to be an important factor affecting rater judgment. The number of words in responses to question three seem equally as important as in ratings on question two. The number of third person pronouns appears to be another important factor correlating highly with judges' ratings.

TABLE 8
VARIABLES CORRELATED WITH JUDGED RESPONSIBILITY
WITH EACH OF THE EIGHT APPLICATION ITEMS

Variable Number	Variable Description	Correlation	Significance Level
Application Question One			
10	Number of Words to Item 1	.63	.01
34	Positive Adjectives to Item 1	.43	.01
27	Negative Adjectives to Item 2	.42	.01
28	Negative Adjectives to Item 3	.42	.01
42	Third Person Pronouns to Item 1	.38	.01
26	Negative Adjectives to Item 1	.31	.02
46	Third Person Pronouns to Item 5	.29	.05
18	Positive Adjectives to Item 1	.28	.05

df = 48

TABLE 8--Continued

Variable Number	Variable Description	Correlation	Significance Level
Application Question Two			
12	Number of Words to Item 3	.51	.01
11	Number of Words to Item 2	.49	.01
43	Third Person Pronouns to Item 2	.41	.01
44	Third Person Pronouns to Item 3	.40	.01
35	First Person Pronouns to Item 2	.39	.01
36	First Person Pronouns to Item 3	.39	.01
Application Question Three			
12	Number of Words to Item 3	.45	.01
11	Number of Words to Item 2	.43	.01
35	First Person Pronouns to Item 2	.36	.02
36	First Person Pronouns to Item 3	.36	.02
43	Third Person Pronouns to Item 2	.33	.05
44	Third Person Pronouns to Item 3	.32	.05

TABLE 8--Continued

Variable Number	Variable Description	Correlation	Significance Level
Application Question Four			
37	First Person Pronouns to Item 4	.46	.01
39	First Person Pronouns to Item 6	.37	.01
16	Number of Words to Item 7	.36	.02
40	First Person Pronouns to Item 7	.32	.05
15	Number of Words to Item 6	.30	.05
Application Question Five			
14	Number of Words to Item 5	.46	.01
38	First Person Pronouns to Item 5	.44	.01
46	Third Person Pronouns to Item 5	.41	.01
42	Third Person Pronouns to Item 1	.33	.05
50	Total First Name	.28	.05

TABLE 8--Continued

Variable Number	Variable Description	Correlation	Significance Level
Application Question Six			
15	Number of Words to Item 6	.53	.01
47	Third Person Pronouns to Item 6	.49	.01
48	Third Person Pronouns to Item 7	.42	.01
16	Number of Words to Item 7	.37	.01
27	Negative Adjectives to Item 2	.34	.02
28	Negative Adjectives to Item 3	.34	.02
40	First Person Pronouns to Item 7	.32	.05
32	Negative Adjectives to Item 7	.28	.05

TABLE 8--Continued

Variable Number	Variable Description	Correlation	Significance Level
Application Question Seven			
16	Number of Words to Item 7	.43	.01
48	Third Person Pronouns to Item 7	.40	.01
21	Positive Adjectives to Item 4	.37	.01
32	Negative Adjectives to Item 7	.36	.02
41	First Person Pronouns to Item 8	.33	.05
40	First Person Pronouns to Item 7	.28	.05
35	First Person Pronouns to Item 2	- .28	.05
36	First Person Pronouns to Item 3	- .28	.05
39	First Person Pronouns to Item 6	- .28	.05

TABLE 8--Continued

Variable Number	Variable Description	Correlation	Significance Level
Application Question Eight			
17	Number of Words to Item 8	.45	.01
41	First Person to Item 8	.36	.02
49	Third Person to Item 8	.32	.05
50	Total First Name	.28	.05
23	Positive Adjectives to Item 6	.28	.05

The mean rating scores on item four are correlated most highly with the number of first person pronouns contained in answers to that question. While other variables are related, the number of first person pronouns correlates highest with rater judgment. Ratings to item five seem largely affected by three variables: the number of words, the use of the first person pronouns, and the use of the third person pronouns appear to have had much influence on the raters' judgments.

On item six rater judgment correlated most highly with the number of words and number of third person pronouns as a basis for their ratings. Number of words and third person pronouns in answers to item seven are not only important for ratings given to item seven but also to the ratings of responses to item six. The number of words and first person pronouns in responses to item eight were highly related to the scores given to the parent written answers.

In general the number of words and third person pronouns appear consistently related with mean rating scores. How important these two variables are, in addition to the other four, in discriminating groups will be explored in the next several sections.

Number of Words.--The issue in Hypothesis 1 was the importance of number of words in the written responses and the conditions of termination. The null hypothesis stated that the number of words in parent responses of unilateral

and bilateral terminators will not differ more than the degree expected by the operations of chance. The means and standard deviations were calculated on the number of words per item given by unilateral and bilateral groups. In order to compare groups, an F test was computed. The results are presented in Table 9.

On items four, five, and six the null hypothesis was rejected since the F value reaches significance at the .10 level. The bilateral group responded with significantly more words per answer on three of the eight items.

Number of Positive Adjectives.--The number of positive adjectives in the responses to each question were tabulated. Means and standard deviations were calculated. An F ratio was used to test the null hypothesis that the number of positive adjectives in parent responses of unilateral and bilateral terminators will not differ more than the degree expected by the operations of chance. The results are presented in Table 10.

The null hypothesis was rejected for application item five only. On item five, the bilateral group wrote a significantly higher number of positive adjectives than the unilateral group. The group differences for the other items were not large enough to be significant.

Number of Negative Adjectives.--In hypothesis 3, the issue was the number of negative adjectives in written responses and the conditions of termination. The null

TABLE 9
F TEST FOR NUMBER OF WORDS IN APPLICATION
RESPONSES OF UNILATERAL AND
BILATERAL GROUPS

Application Questions	Unilateral		Bilateral		F*
	$\bar{X}$	S.D.	$\bar{X}$	S.D.	
1	19.36	11.80	16.56	12.38	0.67
2	18.40	13.52	23.96	24.12	1.01
3	19.60	15.01	23.96	24.12	0.59
4	14.60	10.99	36.28	53.38	3.96**
5	16.76	10.04	27.88	27.87	3.52**
6	13.80	9.19	18.56	8.85	3.48**
7	6.24	8.34	9.12	13.78	0.80
8	6.16	7.26	12.76	34.27	0.89

*df = 1,48

**p < .10

TABLE 10
F TEST FOR THE NUMBER OF POSITIVE ADJECTIVES IN
APPLICATION RESPONSES OF UNILATERAL
AND BILATERAL GROUPS

Application Questions	Unilateral		Bilateral		F*
	$\bar{X}$	S.D.	$\bar{X}$	S.D.	
1	0.24	0.52	0.32	0.56	0.27
2	0.08	0.40	0.12	0.33	0.14
3	0.08	0.40	0.12	0.33	0.14
4	0.08	0.40	0.16	0.62	0.29
5	0.00	0.00	0.28	0.54	6.68**
6	0.04	0.20	0.00	0.00	1.00
7	0.08	0.28	0.00	0.00	2.08
8	0.04	0.20	0.04	0.20	0.00

*df = 1,48

**p < .10

hypothesis stated that the number of negative adjectives in parent responses of unilateral and bilateral terminators will not differ more than the degree expected by the operations of chance. Table 11 presents the results.

The null hypothesis was rejected for application item one. With item six the difference was significant in the direction that was opposite that which was expected. For item six, the bilateral group contained a higher number of negative adjectives.

Number of First Person Pronouns.--The number of first person pronouns written to each question by both groups was tabulated. The null hypothesis stated that the number of first person pronouns in parent responses of unilateral and bilateral terminators will not differ more than the degree expected by the operations of chance. Table 12 presents the results.

The F value was not significant on any of the eight application items. Therefore, the null hypothesis of group difference based on first person pronouns was not rejected. The number of first person pronouns was not a variable that differentiated the groups.

Number of Third Person Pronouns.--In hypothesis 5, the issue was the importance of the number of third person pronouns. The null hypothesis stated that the number of third person pronouns in parent responses of unilateral and bilateral terminators will not differ more than the degree expected

TABLE 11
F TEST FOR THE NUMBER OF NEGATIVE ADJECTIVES IN
APPLICATION RESPONSES OF UNILATERAL
AND BILATERAL GROUPS

Application Questions	Unilateral		Bilateral		F*
	$\bar{X}$	S.D.	$\bar{X}$	S.D.	
1	0.56	1.04	0.16	0.47	3.05**
2	0.12	0.33	0.16	0.37	0.16
3	0.12	0.33	0.16	0.37	0.16
4	0.20	0.50	0.04	0.20	2.21
5	0.08	0.28	0.16	0.37	0.74
6	0.04	0.20	0.28	0.54	4.32**
7	0.04	0.20	0.04	0.20	0.00
8	0.00	0.00	0.04	0.20	1.00

*df = 1,48

**p < .10

TABLE 12
F TEST FOR THE NUMBER OF FIRST PERSON PRONOUNS
IN APPLICATION RESPONSES OF UNILATERAL
AND BILATERAL GROUPS

Application Questions	Unilateral		Bilateral		F*
	$\bar{X}$	S.D.	$\bar{X}$	S.D.	
1	0.48	0.82	0.36	0.56	0.36
2	0.48	0.71	0.92	1.50	1.75
3	0.48	0.71	0.92	1.50	1.75
4	0.64	0.86	1.00	1.50	1.08
5	1.20	0.81	1.44	1.76	0.38
6	0.52	0.58	0.56	0.76	0.05
7	0.48	0.71	0.44	0.86	0.03
8	0.20	0.50	0.24	0.72	0.05

*df = 1,48

by the operations of chance. Table 13 presents the results.

With item number one, the null hypothesis was rejected. While application items five and six did show significance, it was opposite the expected direction. The bilateral group, rather than the unilateral group, contained a higher frequency of third person pronouns on items five and six.

First Name.--The final hypothesis was concerned with the total number of times across all items the child's first name was written by the parent and the conditions of termination. The null hypothesis stated that the total number of times the child's first name was written in parent responses of unilateral and bilateral terminators will not differ more than the degree expected by the operations of chance. As indicated in Table 14, the F value did not reach significance. Therefore, support for the expected relationship was not found.

Discriminating Variables.--The final analysis of the data consisted of determining which variable(s) was the most discriminating. A discriminant functions analysis was performed on the 50 variables. Two variables contained F values significant beyond the .05 level. The two variables included the number of positive adjectives in responses to application item five and the number of third person pronouns in responses to application item six. Bilateral terminators answer item five with a higher number of positive adjectives and item six with a higher number of third person pronouns.

TABLE 13
F TEST FOR THE NUMBER OF THIRD PERSON PRONOUNS
IN APPLICATION RESPONSES OF UNILATERAL
AND BILATERAL GROUPS

Application Questions	Unilateral		Bilateral		F*
	$\bar{X}$	S.D.	$\bar{X}$	S.D.	
1	2.00	2.02	1.12	1.36	3.26**
2	1.84	1.86	1.48	2.26	0.38
3	1.80	1.87	1.48	2.26	0.30
4	1.08	1.12	2.68	5.63	1.94
5	0.80	1.04	2.20	3.14	4.49**
6	1.52	1.45	2.56	1.56	5.99**
7	0.44	0.77	0.36	0.91	0.11
8	0.20	0.50	0.84	3.42	0.86

*df = 1,48

** $p < .10$

TABLE 14
F TEST FOR THE TOTAL NUMBER OF CHILD'S FIRST NAME
IN APPLICATION RESPONSES OF UNILATERAL
AND BILATERAL GROUPS

Variable	Unilateral		Bilateral		F*
	$\bar{X}$	S.D.	$\bar{X}$	S.D.	
Total for First Name	1.32	2.25	1.32	1.63	0.00

*df = 1, 48

When the discriminant functions analysis results are re-considered, however, one crucial question emerges. Why does the number of words not appear as a discriminating factor when it seems to be quite meaningful? While the number of words is significantly correlated with mean rating scores and yields significant F values, this variable does not emerge as a differentiating factor.

CHAPTER V

SUMMARY, CONCLUSIONS AND IMPLICATIONS

Summary

The application form, which is used at the WGC, serves as a substitute for intake interviews. This form provides the clinician with information concerning the nature of the child's behavior as well as the manner in which the parents have responded to the situation. The application items are designed to allow personnel to make decisions regarding which clinician will accept the case. Additionally, this information enables the clinician to formulate predictions regarding the treatment success of each case.

A belief held by many clinicians including those at WGC is that cases in which parents experience little responsibility for their child's problem are not good candidates for therapy. A positive relationship is presumed to exist between increased parental responsibility and successful therapy for the child.

The purpose of this study, then, was to determine if a clinical assumption regarding successful psychotherapy with children could be validated. Specifically, the study asked how adequately a prediction of successful treatment for the child could be made by analyzing parent written responses to

application questions. Put another way, the study attempted to evaluate (a) the relation between parents' expressed attitudes and assumptions regarding the cause of their child's problem, and (b) the conditions under which the parents terminated therapy.

The sample consisted of two groups. The unilateral group contained parents who discontinued the child's therapy of their own volition. The bilateral group contained parents who made mutual termination decisions with the clinician. Responses of the two groups to the application items were used as a basis for the investigation of several issues.

First, a rating manual was constructed by using the parents' written responses. The criterion for rating was assumed responsibility for creating their child's problem. An attempt was then made to cross validate this manual on a new group of unilateral and bilateral cases.

A second issue was to determine whether parent socioeconomic level was related to the successful completion of the child's therapy. Could this variable account for unilateral and bilateral terminations?

A final consideration involved the relationship between various structural elements of parent written responses and the conditions of termination. The structural elements were as follows: (a) number of words in a response, (b) number of positive adjectives in responses, (c) number of negative adjectives, (d) number of first person pronouns, (e) number

of third person pronouns, and (f) the total number of times the parent wrote the child's first name. Several exploratory analyses were performed to determine if structural elements were related to the conditions of termination.

Conclusions

Based on the results of this study the following conclusions were reached:

1. Unilateral and bilateral groups were not different in the degree of judged responsibility. Bilateral terminators were not judged to feel more responsibility for their child's problem than unilateral terminators. Thus the clinical assumption regarding parents was not supported by the data.
2. Parent socioeconomic level was related to termination. A greater proportion of parents from the high socioeconomic level bilaterally terminated than parents from the low socioeconomic level.
3. The raters' judgments were significantly correlated with the number of words and with the usage of first and third person pronouns in the parent responses. These variables were related to the mean rating scores given by the judges.
4. The two most discriminating variables were the number of positive adjectives in responses to application item five and the number of third person pronouns in responses

to application item six. Thus it is possible to conclude that these two items better discriminated groups than parent socioeconomic level.

Implications for Future Research

Based on the results of this study several implications for future research should be considered. Parent responsibility was not shown to be higher among those parents whose child successfully completed therapy than among unsuccessful cases. This occurrence can have numerous implications for future research. Investigations are needed of other factors which may account for the success and failure of therapy. Certain interaction variables between parents, parents and child, parent and clinician, and child and clinician may account for why some therapy cases are successful while others are not.

The second implication concerns parent socioeconomic position. In the present study, children of parents from the high socioeconomic group more often successfully completed therapy than children of parents in the low socioeconomic group. An implication for future research would be to explore the effectiveness of various therapeutic strategies with persons of different socioeconomic levels. For example, one question might be, is a time-limited, contractual type of approach more effective with families from different socioeconomic levels? Another example could be, do parents of

different socioeconomic levels gain more benefit in their relationship with the child if guidance and training sessions are presented in the home as compared to counseling sessions offered at the clinic?

A third implication involves clinical sensitivity. In the present study, regardless of significant inter-rater reliability, there were many instances in which the clinicians might have been using criteria other than the rating manual as a basis for judgments. The number of words and the usage of first and third person pronouns were significantly correlated with the raters' judgments. An important area for future research would be to understand more clearly what the stimulus attributes in clients are that clinicians respond to and what the effects of these responses are. Many transactions between client and therapist may involve events that are not clearly labeled or are mislabeled. The nature of these events needs closer study in order to elucidate what does and does not relate to client improvement.

The final implication concerns the two variables which were found to be significantly discriminate unilateral and bilateral groups. Since a large number of variables were compared, one question does exist. Were these differences artificial or real? An important issue for future research would be to determine if these variables would significantly discriminate between unilateral and bilateral groups using a new sample. Before a scoring system based on these two

variables can be constructed, it would be important to determine if the results of the present study can be replicated with a new group of unilateral and bilateral terminators.

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APPENDIX A

MODIFIED WICHITA GUIDANCE CENTER

APPLICATION FORM

1. Is the child more of a problem at home than at school?
In what way is the child's behavior different at home, school and in the neighborhood?
2. When did the present problem first come to your attention?
3. In what way did the present problem first come to your attention?
4. What, if any, particular events or experiences do you think have caused or led up to the problem?
5. How have you tried to solve the problem? (Has there been any change in the problem as a result of your efforts or those of others?)
6. Do you feel that the child is aware of any problem?
On what do you base your answer?
7. Do mother and father agree as to the existence or extent of the problem? If not, please explain.
8. From what persons or agencies have you sought help in the past? (Please list and give dates of contact.)

(Use reverse side if desired)

APPENDIX B

APPLICATION SCORING MANUAL

I.

- 1 - a. (no response)
b. I think its the same: he just wants to fight constantly.
c. It's the same.
- 2 - a. _____ is not more of a problem at home than he is in school. _____'s problem is mainly at school when acting in a group.
b. He gets into trouble at home, school and in the neighborhood.
c. It differs only in bed wetting.
- 3 - a. At school will not communicate with the teacher, at home lose temper quite often, usually play fine with neighborhood kids.
b. I can't see too much difference in her behavior. She is either very good or very bad.
c. From what I can gather from _____'s teacher he seems to be worse at school. He seems to be worse when he gets with a group of children.
- 4 - a. I think _____'s behavior is just about the same everywhere now.

- b. His behavior is worse at school but it has been noticeable at home also. He doesn't have playmates his age in the neighborhood.
 - c. He's more of a problem at school the teacher can't handle him, at home if we're real strict with him we can handle him some. He gets along with the kids fairly well.
- 5 - a. She really isn't a problem at school. She gets along alright in the neighborhood. She minds pretty well at home. She doesn't seem to want to do anything.
- b. I believe the problem is noted more at school. At home he has a close attachment with his brother but at school and in the neighborhood he keeps to himself.
 - c. Yes, I think she just cooperates less at home than anywhere else. She does dwell on problems more at home than anywhere else.

II. A. (When)

- 1 - a. It came to our attention about 1 year ago through her 2nd grade teacher.
- b. When he first began to sit up when as I stated began to hit his head against the chairs, seeing things that were not.
 - c. His 2nd grade teacher informed us of _____'s peculiar actions in school.

- 2 - a. About 1st grade. Age 6 years.
 - b. I knew _____ has been slapped by the teacher because he showed the clear hand print about thirty minutes after it happened.
 - c. In the first grade when she became violent at school.
- 3 - a. When she stated failing in another grade.
 - b. More so at the beginning of this year. Fights started at school.
 - c. When he first entered kindergarten.
- 4 - a. When I first took _____ to the Dr. it was because of severe pain in the abdomen. I thought it was his appendix. The Dr. took x-rays and found he was acutely constipated. It was back in 69 or 70.
 - b. Some time last school year. Mostly this year. most times when asked to do something he doesn't want to.
 - c. I've always known he is shy but the fire starting just in the last month 5 fires in all.
- 5 - a. About six months ago _____ because unable to go to sleep without a lot of attention from Mother. He also has been jealous of any other of the children getting any special attention.
 - b. During the month of Sept. When I say you have to go to school he cries and says I don't care about him.

- c. It has been there all along but in lesser proportions.

III. (In what way)

- 1 - a. When he first started kindergarten.
 - b. The teacher call me into talk. And she tole me _____ was having this trouble learning.
 - c. When he first began to set up when as I stated began to hit his head against the chairs, seeing things that were not.
- 2 - a. In the 1st grade when she became violent at school.
 - b. Some time in 69 (nightmares).
 - c. More so at the beginning of this year. Fights started at school.
- 3 - a. When she started to school and each time came home with check marks against him, as far as playing well in groups (is willing to accept correction).
 - b. It came to our attention about 1 year ago through her 2nd grade teacher.
 - c. Through the school - about 1 1/2 months.
- 4 - a. Cannot say exactly. But her stomach aches have been for at least 2 1/2 years.
 - b. When I first took _____ to the Dr. It was because of severe pain in the abdomin. I thought it was his appendix. The Dr. took x-rays and found he was acutely constipated. It was back in 69 or 70.

- c. I've always known about this from the time he started playing with other children and his own brothers and sisters.
- 5 - a. I've suspected for past 4 years it was affecting him and when he started soiling his pants we put him in the hospital for tests and Dr. N. could find nothing wrong.
- b. Her problems first started when she was small (3-4 years), they have improved to a degree since mother's remarriage (3 years).
- c. My wife saw it last summer, but I couldn't see it until not long ago.

IV.

- 1 - a. The work at school gets more difficult and less interesting and he learns more ways to waste time and more fun things to be interested in.
- b. No events I can think of in particular.
- c. Being run down by the teachers and kids. The Nuns at _____ are the teachers I am referring to.
- 2 - a. We have questioned _____ over and over, but he can not give a reason for going into the closet and urinating in the Dr. kit bottle and several toys.
- b. Has had this condition since birth - would sleep only a few hours a day even in infancy - always moving.
- c. I don't know.

- 3 - a. _____'s problem had been a steadily increasing one with not any one event leading up to his present condition.
- b. I don't know - because she has always been a very difficult child. Her father and I were divorced in 1970 but she had these problems before then.
- Note: she was the middle child of 3, is now middle of 5, seems to be jealous of little sister. Was more jealous of her when sister was baby.
- c. It could be jealousy. Possibly could be a thyroid problem. Although I don't think so.
- 4 - a. When he was left with his grandma, he was left to do pretty much of what he wanted, when we got him here there wasn't much change.
- b. The birth of our second child although my husband had been very eager to be his father in every sense of the word.
- c. Its just a guess, but being an only child may have something to do with it.
- 5 - a. Perhaps not getting the attention he desires and needed from infancy on.
- b. His been spoiled: his had most his wishes granted all his life.
- c. I feel that in the beginning it was caused by forced toilet training. Yet the Dr.'s say not. Now I am inclined to think he feels like it will hurt me more

than himself, his not using the bathroom.

V.

- 1 - a. Yes, we're tried - no, no long term change.
b. Yes by punishment
c. (no response)
- 2 - a. I don't know what to do about it with his problem.
b. Yes, for a while I wouldn't have a bit of trouble getting him to school now its worse than ever.
c. We have pleaded, begged, punished, restricted, unrestricted, everything we could think of.
Nothing changes for long.
- 3 - a. Since I'm unmarried she has given me some problem at home but not as bad as she was when her first father lived with us.
b. I haven't done anything out of the ordinary to solve the problem. The problem is worse.
c. a. Yes, given him prescribed medication, talking to him about how normal and right it is to have good toilet habits. Also having him wash out soiled underwear.
b. Not for any length of time.
- 4 - a. Personal instruction. Diagnostic center, Dr. B., O.K. school, cub scouts. Gradual improvement - physical condition and attitude deteriorated as described in 2nd year. Attitude toward other rowdy children deteriorates as he gets to know them better -

except in a few areas - marked improvement since use of dexedrine - sleeps all night with less restlessness - responds well to discipline, etc.

- b. Yes. We have tried reasoning, pleading, bribing, punishing. She says she'll co-operate, but doesn't. Very gradual improvement (if any) since leaving ex-husband in 70.
- c. Yes, but we don't really know how to handle him.
- 5 - a. I have tried to give him more personal attention recently. It does seem to be helping.
- b. Working on that now and don't really know about any change except in my attitude towards _____ as his doing much better in the other school.
- c. We've tried to make him feel wanted and needed and giving him responsibility. It has helped some.

VI.

- 1 - a. Because he does not mind any body.
- b. No.
- c. No. Because it haven't stopped or changed at all.
- 2 - a. Yes. It embarrasses him.
- b. Yes he has told us so. He says he doesn't know why he does the things he does.
- c. Yes.
- a. Because he was in the hospital a year ago for chronic constipation and
- b. he has dirty pants when he releases enough

to relieve pressure.

- 3 - a. Yes. The way he acts, like he doesn't care any more.
- b. _____ hasn't verbally indicated that he is aware that there is a problem
- c. No I believe _____ feels that he is a normal boy, but realizes he is a nervous type.
- 4 - a. No. I cannot seem to get through to him when I explain this to him. Nor can anyone else.
- b. I really don't know. She makes such contradictory statements I really don't know what she thinks or what to believe.
- c. He is aware because we have told him that Mrs. _____ is the boss of the class and he is to do as she says. Also told him to try to be especially nice to her.
- 5 - a. Yes, he talks about it with his grand parents and is always telling them about our fighting.
- b. He knows he has a problem because he has told us so many times, but he can't or won't express it in words.
- c. No, I just feel he isn't feeling emotionally secure at the present time.

VII.

- 1 - a. (no response)
- b. No. My husband denies any problem. He says if

there were any that I am totally responsible. I think it started with him, but was compounded by my own inability to resolve it.

- 3 - a. Yes.
- 4 - a. Yes, in a way his father understands to a certain extent that _____ does have problems but he thinks stricter discipline will help him also.
- 5 - a. Yes, however, we cannot agree on the way to cope with the problem.
 - b. Her father does not feel so strongly about this as I do, but has said he will do what ever is best for _____.
 - c. I (father) consider it more of a problem.

VIII.

- 1 - a. (no response)
- 2 - a. None
- 3 - a. Welfare agencies, 1968.
 - b. Only the teachers.
- 4 - a. Just schools and teachers. We didn't realize until now that it was a real behavior problem. Just thought he was being "all boy."
 - b. Board of Education and Sedgwick County Aid to Dependent Children.
 - c. Dr. says no physical problem. Talked to counselor and principal at school.

- 5 - a. Wichita Guidance Center.
- b. No agencies, just school counselors. I've spoken with only two, one at _____ school and she didn't suggest any help was needed professionally - the last was Mrs. _____ at school.
- c. Diagnostic Center and Wichita Clinic.