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The Training of Initial Behavioral Assessment Interview Skills

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THE TRAINING OF INITIAL BEHAVIORAL ASSESSMENT INTERVIEW SKILLS

by

Mark J. Hirsch

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THE TRAINING OF INITIAL BEHAVIORAL ASSESSMENT INTERVIEW SKILLS

Mark J. Hirsch, Ph.D.
Western Michigan University, 1991

Two manuals were used to train behavioral assessment interview skills. The first manual outlined eleven initial responses the therapist must make to determine the controlling variables related to a client's problem. The second manual outlined strategies for dealing with evasive or nonappropriate responses made by a client. Subjects were graduate students from the psychology department of Western Michigan University who had no experience in conducting assessment interviews. Six subjects participated. Simulated therapy sessions between subjects acting as therapists and confederates acting as clients were conducted. Scripts were utilized to standardize confederate responses. Each session dealt with a clinical concern amenable to a behavior analysis.

Confederates provided either appropriate, nonevasive responses to the subjects' questions (Phase 1), or nonappropriate, evasive responses (Phase 2) to a predetermined number of the subjects' questions. Half the subjects received the manuals in complete form, i.e., with examples illustrating therapist and client responses. The other half received manuals minus the examples. Subjects' performance was rated by the number of correct responses emitted as outlined in the manuals. Performance was compared in pre- and post-baseline conditions. Results indicate that both manuals were effective in training the responses they outline. Concerning
the subjects receiving manuals with examples, two subjects required the implementation of feedback in Phase 2 to reach criterion. Concerning the subjects receiving manuals without examples, one subject required the addition of examples to reach criterion in Phase 2. The manual without examples was as effective as the manual with examples, although the inclusion of examples may have added to the efficiency with which the targeted responses were learned. Implications for future research regarding training behavioral interview skills were discussed.
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The training of initial behavioral assessment interview skills

Hirsch, Mark Joseph, Ph.D.
Western Michigan University, 1991
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I would like to dedicate this dissertation to my parents for their considerable emotional and financial support so that my goals could be attained.

Mark J. Hirsch
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CHAPTER I

INTRODUCTION

The present research is a continuation of a study completed by Miltenberger and Fuqua (1985) in which the effectiveness of a manual designed to train basic behavioral interview skills was tested. The manual (see Appendix A) consisted of ten interviewer responses considered important (as judged by a sample of professionals involved in behavioral assessment) in obtaining information regarding the basic dimensions of a client’s problem. Subjects’ skills were assessed via simulated interviews in which subjects acted as therapists and confederates acted as clients. The authors found the manual to be effective in training the targeted assessment skills, but noted that their "clients" were cooperative (i.e., provided the subject with clear, concise answers to their questions) during the simulated interviews. The question that remained, then, is would the manual be effective in training interviewing skills with evasive or "difficult" clients and, if not, would a manual similar in format but designed for use with such clients prove effective?

Another question left unanswered by the first study regards the efficacy of certain components of their manual, which contained examples and nonexamples to illustrate the correct and incorrect manner with which to emit each targeted therapist response. Since the results indicated that the manual was effective in training the targeted responses, it would be useful to know if the examples and nonexamples were necessary. Efficiency could
be improved by utilizing only those elements found to be necessary for training.

The present study attempted to answer the above questions. There were two phases in the study in which all subjects participated. During the first phase of the study, the skill acquisition of subjects receiving the aforementioned manual with examples and nonexamples was compared with subjects receiving the manual without examples and nonexamples. Confederates in this phase played the role of cooperative clients. In the second phase, confederates occasionally supplied evasive responses to subjects' questions. If subjects failed to meet criterion (defined elsewhere) with these "difficult" confederate clients, a second manual (see Appendix C) was introduced. This manual was specifically designed by the present author to train subjects appropriate therapist responses when supplied with an evasive answer by a client. The efficacy of the examples contained in this manual was tested in the same manner as above. The examples, appropriate therapist responses, and evasive client responses were assessed for social validation by professionals experienced in conducting behavioral assessment interviews.
CHAPTER II

REVIEW OF SELECTED LITERATURE

Given the emphasis placed on the delineation and manipulation of target behaviors and their controlling variables, the initial assessment interview has an essential place in the behavior therapist's repertoire. In a survey of a random sample of members of the Association for the Advancement of Behavior Therapy on various aspects of behavior therapy, Swann and MacDonald (1978) found that the respondents used the interview as an assessment procedure with 89.4% of their clients, compared to the use of behavioral self-report measures with 26.9%, the use of personality inventories with 20.2%, and the use of projective tests with 10.1%.

Following the same line of reasoning, Kanfer and Grimm (1977) have noted that "Despite increasing emphasis in behavioral assessment on direct observations and standardized situational tests, self-reports and inventories, the interview has remained a convenient and favorite vehicle for a behavioral analysis" (p. 7). It is perhaps not surprising then that much has been written concerning the clinical assessment interview in general and the initial behavioral interview in particular. What is surprising is the lack of uniformity across therapists regarding the procedures and goals in conducting the interview. Angle, Ellinwood, Hay, Johnson, and Hay (1977), for example, state that "considerable uncertainty exists about the amount of information that constitutes a behavioral assessment," (p. 747) with one
possible source of confusion being that "the guidelines for a comprehensive assessment are described in very general terms" (p. 748). This point is reflected in a review of numerous guidelines for behavioral assessment by Gross (1984) in which he notes that various therapists have emphasized different foci around which the interview is constructed. He notes that Kanfer and Saslow (1959) suggest that the assessment focus on the analysis of the client's problem behavior and its maintaining variables, as well as on motivational and developmental issues, among others. In contrast, Mischel (1973) also emphasizes the importance of organismic or cognitive variables. The debate is basically one of inclusion; that is, what topics of analysis concerning the client should be within the realm of behavioral assessment? This issue is not easily settled and is most likely a reflection of the greater debate over which behavioral phenomena should be within the realm of behavioral analysis. It is important to recognize this as a source of variation of opinion when discussing approaches to behavioral interviewing.

With these considerations in mind, a working definition of the initial behavioral interview should be formed before proceeding further. Murphy (1985) provides a general definition by noting that "an interview has been conceptualized as being different than a conversation in that it usually involves more interaction surrounding a rather narrow topic in the respondent's experience" (p. 312). He delineates three reasons for conducting an interview: the obtainment of pertinent information, clarification of the client's concerns, and data collection for diagnostic purposes. Hawkins (1979) characterizes the behavioral assessment funnel as a five phase approach involving screening and general disposition,
defining and quantifying the presenting concern, designing treatment, evaluating progress, and follow-up issues. He notes that the behavioral interview proceeds with a careful evaluation of various hypotheses concerning the nature of the problem and ends with a commitment to certain hypotheses about the functional relations involved in the problem. Thus, Hawkins sees the interview as a means of gradually specifying and defining targeted behaviors and their controlling variables with continual adjustment of one's conceptualization of the targets of treatment as new information is discovered.

A possible framework for such an analysis is the Kanfer and Saslow (1959) SORC model, in which environmental variables, such as antecedent stimuli (S) and consequences (C), as well as organismic (O) variables, are assessed for their impact on the targeted response (R). The above considerations provide general framework for the goals and procedures of the assessment interview. The primary goal, then, is to operationally define the target behaviors in terms that are both directly observable and empirically measurable, and to form working (ie., treatment oriented) and changeable hypotheses concerning the variables, both organismic and environmental, directly influencing the behavior in question. The procedures directing one towards these goals constitute the body of this study. Secondary goals include forming a therapeutic relationship with one's client to facilitate treatment, the procedures for which are also addressed here.
Structured and Unstructured Approaches
to the Assessment Interview

One may take two general orientations in conducting the initial assessment interview: a structured or an unstructured approach. Both have advantages and disadvantages.

Perhaps the best example of the structured interview is the National Institute of Mental Health Diagnostic Interview Schedule (DIS). As Helzer, Robins, McEvoy, Spitznagel, Stoltzman, Farmer, and Brockington (1985, p. 657) state, "The task set before the authors of the DIS was to construct an interview that the lay examiners could use to inquire about symptoms and other diagnostic criteria and a computer diagnostic program that would evaluate these, as closely as possible, in the way the DSM-III specifies." The DIS offers a structure of closed-ended questions which allows the interviewer, including those not formally trained in the field of mental health, to reach decisions concerning various diagnoses according to the yes/no responses of the respondent. The emphasis is on diagnosis and does not include an analysis of the environmental variables shaping and maintaining the "symptoms", which is the hallmark of a behavioral analysis. Further discussion of the DIS and similar structured interview strategies is beyond the scope of the present discussion; the reader is referred to Robins, Helzer, Croughan, and Ratcliff (1981), Helzer et al. (1985), Robins (1985), and Anthony, et al. (1985) for a more detailed analysis.

The computer has been found useful for many involved in initial assessment. The advantages may include acceptance by patient, decreased investment of the therapist’s time and the client’s money, absence of the...
nonverbal influence of the therapist, and standardization and reliability (in terms of completeness), ("Psychological Assessment," 1983). Also, it is possible that computers evoke a greater degree of disclosure on the part of the client in discussing sensitive, personal issues, such as suicidal ideation or sexual concerns. Computers, however, may also have the disadvantages of being perceived as impersonal, being limited to structured, standardized interviews, and being unable to vary the wording of questions according to the client's level of understanding, (Erdman, Klein, & Greist, 1985). As is the case with the DIS, it must be noted that the computer-conducted interview suffers from the inability to investigate the specific environmental nuances affecting the client's behavior. This is a relatively new endeavor, however, and is limited only by our technology. Further reading can be found in Eisenberg and Delaney (1969), Carr and Ghosh (1983), and Skinner and Allen (1983).

Gross (1984) described various advantages of the unstructured interview, such as flexibility in obtaining both general and specific information as well as the opportunity to observe the client's social behavior during the interview. Murphy (1985) states that the unstructured interview is "most useful in situations where the psychologist is not aware of all the relevant forces impinging upon the respondent" (p. 312). The structured interview, however, is particularly useful when information is obtained from more than one respondent, using a form of the interview in which the verbal behavior emitted by the interviewer is held constant, thus controlling for the effects of the therapist's behavior on interviewee responses. Other forms of the interview are discussed by Murphy, such as the interview in
which the standardization is in relation to the types of information the therapist wishes to obtain, with an allowance for variation in wording. As will become evident later, the approach presented here most closely corresponds with this approach; the interview is structured in terms of the information desired but flexible as to the particular verbal behavior required of the interviewer.

With this balance of structure and flexibility in mind, it is important to consider the manner in which counselor skills are taught. The following discussion pertains to the training of general therapist skills, including those related to the assessment interview.

General Approaches to Counselor Training

The approaches used in training therapist skills vary to the extent that the theory of behavior on which they are based varies. Training initial interview skills illustrates this. Behavioral interviewing emphasizes skills which evoke direct responses regarding causal variables, whereas the psychiatric interview traditionally emphasizes the description of symptoms leading to a valid diagnosis. Despite these differences in the purpose of interviewing there are common approaches to training behavioral and psychiatric interview skills.

The traditional approach to teaching interviewing and counseling behaviors is the didactic approach in which one is taught the theory behind the skill to be learned, and this is often accomplished through lectures and discussions. Vander Kolk (1973) compared two variations of a didactic-experiential approach to counselor training, an approach in which the
subjects engaged in simulated counseling activities, analysis of counseling sessions, and discussions concerning the concepts behind the behaviors they were to learn. These activities were presented in a sequential or an integrated manner. The sequential group was presented with didactic training first and were then exposed to analysis of counseling tapes and role-playing during the last half of the training. The integrated group was presented with similar training activities except they were presented in an integrated manner with immediate feedback and modeling by the instructor. The performance, measured through the subjects' responses to five client statements from the Counseling Simulation Inventory (Carkhuff, 1969), improved for both groups, but the improvement was greater for the group exposed to the integrated didactic-experiential approach. Although I feel it is unclear which component of the approach is responsible for differences in performance, Vander Kolk concludes that "a didactic approach to training is least desirable in terms of producing specific skills. Rather, a structured, systematic method with an emphasis on practice and experiential aspects is best" (p. 267). This is a point to which we shall return to later.

Rioch, Elkes, Flint, Usdansky, Newman, and Silber (1963), in an earlier study, also emphasized an integrated approach. The purpose of this study was to investigate the feasibility of training nonprofessionals (in this case, middle-aged housewives) counseling skills to be used with clients presenting with relatively less severe (i.e., nonpsychotic) complaints. The training approach focused on didactic lectures and discussions, outside readings, writing reports, observation of therapy sessions, practice providing group
therapy for adolescents and their families, interviewing patients, and analysis and feedback concerning their sessions. The trainees' performance was rated according to several criteria, such as professional attitude and interest in the patient. While the authors report that training was successful and discuss the implications for the field of mental health, there is no analysis as to which component of the training package was essential for a successful outcome. The study represents the "kitchen sink" approach to training counseling skills.

The above studies investigated the efficacy of an integrated approach to counselor training. An approach common to many counselor training programs, including some mentioned above, is modeling, in which the instructor emits the therapist response which students are to learn. This may be done in several ways. Thielsen (1971) used a co-counseling approach in which a trainee and supervisor engaged in discussions concerning empathy and conducted a "live" session together, with the supervisor providing feedback. Training effects were evaluated on a scale designed to measure self-concept and on the Counselor Verbal Response Scale (in which four judges rated subjects' responses to audio-taped counselor statements). The co-counseling technique was compared to the traditional approach of attending lectures and discussions regarding empathy skills. The author found that the co-counseling approach was no more effective in teaching empathy skills when compared to the lecture group, but was more effective in increasing positive self-concept. The authors note that some of the subjects found the situational test, in which
they were to respond to audio-taped client statements, aversive and that this may have affected the results.

Rosenthal (1977) used Goldstein's Structured Learning Training (SLT). This approach includes modeling, reinforcement of appropriate response, role-playing, and transfer training to teach confrontation skills in counseling. Two variations of SLT were used: a highly structured, supervisor guided SLT procedure, and a low structured, self-instructional form of SLT (in which subjects worked with a manual rather than a supervisor and engaged in self-contained role-playing). A third group received only brief instruction on confrontation skills. In addition to measuring the effects of different training approaches, Rosenthal measured a "personality" variable called conceptual level (CL), a developmental measure that presumably reflects levels of responsibility, independence, and behaviors involved in generating concepts. Rosenthal wished to investigate whether a particular instructional approach was more suited for subjects with certain conceptual levels. This is an interesting addition to the common approach of testing the efficacy of training without assessing subject characteristics other than experiences regarding the targeted skills.

The dependent variable measures included completion of the Counselor Training Questionnaire, as well as simulated interview with role-playing "clients." Thus, the relative effects of the three instructional approaches, as well as the subjects' CL, on the dependent variables were compared. Results showed that both SLT procedures were superior to the brief instructional group and that one SLT procedure was not superior to the other across all subjects. Subjects with high levels of independence and
conceptual skills benefited from both the structured and unstructured SLT. Subjects with relatively low levels of independence and conceptual skills benefited most from the highly structured form of SLT. The point to be made here is that there are many variables (in this case, "conceptual levels") influencing the outcome and, thereby, the effectiveness of any training technique, including modeling. While one may question the validity of "conceptual levels" as measures of responsibility, independence, etc., this study illustrates well the need to consider such variables when discussing the utility of any training program.

The above approaches utilized modeling as an integral part of the training procedure. The use of modeling via video simulation was investigated by Eisenberg and Delaney (1969). They used video presentations of client responses to assess subjects' skills. Subjects responded to client statements with "counselor tacting response leads" designed to evoke a more precise description of the client's presenting complaints. Four training approaches were compared: a treatment control group, a reinforcement only group (subjects were verbally reinforced for appropriate responses), a modeling-only group (the video-tape included an experienced therapist modeling the appropriate response), and a modeling plus reinforcement group. They found that the modeling group, and particularly the modeling plus reinforcement group, achieved the highest frequency of "counselor response leads." Unfortunately, these skills did not generalize to "live" simulated sessions with role-playing clients; thus, the clinical utility of using only video-taped clients for training may be in question. As the authors point out, one advantage in using video-taped,
role-playing clients is the uniformity of client responses, an important methodological consideration when conducting research. See Resnikoff (1969) for further discussion on and examples of the use of video-tapes in counselor training.

An approach which is common to many of the training methods discussed above, with the possible exception of the didactic approach, is the use of simulated or role-playing clients. While role-played simulations between "therapist" and "client" only approximate the conditions under which actual therapist-client interactions occur, there is the advantage of attaining the dual goal of using simulations to train counseling skills while assessing training effectiveness. Among the studies using simulations are Fine and Therrien, 1977; Fawcett, Miller, and Braukmann, 1977; Iwata, Wong, Riordan, and Lau, 1982; and Stillman, Burpeau-DeGregorio, Nicholson, Sabers, and Stillman, 1983. The first of two experiments reported by Iwata et al., (1982) will be discussed in detail due to its similarity to the first part of the present study. These authors used simulated interviews to train undergraduate and graduate students in psychology specific skills involved in conducting an initial behavioral assessment interview.

Simulated interviews were conducted in the following manner. Subjects were provided with minimal information (name, age, and occupation of the "client" and general description of the problem) prior to starting the interview. Experimental assistants role-played the clients and were provided written scripts outlining a general description of the problems and it's dimensions, antecedents and consequences, prior
treatment attempts, and the priority of the problems to be addressed. Occasionally unscripted probes (i.e., the presentation of an actual problem that the role-playing client had) were presented. The dependent variables involved the occurrence or nonoccurrence of a range of objectively defined therapist responses appropriate for behavior assessment interview. During baseline, subjects were provided with general information concerning the behavioral interview. Training consisted of a detailed definition of the therapist responses, testing on this material, feedback regarding the results of the test, rehearsal of the targeted interviewing responses, and feedback regarding performance on the most recently completed interview. The results indicated substantial improvement in the subjects' targeted behavior after training. This study has much in common with others already mentioned in that role-playing clients in simulated sessions were utilized. This study is notable because no modeling was provided, unlike some of the approaches discussed previously, indicating that in the acquisition of operationally defined responses in simulated settings, modeling may not be a necessary component. This study also illustrates the use of simulations for both training and assessment.

In summary, it can be said that a number of different (but not necessarily divergent) approaches to the training of therapist skills have utility and merit. Due to the varying focus of the above research cited, it is difficult to pinpoint any essential or nonessential component to a training package, but it appears the modeling and/or participation in role-played simulated sessions are effective features. The final judgement regarding the utility of training programs, however, must rest on issues related to
generalization of skills to actual client populations. A training approach is only as effective as the degree it prepares subjects for real therapist-client interactions. In this regard, simulated sessions appear to be the most promising since it is indicated (Eisenberg & Delaney, 1969) that modeling the appropriate therapist responses does not necessarily result in the acquisition of interviewing skills that generalize to simulated sessions. One must then address the issue of generalization of skills acquired from training programs utilizing simulated sessions to the "live" setting in which clients will present a variety of responses to assessment questions. It is reasonable to assume that clients will not always respond to questions in a clear, straightforward manner. None of the above training approaches, however, directly address this issue. Discussed below are various ways in which a client may be uncooperative and some therapist strategies for dealing with such responses.

Nonappropriate Client Responses

Once the targeted initial assessment responses of the therapist are operationally defined and are well established in the therapist's repertoire, one must then discuss the various ways in which a client does not readily supply the type of information that the therapist's query was designed to evoke. For lack of a better term, and because such client responses vary widely in form, I have used the term "nonappropriate client responses" as a general label. Kanfer and Grimm (1977) discuss the client's use of global descriptors, terms which encompass a wide range of observable behaviors and are therefore nonspecific, such as anxiety, depression, etc., as well as
the use of evaluative summaries and descriptions of the by-products of behavioral concerns, citing marital discord and truancy as examples of the former and latter, respectively.

Morganstern (1976) discusses the issue of client expectations and preferences for certain modes of treatment. A client may enter therapy expecting the therapist to ask questions about his childhood, feelings, or dreams. The client may express disappointment when such is not the focus of assessment or treatment. Other concerns mentioned by the author include the client's focus on personality traits, such as moodiness or laziness, to explain problem behavior.

Benjamin (1981) mentions the issue of silence on the part of the client. He notes that this may not be problematic, since the client may be simply thinking before he answers. In other instances, however, silence may be indicative of confusion or a reluctance to answer (i.e., resistance).

The above describes ways in which a client may respond "nonappropriately." Murphy (1985) infers causes for such client responding. Among the inhibiting factors he cites are low motivation, failure to remember, misunderstanding the question, failure to see the efficacy of a question, the provision of socially desirable responses, and a "psychological inability" to provide an appropriate response.

Gorden (1980) also discusses a number of reasons why the client may be resistant to the therapist's probes for information. Under the general heading of "ego threat," he notes that some questions may threaten a client's self-esteem, resulting in complete repression if the threat is severe or hesitation if the threat is less intense. Other examples of nonappropriate
responding resulting from ego threat include evasion, denial, depersonalization (stating that most people would respond in a similar manner given the same circumstances), minimization (minimizing the extent of the behavior), defensiveness, and confession.

Another source of resistance is what Gorden calls the "etiquette barrier," in which the client fails to provide a response he feels the therapist may find socially inappropriate or, conversely, provides an answer which may be viewed as socially acceptable. The client may also fail to respond appropriately if the response causes "trauma" or anxiety. Gorden notes that the above client variables reduce the client's willingness to provide appropriate answers. Factors reducing the client's ability to talk include forgetting, chronological confusion, inferential confusion (errors in induction and deduction), and unconscious behavior.

As can be seen from the above, there are a number of roadblocks that may present themselves throughout the course of the initial assessment interview. It would be inaccurate to view such difficulties as the "fault" of the client; rather, they may be viewed as one of the reasons the client is seeking help from a trained professional. It is the task of the therapist, then, to recognize these roadblocks when they occur and then successfully resolve them so as to obtain the information needed to continue with the course of therapy.

Therapist Strategies to Evoke the Appropriate Client Response

A variety of therapist skills are required to build rapport with a client and avoid or correct nonappropriate responses to well constructed therapist
questions. For the neophyte therapist, learning what information is necessary to obtain in an initial assessment is one thing; obtaining the information from the client, another. As Murphy (1985) states:

A successful interview involves more than a collection of information through questioning. Psychologists must integrate their knowledge of personality, motivation, mental health, and learning with an understanding of the interview process. Best practices, thus, involve an application of the knowledge, attitudes, abilities, and specific skills which result in increasing the probability of desirable outcomes from various types of interviews" (p. 313).

But how are such therapist behaviors taught by instructors, and how are they learned by the beginning therapist? The following authors suggest some possible strategies for evoking pertinent information from the nonappropriate client.

Murphy (1985) further suggests a number of "facilitating factors" the therapist may use in evoking pertinent information from the client. Initially, the therapist must construct an atmosphere of cooperation through the use of verbal (asking for cooperation) and nonverbal (facial expression, stance, etc.) cues. The "comfort level" of the client should be taken into account by the therapist adjusting his verbal behavior to reflect that of the particular client's culture and background, avoiding lecturing the client, and avoiding a judgmental attitude. Empathy, which Murphy defines as "the ability to see the world through the eyes of the respondent while maintaining professional objectivity" (p. 314), is particularly important and depends upon the ability of the interviewer to know the client and his current situation. An interviewer must also possess self-awareness regarding his ability to actively listen to the client as well as how he is
perceived by the client. Just as important, the therapist should be able to recognize when his question is misunderstood by the client, as well as when the client offers resistance or irrelevant information. This is accomplished through the use of reinforcement of relevant verbal statements made by the client, confrontation of the client regarding incongruous statements, as well as the use of follow-up questions. The use of probes, summary statements, and reflections are also mentioned, among others, as means to control the interview.

Kanfer and Grimm (1980) suggest that the therapist foster language which results in the description of problem areas in operationally defined terms. This may not be emphasized in the initial moments of the interview, lest the therapist disillusion a client in need of a sympathetic ear, but this specificity of language must occur if the goals of therapy are to be reached.

Similar reasoning has lead Scheiderer (1977) to suggest that therapists instruct clients in the manner in which they are to respond to questions during the interview, as well as model the correct response. He studied the efficacy of this approach by measuring the degree of self-disclosure and provision of irrelevant information in four groups: Group 1 was verbally instructed to provide accurate and specific information regarding their present concern; Group 2 observed a videotape of a model client demonstrating the desired behavior; Group 3 received a combination of the two approaches; and Group 4 was the control group, receiving no instruction. He found that instruction giving and modeling, as well as the combination of the two, were more effective than no treatment in evoking
the targeted client verbal behaviors. Instruction giving alone was found to be the most effective approach.

Resnikoff (1969) discusses the notion of "convergence," in which the client's verbal behavior follows that of the therapist. If the therapist, for example, focuses on the statements of the client regarding affect, the client will provide more affect-related comments. To test this, a panel of judges rated the verbal behavior of the therapist and client using the "Counselor Verbal Response Scale." The judges also rated "client movement." Although the understanding, affective, and exploratory dimensions were related to therapist effectiveness, the verbal behavior of the therapist and client was found to have a low correlation with one another, indicating that the convergence phenomenon may not apply to the verbal behavior of the therapist and client in the interview process. Thus, this approach may not be sufficient for evoking appropriate responses from the client.

Engler, Saltzman, Walker, and Wolf (1981) discuss an approach to teach medical students communication and interviewing skills. The skills targeted were the establishment of a trusting relationship, facilitation of the patient's self-exploration, the provision of information, support, reassurance, and direction, as well as increasing the physician's awareness of the impact of his behavior on the patient's healing process. The method by which such skills were taught included lectures, modeling, and practice. The training program spanned the course of two years; the first year involved training in the processes involved in interviewing and emphasized affective skills. The second year emphasized the content of the interview, (data collection and problem solving). Performance was evaluated through
the use of paper and pencil measures (the "Levels of Responses Scale" and the "Standard Index of Communication" and "Standard Index of Discrimination") as well as the evaluation of videotaped interviews. Results indicated that empathic, interpersonal communication was improved after completion of the training program. Since this was a study designed for medical students, the content of the interview differs from that of a clinical psychologist, but the common features here are the emphasis on skills said to be related to communication. The methodology of this study is representative of the vast majority of studies cited here in that the independent variable often relied on subjective measures, such as paper and pencil scales or judges’ ratings. It is also of interest to note the vague (i.e., not operationalized) nature of the targeted skills, a characteristic common to many strategies related to increasing therapist-client "communication."

The following is also illustrative of this problem.

In his book, *The Helping Interview*, Benjamin (1981) discusses various therapist behaviors that he considers to be an essential part of the initial interview. He states that:

> I think it is to the establishment of trust and respect that those who teach and write in the field of interpersonal relations primarily refer when they speak of "contact," good "rapport," and good "relationship"; and the atmosphere that may bring these about is what we must further consider now (p. 5).

Although Benjamin calls this "atmosphere" intangible, he describes many ways in which the therapist can create it through his own behavior. For example, if the client remains silent after a question is asked, the therapist may rephrase the question, allow the silence to continue, or "reflect" on the
possible source of the silence; which technique the therapist uses is determined by whether the client is confused, thinking before answering, or resistant, respectively. This, however, raises the question of how easily a therapist can discern motivation for a client’s verbal behavior. Another facilitating set of behaviors comes under the general heading of "respect" which includes attending to what the client says, accepting by means of reflection (which, in turn, is achieved by "deeply emphatic listening and understanding" [p. 123]), and understanding through empathy. The circular nature of the above description is illustrative of the dilemma many face in describing the means by which a therapeutic "atmosphere" is created. Benjamin attempts to describe further the behaviors of the therapist which facilitates the interview. He defines empathy as "feeling yourself into, or participating in, the inner world of another while remaining yourself" (p. 49). Restatement is defined "as an echo, to let the interviewee hear what he has said." (p. 119). Clarification borders on reflection in that the therapist repeats what the client has said, but in more clear, summary-like terms; it may also be used to aid the therapist when she is unclear as to what the client is saying. Interpretation serves a similar purpose for the client when the therapist explains what the client has just said in terms which still reflect the client’s stated perception of his situation. Interpretation may also involve leading the client to analyze his situational statements in terms of alternative points of view. Other therapist behaviors are described, many of which relate to phases of the therapeutic process beyond the initial interview. Benjamin described much of the appropriate therapist behavior in non-operationalized terms and relies on illustrative examples to clarify
his point. This is not so much a criticism as it is an illustration of the difficulty in describing the means by which skilled therapists evoke the "truth" from clients who may, for whatever reason, fail to respond with useful information concerning their reasons for seeking therapy. Also, the failure to operationally define targeted behaviors results in increased difficulty in training such behaviors and replicating research evaluating training procedures.

Gorden (1980) also illustrates the difficulty of describing therapist behavior. One way in which the interviewer may facilitate the flow of information is by providing the client with praise. Sympathetic understanding, catharsis, and the need for meaning on the part of the client to reduce cognitive dissonance are also mentioned as facilitating factors. Gorden states that by recognizing the client's need for meaning, the therapist can use his skills to fulfill that need, which in turn will motivate the client to increase communication. It should be noted that Garden's book is chiefly concerned with the survey interview, (i.e., information collection), but he does refer to and addresses many of the concerns involved in the clinical interview. Many of his comments refer to psychodynamic principles which are difficult to operationally define and observe (such as catharsis, ego threat, and unconscious behavior), which again illustrates the difficulty with which the beginning therapist would have in gaining guidelines for conducting the initial interview.

Wells, Benson, and Hoff (1985) attempted to operationally define many of the behaviors under discussion. They taught first year medical students interviewing behaviors for clarifying the manner in which medical illness
affects the daily life of the patient. Training included a review of the structure, techniques, and goals of the interview, as well as workshops providing practice and feedback. The only evaluation of the program’s effectiveness was student ratings, which were reported to be favorable. As the authors note, "What is relatively unique about the model is the degree to which each component of the model is specified in terms of objectives and behaviors and illustrated with examples that are appropriate for the educational level of students" (p. 187). The authors state that support, reassurance, and empathy are required to build rapport with a client. Their success in providing operational definitions varies. Re-assurance, for example, is defined as "a response that enhances the well-being of the patient on a realistic basis" (p. 184). While this definition is rather vague, the authors’ treatment of empathy is much clearer. They state that "Empathy is a response that demonstrates an accurate understanding and acceptance of the patient’s feelings or concerns. Empathetic interviewing involves three specific steps: detecting and exploring the patient’s concerns and providing feedback on these concerns" (p. 184). Examples of each of the three steps are provided. The authors also provide operational definitions for such therapist behaviors as active listening ["the use of silence plus nonverbal indications of interest, such as nodding; maintaining an open, receptive body stance; leaning forward; maintaining eye contact" (p. 183)], and confrontation ["...focuses the patient’s attention on a component of his experience (such as feelings, behaviors, or statements"), (p. 183)]. By approaching operational definitions for these complex behaviors, teaching
and measuring them becomes much more accessible. This article is a good example of the movement one must take in that direction.

Perhaps the most often mentioned form of therapist response said to evoke client responding is the open-ended question, which Wells, et al. (1985) defines as a statement which "invites the patient to talk and specifies content in general terms" (p. 183). These are questions to which the client must supply more than a "yes" or "no" answer, such as "What do you do when your child has a tantrum?" While such questions are often useful, one does not want to use them indiscriminately. Ivey (1982) has noted that an open-ended question is useful when one wants general information and the closed-ended question helps the client provide specific information and aids the therapist in focusing the interview. He states, however, that "Either of these methods used to excess can be problematic" (p. 83). Benjamin (1981) feels that the open-ended question helps the therapist build good rapport with his client, allowing him a "full scope," a widening of his "perceptual field," a forum for his "views, opinions, thoughts, and feelings," and qualitatively better contact (p. 73). The closed-ended question, however, negates these advantages in asking only for the "cold facts only" (p. 73). The author also warns against asking double questions (questions which offer the client an "either-or" choice) and bombarding the client with questions. The distinction between direct and indirect questions is also made, an indirect question being one in which no question is asked but a reply is implicitly required, such as "I wonder how things went for you this week" (this is an example of what Skinner (1957) calls a "softened mand").
Gross (1984) perhaps finds an intermediate ground in saying that "there is no one correct way to conduct a behavioral interview," and "the therapist might begin the process with minimal structure, using open-ended questions designed to determine what problem prompted the family to seek treatment. After establishing the nature of the difficulty, the therapist might begin to increase the structure of the interview" (p. 70). In this way, the client is able to freely discuss his present concerns in a manner with which he feels most comfortable. Once the therapist has a general description of the problem, he can focus the questions on increasingly specific issues relevant to analysis and treatment.

The focus of the discussion thus far has been on verbal behavior. The nonverbal behavior of the therapist is also said to affect client responding (Gorden, 1980; Benjamin, 1981; Wells et al., 1985). D'Augelli (1974) suggested that smiling, nodding, and leaning forward would facilitate the client's positive perception of the interviewer, while leaning down, staring away from the client, and stammering may detract from the interviewer being perceived in such a manner. A group of therapists were monitored for the above behaviors and their occurrences was compared to the ratings of independent observers as well as the therapists' clients. Overall effectiveness was found to be related to the frequency of smiling and nodding, although these correlations were low. It would appear, then, that while nonverbal behavior plays a role in building rapport with a client, the verbal behavior of the therapist, as well as the verbal interactions between the therapist and client, carries the weight in determining the quality of the interviewing process.
Summary

Although the interview is a major source of information concerning the dimensions of a client's presenting problem, there exist divergent opinions as to the structure and content of the interview. A structured or standardized interview (structured with regard to form and sequence of the questions) is said to be useful when one knows in advance the type of information to be gained and when more than one respondent is involved. One may also design a predetermined structure for the interview, but vary the wording or order of questioning according to the particular situation. An unstructured or nonstandardized approach is perhaps most useful when the therapist has no predetermined notion as to the type of information that is relevant to a particular case. The initial behavioral interview most likely will be structured, in the sense that the behavior therapist knows what "type" of information is required (such as information regarding an operational definition of the problem, a description of antecedents, consequences, etc.) but will vary the content of the interview to fit the characteristics of the client (for example, the content of the therapist's verbalizations may vary according to differing levels of client educational backgrounds). This may be compared to the static form of interview generated by computer or to that found in the DIS.

Just as there are a number of opinions as to what an initial interview should specify, there are also varying approaches to training the skills required to conduct a successful interview. Strategies along these lines include the traditional didactic approach (in which the theory behind interviewing strategies is presented in lecture form) simulation of therapist-
client interactions, modeling of the appropriate therapist response, reinforcement of correct responding, provision of feedback regarding performance, and various combinations of the above. Although there is no conclusive evidence indicating the superiority of one procedure over another, the literature suggests that simulated interview may be the most effective.

Even though one is trained in the structure and content of the initial interview, it is still likely that the client will occasionally respond in a manner that does not add to the pool of information the therapist is collecting regarding the presenting complaints. These "nonappropriate" client responses may come in many forms. The client, for example, may use global descriptors, rather than operational definitions to describe his problem. The client may fail to answer a question due to a lapse in memory, a misunderstanding of the question, the desire to provide a socially acceptable answer, or because to answer would threaten his self-esteem or ego, with such a threat resulting in denial, evasion, or depersonalization. Also, a client's expectations may influence the manner with which he answers a question.

Once the student-therapist is aware of the pitfalls she may encounter during the interactions with the client in the initial assessment interview, it is then necessary to devise techniques to avoid or correct any hindrance to the attainment of information. The therapist may simply ask the client to respond in a particular manner, such as describing problem areas in operational terms. The use of empathy is perhaps the most common approach mentioned for evoking an appropriate response from the client.
Wells, (1985) provides an operational definition for empathy as well as other therapist behaviors which in the past have been described in nonoperational terms. Other common approaches are reflection, confrontation, and interpretation, all of which must occur in an atmosphere of support and trust (i.e., rapport).

Another common strategy is the use of open and/or closed-ended questions. The advantage of the open-ended question is that it allows the client the opportunity to describe the dimensions of the problem in his own words. Closed-ended questions provide the therapist a means to direct and lead the client toward a predetermined goal. Some authors, however, feel that the closed-ended question should be avoided because it hinders the building of proper rapport.

Lastly, some attention has been focused on the effects of nonverbal behavior emitted by the therapist. One study found that smiling and nodding was related to the effectiveness ratings of therapists, but the correlation between the nonverbal behavior and ratings was low.

As can be seen from the above, there are many suggestions regarding increasing a client’s ability or willingness to supply information useful for planning effective treatment. Most approaches, however, fail to provide clear, operational definitions of therapist strategies, making them difficult to learn and objectively measure. Also, the issue of when to use these skills in the course of the therapist-client interaction has not been addressed systematically. The present study was an attempt to provide operational definitions in manual form for the various therapist behaviors necessary in conducting a thorough behavioral assessment interview, including those
that may be useful in obtaining information from nonappropriate clients. The issue related to the appropriate time to use each therapist strategy was also addressed.
CHAPTER III

METHOD

Subjects

Six subjects participated in this study. All were graduate students in the department of psychology at Western Michigan University who responded to requests made to nonclinical graduate psychology classes asking for volunteers. Their ages ranged from 24 to 36. Two were male and four were female. All subjects had completed graduate course work on the basic principles of behavior analysis but had no work experience or course work in conducting behavioral assessment interviews. All subjects were unskilled in behavior assessment interviewing skills, as defined by providing less than six of the targeted responses (to be discussed later) during any baseline interviews. Only six subjects were recruited and all met the above criterion.

Setting and Apparatus

Sessions were conducted in small (8’ x 10’) rooms in a psychology clinic and in a laboratory located on the campus of Western Michigan University. These rooms contained two chairs and a desk. Sessions were recorded on a tape recorder placed between the two participants.
Dependent Variables

Phase One

The occurrences of the following responses were scored for each subject during each session. Each response had to be in the form of an open-ended question (a question that requires more than a "yes" or "no" answer) before it was scored as an occurrence. The sequence or location of the response did not affect whether or not it was scored as an occurrence—it needed only to be presented in its proper form. Detailed definitions of each response can be found in Appendix A. As was the case throughout the study, sessions were audiotaped and scored by the experimenters for the occurrence of the dependent variables using the form found in Appendix B.

1. Asks client for a general description of the problem.
2. Asks client if any other problems exist (this part of the question may be closed-ended) and, if so, asks client to describe additional concerns. This step is repeated until client indicates that no other concerns exist.
3. Sets priority by summarizing the problems mentioned by the client and then asks the client which problems should be addressed first.
4. Asks for specifications (i.e., operational definitions) of the problem behavior.
5. Asks about the onset of the problem, including any events associated with the onset.
6. Asks about dimensions of the problem, such as frequency, duration, magnitude, and latency.
7. Asks about events (antecedents) occurring before the problem behavior is emitted, as well as conditions under which the problem does not occur.

8. Asks about the consequences, both short and long term, of the behavior.

9. Asks about correlated verbal behavior.

10. Asks about goals; that is, what the client would like to accomplish through therapy.

11. Asks client about prior treatment attempts, (this may be in the form of a closed-ended question), and, if they occurred, asks for a complete description of the treatment, (this last question was added to the dependent variables of this phase by the present author).

Phase Two

The dependent variable for the second phase of this study included the eleven dependent variables described above. Additionally, six types of "nonappropriate" client responses to therapists' questions were identified and appropriate follow-up questions for each of these situations were described. Thus, six of the eleven responses were answered "nonappropriately" (i.e., the confederate client failed to provide the information that the question requested) and subjects were required to provide the appropriate follow-up response before an occurrence was scored. The dependent variable for Phase Two, then, included the eleven therapist responses from Phase One plus the additional six responses from Phase Two. The six (out of eleven) initial therapist responses receiving a
nonappropriate response varied across sessions. As was the case for Phase One, the location and sequence of the eleven initial responses were not important, but once a particular nonappropriate client response was provided, the subjects were required to give the corresponding follow-up response. As in Phase One, sessions were scored by the experimenters using the form found in Appendix B. The nonappropriate client responses and the corresponding appropriate therapist responses are listed below. See Appendix C for a more detailed description of these responses.

<table>
<thead>
<tr>
<th>Nonappropriate Client Response</th>
<th>Appropriate Therapist Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Answers with a vague or irrelevant information</td>
<td>Summarizes and restates question</td>
</tr>
<tr>
<td>2. Fails to answer question</td>
<td>Offers potential examples</td>
</tr>
<tr>
<td>3. Describes feelings only</td>
<td>Empathizes and describes questions further</td>
</tr>
<tr>
<td>4. Questions nature of inquiry</td>
<td>Provides behavioral rationale or avoids topic</td>
</tr>
<tr>
<td>5. Expresses disagreement with behavioral orientation</td>
<td>Provides behavioral rationale</td>
</tr>
<tr>
<td>6. Attributes cause of problem to nonpertinent variables</td>
<td>Empathizes and describes question further</td>
</tr>
</tbody>
</table>

**Manuals**

**Phase One**

**Manual One with Examples.** This manual (Miltenberger & Fuqua, 1985; see Appendix A) provided a detailed definition of each of the eleven
responses that made up the dependent variables of Phase One. Also included was a definition of open-ended questions. Each of the definitions was followed by examples illustrating the response. These examples consisted of transcripts of interactions between a therapist and a client and were followed by an explanation as to why the therapist response was appropriate in accordance with the preceding definition. Also included were nonexamples that illustrated incorrect therapist responses, as well as an explanation as to why they were incorrect. The manual ends with a summary of each therapist response.

**Manual One Without Examples.** This manual is identical to the aforementioned manual except that the examples and nonexamples were not included. Definitions of the dependent variables for Phase One were presented without illustration.

**Phase Two**

**Manual Two with Examples.** Manual Two (see Appendix C) began with an introduction that explained the rationale and need for the manual. Included here were explanations of why a client may not provide a therapist with the information requested during an assessment interview; factors such as embarrassment, anxiety, and involuntary attendance were mentioned. Key terms were also discussed, such as "nonappropriate," "summarizing and restating," and "empathizing" and "describing the question further." The manner in which the subject is to integrate the manual during assessment was described by stating that a particular response from the first manual should be emitted and then followed by an
appropriate response from the second manual if necessary. The benefits of using this approach were mentioned.

The manual then named and described potential nonappropiate responses made by the client and illustrated these with a therapist-client dialogue in the same manner as Manual One with Examples. After each example, the nonappropriate nature of the client's response is discussed. Each client nonappropriate response category was followed by the corresponding appropriate therapist response, which was defined and illustrated with examples in the form of a therapist-client interaction. An explanation as to why the example demonstrates the previously mentioned therapist response was provided.

The manual ended with a summary of the nonappropriate client responses and the corresponding appropriate therapist response. The preference for open-ended, as opposed to closed-ended, questions was discussed, and a caveat was provided concerning simple "why" and "what" questions (such as "Why do you feel that way?" and "What do you mean by that?") which may continue to lead the session down an unproductive path due to their nonspecificity.

Manual Two without Examples. This manual was identical to the previously described manual with the omission of the examples illustrating the therapist and client responses.
Procedure

Simulated Sessions

For both phases and across all conditions of this study, the dependent variables were measured in the context of a simulated initial assessment interview. Subjects played the role of therapist and trained confederates (the present author and a research assistant) acted as clients.

The research assistant received training in the form of a review of the manuals and response categories (i.e., the dependent variables) as well as modeling, rehearsal, and feedback regarding the client responses. During each session, the confederate played the role of a client with a clinical problem. The clinical problems did not vary in order of presentation across subjects so that the degree of difficulty was the same for all subjects across all experimental conditions. A different clinical problem was portrayed for each session for a particular subject, thus ruling out practice with a particular clinical problem as a plausible explanation for any improvements in subjects' performance. Scripts for a total of 23 clinical problems were developed (see Appendix D). The clinical problems were selected based on behavior problems commonly addressed in the behavior therapy literature (e.g., Spiegler, 1983). Based on this literature, scripts were developed that identified plausible etiological factors, antecedents, consequences, etc. for each clinical problem (see Appendix E). Confederates were trained using these scripts and were allowed to refer to them during the simulations. The scripts for Phase One contained client responses to each of the eleven targeted therapist responses. Two scripts were used for each clinical problem presented in Phase Two: One script was the same format as the
scripts in Phase One, providing responses or information for each of the eleven assessment categories mentioned above. Additionally, a supplementary script provided nonappropriate client responses to six of the eleven categories and contained the appropriate therapist response category (such as "summarizes and restates question") next to the corresponding nonappropriate client response. An example of a supplementary script for Phase Two is found in Appendix F.

**Phase One**

**General Procedure.** During all sessions in Phase One (with the exception of session three) the confederate client answered subjects' questions in the following manner: Any closed-ended questions were answered with a "yes" or "no" according to the general information provided by the script. Open-ended questions were also answered according to the script. For example, if the subject asked "What happens after you threaten your mother with violence," the confederate would respond with "Sometimes she calls the police, but usually she leaves me alone." Thus, the confederate client answered questions in a direct, nonevasive manner. For session three, the confederate client provided nonappropriate responses to six of the subject's questions as described above in Phase Two. The reason for the inclusion of nonappropriate answers in this session was to probe for the ability of the subjects to respond to nonappropriate responses before the introduction of training of any kind.

**Baseline.** During baseline, subjects performed a maximum of five initial assessment interviews. No training or feedback was provided before,
during, or after these baseline sessions. Each subject received the same written instructions prior to the session stating that his task during the session was to obtain from the client any information needed for a behavioral assessment of the presented problem and that he could end the session at any time (see Appendix G for a copy of the instructions). Simulated sessions were conducted in the manner described above. Baseline continued for each subject until a steady state of total occurrences of appropriate subject responses had been achieved.

**Manual One with Examples Program.** After completion of baseline, three of the subjects were chosen at random to receive Manual One with Examples. Subjects were handed the manual after the last baseline session and were instructed to read it. No evaluation was conducted by the experimenter regarding subjects' comprehension of the manual prior to resumption of the simulated sessions nor did the experimenter interact with the subjects concerning the contents of the manual. The procedure for the simulated sessions after presentation of the manual was the same as during baseline. Confederates responded to subjects' questions in the same manner as during baseline (with the exception of session three). Subjects were allowed to refer to the manual or notes they may have made from the manual during the session. Subjects conducted these assessment interviews (no more than two per day) until three consecutive sessions were completed in which at least 9 out of the 11 targeted therapist responses were emitted. If this criterion was not reached after the completion of five sessions, feedback was provided by the experimenter in the following manner: each of the eleven targeted dependent variables were described and examples
were provided by the experimenter. If the 5th session reached criterion (occurrence of 9 out of 11 targeted responses), feedback was delayed. If the subject failed to reach criterion in session 6 or 7, feedback was implemented.

The content of the feedback corresponded to the particular clinical problem presented in that session. The appropriate form of each response was described and modeled as outlined in the manual. The subjects were allowed to ask any questions regarding the manual and/or the targeted dependent variables at this time. Sessions continued until the aforementioned criterion was reached.

**Manual One without Examples Program.** After completion of baseline, three subjects were randomly chosen to receive Manual One without Examples. The criterion for completion of this phase was the same as above. If the subject failed to meet criterion, Manual One with Examples was provided. No feedback was provided at this time. If the subject still failed to reach criterion after five consecutive sessions with Manual One with Examples, the subject was provided with feedback as described above, and the phase was terminated after criterion was reached for three consecutive sessions.

**Experimental Design.** A multiple baseline across subjects design was utilized to test the effectiveness of each form of Manual One. Accordingly, each subject experienced 4 or 5 baseline sessions before the introduction of their respective manuals.
Phase Two

Phase Two was implemented to assess whether the therapist skills obtained from the first phase were sufficient for conducting an assessment interview with a client who was occasionally evasive and, if not, to assess the effectiveness of a second manual designed for such a purpose.

General Procedure. The same subjects from Phase One participated in Phase Two. The subjects, therefore, were well trained in the interviewing skills of the first phase, as indicated by the fact that each one had reached criterion in that phase to move on to the second phase. Simulated sessions continued to be utilized to assess subjects’ skills. The subjects were allowed to conclude the session at any time.

As was described previously, the confederate clients in this phase responded to six of the eleven subjects’ assessment questions from Manual One in a nonappropriate manner and the subjects were required to provide the appropriate response as outlined in Manual Two. The remaining five of the eleven assessment questions were met with appropriate answers in the manner described in Phase One.

When a subject’s initial assessment question was answered by the confederate in a nonappropriate manner, the subject was allowed to provide two additional responses to evoke an appropriate answer. If the subject’s response was not in the form as outlined in Manual Two (for example, the subject did not empathize and describe the question further when the confederate answered the initial question by describing only feelings) the confederate continued to answer nonappropriately. Should the subject fail to respond with further questioning or fail to provide a question in the
correct form by the second attempt, the appropriate response was provided and the targeted therapist response was scored as a nonoccurrence. The appropriate client response was provided in order to minimize the effects of a nonappropriate answer on the remainder of the session. This response was given even if it meant interrupting the subject should s/he try to move on to another topic.

**Baseline.** During the baseline for this phase, subjects performed three assessment sessions. No feedback or training was provided before, during, or after these baseline sessions. Written instructions (see Appendix H) were provided at the start of each session stating that the "client" will occasionally answer questions in an unclear manner and that the task of the subject is still to try to obtain the information needed for a behavioral assessment.

**Manual Two with Examples Program.** After completion of the baseline sessions, the three subjects who received Manual One with Examples received Manual Two with Examples. Subjects were provided with the manual after the last baseline session in Phase Two. No discussion between the subjects and experimenters concerning the specific content of the manual took place and there were no tests of subjects' comprehension of the manual's content prior to resumption of the assessment session. Subjects were allowed to bring both Manual One and Two, or any notes pertaining to them, into the session and could terminate the session any time they so desired. The criterion for completion of this phase was the same as that described for the first phase. If the subject failed to reach criterion as
described, the feedback phase was added, which consisted of the following:
immediately following the session, the eleven responses making up the
dependent variable from Manual One were reviewed as they pertained to
the current presented problem. The manner in which six of the eleven
inquiries were answered nonappropriately by the confederate was described
and compared to an appropriate client answer; the appropriate therapist
response, as described in Manual Two, was modeled. The experimenter
then answered any questions the subject may have had. Sessions continued
until the aforementioned criterion was reached. Feedback was provided for
each session that did not reach criterion.

Manual Two without Examples Program. After completion of the
second baseline, the subjects who received Manual One without Examples
received Manual Two without Examples. The criterion for completion of
this phase was the same as above. If a subject failed to meet criterion,
Manual Two with Examples was provided. If the subject still failed to meet
criteria, the feedback phase was implemented and the phase was terminated
after criterion was reached for three consecutive sessions.

Experimental Design. As in the first phase, a multiple baseline across
subjects design was utilized to test the effectiveness of each form of Manual
Two.

Data Recording

For Phase One and Two, the tapes from each session were scored for
the occurrence of the dependent variables. The score for each session was
the number of targeted responses as outlined in the dependent variables for
both phases. The maximum potential score per session for both phases was eleven. As noted earlier, in Phase One the subjects were required to emit the defined therapist responses in their proper form for an occurrence to be scored. In Phase Two, the subjects were required to emit the same therapist responses in their proper form but were also required to provide correct follow-up questions for six of the initial therapist responses receiving a nonappropriate client response. A response was scored as having occurred if it was emitted once; if it occurred more than once, these extra responses were not counted. The data sheet is contained in Appendix B. Scoring guidelines can be found in Appendix I.

Interobserver Agreement

A second observer independently scored 25% of the assessment audiotapes for each subject. The second observer was trained in the following manner: the dependent variables from both phases were defined and modeled by the experimenter. Tapes of previous simulated sessions were reviewed and the present author and second observers scored them together, discussing any questions or difficulties that arose. The second observer then scored a session independently. If interobserver agreement was below 85%, the above process was repeated until interobserver agreement was 85% or above for each session. Training to 85% agreement occurred prior to scoring the sessions for reliability.

Reliability was calculated by dividing the number of agreements by the number of agreements plus disagreements and multiplying by 100%. Agreements were scored when both observers agreed that a targeted
response (i.e., dependent variable) had or had not occurred for a particular response category.

The reliability for the dependent variables targeted in Manual One was 91.6% with a range of 73% to 100%.

The reliability for the dependent variables targeted in Manual Two was 87.7% with a range of 73% to 100%.

Social Validation

A group of eight Ph.D. level psychologists with extensive training and experience in behavior therapy from the Psychology Department at Western Michigan University and the Johns Hopkins School of Medicine anonymously completed a paper and pencil social validation Likert Scale form which included the following: For Manual One, the examples illustrating the dependent variables were rated, according to two dimensions: (1) Is the above example representative of a potential therapist-client interaction? and (2) Does the above example illustrate the previously described therapist response category? The negative examples were rated according to the first dimension (1), as well as (2) Does the negative example above clearly differentiate between the desirable and undesirable therapist response.

For Manual Two, the nonappropriate responses made by the client were rated on two dimensions: (1) Is the example representative of a potential therapist-client interaction? and (2) Does the example illustrate the described nonappropriate client response? Appropriate therapist responses were rated according to three dimensions: (1) Is the example
representative of a potential therapist-client interaction? (2) Does the example illustrate the described appropriate therapist response? and (3) To what extent do you agree that the therapist response to each nonappropriate client response is an effective strategy for evoking the desired information?
CHAPTER IV

RESULTS

The results indicate that Manual One was effective in training the targeted therapist skills. The inclusion of examples, while not necessary to bring performance to criterion, added to the efficiency of training, allowing subjects to reach criterion in fewer sessions. Manual One did not adequately prepare subjects for conducting an assessment interview with "difficult" clients.

Manual Two was effective in training four subjects the targeted therapist skills. Two subjects, each receiving Manual Two with examples, required the addition of a feedback phase. For the three subjects receiving the manual without examples, one subject required presentation of the manual with examples to reach criterion, indicating that for this subject, the inclusion of examples augmented performance.

See Table 1 for a summary of the number of correct responses emitted by individual subjects across all experimental conditions. The individual performances of Subjects 1-6 can be found in Figures 1-6, respectively.

Phase One

Of the eleven responses making up the dependent variables for Phase One, the average number of correct responses for all subjects and across all baseline sessions (excluding session 3) was 2.5, indicating relatively low behavioral interviewing skills.

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Table 1

The Mean (and Range) Number of Correct Responses for Individual Subjects Across Experimental Conditions

<table>
<thead>
<tr>
<th>Experimental Conditions</th>
<th>Subjects</th>
<th>Baseline 1</th>
<th>Manual 1</th>
<th>Baseline 2</th>
<th>Manual 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Manual with Examples</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S1</td>
<td>2.0 (1-3)</td>
<td>9.7 (9-10)</td>
<td>4.7 (3-6)</td>
<td>8 (6-10)</td>
<td>9.3 (9-10)</td>
</tr>
<tr>
<td></td>
<td>2.3 (2-3)&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S2</td>
<td>3.2 (1-5)</td>
<td>7.8 (5-10)</td>
<td>6.7 (6-7)</td>
<td>9.3 (9-10)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.8 (3-5)&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S3</td>
<td>2.8 (0-5)</td>
<td>10.0 (0)</td>
<td>4.7 (3-6)</td>
<td>7.0 (5-8)</td>
<td>10.0 (9-11)&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3.7 (3-5)&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S4</td>
<td>3.6 (2-5)</td>
<td>10.2 (9-11)</td>
<td>5.0 (0)</td>
<td>9.7 (9-10)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.0 (3-5)&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S5</td>
<td>1.8 (0-3)</td>
<td>8.3 (4-10)</td>
<td>5.0 (4-6)</td>
<td>8.7 (7-10)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.3 (2-3)&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S6</td>
<td>1.5 (0-2)</td>
<td>8.9 (8-10)</td>
<td>5.3 (4-6)</td>
<td>6.6 (4-9)</td>
<td>8.5 (7-9)&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>2.0 (0)&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup>Corrected score when controlled for nonappropriate client #3

<sup>b</sup>Score when manual with examples required

<sup>c</sup>Score in feedback phase

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Figure 1. The Correct Number of Targeted Responses Emitted by Subject 1 Across Experimental Conditions
Figure 2. The Correct Number of Targeted Responses Emitted by Subject 2 Across Experimental Conditions.
Figure 3. The Correct Number of Targeted Responses Emitted by Subject 3 Across Experimental Conditions.
Figure 4. The Correct Number of Targeted Responses Emitted by Subject 4 Across Experimental Conditions.
Figure 5. The Correct Number of Targeted Responses Emitted by Subject 5 Across Experimental Conditions.
Figure 6. The Correct Number of Targeted Responses Emitted by Subject 6 Across Experimental Conditions.
There were no upward trends during baseline. The range of correct responses was 0 to 5 and baselines were equivalent regarding the mean number of targeted responses emitted. Thus, none of the subjects emitted six or more of the targeted responses, which was the cut-off point that would have precluded further participation in the study.

As can be seen from Figures 1-6, the subjects rapidly improved their performance after the introduction of Manual One. For Subjects 1, 2, and 3, who received the manual with examples, only Subject 2 required more than three sessions to complete this phase. For Subjects 4, 5, and 6, who received the manual without examples, Subjects 5 and 6 required more than three sessions to complete the phase, indicating that inclusion of examples may have been beneficial for these subjects to acquire the outlined skills.

Phase Two

The baseline for Phase Two, in which confederate clients occasionally provided nonappropriate answers, showed a marked decrease in performance for all subjects, indicating that the skills learned from Manual One were not sufficient for training these subjects to respond to nonappropriate clients. Since only six of the eleven therapist response categories from Manual One received a nonappropriate answer, the subjects' performance during this baseline was an improvement over their performance in the Phase One baseline. This indicated that the subjects retained skills learned from the first phase and that the addition of occasional nonappropriate client responses resulted in a decrease in performance.
With the exception of Subject 6, performances improved after the introduction of Manual Two. Of the subjects receiving Manual Two with Examples, Subjects 1 and 3 failed to reach criterion (three consecutive sessions in which nine or more of the targeted responses are emitted) after their fifth session and required the implementation of feedback. Once feedback was provided, both subjects quickly reached criterion. Subject 2 reached criterion without requiring feedback. Regarding Subjects 4, 5, and 6, who received Manual Two without Examples, only Subject 6 failed to reach criterion after the fifth session and required provision of Manual Two with examples, after which criterion was reached. Subjects 4 and 5 were able to reach criterion using Manual Two without Examples alone.

Social Validation

All examples contained in Manual One were measured for social validation using versions of the Likert Scale. All examples contained in Manual Two, as well as the appropriate therapist response categories, were also measured for social validation via versions of the Likert Scale. Table 2 shows the social validation questions, the corresponding Likert Scale, and the mean and range of social validation responses.
Table 2
Social Validation Questions, Likert Scales, and Mean (and Range) of Responses

<table>
<thead>
<tr>
<th>Questions</th>
<th>Likert Scale</th>
<th>Mean</th>
<th>(Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Manual One</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is above example representative of a potential therapist-client interaction?</td>
<td>(1) very representative to (5) very unrepresentative</td>
<td>1.6</td>
<td>(1-5)</td>
</tr>
<tr>
<td>Does the above example illustrate the previously described therapist response category?</td>
<td>(1) excellent example to (5) very poor example</td>
<td>1.7</td>
<td>(1-5)</td>
</tr>
<tr>
<td>Is the above negative example representative of a potential therapist-client interaction?</td>
<td>(1) very representative to (5) very unrepresentative</td>
<td>2.2</td>
<td>(1-4)</td>
</tr>
<tr>
<td>Does the negative example above clearly differentiate between the desirable and undesirable therapist response?</td>
<td>(1) very clear to (5) very confusing</td>
<td>2.0</td>
<td>(1-4)</td>
</tr>
<tr>
<td><strong>Manual Two</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the above example representative of a potential therapist-client interaction (for the nonappropriate client response)?</td>
<td>(1) very representative to (5) very unrepresentative</td>
<td>1.9</td>
<td>(1-4)</td>
</tr>
</tbody>
</table>

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Table 2--Continued

<table>
<thead>
<tr>
<th>Questions</th>
<th>Likert Scale</th>
<th>Mean</th>
<th>(Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Two</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does above example illustrate the previously described nonappropriate client response?</td>
<td>(1) excellent example to (5) very poor example</td>
<td>2.0</td>
<td>(1-4)</td>
</tr>
<tr>
<td>Is above example representative of a potential therapist-client interaction (for the appropriate therapist response)?</td>
<td>(1) very representative to (5) very unrepresentative</td>
<td>1.5</td>
<td>(1-4)</td>
</tr>
<tr>
<td>Does above example illustrate the previously described appropriate therapist response?</td>
<td>(1) excellent example to (5) very poor example</td>
<td>1.6</td>
<td>(1-4)</td>
</tr>
<tr>
<td>To what extent do you agree that the therapist response to each nonappropriate client response is an effective strategy in this case?</td>
<td>(1) strongly agree to (5) strongly disagree</td>
<td>1.6</td>
<td>(1-2)</td>
</tr>
</tbody>
</table>

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CHAPTER V

DISCUSSION

General Discussion of Results

The present study attempted to answer the following questions:

1. Is a training manual designed to teach basic interviewing skills adequate in training such skills for use with a nonappropriate client?

2. If not, would a manual designed specifically for use with nonappropriate clients prove effective in training such skills?

3. Are illustrative examples necessary in training interviewing skills with appropriate and/or nonappropriate clients?

The efficacy of Manual One in training the targeted interviewing skills was previously demonstrated (Miltenberger & Fuqua, 1985) and the findings have been replicated here. None of the subjects receiving Manual One, whether with or without examples included, required the addition of a feedback stage. The targeted responses, then, were amenable to the training manual format when the confederate clients provided appropriate answers to the subjects' questions. This indicates that such skills can be learned by the beginning therapist in an efficient and time-saving (for both the instructor and student) manner through the use of a manual.

The second baseline was introduced to test the adequacy of the skills targeted in Manual One in conducting an interview with "difficult" or nonappropriate clients. When such clients were introduced, none of the subjects reached criterion for any of the three baseline sessions. The
subjects' task in the first phase was relatively straightforward in that they were required to emit the eleven targeted responses as outlined in Manual One, with the confederate client providing appropriate responses to the questions. In Phase Two, the task of the subjects became more difficult in that they were required to provide the eleven targeted responses from the first phase and, in addition, were required to recognize when the confederate client answered nonappropriately, identify the manner in which the answer was nonappropriate, and then provide an additional therapist response. Baseline Two indicated that the skills acquired from the first manual were not sufficient for use with a nonappropriate client. Manual One, therefore, did not render the subjects sufficiently trained to emit the complex responses described above. The subjects either failed to recognize the occurrence of a nonappropriate response or were unable to provide an adequate follow-up response.

The next question, then, is would a manual designed for use with a nonappropriate client prove effective? With the exception of Subjects 1 and 3, who continued to show the aforementioned deficits and thus required the addition of a feedback phase, the answer appeared to be yes. Subjects 2, 4, 5 and 6 were able to incorporate the targeted responses of Manual Two with those of Manual One to evoke an appropriate response from the difficult confederate client of Phase Two. This is important because an integral part of clinical training should include techniques designed to aid the therapist in evoking responses from the client that lead to effective treatment.

Concerning the efficacy of the examples contained in Manual One, none of the subjects receiving the manual minus the examples required the
addition of examples to reach criterion, although for Subjects 5 and 6 (who required more than three sessions to reach criterion) the addition of examples may have added to the efficiency with which the targeted skills were learned. There is a need for replication to assess the generality of this finding.

Concerning the efficacy of the examples contained in Manual Two, it is interesting to note that the only subjects requiring the addition of a feedback phase had received the manuals with examples, indicating that the inclusion of examples was not sufficient to allow them to reach criterion. It is unknown, however, what their performance would have been had they received manuals without examples. Concerning the subjects receiving Manual Two without Examples, only Subject 6 required the addition of the examples to reach criterion. For this subject, then, examples illustrating the nonappropriate responses of the client and the appropriate responses of the therapist proved helpful in learning the targeted behavior. Subject 5, who required six sessions to reach criterion, may have benefited, in regard to efficiency, by the addition of the examples. It is difficult to arrive at a conclusive answer regarding the efficacy of the examples because of the variable performance across subjects with regard to the number of sessions required to reach criterion. It appears, however, that the inclusion of examples may at least add to the efficiency in which targeted responses are learned, and in some cases may be necessary for subjects to reach an acceptable criterion.
The Feedback Phase

As previously noted, Subjects 1 and 3 required implementation of a feedback phase to reach criterion in Phase Two. For these two subjects, then, the provision of the second manual alone was not sufficient in training the more complex skills targeted in Manual Two. It is interesting to note that criterion was reached quickly after feedback was provided and the provision of feedback which occurred after each session in the feedback phase as well as after the last session that failed to reach criterion in the prior phase, required only an extra 15-30 minutes per session. Thus, it could be said that, even with the introduction of a feedback phase, the manual was efficient in training the targeted skills. The utility and efficiency of the present approach, ultimately, will be found in comparing it with more traditional, didactic approaches which, by definition, require continuous interaction between the trainer and the student. One of the purposes of the manuals was to reduce the time required for the experienced interviewer to train interviewing skills to students. Another purpose was to define interviewing skills in a concise and systematic manner, rather than relying on lectures and field experience to shape, perhaps by chance, interviewing skills. I have added the notion of accidental shaping of skills because this may be an issue if a client’s nonappropriate answer is a discriminatory stimulus for the emittance of inefficient or inappropriate responses (such as asking a barrage of closed-ended questions) by the beginning interviewer. This could be an unfortunate consequence of the "learning by doing" approach that may not
include specific guidelines regarding interactions with difficult clients. This is a corollary issue with respect to the utilization of a feedback phase, but the point here is that such a phase does not detract from the overall efficiency of the present approach.

Carroll and Monroe (1979), in a review of studies related to the training of medical interviewing skills, regard the provision of feedback as a "crucial variable." In a statement that is relevant to Phase Two of the present study, the authors conclude that "Without structured feedback from an instructor, peer, or simulated patient, these students can fail to gain any insight into the more complex interpersonal processes of the interview," (p. 498). The present study was designed in a manner that included a feedback phase only if a predetermined criterion was not reached. It is perhaps arguable that feedback for all subjects and after each session may have been the most effective approach to training interviewing skills, allowing subjects to reach optimal (i.e., criterion) performance sooner than they would without the benefit of feedback. Such an approach, however, would have obscured the delineation of the efficacy of the manuals alone.

Differences in Subjects' Performance:
Possible Explanations

As can be seen from the results, not all subjects performed equally. There are several possible explanations for performance differences.

Different levels of preparation may account for some variability. Subjects were provided with the manuals after baseline sessions. There was no test or measure of subjects' comprehension of the manuals' material prior to resumption of sessions. It is likely that each subject prepared for
future sessions in a different manner (for example, reading the manual versus reading and taking notes) and with varying degrees of effort. As will be discussed later, testing for levels of comprehension prior to the continuance of sessions may have allowed for more uniformity between subjects in each group (those receiving the manuals with or without examples). Such a procedure was not implemented for the following reason: It was desired to test the efficacy of the manuals in the least obtrusive setting as possible; that is, the provision of the manuals, wherein the subjects were instructed simply to read them, is analogous to a situation in which one attempts to learn the targeted skills "on one's own," as would be the case if one independently acquired the manuals for one's own use. The manner with which the manuals were presented was an attempt to reflect what is likely to occur outside of this study. If the manuals were utilized in an academic setting, such as an instructional tool in a class on behavioral interviewing, a diligent instructor is likely to test the students on the materials to ensure that they have read carefully. In a clinical practicum setting, however, it is possible that such materials would be provided as part of a general package and no formal testing may occur. Perhaps the latter is an example of worst case scenario, but it was desirable to test the efficacy of the manuals under these conditions. It is important to note that all subjects showed improvement after presentation of the manuals, indicating that they had read them, but they may have differed in how diligently they were studied.

Another factor which may account for performance differences is suggested by Rosenthal (1977) in a study which compared self-instruction
with the Structured Learning Approach (which included modeling, role-playing, positive feedback, and transfer training) in training counselor confrontation skills. She notes that "current research suggests that learning is maximized when different training approaches are matched with different trainees" (p. 231). Citing Hunt's notion of conceptual level (CL), defined as a "developmental hierarchy of increasing self-responsibility, independence, and ability to generate concepts" (p. 232) as a guide to deciding which training approach is most suited for particular trainees, she noted that the self-instructional approach to training was more effective with subjects scoring high on the CL measure than with those scoring low. The present study was, with the exception of the feedback phase, a self-instructional approach. It is possible that differences in performance were, in part, a reflection of differences in the behaviors referred to above as conceptual levels. One does not assume, of course, that all subjects enter a research project with equal repertoires and histories and this is one rationale for random assignment of subjects to treatment groups, as was the case in determining which subjects were to receive manuals with examples versus without examples. In the comparison of individual subjects' performance, however, differences may be due, in part, to the interaction between the self-instructional nature of this study and the past experiences each subject has had with such an approach.

Issues of Generalization

The improvement in targeted interviewing skills by the subjects was evaluated via simulated assessment interviews. As will be noted later, there
was no evaluation of these therapist skills with "real" clients. The manuals were proven effective in training the targeted skills, which were, in turn, assessed for social validation by experienced behavioral assessment interviewers. The use of the simulated interview, as stated previously, has a long history in training programs. The necessity of such an approach is particularly relevant for Phase Two of the present study. As Carroll and Monroe (1979) note, "...spontaneous interviews may fail to exhibit the expected interview behaviors, and a series of such interviews may exhibit only a limited range of the expected behaviors" (p. 498). As my own interviewing experiences, as well as the results of the social validation, have indicated, the nonappropriate responses of the client outlined in Manual Two do occur in actual behavioral assessment sessions. It is unlikely, however, that they occur in a systematic and standardized manner, as was the case during the simulated sessions in the present study. Real clients will emit a wide range of nonappropriate behaviors within and across assessment sessions, perhaps with no reliable form or frequency; thus there is a need for testing of skills in a simulated setting where the characteristics of the nonappropriate response could be standardized across sessions and subjects. Also, since nonappropriate behaviors occur with low and unpredictable frequency during real interviews, it is desirable for students to learn appropriate responses by artificially increasing their exposure to training opportunities via simulations.

This rationale is pertinent to the skills outlined in Manual Two, where the emphasis is placed on the verbal interaction between the therapist and client. Such is not necessarily the case for Manual One, which emphasized
distinct questions the therapist must emit to evoke an initial (and hopefully appropriate) response from the client. The evaluation of such skills is perhaps more readily assessed in "live" settings.

One study that tested for the generalization of acquired behavioral assessment skills with real clients was Iwata et al., (1982). This study consisted of two parts. In the first part, the authors utilized simulated interviews to assess the effects of their training program, which consisted of detailed descriptions of the targeted therapist responses as well as role-playing on interviewer responses and was thus similar to Manual One. The effects on client responses were also measured according to two dimensions: the client's provision of pertinent information and agreement with treatment suggestions. The results established the effectiveness of the training procedure and indicated a high degree of correspondence between therapist and client behavior (i.e., improvements in interviewing skills and client supply of useful information). In the second experiment of the study, the authors repeated, with few variations, the above procedure, except this time real clients, from an outpatient clinic, were involved. As was the case with the first experiment of the study, the training procedure was successful in increasing the occurrence on the targeted interviewer responses and a close correspondence between therapist and client behavior was found. The authors note that it was rare for the client to provide nonappropriate responses to the therapists' questions. Again, this points to the necessity of evaluating Manual Two in the present study within the simulated session context. Also, while nonappropriate responses may be rare, it is important for the beginning interviewer to know how to react when they do occur. As
the authors note, one limitation of their study was a lack of "a thorough analysis of behaviors related to interpersonal effectiveness, a variable that may affect clients' responding to all types of questions" (p. 201). The present study has attempted to approach such an analysis by providing a means by which the therapist may address a client with an opposing agenda (such as those who take issue with the behavioral approach). The validity of the contents of the manuals should be assessed in an actual clinical setting to determine how an actual client would respond to the rationales presented.

Improving the Present Study: Considerations

In considering possible improvements regarding the present study, it is important to note that parts of this discussion involve aspects which are "inherent" in the design and may be viewed as "necessary evils." I have already mentioned, for example, the necessity of testing the efficacy of the manuals within a simulated setting. While an effort was made to present the scripted client in as realistic a manner as possible, such settings were, by definition, contrived. For example, in Phase Two, the subjects were told (see Appendix H) that the confederate clients would periodically provide difficult responses to questions. One could argue that the subjects "expected" the confederate client to be difficult and, after the introduction of Manual Two, were prepared to respond with an appropriate therapist response. Also, subjects were acquainted with the confederates and obviously were aware of the simulated nature of the problems discussed. Such would not be the case in a live interview with a real client who is
discussing a personal problem, most often with some degree of anxiety. The stakes are higher in the latter setting and the pressure, for both client and therapist, is greater. It is most difficult to recreate this atmosphere in a simulated setting; thus, there is a need to assess generalization of skills with real clients.

Another consideration for possible improvement is the lack of focus on the introductory and closing behavior of the therapist at the beginning and end of each session, respectively. Although the manner with which a therapist begins and ends a session was discussed in Manual One, the behaviors themselves were not measured. These are, of course, vital aspects of the initial assessment interview and their exclusion here as targeted behaviors (i.e., dependent variables) should not detract from their relative importance.

Another area of improvement regards the desirability for the observers scoring for the occurrence of the targeted behaviors to be "blind" with respect to which phase in the study a particular session is occurring. Such was not the case here due to the distinct nature of the appropriate vs. nonappropriate responses of the confederate client (in Phases One and Two, respectively) as well as the level of performance of the subjects with regard to the targeted behaviors. The effects of the lack of "blindness" on the part of the observers is unknown. The high degree of interobserver agreement, however, indicates that this has not had a deleterious effect. It is possible that both observers were biased, but this may be an unavoidable problem due to the reasons noted above.
A related point regards the very nature of the dependent variables of the second phase. It was the task of the observers, as well as the confederate client during the sessions, to identify if and when the subjects emitted the targeted appropriate therapist response after receiving a nonappropriate client response. Although the targeted responses (such as empathizing, restating, etc.) were well defined in Manual Two, the decision as to whether the subject actually emitted the response was not a completely objective one. This observation is particularly pertinent when the targeted response was empathizing. Empathy may come in various forms and the observer must discern certain key features (such as the acknowledgement of what the speaker has just said) to score the response as having occurred. This results in the observer having to use his "judgement" in some cases. As was the case previously, however, the high degree of interobserver agreement indicates that the dependent variables were well defined and amenable to objective observation.

Implications for Future Research

It is hoped that the present research has established a foundation upon which future research will yield operationally defined guidelines for behavioral assessment interviewing skills. Although the area covered here has been extensive in relation to the therapist's skills in emitting the proper assessment questions and evoking appropriate responses, there are other important interviewing skills to be addressed.

As has been mentioned previously, the nonverbal skills of the therapist during the interview (such as posture, eye contact, vocal intonation,
appearance, etc.) play an integral role in building rapport with a client and most likely will have a direct influence on the manner in which the client responds to the interview process. Guidelines, in a form similar to the training manuals presented here, may prove to be cost and labor efficient, adding to the probability of a successful interview. It may be more difficult, however, to describe nonverbal therapy skills in manual form; the addition of modeling via videotape may be required.

An operationally defined guide to beginning and ending the interview should also have merit, since these are often awkward stages of the interview for both therapist and client. The manner in which one introduces oneself to the client, as well as attending to the proper point in the initial stages of the interview in which to begin the actual assessment questions, will set the tone for what is to follow. The manner in which the interview is concluded may influence the probability of return visits from the client.

The initial behavioral interview is often assumed to apply only to those situations when the presenting difficulty is readily amenable to a "simple" behavioral analysis (investigation of antecedents, consequences, etc.). Indeed, the presented problems in the present simulated interviews were designed with that particularly in mind. An experienced therapist might argue that such an approach only reaches the tip of the iceberg and that the presenting complaint is merely a component or result of a more general pathology of the system (family, peers, marriage, etc.) within which the targeted client interacts. Reflecting upon my own clinical experience, this is very often the case, but this does not preclude a behavioral analysis
within a systems framework. It is often unclear, however, how one goes about discovering hidden issues and agendas that the client may be reluctant or unable to provide. Achievement of such a thorough understanding of the client's "situation" within the present framework is perhaps the greatest challenge presented here.

Lastly, the final utility of the present, as well as future, research lies in the validity such approaches have in the actual (real) interactions between therapist and client. This issue has previously been discussed at length and shall not be repeated here.

Conclusion

The manuals presented here are meant to provide the beginning therapist with a guide to obtaining pertinent information from a client within a behavioral assessment interview framework. They are seen as a starting point, a framework upon which the complex skills related to helping can evolve, not an endorsement for a "cookbook" approach to therapy. It is often said that the provision of therapy is an art and the process of therapy is often described in mystical (vague, nonoperational) terms. While such references may add to the perceived power of the therapist, they do not promote the teaching of therapy skills to students. There is a need to operationalize what an effective therapist does so that information and skills can be passed along to therapists in training. While it is certainly true that didactic discourse, practice, feedback, and experience are integral in shaping therapeutic skills, the presented method should make the attainment of such skills much less painful, costly, and inefficient.
Appendix A

The purpose of this manual is to teach the reader to conduct a behavioral assessment interview. Ten behavioral assessment questions are presented. Each question is described, and then positive and negative examples are provided for the reader to critique.

The function of an assessment interview is two-fold: the therapist tries to create rapport with the client and tries to obtain specific information about the problem. By asking behavioral assessment questions, the therapist obtains information necessary to do a behavior analysis of the client’s problem. This manual will focus on teaching you how to ask the necessary assessment questions rather than how to establish rapport with the client. Although establishing rapport is an important function of the interview, this skill can be learned from many other sources.

In an assessment interview, the therapist typically is meeting the client for the first time and should therefore take a few minutes to make the client feel comfortable. This can be accomplished by offering the client coffee or another beverage, by escorting the client to the meeting room, and by showing the client where to sit. The therapist makes introductions, saying what he or she would like to be called, and asking the name with which the client is most comfortable. After a moment or two of social conversation, the therapist describes the purpose of the interview and tells the client what to expect in the session. The therapist explains to the client that he or she will ask a number of questions about the problem, and that
the questions may be quite detailed so that specific information can be obtained. This information is necessary in order to fully understand the problem and to develop a treatment program for the problem. The therapist should solicit any questions the client might have about the interview at this time. Also at this stage, the therapist asks general questions about the client’s background (i.e., living arrangement, job, school, family, etc) in order to get acquainted and to be able to put subsequent assessment information in the context of the client’s life. After this preliminary state of the interview, the therapist begins the behavioral assessment part of the interview. The assessment is conducted by asking the set of behavioral assessment questions to be described next.

Before moving to the specific assessment questions, you should understand the difference between open-ended and close-ended questions, since open-ended questions are an important component of each of the assessment questions you will learn.

**Open-ended Questions**

Since the main purpose of the assessment interview is to derive useful information about the client’s problem, a therapist should ask the types of questions which produce the most information. Open-ended questions do this by asking the client to talk about, to describe, or to explain something. In response to an open-ended question, the client provides information.

A closed-ended questions, on the other hand, requires simply a "yes" or "no" answer, or requires the client to choose between different examples
provided by the therapist. With a closed-ended question, the therapist provides information and asks if it is accurate or true, whereas with open-ended questions, the client is asked to provide information.

Some examples of open-ended questions follow:

**Therapist:** What happens when you lose your temper?

**Client:** Well, I start to lose control and yell at people and sometimes I even throw things. I never get violent with people though; I would never hit anybody.

**Therapist:** Would you describe situations in which you lose your temper?

**Client:** It usually happens when I'm under stress, like when I'm rushing or when things aren't going right. People set me off, too, when they don't do things right.

**Therapist:** How do you react to people when you are angry with them?

These questions are all open-ended. Each question asked the client to describe or talk about this behavior and the situations related to it. Each one required the client to provide information. None of these questions could be answered with a simple "yes" or "no" answer by the client.

Contrast these questions with the following closed-ended questions.

**Therapist:** Do you outwardly show your anger when you lose your temper?

**Client:** Yeah, I guess I do, usually.

**Therapist:** Are you ever physically violent with others when you lose your temper?

**Client:** No, never.
**Therapist:** Do you get verbally abusive, like raising your voice or yelling at people?

**Client:** Yes, I yell at people when I’m upset.

In response to each of these closed-ended questions, the client could merely respond with a "yes" or "no" answer. The therapist made assumptions about the problem and asked the client whether or not they were accurate. Besides possibly offending the client by putting words in his or her mouth, this is an inefficient way to derive information since the therapist must guess about the relevance of each closed-ended question to the client’s problem. The client is the person experiencing the problem and should therefore be the one to describe it in response to open-ended questions. One open-ended question asking the client to describe what happens will typically yield more information than many closed-ended questions where the client answers "yes" or "no" to your assumptions about the problem.

You now have an understanding of open-ended questions and the preliminary stage of the interview in which the therapist describes the session and tries to make the client comfortable. Presented next are the behavioral assessment questions necessary to conduct the assessment phase of the interview.

The reader is encouraged to take notes while reading this manual in order to aid in understanding and recalling the main points.
Asking for a General Description of the Problem

Since the purpose of the assessment is to gather information about the client's problem, the therapist starts with a question asking for a general description of the problem. This question must be open-ended. It functions to get the client to identify the problem and start talking about it. Asking for a general description of the problem can be done directly: for example, "Would you describe the problem for me?", or it can be stated more indirectly: For example, "Can you tell me what brings you here today?" In either case, you want the client to start talking about the problem in response to your opening questions.

In summary, two criteria must be met when asking for a general description of the problem:

1. The therapist uses an open-ended question
2. Asking the client to start talking about the problem.

An example follows:

*Therapist:* What would you like to talk about today, Susan?

*Client:* I'm having some problems with my boyfriend, Ron. We seem to be fighting a lot more than we used to, and it really upsets me.

Another good example might be:

*Therapist:* Now that we have discussed the purpose of this meeting, would you tell me about the problem which has brought you here today?

Each of these questions was open-ended and each asked the client to start talking about the problem. The response to such questions will give
the therapist an indication of the problem area so that he can formulate more specific questions and continue the assessment.

Provided next is a negative example of a therapist asking for a general description of the problem. Observe this example and determine why it is done incorrectly.

Therapist: It says on the intake sheet that you are concerned about fighting with your boyfriend, is that right?

Client: Yes, that's what I'm here for.

Here the therapist did not use an open-ended question. Rather, he asked a "yes" or "no" question about the problem. The client was not asked to start talking about the problem, but merely to verify the accuracy of the therapist's statement. Next is another negative example of a therapist asking for a general description of the problem. Look at this example and decide what is wrong with it.

Therapist: To start with, Susan, would you describe a little bit about yourself, such as your current living situation, your job, and your family?

Client: Okay, right now I live in an apartment with three girlfriends from school. We're all seniors. I'm a social work major. My only job is typing papers for people since I have a full load of classes. My family is in Illinois; I make it there three or four times a year.

In this case, the therapist used an open-ended question, but did not really ask the client to start talking about the problem. Rather he asked for background information on the client. Although background information is
useful, the start of the assessment should focus on the problem since that is the reason the client is there.

To summarize:

The therapist starts the assessment with a question asking for a general description of the problem.

To do this:
1. The therapist uses an open-ended question that
2. asks the client to start talking about the problem.

Before moving to the next assessment question, it should be noted that a particular question topic is not complete until the client answers the assessment questions with relevant information. Whenever the client does not answer an assessment question, or answers with irrelevant information, the therapist should rephrase the question and ask it again. The value of each type of assessment question ultimately depends on whether the client answers it with relevant information.

Probing for Other Problems

Now that the therapist has started the assessment and has a general idea of the problem area, he or she should probe to see if other problems exist. To probe for other problems, the therapist can ask the client such questions as, "Is there anything else that's bothering you?" or, "Are there other problems you'd like to talk about?" Each is a closed-ended question, but in response, the client will acknowledge whether or not another problem exists. If the client answers "yes", the therapist then asks for a
description of the problem. After the client talks about the problem, the therapist should again ask if other problems exist until the client says "no" or indicates that any remaining problems need not be addressed in therapy.

In summary, then, to probe for other problems, the therapist:

1. Asks whether other problems exist.
2. If yes, asks the client to describe the problem.
3. The therapist then asks again if other problems exist until the client says "no".

An example follows:

**Therapist:** Susan, you’ve described the trouble you’re having fighting with Ron. Before we talk more about that, is there anything else you want to talk about?

**Client:** Well, I am having a pretty bad semester grade-wise; it’s starting to give me a little anxiety.

**Therapist:** Would you tell me more about that?

**Client:** This semester, I am barely pulling a C or D average. It’s the first time my grades have ever gotten below a B.

**Therapist:** So you’re also worried about the problem with your grades this semester. Is there anything else you’d like to talk about in addition to grades and the fighting with Ron?

**Client:** No, everything else seems to be going okay.

In this example all the criteria were met. The therapist asked if other problems existed, asked the client to describe the problem, and then asked if there were still further problems until the client said no. If only one problem area had been identified, the therapist would have continued
with the assessment by asking for a description of the behaviors involved in the problem.

Next is a negative example in which the therapist attempts to probe for other problems. Look at this example and decide what is wrong with it.

_Therapist:_ Is there anything else that’s bothering you, Susan, besides the fighting?

_Client:_ Yes, my grades in school are pretty bad this semester. I really need to get them up.

_Therapist:_ Okay, then what would you like to work on first?

In this example, the therapist does start off by asking if any other problems exist. He then asks the client for priority without first asking her to describe the problem or asking if any other problems exist.

Next is another negative example of a therapist probing for other problems. Determine why it is done incorrectly.

_Therapist:_ You’ve talked about your fighting with Ron, are there any other problems you’d like to deal with?

_Client:_ Yes, my grades in school are pretty bad this semester.

_Therapist:_ Would you like to tell me a little more about that?

_Client:_ I just seem to be getting C’s and D’s where I used to get all A’s and B’s. It’s starting to get me worried.

_Therapist:_ I can imaging that is upsetting, so let’s focus on that problem first. Would you try to talk about what’s contributed to your falling grades?

Here the therapist asked if other problems existed and asked the client to describe the problem when she said “yes”. However, he did not ask
for further problems, so he does not know if the client has identified everything that is troubling her. Also, the therapist decided on the priority problem. This is the client’s responsibility.

When probing for other problems, the therapist determines the range of client complaints or presenting problems by asking if other problems exist until the client says no. The therapist also forces the client to think about each of the problems mentioned by asking for a description.

In summary then, the criteria which must be met when probing for other problems include:

1. The therapist asks whether other problems exist and
2. if so, asks the client to describe the problem.
3. The therapist then continues to ask whether other problems exist until the client says "no".

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Asking the Client to Set Priority

Having just asked the client to identify and briefly describe all the problems to be addressed, the therapist should now ask which problem has the highest priority. To set priority, the therapist summarizes the problems identified and asks the client to decide which problem to address first. Asking the client to decide on priority must be an open-ended question. It would not be appropriate for the therapist to tell the client which problem has the highest priority. If asked for an opinion, the therapist may offer advice on the pro’s and con’s of working on one problem versus another, but should leave the decision to the client.
In summary then, to set priority the therapist:

1. Summarizes the problems identified by the client.
2. Uses open-ended questions
3. to ask the client which problem to work on first.

An example follows:

**Therapist:** You have identified two problems, the fighting with Ron and your low grade average this semester. Which one should we address first?

**Client:** Oh, the fighting with Ron, without a doubt. It’s making me miserable. In fact my grades might just get better naturally if I can get settled with Ron.

In this example, the therapist first **summarized the problems**, and then used an **open-ended question to ask which problem the client wanted to address first**. The client responded by stating which problem had the highest priority.

Next is an example in which the therapist attempts to set priority, but does not meet all the criteria. Observe this negative example and determine why it is done incorrectly.

**Therapist:** Susan, you have identified fighting with Ron and your falling grades as two problems you’d like to work on. Why don’t we start by trying to get your grades back up?

**Client:** Okay, but I also want to get things straightened out with Ron soon, too.
Here the therapist summarized the two problems, but then went on to set priority himself by deciding which problem to address first. He did not ask the client which problem she wanted to work on first.

Next is another negative example.

*Therapist:* Susan, which problem would be most important for us to deal with?

*Client:* I don’t know, they’re both upsetting.

*Therapist:* Yes, I’m sure they are. Why don’t we try to work out your fighting with Ron first?

*Client:* We just end up getting mad at each other.

*Therapist:* Okay...What is it that’s said or done that causes you to get upset?

*Client:* Oh, Ron just doesn’t understand the things I say or what I’m going through.

*Therapist:* I see...so tell me Susan, what do you say that Ron doesn’t understand?

*Client:* You know, things are going bad with school and I try to talk about the problem when I see Ron. I just want to tell him how bad I feel, but I don’t think he cares.

*Therapist:* You don’t think Ron is concerned? Why? What does he say?

*Client:* He calls me a complainer. Sometimes he tells me to quit bitching or to shut up about school.

*Therapist:* I see...then what happens?

*Client:* I yell at him and say he doesn’t care about me or something like that, or we argue or bitch at each other.
In this example, the therapist got a problem description from the client by asking such questions as, "What goes on when you fight?", "What do you say?", "What does he say?", or "Then what happens?" Each of these questions asks for a description of behavior. Each was open-ended. In response to them the client described behaviors involved in fighting. Thus the questions were appropriate and the client provided relevant information.

Presented next is another example of a therapist asking for a description of the problem behaviors. This is a negative example because the therapist does not execute the skill correctly. Look at this example and determine why it is done incorrectly.

*Therapist:* Tell me Susan, do you yell a lot when you fight with Ron?

*Client:* Yeah, we usually do raise our voices with each other.

*Therapist:* I see...and are you the one who usually starts the fighting?

In this case the therapist did not summarize the problems before asking for priority. Also, after using an open-ended question, but failing to get an answer, the therapist chose priority rather than the client. The therapist should restate questions asking for priority until the client can decide, since only the client can identify which problem causes the most distress and thus needs to be addressed first.

In summary then, the criteria which must be met when setting priority include:

1. The therapist summarizes the problems and
2. uses open-ended questions
3. to ask the client which problem to work on first.
Asking for a Description of Problem Behaviors

Once the client has identified the problems and decided which one to work on first, the therapist should ask questions which direct the client to talk about that problem in terms of specific behaviors. The therapist should ask the client to describe the problem behaviors in concrete terms. To describe her problem behavior, the client should state how she is acting, what she is saying or doing, exactly what the behavior is in which she engages.

If the client does not provide specific information about the problem behaviors, the therapist should continue to ask for specifics until he gets this information. If she still has trouble providing a description of the behavior, the therapist can also ask the client to describe a recent example.

In summary then, two criteria must be met when asking for a description of the problem behavior:

1. The therapist uses open-ended questions and
2. asks for a description of specific behaviors.

An example follows:

**Therapist:** Would you talk about what goes on when you fight with Ron?

**Client:** Not really, Ron usually starts it.

**Therapist:** Okay, have you ever tried to stop it once Ron starts a fight?

**Client:** I’d like to, but we both get caught up in it.

In this example, the therapist used all closed-ended questions, rather than open-ended questions. He did not ask the client to talk about or describe behavior. Rather he asked whether or not certain behaviors were
occurring. Usually this approach will severely limit the amount of information the client provides about the problem behaviors.

Provided next is another example in which the skill is not executed correctly. Determine why it is done incorrectly.

*Therapist:* This fighting with Ron sounds like it would be upsetting. How does it make you feel, Susan?

*Client:* Well of course it upsets me. I guess I feel sort of helpless. You know we just keep fighting, but I don’t really want to.

*Therapist:* Okay, so you feel helpless in this situation. How often do you feel this way?

*Client:* Oh, just now and then when I think about the fighting and how I wish we could stop it.

The skill was not executed correctly because the therapist never asked for a description of behavior. He asked how the client feels about the problem, but he did not ask her what behaviors were involved in fighting. Although the client’s feelings are important, the objective of this assessment question is to get a description of the problem behaviors. Therefore, the therapist should ask questions directed at this and continue until a description of the problem behaviors is provided.

To summarize, when asking for a description of problem behaviors, the therapist:

1. Uses open-ended questions
2. and asks for a description of specific behaviors until the client provides a description.
It should be noted that it usually takes a number of different questions before a topic is thoroughly covered in session. For example, when asking for a description of problem behaviors, the therapist may not feel the information is adequate until the client has responded to a variety of questions with ample descriptions of the behaviors involved. A therapist should cover each assessment area thoroughly, asking as many questions as necessary to get a complete description from the client.

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**Asking for the Relevant Dimensions**

The client has already described the problem behaviors, so the therapist should now ask about the relevant dimensions of the behaviors. A therapist will usually ask for the frequency and duration of problem behaviors, but magnitude and latency can also be important dimensions. Information on the dimensions of a problem is important because it can indicate how serious the problem is. For example, we might consider a young child’s tantrums more serious if they occur five times a week for 60 minutes at a time, rather than once a month for 5 minutes. Also by assessing the dimensions of the problem, the therapist can observe any changes in the behavior once treatment is implemented.

When asking about the dimensions of a problem behavior, the therapist uses open-ended questions and asks about the dimensions most relevant to the behavior. Frequency and duration are relevant when the therapist wants to know how often or for how long the behavior occurs. Magnitude is relevant when the intensity of the behavior is important. The
therapist asks about the latency to discover how long it takes from the occurrence of some stimulus to the onset of the response. Often the problem behavior has more than one relevant dimension, so the therapist may have to ask a number of different questions about the dimensions.

In summary, two criteria must be met when asking about the dimensions of the problem behavior:

1. The therapist uses open-ended questions
2. and asks about the relevant dimensions, either frequency, duration, magnitude or latency.

An example follows:

Therapist: How often do you get into these arguments with Ron?
Client: It seems like every time we're together we end up fighting. So it must go on 3 or 4 times a week.
Therapist: You see Ron 3 or 4 times a week and fight with him each time you see him?
Client: Yes, that's how bad things have gotten.
Therapist: Okay, can you tell me about how long your fights usually last?
Client: Anywhere from a few minutes to a half-hour. I guess it depends on how stubborn we are.

In this example the therapist used open-ended questions to ask how often the behavior occurred as well as how long the behavior lasted. Answers to these questions provided information on the relevant dimensions, frequency and duration. Thus both criteria were met: the therapist used open-ended questions and asked about the important
dimensions of the problem behavior. The client then responded to these questions with information about the frequency and duration of fighting.

The following is a negative example.

**Therapist:** How does this frequent fighting affect you, Susan?

**Client:** Of course it upsets me. I feel awful after we've had a fight.

**Therapist:** I can imagine it must be upsetting. Have you discussed your feelings with Ron?

**Client:** Yes we've tried to talk about it, but we don't get anywhere.

This was a negative example because the therapist did not ask about the dimensions of the problem. He did not ask about frequency, duration, magnitude, or latency; rather, he asked about the client's feelings. Next is another negative example.

**Therapist:** Do you and Ron get into these fights very often?

**Client:** Yes, it seems like all the time.

**Therapist:** Do you fight with him every time you're together?

**Client:** Yes, just about every time.

In this example the therapist used closed-ended questions. He asked "yes" or "no" questions about how often the problem occurred. The client did not respond with any specific information about the frequency, rather she merely confirmed the therapist's assumptions. Closed-ended questions can be particularly annoying to the client when the therapist's assumptions are not accurate. The therapist does not have to make assumptions to ask open-ended questions. Rather he puts responsibility on the client to provide that information.
Once again, two criteria must be met when asking about the dimensions of the problem behavior.

1. The therapist uses open-ended questions
2. and asks for the relevant dimensions: frequency, duration, magnitude, or latency.

Asking About Correlated Verbal Behavior

Up to this point, the therapist has gotten information on the client's problems, the problem to be addressed first, the specific problem behaviors, and the dimensions of the problem. It is now important to assess the client's correlated verbal behavior, his or her thoughts, or self-talk, related to the problem.

Information on the problem behavior and controlling variables is often incomplete without a description of the client's self-directed verbal behavior. What the client thinks or says to himself or herself may be related to the problem behavior in a number of ways. The client's self-talk may be part of the problem; for example, obsessive thoughts or negative self-statements. Self-talk may function as an antecedent to the problem, as in the case of self-instructions or rules; or it may function as a consequence when the client makes self-reinforcing or punishing statements.

When asking for correlated verbal behavior, the therapist may ask the client such questions as "What are you saying to yourself?", "What are you thinking?", "Can you remember the thoughts you were having?", or "What were you telling yourself at the time?" Each of these questions
prompts the client to describe covert or overt verbal behavior which may be related to the problem. In some cases clients may have difficulty remembering their thoughts on specific occasions. In such cases the therapist may rephrase questions, and if the client still cannot remember, the therapist may provide examples in an attempt to prompt the client's recall. For example, "I know it's often hard to remember your specific thoughts. I've found that people in your situation sometimes have thoughts like.....Are you thinking anything like that?" The two criteria which must be met when asking for correlated verbal behavior are:

1. The therapist uses open-ended questions
2. to ask what the client is thinking before, during, or after the problem occurs.

An example follows:

*Therapist:* Susan, can you recall what you are thinking as you argue with Ron?

*Client:* I don't think I'm really thinking about anything. Once we start arguing or fighting I don't really think about it, it just happens.

*Therapist:* Okay, once you start fighting you don't really think about what you're saying. How about before a fight starts; can you recall what you are thinking about or saying to yourself?

*Client:* Well...Usually on my way over to Ron's I'm kind of down on myself for my grades. I guess I'm just thinking about how bad I'm doing this semester and how I might flunk, and I get kind of overwhelmed thinking of the work it would take to pull B's
out of this semester. And sometimes I'll get mad at Ron even before I see him because he doesn't even try to understand me when I'm upset about school.

*Therapist:* It sounds like you're thinking some negative or depressing thoughts about school before you see Ron.

*Client:* Yeah I am, and then when I see Ron I end up talking about it. Whining, Ron calls it.

*Therapist:* And as you said earlier, that's when the fights usually start. Let's shift gears and consider what occurs after a fight. What kind of thoughts do you have at that time?

*Client:* Well, usually I don't think about it afterwards. But, maybe the next day or even later, I'll think about how bad I feel when we fight. I worry that it's going to break us up. I guess I really let it get me down sometimes.

In this example, the therapist used *open-ended questions* and asked about the client's thoughts related to the problem, fighting. In this case the therapist asked what the client was saying to herself or thinking before, during, and after the fighting. Thus the therapist asked appropriate questions and the client responded with information about her thoughts.

Next is a negative example.

*Therapist:* Susan, how do you feel as you are fighting with Ron?
Client: Usually, I'm feeling angry when we fight. You know how upsetting a hassle can be.

Therapist: Yes, it can be very upsetting. How do you feel then, after a fight?

Client: Well, I'm still upset and angry if we don't make up. Otherwise, I feel pretty happy if we can make up after the hassle.

In this example, the therapist did use open-ended questions but did not ask about the client's thoughts or verbal behavior. Rather, the therapist asked about her feelings. This can provide useful information about the client's physiological or emotional responding but it does not fit the category of client verbal behavior.

Next is another negative example.

Therapist: Susan, do you think about fighting with Ron before you get together with him?

Client: Oh, sometimes but not usually right before we get together.

Therapist: How about after a fight; do you ruminate about it and make it worse for yourself?

Client: No, I may think Ron's a jerk, but I don't ruminate over the fight itself.

In this example, the therapist used closed-ended questions. He did not ask the client to describe what she was thinking, but rather asked whether she thought specific thoughts. These questions would only be appropriate after a number of open-ended questions were tried and the client failed to respond to them. Even then, closed-ended questions should
be posed tentatively as examples of what the client might be thinking in the situation. For example, "You seem to be having trouble recalling your thoughts in that situation, are you thinking...?" The client can respond "yes" or "no" to your examples which might then help the client recall her own thoughts.

In summary, the two criteria to be met when asking for correlated verbal behavior are:

1. The therapist uses open-ended questions and
2. asks what the client is thinking before, during, or after the problem occurs.

Clients often have difficulty recalling their thoughts in problem situations, since many people are not aware of what they are thinking at a particular point in time. Therefore the therapist should take time to ask a number of questions to help the client remember and describe what she is thinking in relevant situations. If the client still cannot remember, the therapist may ask the client to record her thoughts for use in the following session.

Asking about the Onset of the Problem

Up to this point the client has identified and described the problem in some detail. It is useful now to determine when the problem first started and whether any other events were correlated with the onset. This information can provide clues to the possible causes of the problem.
Three criteria must be met when asking about the onset of the problem:

1. The therapist uses an open-ended question to
2. ask when the problem first began and
3. then asks if any other events were associated with the onset.

An example follows:

**Therapist:** When did you first start fighting with Ron like this?

**Client:** Seems like it really all started at the beginning of the semester.

**Therapist:** Was anything else happening about that time that may have been related to the fighting?

**Client:** I don’t know. That’s when I moved into the apartment with my friends. Before then I was living in the dorm. Moving was the only thing that changed then except for the start of the new semester.

In this example, the therapist used an open-ended question and asked when the problem first started. He then asked if other events were associated with the onset. In response to these questions, the client provided relevant information.

Next is a negative example. Look at this example and determine why it is done incorrectly.

**Therapist:** Did your fighting with Ron start recently?

**Client:** Yeah, it hasn’t been going on too long.
In this example, the therapist used a closed ended question and thus did not get very specific information. He also failed to ask about events associated with the onset of the problem. Next is another negative example.

**Therapist:** When did your fighting with Ron become a problem?

**Client:** I think it was about two months ago. Yeah that's right; we started to fight a lot just when this semester started.

Here the therapist used an open-ended question to ask when the problem began, but did not ask about other events that may have been associated with the onset of the problem. The therapist should ask for events associated with the onset to try to get clues about the causes of the problem.

To correctly ask about the onset of the problem, a therapist must:

1. Use an open-ended question to
2. ask when the problem began and
3. then ask if other events were associated with the onset.

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**Asking for Antecedent Conditions**

Once the therapist has gathered descriptive information about the problem, he or she should then focus on potential controlling variables: the antecedents or consequences to the problem behavior. Antecedents are events including the behavior of others, which occur immediately before the problem behavior. The situation in which the problem occurs, the actions of other people or the client's own thoughts or actions, may be important antecedents. When asking for antecedents, the therapist uses open-ended
questions and asks the client to describe what occurs just prior to the occurrence of the problem. After receiving this information, the therapist should then ask under what circumstances the problem does not occur. Knowledge of the circumstances under which the problem does and does not occur will contribute to the analysis of the problem.

The three criteria which must be met when asking for antecedents include:

1. The therapist uses open-ended questions and
2. asks what occurs just before the problem behavior.
3. The therapist also asks under what circumstances the problem does not occur.

An example follows:

Therapist: Susan, can you tell me what usually happens just before you fight with Ron?

Client: Pause...Well, it's usually when I go over to his apartment.

Therapist: Okay, so you usually fight when you're at Ron's?

Client: Yeah.

Therapist: Can you think of anything in particular that happens when you're with Ron that leads to a fight?

Client: I've been getting in bad moods lately about my grades in school. I guess I'm in a bad mood a lot when I see Ron.

Therapist: What do you do when you're in a bad mood?

Client: I either sulk or I'm short-tempered and snap at Ron. I guess I've been doing that a lot lately. Ron doesn't like it either.

Therapist: Is this what usually happens before you have a fight?
Client: Yes, it is.

Therapist: If you usually fight at Ron’s when you are sulking or short-tempered, in what circumstances do you not fight with Ron?

Client: We don’t fight in public, like if we go out someplace.

Therapist: Any other circumstances?

Client: Even at Ron’s place, if there is someone else there we won’t fight.

This was a positive example because the therapist used open-ended questions and asked the client what happens before she engages in the problem behavior, fighting. He asked for antecedent until the client provided specific information about them. The therapist then asked for the circumstances in which the problem did not occur.

Presented next is a negative example of a therapist asking about antecedent events. Determine why it is done incorrectly.

Therapist: Would you say that it’s you or Ron who usually starts the fighting?

Client: I don’t know. The fights just seem to happen.

Therapist: Do you fight with Ron in public or do you keep the fighting private?

Client: It’s always in private.

In this example the questions were closed-ended. The therapist did not ask for information, but rather asked the client to choose between two alternatives that he provided. Open-ended questions which require the client to describe something usually result in more useful information.

Another negative example follows:
Therapist: Susan, would you describe what happens just before you and Ron start fighting?

Client: Well, I guess I’ve been in some cranky moods lately about my grades. I’m sure it must affect how we get along.

Therapist: Your mood certainly can influence your actions. Can you think of how you act when you’re in that mood before a fight with Ron?

Client: I’m either feeling sorry for myself and complaining about school or sometimes I’m short-tempered and then I can get nasty at Ron or get sarcastic.

Therapist: So you’re saying that before a fight starts you’re either complaining about school or else you’re short-tempered or sarcastic.

Client: Yeah, that’s what usually happens.

Here the therapist asked good open-ended questions about what happened before the fighting and the client provided that information. However, the example was not complete. The therapist should also have asked under what circumstances fighting did not occur in order to get a complete picture of the antecedent conditions.

To summarize, when asking for antecedent conditions:

1. The therapist uses open-ended questions to
2. ask what occurs just before the problem behavior
3. and asks under what circumstances the problem does not occur.
Asking About the Consequences

Besides requesting information on the antecedents to the problem behavior, the therapist should also ask about the consequences. Together the antecedents and consequences may comprise the controlling variables for the problem and are thus important for a behavior analysis of the problem. The consequences include those events which occur immediately after the problem behavior. Relevant consequences may include the behavior of others, environmental events, activities or any physical changes in the environment resulting from the behavior. The client's own thoughts or actions may also function as consequences for the problem behavior.

When asking for the consequences, the therapist
1. Uses open-ended questions and
2. asks the client what occurs immediately after the problem behavior.

The therapist should continue to ask such questions until the client provides information about the consequences.

An example follows:

*Therapist:* Susan, I'm interested in the usual consequences for your fighting with Ron. Can you think of what usually happens after you've had a fight?

*Client:* Well, after we've argued or yelled at each other for a while, sometimes I get upset and start crying.

*Therapist:* And then what happens?
Client: Well, usually I’m upset for a while, but then we make up and we both say we’re sorry, and we hold each other for a while. Things are better after we make up.

Therapist: I’m sure they are. Does it always happen this way, you get upset and cry and then you both make up?

Client: No, not always. Sometimes I just get mad and leave, or don’t talk much the rest of the evening.

Therapist: So you usually make up and hold each other after a fight, but sometimes you leave while you’re still angry, or you quit talking?

Client: Yes, that’s how it happens.

This was a good example because the therapist used open-ended questions to ask what happened immediately after the problem behavior, fighting. He continued with the questions until he got clear information from the client about the consequences. Of course, even further questions could have been asked, such as, "What do you say when you make up with each other?", or "How physical do you get when you hold each other after a fight?", or other questions to help pinpoint the specific details of their actions.

Next is a negative example of the therapist asking about the consequences. Determine why it is incorrect.

Therapist: Susan, would you describe the types of activities that you and Ron do together for fun?

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Client: We go to the bar and to parties together. Sometimes we just watch T.V. We enjoy sleeping together. And we play softball on the same team.

In this example the therapist asked important questions about reinforcing activities, but he did not talk about the consequences of any behavior. To ask about consequences, the therapist should ask what occurs after a specific behavior.

Next is another negative example.

Therapist: Do you usually get upset after a fight with Ron?
Client: Oh yes, these fights are always upsetting.
Therapist: Do you try to talk to Ron after a fight to see what you can do to keep them from occurring?
Client: Not really, usually I'm too upset to talk rationally about things.

Here the therapist asked about consequences, but used closed-ended questions. Instead of the closed-ended questions, "Do you get upset?" and "Do you try to talk to Ron?", the therapist could have asked open-ended questions about events occurring immediately after a fight. In each case, the closed-ended questions produced a yes/no answer, whereas open-ended questions ask the client to provide information.

In summary, when asking for the consequences to the problem behavior, the therapist:
1. Uses open-ended questions and
2. Asks what happens immediately after the problem behavior.
Asking for Goals

One important component of the assessment interview is to get a clear statement of the client's goals. By stating his or her goals, the client tells you exactly what he or she wants to change about the problem. The treatment program is developed to achieve the client's goals.

When asking for goals, the therapist should ask for the specific changes in behavior desired by the client. Goals should be stated in objective terms indicating the behavior change and the performance criterion. The performance criterion identifies the exact change in behavior desired by the client. With a clear criterion for the desired behavior change, both the therapist and the client can evaluate whether the goal was achieved.

In summary when asking for the client's goals, the therapist must:

1. Use open-ended questions to
2. ask what behavior changes the client wants to accomplish
3. and the desired performance criteria.

An example follows:

Therapist: Susan, we've talked about your problem fighting with Ron, can you tell me now, just what you'd like to see changed?

Client: I want to stop yelling and arguing. When we disagree, I want to talk calmly about things. I don't want to say things that get us angry at each other.
Therapist: Fine, that’s very clear. And you say you want to stop those things altogether?

Client: Yes.

In this example the therapist used open-ended questions to ask what changes the client wanted to make. He further asked the client to state her goal in terms of specific behavior change. The client stated a criterion when she said she wanted to stop fighting altogether and the therapist confirmed the criterion. With the client’s goal stated clearly, both client and therapist can determine when the goal is met.

Provided next is a negative example.

Therapist: Susan, what would you like to accomplish by working with me?

Client: I really want to get along with Ron and feel better about myself and our relationship.

In this example, the therapist did not ask for the specific behavior changes desired by the client. He asked what the client wanted to accomplish, but did not follow-up with a question about specific behaviors or the desired performance criteria.

Next is another negative example.

Therapist: Susan, would you like to change your moodiness and quit sulking or snapping at Ron? I think that might help prevent the fighting.

Client: Sure, if that will change things for us.

In this case the therapist used a closed-ended question. He suggested the goal for the client and asked for her approval. He did not provide the
client with the opportunity to formulate her own goal. The client is experiencing the problem and should thus be the one to decide what changes she wants to make.

In summary, when asking for the client's goals:
1. The therapist uses open-ended questions
2. asks what behavior changes the client desires
3. and the performance criteria.

Asking About Prior Therapy Attempts

Before completing the assessment interview and devising a treatment program, it is important to assess the client's past treatment attempts. Information regarding treatments the client has previously tried will be valuable when developing the current treatment program.

When asking about specific past attempts, the therapist may start with closed-ended questions, such as "Have you sought professional help concerning this problem in the past?" If the client answers "yes", an open-ended question should follow; for example, "Tell me about your past experiences in dealing with this problem." Besides asking about professional help, ask how the client has dealt with the problem in the past.

In summary, when asking about prior treatment attempts, the therapist must:
1. Ask if prior treatment attempts have been made.
2. If the answer is "yes", then use open-ended questions to
3. ask for a description of past attempts.
An example follows:

Therapist: Susan, can you describe any prior attempts you and/or Ron have made to stop arguing and yelling at each other?

Client: Well, I've discussed the problem with my psychology professor.

Therapist: What was his advice?

Client: He said that we should make rules on how to have a fair fight, such as no yelling or insulting.

Therapist: What happened then?

Client: We tried to follow the rules, but ended up breaking them anyway.

Therapist: In what other ways have you tried to solve the problem?

Client: That’s about it, really.

In this example, the therapist uses a closed-ended question to ask if any attempts have been made in the past to deal with the problem. Once the client answered affirmatively, open-ended questions were used to determine the nature of these past attempts. The therapist then asked if any further attempts were made until the client answered "no."

Provided next is a negative example:

Therapist: Susan, is there any type of therapy that you or Ron object to trying?

Client: I don't think that Ron would want someone working with us on this problem outside of this office.

Therapist: So no home visits, for example.

Client: That’s correct.
In this example, the therapist asks the client about objections to possible strategies for treatment. This is not an unreasonable question to ask when devising treatment plans, but it is not pertinent to the question prior to treatment.

Another negative example follows:

*Therapist:* Susan, have you or Ron seen anyone concerning this problem before?

*Client:* Well, I've talked about this problem with my psychology professor.

*Therapist:* Did he help you with the problem at all?

*Client:* He tried, but our fighting seemed to get worse, if anything.

In this example, the therapist asks only closed-ended questions, thus never obtaining specific information concerning prior attempts in dealing with the problem.

In summary, when asking for the client's prior treatment attempts, the therapist must:

1. Assess whether prior treatments have been made
2. and, if the answer is "yes", used open-ended questions to
3. ask for a complete description of the past attempts.

**Summary**

When all eleven assessment questions are used appropriately in an interview, they should produce the information needed to do a behavior analysis of the client's problem. Based on this analysis, the therapist can then develop a treatment program to achieve the client's goals.
The eleven assessment questions presented in this manual are:

1. Asking for a general description of the problem.
2. Probing for the existence of other problems.
3. Asking the client to set priority.
5. Asking about the relevant dimensions.
6. Asking about correlated verbal behavior.
7. Asking about the onset of the problem.
8. Asking for antecedent conditions.
9. Asking about the consequences.
10. Asking for the client's goals.
11. Asking about prior treatment attempts.

Since the assessment interview is an active and direct encounter with the client aimed at collecting assessment information, the value of each question is determined by the information the client provides in response to it. Therefore, if a client fails to respond to a particular assessment question, the therapist should restate the question or ask similar questions until the client is able to provide relevant information.

The order in which these assessment questions are asked will vary with the types of information the client is providing. However, the order they are presented in this manual is a reasonable guide to follow. The assessment always starts with a question asking for a general description of the problem, and then it moves on from there. Often, the therapist may ask for particular assessment questions and then return to it later in the interview if more information or detail is needed. Each area of assessment
should be covered until clear and thorough information is provided; and this may require the therapist to ask quite a few questions in some areas.

Upon entering the assessment interview, the therapist should bring an outline or checklist in order to remember to ask each of the assessment questions. It is perfectly reasonable for the therapist to take notes as the client answers questions in order to keep track of the information being provided. This can help the therapist determine which questions to ask next.

The therapist must remember the following guidelines during the interview:

1. Provide the client time to answer each question. Don’t fire questions rapidly or answer questions for the client.
2. Don’t interrupt the client (unless extremely necessary because of long, rambling, or off-subject answers by the client).
3. Maintain a good level of eye contact: Don’t stare at your notes, but don’t stare at the client either.
4. Provide a friendly, reinforcing atmosphere. Praise the client for answering questions and being cooperative. Smile when appropriate.
5. Nod your head and provide other sorts of feedback when the client is answering questions. Saying “um hum”, and briefly summarizing client answers occasionally indicates to the client that you understand what is being said.
6. When you are finished with the interview, inform the client that you are through asking questions, and thank the client for participating.
Appendix B

Subject Scoring Sheet
Appendix B

Subject _____________________ Date ___________ Observer _____________
Primary ________________ Reliability __________ ( % ) Client I.D. _________
Phase __________________________ Session ________________________

1. **General description of Problem:**
   Uses open-ended questions to ask for general description of problem.

2. **Other problems:**
   Asks if other problems exist.
   Asks if other problems exist until client says "no".

3. **Priority:**
   Summarizes problems
   Open-ended question to ask for priority

4. **Problem behaviors:**
   Open-ended question asks to describe problem behaviors

5. **Onset:**
   Open-ended questions to ask about onset
   Events associated with onset

6. **Correlated verbal behavior:**
   Open-ended question asks about client verbal behavior
7. \textbf{Antecedents:}

Open-ended question asks about antecedents

Situation where problem does not occur

8. \textbf{Consequences:}

Open-ended question asks about consequences

9. \textbf{Dimensions:}

Open-ended question asks about:

- \text{frequency}
- \text{duration}
- \text{magnitude}
- \text{latency}

10. \textbf{Goals:}

Open-ended question asks for description of desired behavior

11. \textbf{Prior treatment attempts:}

Asks if other treatments have been tried

Uses open-ended questions to assess specifics of such attempts

12. \textbf{Closed-ended questions}

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Appendix C

Manual II
Appendix C

Introduction

The preceding manual has dealt with the responses a therapist should make in obtaining the information necessary in conducting an initial assessment interview with a client. In ideal circumstances, the therapist will present the client with the appropriate open-ended question, and the client will supply the relevant information, allowing the therapist to make a reasonable analysis of the dimensions and causal variables involved with the presented problem. Such circumstances, however, do not always occur in the actual clinical setting. A client may not readily provide the necessary information, even though the therapist correctly emits the responses as outlined previously. The reasons why a client does not respond appropriately are varied. A client may be embarrassed about certain aspects of the problem and thus will respond in a vague manner or not at all. Often times, the client may be upset about a current problem to the point of confusion, providing irrelevant or even erroneous information. Therapists also occasionally see clients who are not voluntarily attending sessions, such as those clients who are involuntarily admitted to psychiatric units, whose attendance is ordered by the court, or whose participation is strongly prompted by another, such as a loved one or an employer. Clients who attend sessions under these circumstances are often reluctant to provide information, (perhaps because they do not see themselves as having a
problem), or may even express hostility and resentment towards the therapist. Such circumstances can greatly impede the progress of assessment and treatment unless dealt with properly.

The following manual will discuss some of the more common nonappropriate responses a client is likely to make. The term "nonappropriate" simply refers to the fact that the client answers the therapist in a manner which does not forward the therapist in his goal of obtaining the relevant information needed in making a complete assessment of the client’s current problem. The term is not meant in a derogatory manner as related to the client’s behavior.

After each nonappropriate response has been described, the appropriate therapist response will follow. It is important to remember that these are not static responses which must be made following each nonappropriate response. Rather, they are guidelines which are useful in helping the therapist evoke relevant information from the client. While most of the responses are self-explanatory, two of the therapist responses outlined in the following pages shall be defined here for purposes of clarification and to avoid confusion. The first response is summarizing and restating. This involves summarizing the information the client has just provided and then rephrasing the question in a manner which integrates this summarization. The second response is empathizing and describing the question further. This involves expressing to the client that you understand what the client has just said and then explaining to the client how the therapist’s questions are related to the client’s statements. Empathizing may also involve reassuring the client that what they have just expressed is
not abnormal or necessarily inappropriate. These responses, as well as other therapist responses, will be illustrated through the use of examples in the following pages.

The responses outlined below are to be used after the initial therapist response contained in the previous manual has failed to evoke the appropriate assessment information from the client. In other words, the particular response from Manual I should be asked first, and then followed by the appropriate response from Manual II if necessary. Also, the caveat concerning open-ended questions also applies here. A naive therapist, when confronted with an evasive client, might react by asking a barrage of closed-ended questions in the hope of eventually narrowing down the resultant information to the details useful in an assessment. This not only wastes valuable time but also may be highly aversive to a client who already finds the assessment situation uncomfortable. Therefore, the following information will hopefully aid the therapist to conduct a pleasant and efficient assessment interview even when presented with a nonappropriate client.

**Nonappropriate Responses by the Client and Corresponding Appropriate Therapist Responses**

1. **Client Answers Vaguely or with Irrelevant Information:** Often times, when a client is asked by the therapist to describe a certain aspect of the presented problem, the client will respond with an answer which is not pertinent to the problem at hand or will provide an answer which is unclear to the therapist. An example follows:
*Therapist:* Susan, you’ve said that you have a problem relating to your boyfriend and that you do not seem to get along as well as you did when you first started going out together. Describe for me exactly what you mean by that.

*Client:* Well, we just don’t seem to understand each other anymore. My friend and her boyfriend have such a good, open relationship and I feel kind of jealous of that, you know?

The therapist starts by summarizing what the client has already stated and is now trying to obtain specific information about the problem. The client responds by rephrasing her problem in general terms and then adds information about her friend’s relationship which, while possibly being pertinent to the goal of the therapist, adds nothing to the description of what is actually occurring in the present problem.

**Appropriate Therapist Response: Summarizing and Restating.**

Often times, when a client answers a question vaguely, it is helpful to summarize what the client has already stated concerning the problem and then restate the question in terms the client may understand. An example follows:

*Therapist:* Susan, describe for me the problem you are having with your boyfriend.

*Client:* We don’t get along with each other. We used to communicate with each other really well, but now we don’t relate to each other as well.

*Therapist:* So you feel that you have a problem communicating with your boyfriend and this could be leading to your frequent fights.
Tell me what you mean when you say that you have problems communicating.

In this example, the client has responded to the therapist’s question by describing the problem in general, vague terms. The therapist summarizes what the client has just said and then restates the question in a more specific manner, helping the client define exactly what the problem is in behavioral terms. This rationale is also helpful when the client starts to inadvertently change the subject or avoid the topic reflected by the therapist’s questions.

2. Client Fails to Answer the Question Asked by Therapist: When asked a particular question by the therapist, the client may not respond to the question or may state that she does not remember or know the information. An example follows:

*Therapist:* Susan, describe for me any events occurring at the time you and Ron started having problems in your relationship that might have caused or added to the problems.

*Client:* Gee, I can’t even remember exactly when we started having these fights. It just seems that one day I woke up and realized that we hadn’t been getting along for some time.

The therapist asks an open-ended question concerning the events associated with the onset of the problem. The client cannot respond because she states that she can not recall exactly when the problem first started to occur, only that she had a vague awareness that the problem has existed for some time.
Appropriate Therapist Response: Offering Potential Examples.

When a client has trouble responding to the questions asked by the therapist, stating that she does not know or remember the answer, it is helpful to provide examples for the client. The examples should end with an open-ended question. The following example will illustrate:

**Therapist:** Susan, describe for me anything that might have been happening in Ron's or your life which might have caused or added to the problem of fighting. Think back to the time the fights first started.

**Client:** I don't really remember when we started fighting.

**Therapist:** Think of your relationship as being divided into months. You've known each other for a year. Were the fights starting during the second month, the third, the fourth...?

**Client:** I guess it was somewhere around the sixth month, after we had been going out for about half a year.

In this example, the therapist provides a framework of examples from which the client can choose an approximate answer. Notice that the therapist provides the client with a "running start" by naming time periods from which to choose. This is, by form, a closed-ended question, but functionally it serves as an open-ended question by encouraging the client to continue with her own information. Another example follows:

**Therapist:** Susan, what happens immediately before you fight?

**Client:** I don't know. All sorts of things.
**Therapist:** Often times, when couples fight, somebody says something rude or something that hurts the other just before the fight really starts. What about in your case?

**Client:** Ron doesn’t really say anything rude. He just ignores me when I’m talking to him sometimes and that makes me mad.

In this example, the therapist has given the client an example to both illustrate the kind of information he is looking for, as well as to help the client think of what occurs in her situation. He ends the example with an open-ended question, prompting the client to provide information.

3. **Client Answers Question Concerning Behavior by Describing Feelings.**

Many clients come into therapy with the expectation that they will be asked to talk about their feelings and emotions, and little else. A client, therefore, may continuously try to respond by describing how they feel about their particular problem, even when asked to describe concrete behaviors. The following example illustrates:

**Therapist:** Susan, you’ve stated that you fight with your boyfriend quite often. What exactly occurs when you fight?

**Client:** When we fight, I really get depressed about it.

**Therapist:** What is it that you do while the fight is actually taking place?

**Client:** I get really angry and upset at him, and that makes me feel bad.

In this example, the therapist is interested in actual behaviors involved in fighting. The client, however, continuously responds by describing how she feels during and after arguments with her boyfriend.
Appropriate Therapist Response: Empathize and Describe Question Further. When the client answers a therapist's questions by describing feelings rather than behavior, it is helpful for the therapist to acknowledge and empathize with what the client has just said, (for example, "I can understand why that would upset you"), and then explain to the client that you must learn more about the behaviors involved with the problem in order to deal with the client's feelings. An example follows:

Therapist: Susan, what occurs when you fight with Ron? What is it that you or Ron do when you fight?

Client: While we're fighting, I get really angry at him and become very upset. Later, after the fight, I feel bad about some of the things I might have said.

Therapist: Most people feel bad after fighting with someone they care about, even a little guilty after the fight. It is important now to find out exactly what happens when you fight that makes you feel angry and bad.

In this example, the client expresses feelings when asked to describe what occurs when she fights with her boyfriend. The therapist responds by assuring the client that the feelings described are normal in such a situation, and then urges the client to talk about particular behaviors in order to get to the root of her feelings. By doing this, the therapist has empathized with what the client has just said and has directed her to respond in a more appropriate manner.

4. Client Responds by Questioning the Therapist's Inquiry or Avoids the Topic Under Discussion: A client may not understand why each question

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asked by the therapist is pertinent, especially if the client has no knowledge of the behavioral orientation. An example follows:

**Therapist:** I would like you to describe for me any situations in which you are with your boyfriend and you do not fight.

**Client:** Well, when we don’t fight, obviously, we are getting along fine. I’d rather talk about the times when we do fight.

In this example, the therapist is attempting to assess specific environmental variables which may influence fighting behavior. The client, however, indicates that, to her, such questions seem to be getting away from the actual problem.

**Appropriate Therapist Response:** Providing the Behavioral Rationale. When the client questions the efficacy of the type of questions asked by a behavior therapist, particularly if the client has no knowledge or background in behavior principles but rather is accustomed to talking about feelings or early childhood events when dealing with behavior problems, the following rationale is useful: The therapist should explain to the client why such (behavioral) questions are important. An example will illustrate:

**Therapist:** I would like to talk now about any situations in which you do not fight with your boyfriend. In other words, describe for me some particular times in which the two of you are getting along well.

**Client:** Shouldn’t we focus on the times that we do fight?

**Therapist:** Well, it would be helpful to identify differences between the situations when you fight and when you don’t. In this way,
maybe we can pinpoint some of the key things that set off your fights.

Note that in this example the therapist did not go into a lengthy discussion or lecture concerning the importance of determining variables relevant to the antecedents involved with the problem. The therapist provides a simple explanation as to why a particular question is important.

5. Client Expresses Disagreement with Therapist's Behavioral Orientation: The client may disapprove of or even resent the type of questions the therapist is asking. As mentioned earlier, for example, clients often prefer to discuss feelings rather than particular behavior, as illustrated by the following example:

**Therapist:** How long do your fights with Ron usually last?

**Client:** Why do you want to know that? It's not really how long they last that matters; it's how I feel after the fight, regardless of whether it lasts five minutes or five hours. I mean, my real problem is how I feel about the fights, not how long they last.

The therapist is interested in specifying the dimensions of the problem. The client, however, feels that the particulars of the problem are not as important as the way she feels as a result of the difficulty.

**Appropriate Therapist Response: Providing the Behavioral Rationale.**

As in the previous nonappropriate client response (#4), the therapist must explain why certain questions are important, as in the following example:

**Therapist:** Susan, how long do your fights with Ron usually last?

**Client:** What difference does that make? I feel bad about the fights no
matter how long they last. I would really rather talk about how this constant fighting makes me feel.

*Therapist:* I agree that your feelings are very important. In order for us to understand those feelings and to help you feel better, it is important that we thoroughly understand exactly what is happening when you fight, as well as why. That is why I want to make sure that I understand all aspects of the problem.

In this example, the therapist does not discount the client's views on the orientation of therapy. Rather, he integrates what she has said with what he wishes to accomplish, (i.e., assessing the dimensions of the problem), so as to assure the client that he understands what she is saying and they both are working essentially towards the same goal.

6. **Client Attributes Cause of Problem Behavior to Nonpertinent Variables:** References to personality variables or traits of the client or others in attributing the source of difficulty to nonpertinent events may be a problem for some clients. Clients may also "intellectualize" about the source of difficulty, providing irrelevant theories concerning their present difficulties.

An example follows:

*Therapist:* Describe for me what typically occurs right before you start to argue with Ron.

*Client:* Well, Ron is a very stubborn person. He can be pretty argumentative when he wants to be. I'm not trying to put all the blame on him, but it's usually his stubbornness which causes the fight.
In the preceding example, the client has attributed the cause of her arguments to a personality characteristic ("Stubbornness") of her boyfriend. This, in fact, only hints at the actual causes of the problem.

The following example illustrates the way in which a client may offer possibly irrelevant theories as to why the problem exists:

Therapist: Susan, what usually occurs right after you have a fight with Ron?

Client: Ron usually pouts. I think he got that from his mother. Whenever she does not get exactly what she wants, or if things aren’t going her way, she’ll usually just sit and pout, not talking to anyone.

In this example, the client states in brief terms how Ron reacts to their fights, and then continues by theorizing why he reacts in such a way. This information, regardless of its validity, adds little to the assessment of the presenting problem and, indeed, shifts the focus of the analysis away from pertinent areas of information.

Appropriate Therapist Response: Empathize and Describe Question Further. This response is similar to the response made to the nonappropriate behavior of the client involving answering questions by describing feelings (#3). The following example will illustrate the manner in which empathizing and further elaboration of the question also is suited for the present problem.

Therapist: Describe for me what usually occurs right before you have a fight with Ron.

Client: Ron is usually being stubborn about something. He tends to
be pretty difficult to get along with sometimes.

**Therapist:** When you say that Ron is being stubborn about something, what exactly is happening? If it helps, think of an example.

**Client:** I remember that we had a pretty bad argument last weekend. I wanted to go to the movies, but he said he would only go if we saw this really gory movie he's been wanting to see. He knows that I hate movies like that. We ended up arguing about which movie to see until it was too late to see anything.

**Therapist:** I can see how that type of situation would upset you. If we can identify some of the things which cause you and Ron to fight, such as a disagreement over how to spend an evening, you can learn how to change or avoid them, so let's focus more on what usually occurs before you fight.

In this example, the client attributes the cause of her fights with her boyfriend to his stubbornness. This does not add to the information needed to understand what is occurring just before a fight. The therapist prompts the client to specify what she means by "stubborn" by asking her to think of an example. Once an example is provided, the therapist acknowledges (empathizes) that such a situation is indeed stressful and then integrates the information to continue the line of questioning. The client is then able to start discussing particular behaviors.
Summary

As can be seen from the above, some of the appropriate therapist responses apply to more than one of the nonappropriate responses made by the client. For example, by providing the behavioral rationale behind a particular question, one can effectively deal with a client who questions the efficacy of a particular therapist response or avoids the topic under discussion (nonappropriate response #4) as well as deal with a client who expresses disagreement with the behavioral orientation (nonappropriate response #5). Also, by empathizing and describing the question further, the therapist is able to conduct the assessment interview effectively with a client who tends to answer questions by describing feelings or by attributing the cause of the presented problem to nonpertinent variables, (nonappropriate response #3 and #6, respectively).

As stated earlier, it is helpful to offer potential examples when a client fails to answer a question because they claim not to know or remember the information (nonappropriate response #2). This does not mean that the therapist should ask a series of closed-ended questions, such as "Do you do X?", "Do you do Y?", etc. This would be time consuming and tedious for both the client and therapist. It is best to offer a few examples followed by an open-ended question, such as "What is it that you do in your case?" In this manner, the client is again asked to supply information beyond a "yes" or "no" answer.

Finally, when a client responds with vague or irrelevant information (nonappropriate response #1), the therapist should respond by
summarizing what the client has just said and then restating the question, integrating the client's comments with the new question.

One last comment concerning a therapist's response to nonappropriate responses by the client should be noted. When a client answers the therapist's questions in a vague manner, (such as in saying that the problem with a relationship is that the client does not relate well with her boyfriend, as in nonappropriate response #1), the therapist may be tempted to ask why such a state of affairs exist. Asking the client why something occurs, however, is often equivalent to asking the client to provide his or her interpretation of the situation, which may be relevant but may not be appropriate during the initial assessment interview. The therapist is concerned with assessing the dimensions in behavioral terms and questions which evoke subjective interpretations from the client often will confuse the assessment process. The same concern applies to a situation in which the client responds to the therapist's questions by describing the feelings associated with a particular problem, (see nonappropriate response #3). When the client responds, for example, that she feels sad or depressed, asking the client why she feels that way may not lead to an answer stated in useful behavioral terms. Rather, the client may continue to respond in a nonproductive manner. The correct therapist response, as outlined in the manual, should eliminate many of these problems by prompting the client to avoid subjective interpretations and supply, instead, specific answers in behavioral terms.

Asking the client what s/he means by a certain response, (such as if s/he answers in a vague manner or cites nonpertinent variables as a cause
of the problem, as in nonappropriate response #1 and #6, respectively), is also not always sufficient enough to evoke the proper information because it is not specific enough. It is important to construct a question in such a manner that the client will understand specifically what the therapist is looking for. "Why" or "What" questions, as described above, will not always achieve the therapist’s ends but rather may lead the session down another unproductive path. The responses described in the preceding manual, while more complex than simple "why" or "what" questions, should save time and effort throughout the interview session by allowing the client to respond in an appropriate manner.

By integrating the basic responses of Manual I with the modified responses of Manual II, one is able to conduct a thorough behavioral assessment interview resulting in the analysis of the causal variables affecting the client’s behavior. The time required to conduct such an interview depended upon the client and the complexity of the presented problem, as well as the skill of the therapist. The manuals presented in this study should provide the novice therapist with a good start.
Appendix D

Clinical Problems
Presented in the Simulated Sessions
APPENDIX D

Clinical Problems
Presented in the Simulated Sessions

1. A 40 year old married male with three children who looks in the windows of other people's apartments at night for the purpose of sexual arousal, (i.e., voyeurism).

2. A 20 year old factory worker who engages in temper outbursts both at work and home.

3. A 25 year old female secretary who is unassertive at work.

4. A 35 year old housewife who suffers from frequent arguments with her spouse.

5. A 16 year old female high school student with an eating disorder, (binges and purges, i.e., bulimia).

6. A 21 year old male college student who becomes anxious in group situations.

7. A 22 year old female college student with a phobia of spiders.

8. A 40 year old male with an 8 year old noncompliant son.

9. A 26 year old male graduate student with the "nervous" habit of biting the inside of his mouth.

10. A 30 year old female with a 4 year old son who exhibits severe tantrums.

11. A single 28 year old who smokes two packs of cigarettes a day.
13. A 15 year old male who makes threats of violence against his mother.
14. A 21 year old male college student who is 50 pounds overweight.
15. A 25 year old male alcoholic.
16. A 48 year old married male accountant with facial tics.
17. A 15 year old female high school student with poor academic performance.
18. A mother with a 2 year old child with extreme food selectivity.
19. A 28 year old male hospital orderly with obsessive thoughts concerning diseases.
20. A 21 year old male janitor who is continuously late in reporting for work.
21. A 29 year old male employed as a convenience store clerk who compulsively steals from his place of employment.
22. A 21 year old male college student who is a chronic marijuana user.
23. A 22 year old college student who watches TV excessively, (i.e., to the point where it interferes with other activities).
APPENDIX E

Simulated-Session Script
Phase I
APPENDIX E

Client I.D.: 19

Background Information: Father is present to see therapist concerning his 2 year old son, Robert. The father is an attorney. The mother is a housewife.

1. General Description of Problem: Robert refuses to eat most foods. There is no medical reason for this.

2. Other Problems: Robert also has temper tantrums when not allowed certain requests. This occurs up to twice a day.


4. Problem Behaviors: refuses to eat; pushes food away; cries, screams, kicks; refuses to feed self or allow others to feed him.

5. Dimensions: Frequency 2-3 times per day Duration entire meal Magnitude Latency

6. Correlated Verbal Behavior: Robert will scream and say "no" when food is presented. Will ask for candy, other sweets.

7. Onset: Six months ago. Mother started "bribing" child with sweets to get him to eat vegetables.

8. Antecedents: Presentation of any food other than "sweets"; does not occur at breakfast if sugary cereal is presented.

9. Consequences: Parents give him dessert or cereal at meals so he "won't starve to death."

10. Goals: Robert will eat all foods without refusal.
11. **Other Treatment Attempts:** Yes, pediatrician says there is not
physical reason why he will not eat and suggested that they give him _____
dessert only after all other food is eaten. This, however, has not been _____
successful.
APPENDIX F

Simulated-Session Script
Phase II
APPENDIX F

Client Problem # 19

1. General description of problem: Client:

Therapist:

2. Other Problems: Describe Feelings:

Client: We feel frustrated with many of his problems; a lot of what he does makes us angry.

Therapist: Empathize and describe question further

3. Priority: Fail to answer

Client: I don’t know. Everything seems important. I don’t know where to begin.

Therapist: Offer potential examples, ending with an open-ended question.
4. **Problem Behaviors**: Answers with vague or irrelevant information.

   **Client:** He doesn't eat well at all. He doesn't react to food like normal kids.

   **Therapist:** Summarize and restate.

5. **Onset**: When did problem first occur? Events associated with onset: Attribute cause to nonpertinent variables.

   **Client:** He's become really stubborn. I think he got this from grandmother. She's really stubborn too.

   **Therapist:** Empathize and describe question further.

6. **Correlated Verbal Behavior**:

   **Client:**

   **Therapist:**

7. **Antecedents**:

   a) Asks about antecedents
   b) Situations where problem does not occur
   Questions inquiries/avoid topic

   **Client:** That seems like an odd question. Shouldn't we focus on why he's like this?

   **Therapist:** Provide behavioral rationale.
8. **Consequences:** Expresses disagreement with behavioral orientation

<table>
<thead>
<tr>
<th>Client:</th>
<th>I don't think that's important. We are wasting time discussing this!</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapist:</strong></td>
<td>Provides behavioral orientation.</td>
</tr>
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9. **Dimensions:**

<table>
<thead>
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<th><strong>Client:</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Therapist:</strong></td>
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</table>

10. **Goals:**

<table>
<thead>
<tr>
<th><strong>Client:</strong></th>
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<tbody>
<tr>
<td><strong>Therapist:</strong></td>
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</table>

11. **Prior Treatment Attempts:**

<table>
<thead>
<tr>
<th><strong>Client:</strong></th>
<th><strong>Re: Specifics of such attempts</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapist:</strong></td>
<td></td>
</tr>
</tbody>
</table>
Appendix G

Interview Instructions I
APPENDIX G

Interview Instructions

You are functioning as a therapist conducting an initial interview with a client. The client has come to you with a problem and your job is to gather sufficient information to analyze the problem.

Behave as you would with a real client, conducting a clinical interview. Do your best; try not to get too nervous. This interview is to assess your current skills. You can end the interview at any time, either when you have nothing more to ask, or when you think you have gathered sufficient information. Good Luck!

1. Do not discuss your performance or any other aspects of the study with other subjects. This would influence or bias your performance and theirs.

2. Do not attempt to improve your interview skills in any way on your own (for example, reading in books or articles, talking to people, etc.). This would confound the effects of the training procedures provided as part of the study.

3. Please report any reading, other class-related activities or job performances which are related to behavioral interviewing. This information is needed so that we can be aware of potential extraneous influences on your performance.

(Miltenberger and Fuqua, 1985).
Appendix H

Interview Instructions II
APPENDIX H

Interview Instructions

At certain times throughout this study, you will be asked to conduct an assessment interview with a client who does not answer all of the therapist’s questions with a clear answer. Your job is still to gather sufficient information to analyze the problem and you should attempt to do this in the manner you feel is best. As noted in previous instructions, each interview is conducted to assess your current skills. Try not to get too nervous. You may end the interview at any time, either when you have nothing more to ask, or when you have gathered sufficient information.

1. Do not discuss your performance or any aspect of the study with other subjects. This would influence or bias your performance and theirs.

2. Do not attempt to improve your interview skills in any way on your own. This would confound the effects of the training procedures provided as part of the study.

3. Please report any reading, other class-related activities, or job performances which are related to behavioral interviewing. This information is needed so that we can be aware of potential extraneous influences on your performance.
Appendix I

General Scoring Guidelines
APPENDIX I

General Scoring Guidelines

1. Score closed-ended questions (CEQ) only after the first assessment question is asked, (i.e., do not score the CEQ occurring during social introductions). CEQ are also not scored during closing comments.

2. In general, if any confederate client provides the answer to a question before it is asked, score that response category or that section of the response category as not applicable.

3. In Phase One, if the subject provides a summary of information provided by the confederate client, score this as a CEQ only if the summary goes beyond the information already provided.

4. CEQ are allowed for response categories 2a, 2c, 5b, 7b, and 11c. All other response categories should be in the form of open-ended questions (OEQ).

5. Each section of a response category must be properly emitted by the subject (as designed in the manuals) for that response category to be scored as an occurrence.

6. A question in which the confederate client is asked to choose between two or more options, (such as "What happened next, X or Y?") is scored as a CEQ except when the question is related to setting priority, as in response category 3.

7. Questions that begin with "Could you...", "Would you...", or "Can you...", (for example, "Can you describe the problem for me?") are
closed-ended in form but open-ended in function and should not be scored as CEQ.

8. Regarding the setting of priority (response category 3), the subject must summarize each problem identified by the confederate client.

9. If a number of questions are strung together in one utterance, only score the last question. Each utterance is separated by the response to the question by the confederate client. The exception to this is when the targeted therapist response involves more than one response, as in Phase Two.

10. If a subject’s question is answered non-appropriately (Phase Two), the subject must provide the complete appropriate response, (for example, summarize and restate), before the response is scored as an occurrence.
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