

THE UNIVERSITY OF MANITOBA  
THE EFFECT OF DECREASING CONTENT CLARITY OF PATIENT  
COMMUNICATION ON THE EFFECTIVENESS OF A-B  
SUBJECT THERAPISTS' RESPONSES

by

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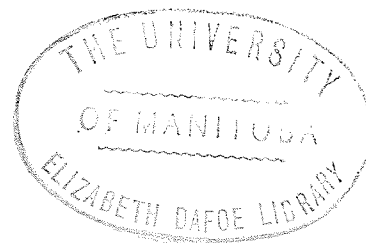
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## ABSTRACT

In studying the therapeutic relationship between schizophrenic patients and their therapists, Whitehorn and Betz (Betz, 1962) noted differences in the clinical styles of effective and ineffective therapists. Therapists who were effective were designated As and were also found to score high on the Lawyer and CPA Scales of the Strong Vocational Interest Blank, while therapists who were ineffective with schizophrenics were designated Bs and scored high on the Printer, Mathematics and Physical Science Teacher Scales. Refinement of the SVIB as a predictive instrument indicated that the critical items were those primarily tapping interests in mechanical-technical-manual activities. A therapists respond with disinterest while Bs respond with interest in these activities. In a later study, McNair, Callahan, and Lorr (1962) found B type therapists to be more effective than As with neurotic patients. As a result the A by schizophrenic and B by neurotic patient type interaction effect was formulated.

Correlational evidence tentatively suggests that Bs may be more content bound in their perceptions than As. One correlate, field-independence, indicates that this focus on content also occurs in interaction with others. It may be that this hypothesized content-boundedness of Bs affects their communications resulting in responses which are not specific and personally relevant to the patient.

The present study, a psychotherapy analogue, was designed to test the notion that Bs are content-bound in interpersonal interaction. Based on this notion it was hypothesized that Bs would make shorter, less specific, and relevant comments to patient communications as the clarity of the patients'

comments became less clear.

Sixty untrained subject therapists were instructed to respond in a helpful manner to a videotape enactment of a patient with emotional problems underlying vocational difficulties. The videotape was played at three levels of content clarity which were constructed by means of an electronic filtering device. No differences were obtained between As and BS with regard to specificity of their responses or response time in any of the three conditions. Possible explanations for the results were discussed along with ideas for future research.

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## CHAPTER I

### INTRODUCTION

For many theorists a significant element of therapeutic success has been thought to be the patient-therapist relationship. Despite this belief little substantive research has been conducted on the patient-therapist relationship until recently. A prolific area of investigation of this relationship was stimulated by a project at the Phipps Psychiatric Clinic in the mid-50's.

Betz (1962) in her review of the Whitehorn and Betz (1955) study which used the participant-observer method attempted to identify some of the crucial aspects in the patients. Therapists' reports indicated that schizophrenics who improved were those who developed a trusting confidential relationship with the therapist. These results impelled them to initiate further research to determine if personality differences in therapists were related to effectiveness with schizophrenic patients. From their study of case records, they discovered that differences in clinical style in therapeutic interaction with schizophrenics could be distinguished. Therapists effective with schizophrenic patients (designated A's) differed from ineffective therapists (designated B's) in that they (A's) grasped the "personal meaning and motivation of the patient's behavior going beyond mere clinical description; selected personality oriented goals; and were more actively and openly involved in the therapy interaction" (Betz, 1962, p. 44). These results were cross validated on a small independent sample at the Phipps Psychiatric Clinic.

Subsequent to these findings, Whitehorn and Betz (Betz, 1962) undertook to locate an objective means of discriminating between A and B therapists. They found that four scales of the Strong Vocational Interest Blank (SVIB) distinguished between A and B therapists. On the Lawyer and CPA Scales, As were high while Bs were high on the Printer, Mathematics and Physical Science Teacher Scales. Endeavoring to further elucidate the personal characteristics of A and B therapists, the responses of the As and Bs to individual SVIB items were examined. From this analysis 23 items were identified which differentiated A and B therapists' interests. Bs endorsed items ostensibly measuring interest in mechanical-manual-technical activities while As were characterized by items suggesting a problem solving approach. Items measuring mechanical interest or some variation of them have since been used as a means of defining the A-B status of therapists.

In a follow-up to the Whitehorn and Betz studies, McNair, Callahan and Lorr (1962) selected therapists from V.A. Outpatient clinics and forty neurotic patients being treated by them. The dependent measures consisted of the Taylor Manifest Anxiety Scale, Barron's Ego Strength Scale, Symptom Checklist, and self-rating by the patient. Therapists rated the patient with regard to severity of illness, interview relationship changes, interpersonal changes, and symptom decrease. In addition, an independent evaluation was obtained from a psychiatric social worker. In general, the results indicated that B therapists were more effective than A therapists with outpatient neurotics.

Taken together these studies suggest the presence of a therapist-by-patient type interaction effect. Analogue studies have tended to



corroborate the A by schizophrenic and B by intrapunitive neurotic interaction effect (Berzins & Seidman, 1968, 1969; Carson, Harden, & Shows, 1964; Dublin, 1969; Kemp, 1964; Sandler, 1965; and Seidman, 1971). In addition, the analogue studies suggest that the A-B dimension may be reflecting individual differences in personality style independent of training. Consequently, correlational studies using untrained individuals as well as psychotherapists have attempted to explicate the personality correlates of the A-B dimension. Some correlational studies relevant to the present thesis have found that Bs are more competent in natural science than in verbal skills (Dublin, Elton, & Berzins, 1969) and B undergraduates also scored lower than As on the aesthetic scale of the Allport, Vernon, and Lindsey Study of Values assessment device (Kenworthy, 1968). Similarly, Johnson, Neville, and Workman (1969) administered the MMPI, and Cattell's 16PF to patients classified on the basis of their A-B scores. The results indicated male B patients were less sensitive and imaginative and more tough-minded and ruled by external realities. These studies suggest that Bs do not attend to noncontent cues since they imply that Bs are more content bound in their perception. However, Berzins, Barnes, Cohen, and Ross (1971), using the Jackson Personality Research Form obtained contradictory results, in that Bs scored higher than As on the Sentence Scale, which presumably measures sensitivity to many forms of experience.

A further correlate of the A-B dimension which has been investigated with various populations is cognitive differentiation. B type undergraduates and subject therapists are reported as being field-independent, while A type therapists and undergraduates are seen as less field-independent and

more variable (Pollack & Kiev, 1963; Shows & Carson, 1965).

In reviewing the available data, Witkin (1965) reports that field-independent subjects have been found to show less incidental learning when the incidental material consisted of human faces; however, the opposite results occurred with nonhuman incidental material. Also, Witkin (1965) reports that field-independent subjects tend to show a separation of thought and feeling. Additional support that field-independent subjects and perhaps their B counterparts are content bound and fail to make use of concontent cues is seen in Witkin's comments:

Individuals with an analytical style in contrast to those with a global approach...show a relatively intellectual approach to problems ...and they are less attentive to subtle social cues given by others (Witkin, 1962, p. 156).

Since psychotherapy relies heavily on the reciprocal understanding of the patient and therapist's verbal communications, we might reflect on how Bs neglect of noncontent cues influences the responses he makes in therapeutic interaction with patients. The personal meaning of the patient's verbalizations is largely determined by the noncontent (expressive and nonverbal) cues accompanying them (Mehrabian, 1969). If Bs do not attend to these cues as proposed above, but focus primarily on the content of the message, we would expect them to grasp less of the personal meaning being conveyed. Consequently, their responses would tend to be more general and less personally related to the patient's individual difficulties.

Consistent with the above speculation is the Betz and Whitehorn (1955) study on the goals pursued by A and B therapists in therapy situations. They found B therapists focused on psychopathologically oriented goals such as symptom decrease and increased socialization, while As stressed personal-

ity oriented goals. B therapists' goals thus appear to be less individualized and based more on external norms than those of A therapists. It can also be recalled that the success of B therapists with neurotic patients was assessed primarily by measures of symptom decrease (McNair, Callahan, & Lorr, 1965). A recent study by Hoffnung and Stein, (1970) had A and B subject therapists respond to four questions after hearing a description of a hypothetical patient communicating in a normal, neurotic, schizophrenic, or ambiguous style. These questions were designed to evaluate the subject's interpretive style, empathic understanding, positive regard, and personal involvement and interest in helping the patient. In addition, responses were also analyzed to determine the number of words and the number of feeling words. The results showed that Bs were less depth-directed, as determined by their tendency to respond to the more literal elements in the patient's communication; and also used fewer feeling words with all patient types. A further finding was the tendency for Bs to offer help of a more general nature than As to schizophrenic and ambiguous patient communications. Travland (1967) investigated the interpersonal reactions of A and B type subjects to individuals communicating in either a Dislike-Hostile (DH) or Like-Friendly (LF) manner. As were found to make less ambiguous evaluations in the DH condition; that is, they communicated their interpersonal reactions in terms corresponding closely to the social cues on which the reactions were based. Along the same line are the results of a study by Segal (1970) with neurotic patients. He found As were less directive and interpretive and placed less emphasis on having patients respond to specific questions or ideas but responded in a manner which encouraged greater expression on the client's part.

There is a kernel of support in many of the studies reviewed above to the contention that B subjects' responses in interaction with patients are content bound and consequently tend to be general in nature rather than specifically and personally relevant to the patient's difficulties.

B subjects' mode of response is hypothesized as similar in all therapeutic interactions regardless of patient type, it is probably not as detrimental with neurotic as with schizophrenic patients since it is with schizoid patients that Bs have been found less effective than As, (Berzins, Ross, & Friedman, in press; Betz, 1962, 1967). In order to account for the differential effectiveness of B type subjects' mode of responding, we must consider the differences between schizophrenic and neurotic communication.

Comparatively, the neurotic's verbal content is clear, grammatically sensible and conveys at least some information about the patient's problems. In contrast, the content of the schizophrenic's communication is often bizarre, nonsensical and carries little information by itself about the nature of the schizophrenic's problem. Decoding such content necessitates making much greater use of the noncontent cues. Since Bs may tend to pay scant attention to these cues, they would probably be unable to accurately interpret the schizophrenic's message and subsequently understand the nature of his problems. Thus, Bs' general responses based on the content would have little personal relevancy. The findings of Hoffnung and Stein (1970) cited earlier with regard to the type of help offered by Bs to schizophrenic and ambiguous patient type communications seems consistent with the above hypothesis. A corollary of this hypothesis which is suggested is that a linear relationship should obtain between sensibility of verbal content and

ease and specific relevance of Bs' responses. Thus, Bs' ineffectiveness would tend to become more evident as the patient's verbal content becomes less clear and comprehensive, characteristic of increasingly severe schizophrenic disturbances.

Evidence from the A-B literature indirectly lends support to this idea. Stoler (1966) found B psychiatric residents preferred the less disturbed patients and also rated schizophrenic patients lower on likeability than did As. In a later study Anzel (1968) reported that B undergraduate students reacted less positive to severely disturbed patients than did As. Similarly, Silverman (1967) after reviewing the literature on A-B personality traits and perceptual styles speculated that Bs are more restrictive and condemning of bizarre nonreality oriented behaviour.

An interesting approach to studying the interaction effect was taken by Trattner and Howard (1970). They established expectancies in A and B hospital attendants regarding the level of social competence of schizophrenic patients to which the subjects were to administer the Rosenthal picture-rating task. The results showed a tendency for B therapists to bias in favour of the high social competence schizophrenics who presumably are closer to neurotics (or less severely disturbed patients) on a social competence dimension (Zigler & Phillips, 1961).

More directly supportive of the above hypothesis is a study by Whitehorn and Betz (1957) in which B therapists achieved improvement rates similar to A therapists with severe schizophrenics when insulin was combined with psychotherapy which ostensibly makes the patient more accessible to treatment and decreases his symptoms. More recently, Betz (1963) reported

that B therapists were as effective as A therapists with nonprocess schizophrenics but were poorer than As with process schizophrenics. These results were not corroborated in a similar study by Stephens and Astrup (1965). Although an attempt was made to simulate the conditions of the previous Betz study, there is some question as to whether the same criteria were used to define process and nonprocess schizophrenia and thus as to whether the groups in the two studies were comparable. Consequently, this study can not be taken as disconfirming the previous findings.

In addition to the Stephens and Astrup study recent work by Bednar and Mobley (1970) has cast some doubt on the clinical replicability of the interaction hypothesis. In their studies, they found no difference between A and B therapists in either the therapeutic relationship with schizophrenics or in preference for schizophrenic and neurotic patients. Two arguments, however, can be raised against interpreting the results as invalidating the interaction hypothesis and more specifically B therapists ineffectiveness with schizophrenics. In the first place, the A-B scale used by Bednar and Mobley was the Campbell 80-item scale which has recently been found to have little relationship with the original Whitehorn-Betz scale (Seidman, in press). In addition, as pointed out earlier, the extent of B therapists' ineffectiveness may vary with the degree of severity of the schizophrenic patient. No attempt was made by Bednar and Mobley to determine severity of disturbance of the schizophrenic patients. In view of these two considerations Bednar and Mobley's failure to replicate is understandable.

Although attempts have been made to account for the interaction effect one variable which has not been considered is the communicative

process between patient and therapist. The present study is an attempt to examine the A-B therapist-by-patient-type interaction effect in terms of the communication process. The thesis being that B therapists are ineffective with schizophrenic patients because they are less sensitive to the nonverbal and expressive cues of communication and focus instead on the verbal content. As a result their responses tend to be of a general nature and less specifically related to the patient's problems. As the verbal content of a message becomes less sensible and clear and thus provides less information about the nature of the patients' distress, B therapists's responses increase in generality and decrease in personal relevancy. Consequently, they are less effective.

Based on the previous discussion the following hypotheses were proposed:

1) B-type subject-therapists will be rated as showing less concreteness and specificity of response and briefer response times relative to A-type subjects in all three stimulus conditions.

2) Both A and B type subjects will be rated as showing less concreteness and specificity of response and briefer response times as the clarity of the content is decreased.

3) B-type subjects in comparison to A-type subjects will show a greater decrease in concreteness and specificity of response and response duration as the verbal content becomes less clear.

## CHAPTER II

### METHOD

#### Subjects

Subjects (Ss) were 60 male University of Manitoba summer school students enrolled in psychology courses. Most of the Ss (N = 54) participated in the study in partial fulfillment of requirements for the introductory psychology course. A few other Ss (N = 6) were obtained from other undergraduate courses in psychology because of the small summer school population taking introductory psychology. These Ss participated on a voluntary basis. The A-B scale was administered to all males enrolled in these psychology courses from which the above 60 were then chosen.

#### A-B Scale

A 19-item version of Kemp's (1964) 31-item modification of the Whitehorn-Betz A-B scale was used in this study. This version consists of 14 Strong Vocational Interest Blank and 5 Minnesota Multiphasic Personality Inventory items. The scale was scored in the B direction; high scores indicate B status and low scores A status (see Appendix A). Thirty Ss were chosen with scores of 13 or above (designated Bs). Another 30 were chosen with scores 7 or below (designated As). These cut-off points represent the approximate outer quartiles of the AB distribution. The mean score of the A group in this sample was 5.2 (S.D. = 1.85) and the mean score of the B group was 14.4 (S.D. = 1.47). The Ss ranged in age from 19 to 46 with a mean of 24.



Stimulus Materials

Three videotapes were prepared to authentically depict the verbal, vocal, and expressive modes of communication of a male college age patient with emotional difficulties underlying his expressed vocational and educational problems. An attempt was made to minimize symptoms characteristic of neurotic or schizophrenic patients in order that the focus might be on the form of communication rather than the specific symptomatic content; however, this was difficult to attain, particularly in regard to neurotic symptomatology. A male graduate student in Clinical Psychology role-played the patient. The script (presented below) consisted of four brief segments.

Segment #1. - I'm really having a lot of trouble with my studies and things. I don't know - it's getting worse and I've got to do something about it because I'll make a perfect flop of my year at college. I can't keep wasting my father's money. I'm - uh - in some subjects I'm failing which I wouldn't fail I'm sure, - if I wasn't all hung up about everything.

Segment #2. - I haven't written to my parents about my difficulties. They haven't been much help to me in the past when I've had these problems and if I can keep this from them as much as possible, I'm going to. But there's my lousy grades to explain. I feel I've got to tell them, because there's no way I can keep it from them - even if they can't take it the way they should. I've already flunked my gym course. They'll know there's no way you can flunk gym unless you don't go. They'll ask why.

Segment #3. - I sort of think they'll condemn me for what's happened. - That's the way they've reacted in the past whenever I had difficulty making a go of things. They've said "It's your fault, you don't have enough will power, you're not interested." I was sort of telling them I'd

improved this year at college. I was all right the first term. Well - I wasn't really all right but I just went downhill. (Pause). I'm pretty sure my father will put me down for doing so poorly. He doesn't know what it's like to have these problems, "lack of ambition" is what he'd say.

Segment #4. - I don't think he's capable of understanding me and why I've had difficulty with my courses this year, because we don't get along - at all. I used to feel bitter because he couldn't understand why I had problems. But now I - I'm sort of ashamed he's my father - I'm sorry to say that but that's my opinion. I don't have a clue how they're going to react when I write them about this mess. I - I don't know - I feel like I'm in a real bind.

Three levels of clarity of the verbal content of the patient communication were constructed by means of an electronic filtering device. The tape of the patient's communication was passed through the electronic device which filtered out the high frequency sounds which carry the verbal content of the message, while leaving in the vocal affective cues by allowing low frequency sounds to be passed through unaltered (Fletcher, 1953). The high clarity condition was established without raters and consisted of playing the tape segments without any filtering. The low clarity stimulus condition was established using the subjective estimate method (Torgerson, 1958) for multiple stimuli since this method requires subjects to make direct quantitative judgments of the amount of a specified attribute that is possessed by each of the stimuli. Three levels of content clarity in which sounds above the following frequencies were removed (100 cps; 200 cps; 400 cps) were chosen a priori by E to present to the raters. These represented the three lowest frequencies on the filter.

The raters, two male and two female graduate students in Clinical Psychology, individually listened to segment one of the videotape stimulus with the three different frequencies removed. These three conditions of content clarity were presented in a random order and each rater was instructed to rate each presentation on a five point scale of audibility (1 = inaudible, 3 = audible but with strain, 5 = completely clear). This procedure was administered five times to each rater in order to reduce the effect of variability of judgment. The ratings of the four raters were then examined and the stimulus frequency whose modal rating was 2 was selected on an a priori basis as representing the low clarity condition, i.e., barely audible. Consequently, the 100 cps level was selected for the low clarity condition.

In order to determine the medium level of content clarity the equisection procedure of bisection was used (Torgerson, 1958). In the bisection method S is presented with two standard stimuli in this case high and low content clarity conditions and then asked to determine the stimulus value which will divide the interval between the two standard stimuli into two equal intervals. The particular psychophysical method used to obtain the estimate was the method of limits in which E presents a range of the stimulus values and S indicates for each one whether it is midway between the two standard stimuli. Another reason for choosing the bisection method is that it is the best method for scaling psychophysical attributes. The same four raters were used in this procedure as in the subjective estimate procedure in order to increase reliability between the two judgments of low and medium clarity. Each S was presented with a series of three stimulus conditions each series consisting of the previously defined low and high clarity condi-

tions and a middle clarity condition which was varied with each presentation. The middle stimulus consisted of playing the initial segment of the videotaped stimulus in random order for each trial with frequencies of 200, 400, and 800 cps removed. Each rater was presented individually with the series and asked to indicate by a yes or no response whether each level was midway between the high and low conditions. The entire series was presented to each rater five times. The frequency level most often designated yes was selected as representative of the medium clarity condition. The mode for the yes responses was the 400 cps level - the medium level of content clarity condition.

#### Dependent Measures

Subject therapists' responses were assessed by means of a scale developed by Carkhuff (1970) designed to measure personally relevant concreteness and specificity of expression (Appendix B). This scale allows assessment on a five point scale with scale point 1 characterized by no attempt to lead the discussion into the realm of personally relevant specific situations and feelings, but dealing instead with vague and anonymous generalities. At the other end, scale point 5 is characterized by facilitation of all personally relevant feelings and experiences in concrete and specific terms. Scale point 3 constitutes the minimally facilitating level at which the therapist enables the patient to discuss personally relevant material in specific and concrete terms.

Two graduate students in Clinical Psychology were trained as raters on the specificity scale. Training on the dimension was carried out for approximately eight hours and consisted of (1) careful reading of the

Carkhuff definition of the scale points, (2) discussion of the dimension, (3) rating of audiotape recorded responses of professional therapists from actual therapy sessions, and (4) rating and discussion of a number of audiotape-recorded responses (collected for practice ratings), to the stimuli employed in this investigation.

All responses were rated independently without knowledge of the Ss A-B status. All responses to segment number three were rated first by rater I, followed by the responses to segments numbers one, four, and two, while rater II followed the sequence two, four, one, and three. Interrater reliability for the specificity scale was ( $r = .58$ ).

The second major dependent measure was a structural index-response time which was defined as the time elapsed from the point at which the patient communication ended until the S indicated he had completed his response.

#### Post-Interaction Questionnaire

After responding to the tape segments each S was asked to make ratings using 5- and 7-point scales (Appendix C). The first five of these items and the seventh measuring the Ss' subjective reactions to the patient and Ss' assessment of the patient's level of disturbance were adopted from a previous study (Seidman, 1971). The sixth item dealt with the Ss' evaluation of the clarity of the audio of the taped segments. The first seven items were rated on 5-point scales. In order to assess the validity of the behavioural style intended by E, Ss were asked to rate to what extent each of 21 statements were characteristic of the patient (1 - not at all characteristic, 7 - very characteristic). The last seven items were designed to

elicit information regarding the Ss' feelings about participating in the study, his vocational interests and the extent of his prior knowledge about the study.

### Procedure

Ss who participated in the study were telephoned by E and asked if they were interested in participating in a study of psychotherapy. They were told they would see and hear a videotape recording of an actual patient in therapy and would be asked to make helpful responses to the patient. Ss who agreed were given information on where to go and an appointment was arranged. Ss were randomly assigned to one of the three stimulus conditions - high, medium, or low content clarity. Each S upon arrival was shown into a room with a videotape monitor, a microphone and a box with a switch. E then explained to S that he would see and hear an actual college patient in psychotherapy and that at four different intervals the screen would go blank. The S was instructed that each time the screen went blank he was to respond in as helpful a way as he could to the patient's remarks. It was stressed that S should respond in terms of his own feelings toward the patient and not as he felt a trained therapist would respond. The S was then instructed to push the switch when he had finished responding and the videotape would resume, however, if he felt silence would be most beneficial to the patient he was instructed to push the switch without responding but that the videotape would not resume for about 15 seconds. (This was to discourage Ss from refusing to respond simply by pressing the starter button each time the recording was interrupted). Ss were told there would be four interruptions and were also alerted in all conditions to the fact that the audio might be

difficult to understand and that they should do the best they could.

After S had completed his responses to the four segments, he was asked to fill out the post-interaction questionnaire. Upon completion of the questionnaire, the study was discussed with S and E attempted to answer any questions and ascertain whether S had any prior information concerning the experiment. S was then thanked for his participation and told that he would receive a letter (see Appendix D) in the mail with more complete information about the study when it was completed.

## CHAPTER III

### RESULTS

#### Validation of Stimulus Materials

In order to determine if the stimulus materials were perceived similarly by As and Bs a 2 x 3 (therapist-type x level of content clarity) analysis of variance with no repeated measures was carried out on the 21 symptom characteristics and six other items on the post-interaction questionnaire (Appendix C). No significant main effects ( $p > .05$ ) were obtained for level of content clarity on any of the twenty-one symptom characteristics. Only one significant therapist-type main effect occurred, this was on the depressed item (Item #8, Appendix C). Bs tended to see the patient as more depressed than As ( $F = 5.72$ ,  $df = 1/53$ ,  $p < .01$ ), however, since this was only one of 20 scales this result could have been a chance effect. There were also no significant interaction effects for any of the symptom characteristics. In general the stimulus materials were perceived similarly regardless of Ss' A-B status or level of content clarity.

The overall means for the 21 symptom characteristics rated on 7-point scales are presented in Table 1 in decreasing order from most to least characteristic of the patient-stimuli. An examination of these means indicates that Ss perceived the patient as distressed, confused, feeling rejected, depressed, desperate, anxious, having conflicting feelings about others, and as having vocational and study difficulties (all ratings  $\geq$  scale point 5). These means also suggest that the patient was not perceived by Ss as having hallucinations and suicidal tendencies (scale point ratings  $< 3$ ). It seems



TABLE I

Means and Standard Deviations for Patient Symptom  
 Characteristics in Order of Decreasing Size

	<u>M</u>	<u>S.D.</u>
Distressed	6.09	1.08
Vocational and Educational Problems	5.98	1.09
Confused	5.92	1.12
Difficulty in Coping with Studies	5.74	1.33
Feels Rejected	5.52	1.37
Depressed	5.46	1.32
Conflicting Feelings About Others	5.43	1.43
Desperate	5.24	1.53
Anxious	5.04	1.66
Self-depreciating	4.47	1.68
Angry at Himself	4.43	1.70
Angry at Others	4.18	1.77
Expects Harm	3.96	2.06
Apathetic	3.67	1.60
Avoids People	3.51	1.69
Withdrawn	3.42	1.81
Suspicious	3.06	1.70
Headaches	3.00	1.76
Suicidal Thoughts	2.57	1.68
Has Hallucinations	2.14	1.53

reasonable to conclude that the patient was perceived by Ss as intended--a person with emotional problems underlying his vocational and educational difficulties. In addition, Ss tended to see the patient as possessing a few neurotic characteristics (e.g., depressed) but none of the traditional schizophrenic characteristics. Therefore, we can conclude that the stimulus materials were valid for the purposes of the present study.

In addition, the patient was seen as moderately disturbed, receiving a mean rating of 3.17 (1 = not disturbed at all, 5 = very disturbed) on an item asking S to rate the degree of patient disturbance.

The Ss were highly involved in the task regardless of the level of content clarity or their A-B status ( $M = 4.60$ , where 5 = attention wandered rarely, item #29, Appendix C). This is especially interesting in view of the finding that only about one-half of the Ss expressed any interest in the field of mental health (Item #31, Appendix C).

A clarity condition main effect was obtained with regard to the dimension of Ss difficulty in understanding what the patient said (Item #6, Appendix C) ( $F = 14.00$ ,  $df = 2/54$ ,  $p < .01$ ). Scheffé's post hoc multiple comparison test was performed on the differences between the means of the three levels of clarity. The results indicated a significant difference between the high and medium clarity conditions and the high and low clarity conditions ( $p < .01$ ). Consequently, it appears both the medium and low clarity conditions were more difficult for Ss to understand regardless of A-B status. Although a significant interaction effect was obtained for this dimension ( $F = 3.30$ ,  $df = 2/54$ ,  $p < .05$ ) a post hoc comparison of mean differences for As and Bs in each clarity condition failed to produce a significant difference between the two groups compared at each clarity level.

In spite of difficulties in understanding the patient and a divided interest in the mental health field the majority of Ss indicated that they found the experience quite worthwhile ( $\bar{M} = 2.63$ , 1 = very worthwhile, 5 = not worthwhile at all) and would volunteer again if given the opportunity ( $\bar{M} = 1.93$ , 1 = No, 2 = Yes).

### Specificity

A 2 x 3 analysis of variance was performed on the mean specificity ratings summed over all four segments. No significant therapist-type or level of clarity main effect and no interaction effect occurred (Table 2). Similar results were obtained for each of the four individual segments.

TABLE 2

Analysis of Variance for Specificity Ratings  
Summed Across All Four Segments

Source	SS	df	MS	F
Groups	0.0665	1	0.0665	0.05
Levels	6.0249	2	3.0125	2.23
Groups x Levels	1.0585	2	0.5293	0.39
Within Cells	73.000	54		
Error	-0.000		1.3519	
Total	80.1500	59		

Thus contrary to prediction As and Bs did not differ with regard to specificity of response in any of the three levels of clarity.

Response Time

A 2 x 3 analysis of variance computed on the structural index, response time, measured in seconds, yielded no significant main effects for therapist-type or level or content clarity and no interaction effect (Table 3). This was true both in regard to sum of response time across all four segments and for each individual segment. It appears from these results that neither A-B status nor level of content clarity influenced Ss response time, contrary to expectations.

TABLE 3

Analysis of Variance for Individual Response  
Times Summed Across All Four Segments

Source	SS	df	MS	F
Groups	5510.6250	1	5510.6250	0.50
Level	16130.0039	2	8065.0000	0.74
Groups x Level	23689.3789	2	11844.6825	1.08
Within	591477.7511	54		
Error	-0.5703		10953.2891	
Total	636807.1875	59		

Frequency of No Response

In view of the large number of no responses which were obtained it was felt this would be a potentially important dimension to consider in the study. A contingency table constructed for the frequency of Ss no

response (Table 4) revealed a significant difference in the number of no responses with regard to therapeutic type ( $\chi^2 = 4.2$ ,  $df = 1$ ,  $p < .05$ ) in that As failed to respond to a patient communication more often than Bs failed to respond. No significant differences were found among the three levels of content clarity with regard to the frequency with which Ss failed to give a response ( $\chi^2 = 2.67$ ,  $df = 2$ ,  $p > .05$ ). Thus, contrary to expectations, based on the literature, As tended to respond less often across all levels of content clarity than Bs.

TABLE 4

## Matrix of Frequency of No Responses

		<u>Level of Clarity</u>		
		High	Medium	Low
Therapist Type	A	10	16	25
	B	2	9	21

Subjective Reactions

The subjective reactions of the Ss to the patient (Items #1, 2, 3, 4, 7, Appendix C) were subjected to a 2 x 3 analysis of variance. No significant main effects or interaction effects occurred for items one through four concerning Ss satisfaction with his response, comfort in listening to the patient, difficulty in choosing among possible responses and in making helpful responses. The means for these items (Table 5) indicate that in general Ss were dissatisfied with their responses ( $M = 2.32$ ) and found it quite

TABLE 5

Means of Items Measuring Subjective Reactions of Ss

Item	M	S.D.
1. How <u>satisfied</u> were you with the responses you made?	2.32	1.30
2. As you listened to the patient speaking, how <u>uncomfortable</u> were you?	2.55	1.19
3. How difficult was it to <u>choose among the</u> <u>things you thought of to say?</u>	2.83	1.30
4. How difficult was it to think of <u>helpful</u> things to say?	3.28	1.47
5. Judging the patient as you would any person would you say you <u>disliked</u> - <u>liked</u> the patient?	3.31	0.93

difficult to think of helpful responses ( $\underline{M} = 3.28$ , 5 = very difficult); however, they tended to feel comfortable listening to the patient ( $\underline{M} = 2.55$ , 1 = very comfortable) and had little difficulty in choosing among possible responses ( $\underline{M} = 2.83$ , 1 = not difficult at all). A significant therapist-type main effect was obtained with regard to Ss liking of the patient (Item #7, Appendix C,  $\underline{F}_1 = 6.71$ ,  $\underline{df} = 1/53$ ,  $p < .01$ ). Bs tended to like the patient better than As regardless of level of content clarity. This is consistent with the A by Schizoid and B by Neurotic patient-type interaction effect since the patient in this study more closely resembles a neurotic prototype

than a schizoid as indicated by the results presented above for the symptom characteristics (Table 1).

#### Intercorrelation of Dependent Measures

An intercorrelation matrix was obtained for the dependent variables. Contrary to expectation, no significant correlation was obtained between the specificity rating and response time (Table 6).

In addition, a significant correlation was found between total response time and difficulty in choosing among responses ( $p < .02$ ). Thus the longer the response time the more difficult it was for the S to choose among his possible responses.

An interesting correlation which appeared was that between response time and liking for the patient ( $p < .01$ ), in that the greater the Ss liking for the patient the longer was his response time. Although some statistically significant correlation coefficients were obtained we must consider the possibility that these can be attributed to chance especially in view of the smallness of the sample.

TABLE 6

## Intercorrelation Matrix for Dependent Measures

Variable	Sum of Specificity Ratings	Response Time (Sum)	Satisfied with your Response	Uncomfortable Listening to Patient	Difficulty of Choosing Responses
Sum of Specificity Ratings					
Response Time (Sum)	+1.12				
Satisfied with Response	-.01	.05			
Uncomfortable Listening to Patient	+0.06	-.01	-.20		
Difficulty of Choosing Response	+0.22	+0.36**	-.23	+0.20	
Difficulty of Thinking Helpful Responses	-.08	+0.02	-.44***	+0.22	+0.41***
Severity of Patient Disturbance	+0.15	-.03	-.17	+0.35**	+0.20
Liked the Patient	-.04	+0.39***	.18	+0.18	+0.14

Note: Two-tailed test of Pearson Product Moment correlations with 59 df.

\*  $p > .05$   
 \*\*  $p > .02$   
 \*\*\*  $p > .01$



Variable	Difficulty Thinking Helpful Responses	Severity of Patient Disturbance	Understanding Patient	Liked the Patient
Sum of Specificity Ratings				
Response Time (Sum)				
Satisfied with Response				
Uncomfortable Listening to Patient				
Difficulty of Choosing Response				
Difficulty of Thinking Helpful Responses				
Severity of Patient Disturbance	+ .01			
Understanding of Patient	+ .11	- .02		
Liked the Patient	- .16	.16	.00	

Note: Two-tailed test of Pearson Product Moment correlations with 59 df.

\* p > .05  
 \*\* p > .02  
 \*\*\* p > .01

## CHAPTER IV

### DISCUSSION

The major hypotheses of the present investigation were not supported. B subject therapists did not exhibit less specificity in responding or briefer response times than As. Subject therapists did not exhibit less specificity in responding or briefer response times as the clarity of the patient-type communication decreased. Furthermore there was no apparent interaction of A-B subject-type status and the patient-type clarity condition with regards to either specificity or response time.

The failure to obtain the predicted interaction effect or the stimulus main effect for the specificity dimension can, post hoc, be partially and tentatively explained in terms of the inappropriateness of the measuring instrument for the population under study. The Carkhuff scale of specificity and concreteness of response appears to have been too sophisticated a measure for assessing the responses of the untrained population of subject-therapists used in this investigation. This is indicated by the low variability of the ratings for the Ss in that 92% of the responses received specificity ratings of one or two on the five point scale. This suggests that the subject therapists either made no attempt to lead the discussion into the area of personally relevant situations and feelings or that they didn't facilitate the discussion of relevant feelings and experiences in specific and concrete terms. We may conclude tentatively from such results that the ability of the therapist to enable the patient to discuss his personally relevant feelings and experiences in specific and concrete terms is thus a therapeutic variable

which depends on training to a large extent.

A further comment with regard to the specificity dimension is that in the development of the major hypotheses it was believed that as the content clarity decreased Ss would attend more to the noncontent cues such as vocal and facial expression and that As would be more adept at using these cues. However, Ss who found the audio difficult to understand often reported to the E that they did not look at the patient but attempted to hear what he said by placing their ear close to the speaker thus cutting off their view of the patient. Thus, it is possible that the method employed in this study of lowering content clarity to force the use of noncontent cues actually precluded the use of these cues, with the consequent result that the study may not have been tapping the actual variables for which it was designed.

It should be cautioned that even with the correction of the above methodological inadequacies the hypotheses of this study might not bear fruit. Response time also failed to produce the predicted differences between As and Bs in the different levels of clarity. However, it should be pointed out that actual time of responding may have been a more appropriate index since a long prerespone silence was noted for many Ss. This long prerespone silence may have been due to the difficulty in understanding the audio since both the medium and low clarity conditions were significantly more difficult to understand than the high condition. This may have resulted in Ss giving more consideration to their responses before verbalizing them. Consistent with this speculation is the finding that response time correlated significantly (Table 6) to difficulty in choosing among responses. Consequently, different results may have been obtained if an index of actual time spent responding had been used.

Furthermore, response time seems to have been more influenced by Ss liking for the patient than by A-B status or level of content clarity (Table 6).

The results on the liking rating are of particular interest. Bs tended to like the patient-type stimulus more than As regardless of level of content clarity (Table 6). Since the patient-type stimulus in this study did resemble a neurotic prototype (Table 1) these results appear consistent with those of Stoler (1966), who found that B type psychiatric residents preferred the less disturbed patients.

Furthermore, response time increased with Ss liking for the patient-type (Table 6). The prominence of the liking dimension in the present study may be related to possible S identification with the patient and his problem; since, a number of Ss reported to the E that they could identify with the patient having experienced similar difficulties themselves. Ss who could identify with the patient would probably have more to say to the patient and thus have longer response times. Therefore, identification with the patient may account for the relationship between response time and liking for the patient. Identification with the patient may also be related to Bs greater liking for the patient since he tended to approximate a neurotic prototype. Thus, we would expect a stronger identification and consequent liking by Bs of the present patient stimulus on the basis of the A by schizophrenic, and B by neurotic patient-type interaction effect.

Other studies have suggested that the interaction effect is the result of complementarity between patient and therapist since Bs adjustive modes resemble those of the schizoid while As resemble the neurotic's stress reactions (Berzins, Friedman, & Seidman, 1969; Sandler, 1965; Seidman, in press,

1971). However, we must consider that the above studies included the more severe neurotic symptoms which were absent in the present study and which may have prevented normals from identifying with the patient in these earlier studies.

In view of the relationship between liking for the patient and response time, and the tendency for Bs to like the patient more than As we may speculate that the greater frequency of no response for As may have also been influenced by liking for the patient-type stimulus. The greater frequency of no responses for As may also be related to the tendency for As to be cautious in self-expression and less daring than Bs (Berzins, Barnes, Cohen, and Ross, in press). Thus, in the present study with the difficulty in understanding the patient which occurred two-thirds of the time and the scarcity of information received about the patient in the brief segments, As may have been reluctant to offer help feeling they did not have enough understanding of the patient's problem. The results are also consistent with the findings of earlier analogue studies in which As were less effective with neurotic patient-types.

Although the present study failed to substantiate the predicted hypotheses, these hypotheses were not necessarily invalidated in view of the deficiencies of the present study such as the use of a scale too sophisticated for an untrained population and the choice of stimulus materials with their concomitant limitations for the purpose of the study.

In view of the importance of all aspects of communication in the therapeutic situation an attempt should be made to replicate the study using professional therapists and using stimulus materials which force the use of noncontent cues without loss of the content. Such stimuli might be

developed by constructing segments of communication which include various levels of thought and speech disorganization characteristic of increasing severity of schizophrenia.

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APPENDIX A - A-B SCALE

## INTEREST SCALE

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Local phone number \_\_\_\_\_

For the following items, please respond in terms of the degree of interest you would have in each of the relevant activities, school subjects, or occupations by circling the appropriate alternative. Work rapidly.

	<u>Like (L)</u>	<u>Indifferent (I)</u>	<u>Dislike (D)</u>
1. Ship officer	L	I	D
2. Mechanical engineer	L	I	D
3. Photoengraver	L	I	D
4. Toolmaker	L	I	D
5. Making a radio set	L	I	D
6. Building contractor	L	I	D
7. Looking at shop windows	L	I	D
8. Marine engineer	L	I	D
9. Manual training	L	I	D
10. Mechanical drawing	L	I	D
11. Adjusting a carburetor	L	I	D
12. Cabinet making	L	I	D
13. Carpenter	L	I	D

Answer the following items as truthfully as possible by circling the appropriate alternative. Work rapidly.

	<u>True (T)</u>	<u>False (F)</u>
14. I think I would like the kind of work a forest ranger does.	T	F
15. I like mechanics magazine	T	F
16. In school, I was sometimes sent to the principal for cutting up.	T	F
17. It does not bother me that I am not better looking.	T	F
18. People often disappoint me.	T	F
19. I have mechanical ingenuity (inventiveness).	T	not sure F
20. I am good at finding my way around unfamiliar places.	T	F

APPENDIX B - SCALE FOR PERSONALLY RELEVANT  
CONCRETENESS OR SPECIFICITY

Personally Relevant Concreteness or Specificity of

Expression in Interpersonal Processes

A Scale for Measurement

Level 1

The first person leads or allows all discussion with the second person(s) to deal only with vague and anonymous generalities.

Example: The first person and the second person discuss everything on strictly an abstract and highly intellectual level.

In summary, the first person makes no attempt to lead the discussion into the realm of personally relevant specific situations and feelings.

Level 2

The first person frequently leads or allows even discussion of material personally relevant to the second person(s) to be dealt with on a vague and abstract level.

Example: The first person and the second person may discuss "real" feelings but they do so at an abstract, intellectualized level.

In summary, the first person does not elicit discussion of most personally relevant feelings and experiences in specific and concrete terms.

Level 3

The first person at times enables the second person(s) to discuss personally relevant material in specific and concrete terminology.

Example: The first person will help to make it possible for the discussion with the second person(s) to center directly around most things which are personally important to the second person(s) although there will continue to be areas not dealt with concretely and areas which the second person does not develop fully in specificity.

In summary, the first person sometimes guides discussions into consideration of personally relevant specific and concrete instances, but these are not always fully developed. Level 3 constitutes the minimal level of facilitative functioning.

Level 4

The facilitator is frequently helpful in enabling the second person(s) to fully develop in concrete and specific terms almost all instances of concern.

Example: The facilitator is able on many occasions to guide the discussion to specific feelings and experiences of personally meaningful material.

In summary, the facilitator is very helpful in enabling the discussion to

center around specific and concrete instances of most important and personally relevant feelings and experiences.

#### Level 5

The facilitator is always helpful in guiding the discussion so that the second person(s) may discuss fluently, directly and completely specific feelings and experiences.

Example: The first person involves the second person in discussion of specific feelings, situations and events, regardless of their emotional content.

In summary, the facilitator facilitates a direct expression of all personally relevant feelings and experiences in concrete and specific terms.

APPENDIX C - POST INTERACTION QUESTIONNAIRE

Post-Interaction Questionnaire

Clinical Judgments.

Circle the appropriate alternative. Work quickly.

1. How satisfied were you with the responses you made?

Very unsatisfied 1 2 3 4 5 Very satisfied

2. As you listened to the patient speaking, how uncomfortable or uneasy were you?

Very comfortable 1 2 3 4 5 Very uncomfortable

3. How difficult was it to choose among the things you thought of to say?

Not difficult at all 1 2 3 4 5 Very difficult

4. How difficult was it to think of helpful things to say?

Not difficult at all 1 2 3 4 5 very difficult

5. How emotionally disturbed would you judge the patient to be?

Not emotionally disturbed at all 1 2 3 4 5 Very disturbed emotionally

6. How easy did you find it to understand what the patient said?

Very easy 1 2 3 4 5 Very difficult

7. Judging the patient as you would any person, would you say that you

Disliked the patient Liked the patient  
very much 1 2 3 4 5 very much

- 8 - 23. Below is a list of characteristics found in different types of patients. Indicate by circling the appropriate number, how strongly these characteristics apply to the patient you've just heard.

1 - not characteristic at all

7 - very characteristic

- |                                       |   |   |   |   |   |   |   |
|---------------------------------------|---|---|---|---|---|---|---|
| 8. depressed                          | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. difficulty in coping with studies  | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. conflicting feelings about others | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. apathetic                         | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. anxious                           | 1 | 2 | 3 | 4 | 5 | 6 | 7 |



1 - not characteristic at all7 - very characteristic

- |                                       |   |   |   |   |   |   |   |
|---------------------------------------|---|---|---|---|---|---|---|
| 13. suspicious                        | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14. desperate                         | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15. has hallucinations                | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16. withdrawn                         | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17. headaches                         | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18. expects harm                      | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 19. avoids people                     | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20. self-deprecating                  | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 21. vocational &/or academic problems | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 22. feels rejected                    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 23. distrusts others                  | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 24. distressed                        | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 25. confused                          | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 26. angry at himself                  | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 27. suicidal thoughts                 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 28. angry at others                   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

29. It is sometimes difficult to maintain attention to videotape recordings like the one you saw and heard. How often would you say you found your attention wandering to other things?

Attention wandered very often 1 2 3 4 5 Attention wandered rarely

30. What are your occupational plans? (List the type of work or profession you presently plan to enter.) \_\_\_\_\_

31. Do you have any interest in a mental health field (e.g., psychiatry, psychology, or social work) as a vocation? (yes or No) \_\_\_\_\_

32. Overall, how worthwhile did you find the opportunity to participate in this study?

Extremely worthwhile 1 2 3 4 5 Not at all worthwhile

33. Knowing what you know, if you had the opportunity, would you volunteer again? (Yes or No) \_\_\_\_\_

34. Had you heard anything about this study preceding your participation? (Yes or No) \_\_\_\_\_ If yes, exactly what had you heard? \_\_\_\_\_

35. If you are interested in hearing about the results of the study, write your name and home address below so that this information can be forwarded to you when the data has been analyzed.

APPENDIX D - FEEDBACK LETTER

August 20, 1971

Dear

As you may recall you participated in a laboratory study of psychotherapy at the University of Manitoba early in July. This letter is the feedback letter you were told you would receive giving details of the study and its results.

You were selected to participate in the study on the basis of your score on an interest scale which you filled out in your Psychology class. Interest in the items indicated technical-mechanical interests which have been found to be predictive of success with neurotic patients. Disinterest or indifference to the items have been found to be predictive of success with schizophrenic patients. Each person participating viewed the videotape of a patient in one of three conditions. In one condition the audio was played as clearly as possible, in the other two conditions the clarity of the audio was decreased so it was more difficult to understand what the patient said. The purpose of reducing the clarity was decreased so it was more difficult to understand what the patient said. The purpose of reducing the clarity was to determine if people could grasp some of the patient's problem from his facial expression and the way he expressed himself even though some of you were unable to hear exactly what he said. I was also interested in seeing if people whose interests differed responded differentially to the patient in these three conditions. Although the data has not been completely analyzed as yet the results to date appear to be contrary to expectations.

At the time you participated you were told the person you saw and heard was an actual patient. This was to make the situation as authentic as possible. For obvious ethical reasons, however, the person you saw was not an actual patient but a graduate student in Clinical Psychology who was trained to role-play the patient. Thank you again for your participation and cooperation.

Sincerely,

Sharon McGuigan