A Reliability Study of a Sew System for Coding Family Therapists' Verbalizations

Judith Mayerovitch
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A RELIABILITY STUDY
OF A NEW SYSTEM FOR CODING
FAMILY THERAPISTS' VERBALIZATIONS

by

Judith Mayerovitch

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
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Western Michigan University
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Judith Mayerovitch
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In his discussion of the present status of research in the area of family therapy, Winter (1971, p. 98) remarks that "it would be a distortion of reality to have therapy defined solely by those variables which are most amenable to objective measurement. But we must begin somewhere, and we should strive to objectify the more subtle aspects of therapy, even if we know we can never achieve perfect success." In line with this view, and as part of an extensive research effort concerned with process and outcome in family therapy, the research team at the Institute of Community and Family Psychiatry, Jewish General Hospital, Montreal, has been attempting to identify and define variables of both family and therapist behaviour which may eventually prove to be indicators of therapeutic success or failure, given the matching of a family of particular characteristics with a therapist displaying a particular style of intervention.

The present study deals solely with variables of the therapist's verbal behaviour during the course of conjoint family therapy sessions. It involves an attempt to establish the reliability and the utility of a new coding system, the Chagoya-Presser Scale for Describing the Content of Family Therapists' Verbal Interventions (C-P Scale). This system has been designed, as its name suggests, to codify therapist behaviour in terms of the content of therapeutic interventions. It is a system which utilizes the methodology of content analysis, an approach which has been widely used in psychotherapy research. Content analysis can be described as a method for studying the content of communications in an objective, systematic
and quantitative way (Auld & Murray, 1955).

Prior to the present study, the as yet unpublished scale consisted of twenty-two variables which a group of professionals (most of them supervisors of family therapists in training) felt might be useful in profiling, in terms of frequency of occurrence, different therapeutic styles. The reliability of the scale had not been systematically verified, nor had it ever been used for research purposes. Rules for coding had been refined to a point, but careful scrutinizing of the operational definitions of the categories remained to be done.

The present work, then, involves an attempt to (a) improve the existing scale with the aim of establishing it as a potentially useful tool in further family therapy research efforts, (b) test the reliability of this new coding instrument, (c) in a preliminary study dealing with consistency of therapists' profiles over time, assess some of the potential uses of this tool as an objective means of classifying content aspects of family therapist style. This latter study, though somewhat limited in terms of external validity due particularly to small sample size, will serve to exemplify some of the ways in which the scale may be utilized in future research.
HISTORICAL BACKGROUND

The literature which relates to the present study can be divided into two basic areas: content analysis, and reliability testing using the inter-judge consistency approach. Representative papers describing previous work in both these areas will be discussed in this review.

Content Analysis Studies of Individual Psychotherapy

The methodology known as content analysis is one which, through the use of verbatim interview material, allows for the objective measurement of what has transpired verbally during a psychotherapy session. Content analysis can be described generally as a method for studying the meaning properties of language (Murray, 1956). Studies reported in the psychological literature which have utilized this methodology have concentrated primarily on developing objective and descriptive categories applicable to the process of individual psychotherapy. These studies, when dealing with the therapist's verbalizations, allow for comparisons of the behaviour of different individuals, or of the behaviour of the same therapist in different sessions with the same or with different patients. Most of these content analysis studies have utilized sound recordings of actual psychotherapy sessions, while others, like the present study, have involved simulations in the form of motion pictures or video-tape recordings.
Descriptions here will be of content analysis studies which have been aimed, in part or in whole, at classifying therapist behaviour. Some have involved the content analysis of the verbal behaviour of patients as well, and purposed to describe interactional and causal aspects of therapist and patient behaviour during the course of psychotherapy sessions.

The earliest studies of psychotherapy utilizing content analysis are those of Porter (1943a, 1943b) and Snyder (1945). Porter's scale was based on a theoretical analysis of publications on how to counsel, and on an empirical analysis of phonographically recorded interviews. He included twenty-four categories in which he emphasized the degree to which the therapist takes responsibility for the interview (Auld & Murray, 1955). Snyder carried out a rather extensive study of the verbal behaviour of both participants in non-directive (client-centered) therapy. His therapist categories included, among others, Restating Content, Clarifying Feelings, Interpreting, Leading, Accepting etc. In his study, Snyder broke down each statement of both therapist and client into the essential ideas present, and it was each idea that served as the unit for coding. Snyder drew conclusions about the nature of non-directive therapy in terms of changes in the frequencies of categories during the course of treatment. He attempted to relate certain of the therapists' behaviours with those of the clients involved.

Murray (1956) carried out a study utilizing content analysis in which the major focus was on the patient's behaviour. However, he did include some therapist variables which were based on the
dichotomy of active versus passive interventions. The sub-categories included in his therapist scale were derived from the learning theory of Dollard and Miller, and from psychoanalytic theory.

Hans Strupp (1957a, 1957b, 1960) has devised a rather elaborate content analysis system which he has used primarily to compare and contrast the behaviour of different therapists in individual sessions. The coded unit in his system is the single therapist communication. Each unit is classified according to a) Type of Activity, b) Depth-Directedness, c) Dynamic Focus, d) Initiative, e) Therapeutic Climate. Strupp chose to use raters who were themselves psychotherapists, and their ratings were guided by background information which they were given concerning the history of the particular therapist-patient interactions up to that point. Strupp (1963) has since developed six motion pictures simulating individual psychotherapy sessions with psychotic 'patients'. At varying intervals in these films, the words "What would you do?" are flashed. Subjects in studies in which Strupp has used these films were asked to record in writing what they would say were they treating the 'patient' involved. Strupp felt that studies in which these films were used, though giving up a certain degree of realism, were enhanced in terms of experimental control.

Saslow and Matarazzo (1959) investigated, using an instrument called the Interaction Chronograph, variables of both patient and therapist behaviour. They concentrated on time units of behavioral interaction and, for the therapist, included such measures as total units of speech and frequency of interruption. Kanfer, Phillips, Matarazzo and Saslow (1960) followed up this work by studying the
possible relationship between these temporal variables and the functional content of interventions. They were particularly interested in the immediate and subsequent effects of interpretations on the duration of patients' utterances, holding the hypothesis that the effects of interpretations as a category of interviewer responses differ from those of exploratory or information-seeking statements. Tapes coded in this study involved a standardized interview in which the 'therapist's' verbal and gestural interventions were limited to five seconds, and in which specified types of interventions were made at predetermined points in the interview.

Among the most validated works in the field of content analysis applied to individual psychotherapy is that of Dollard and Auld. In their book, "Scoring Human Motives" (1959), they describe twenty different categories denoting conscious and unconscious affect as expressed by the patient, and six categories denoting the type of verbalizations made by the therapist. In the Dollard and Auld system, typed transcripts of therapy sessions are unitized according to certain grammatical rules.

In a study aimed at clarifying the way in which the therapist's anxiety affects his therapeutic work, Bandura, Lipsher, and Miller (1960) used as their unit of measurement, an interaction sequence: patient-therapist-patient. They classified therapist responses as approach reactions, avoidance reactions, and responses irrelevant to this dichotomy. In this study they looked at the relationship between therapist interventions and the patient's subsequent behaviour with respect to the object of his expressions of hostility.
There have been a number of studies dealing with the Rogerian client-centered variables. Truax (1960), for example, found that high levels of accurate empathy, unconditional positive regard and self-congruence on the part of the therapist led to successful outcome. Barrett-Lennard (1962), utilizing what he called the Relationship Inventory, studied changes in therapy due to different levels of variables of therapist behaviour. Van der Veen (1965) was particularly interested in the effects the patient and therapist had on each other during the course of therapy. He conceptualized the behaviour of patient and therapist to include functions of the participant himself, the person with whom he is interacting, and the particular combination of the two. He found support for his model by coding excerpts of sessions involving different patient-therapist combinations. The therapist variables he studied were congruence and accurate empathy, while those of the client were in the areas of problem expression and immediacy of experiencing.

Howe and Pope (1961) developed two scales to assess the Activity Level of therapist verbal responses which they applied to several published initial psychotherapeutic interviews. Their first eleven-point scale defined activity in terms of Ambiguity, Lead and Inference. Their second scale classified therapist responses into the categories of Simple Facilitation, Exploration, and Clarification. The authors found that both of their scales could be reliably used by untrained, professional raters.

Rice (1965) carried out a study concerned with therapist style and case outcome which focused primarily on process rather than
content variables. She looked at vocal and lexical aspects of therapist behaviour. That is, she was more interested in the way in which a theme was presented by the therapist than in its actual content. Her coding system was applied to audio-taped interviews, and her unit for coding was the total therapist response. All tapes used in this study were of Rogerian therapists, and Rice concluded that her system tapped aspects of behaviour that vary widely even among therapists of a single persuasion, that vary over the course of a single therapeutic case, and which were clearly related to independently assessed characteristics of therapists and case outcome.

Ornston, Cicchetti, Levine and Fierman (1968) have examined verbal behaviour patterns of psychotherapists to determine parameters related to various levels of training. They utilized a video-tape of a psychotic 'patient' and had the subjects in their study, both novice and experienced therapists, respond to this filmed 'patient' as they would were they in a therapy session with him. The authors found that novice therapists asked significantly more questions than experienced ones, that experienced therapists used more words per response and made more statements overall. These researchers reported later (Cicchetti, Ornston and Towbin, 1968; Ornston, Cicchetti and Towbin, 1970) that the responses six months later of the same novice therapists performing again in this situation proved to resemble much more than earlier those of their experienced counterparts. In two subsequent showings of the film, the differences between the novice and experienced therapists' responses diminished even further. The authors found support for their argument that it
was training rather than patient contact which accounted for the change over time in the responses of the initially inexperienced therapists.
Bales' (1950, 1970) Interaction Process Analysis (IPA) is a
content analysis system which has been extensively applied to de-
scriptions of interactional patterns in small groups. The original
IPA, which consisted of twelve categories, and its modified versions
have been used in a variety of ways. The categories in the IPA deal
primarily with the way in which people accept or reject proposals,
and give and receive information. The scale has been used to ascer-
tain the stability of the behavior of individuals interacting in the
same group on different occasions (Borgatta & Bales, 1953) and in
different group situations (Borgatta, 1964). Modified versions of
the IPA have also been used in a variety of studies of interactional
behaviour patterns in families (O'Rourke, 1963; Cheek, 1964; Winter
& Ferreira, 1967), but the authors of these studies have failed to
find any consistently meaningful patterns using this procedure.

Content analysis studies of interactional patterns during the
course of family therapy sessions, which have been undertaken at the
Jewish General Hospital, have centered on what is considered in this
setting to be the major focus for therapeutic attention, namely,
affective interaction (Guttman, Spector, Sigal, Epstein & Rakoff,
1972). A coding system was devised by this team (Guttman & Spector,
1971) which was, for family members' behaviour, based on a distinc-
tion among Emergency (fear, anger etc.), Welfare (support, sympathy
etc.) and Neutral (description of facts) emotions. Speeches made by
family members are categorized, in this system, according to their underlying feeling tone, their direction (to whom) and the object of the emotion involved. Although Dollard and Auld's (1959) content analysis system was found to be inapplicable to the coding of family interaction (Lamontagne, 1965), two of their categories used to describe therapist behaviour, Drive (D) and Interpretation (I), were retained for use in these family therapy studies. Drive has been described (Postner, Guttman, Sigal, Epstein & Rakoff, 1971) as any remark having as its aim to stimulate interaction, get more information, or give support. Interpretations are statements which intend to help clarify motivation, and lead to further understanding in family members.

In early studies done at the Jewish General Hospital (Postner, Guttman et al., 1971; Guttman, Spector, Sigal, Rakoff & Epstein, 1972) coding was done from typed transcripts utilizing the Dollard and Auld (1959) unitizing method. Later it was found that an equivalent method of coding could be done directly from audio-taped therapy interviews, utilizing five-second intervals as the coding unit for family members' verbalizations (Guttman, in press) and ten-second intervals for those of the therapist (Guttman, Sigal & Chagoya, in press). This direct coding method was found to be a much more economical one in terms of time and energy expended, for the tedious task of transcribing and unitizing tapes could be eliminated.

In their study dealing with process and outcome in family therapy, Postner, Guttman et al. (1971) found that the level of a therapist's output with a particular family stays relatively stable,
and that the differences between a therapist's output for different families are much greater than the differences between his output for several sessions with the same family. They also found that the ratio of Drive to Interpretation, D/I, tended to decrease as family therapy progressed, and that families involved with therapists who exhibited a low D/I ratio in early therapy sessions tended to drop out of treatment prematurely. The authors felt that perhaps excessive Interpretations given too freely early in treatment stir up a great deal of anxiety, causing the family to flee.

Like Strupp (1963), who found the need to create standard films of individual therapy to be utilized in content analysis studies of therapist verbal behaviour, our research team felt that it would be advantageous, in terms of the experimental control involved, to create a simulated family therapy session on video-tape (SF) which family therapists could then 'interview' (Sigal, Guttman, Chagoya & Lasry, in press). In brief, four members of our research staff took the roles of a mother, father, a teen-age son and daughter, and interacted as a family in treatment in our clinical setting might. The tape used in the studies to date includes no 'therapist', but merely these four individuals interacting along a variety of predetermined themes for a total of twenty-five minutes. Subjects (therapists in training) in studies utilizing this taped SF have been asked to interact with the 'family' as they would were this one they were treating. Their comments were audio-taped, and, in past studies, these tapes were coded utilizing the Drive-Interpretation distinction and certain temporal variables (length of speeches, number of speeches.
etc.). In addition, segments of tapes of real family therapy sessions involving these same therapists were coded in like manner. It was found in this study (Sigal, Guttman et al., in press) that there were stable individual differences in some of these coded aspects of therapeutic style, and that performance in the SF situation was predictive of some of the measured variables in real therapy sessions.

The C-P Scale involved in the present study was originally devised as a means of expanding upon the rather crude existing scale for coding therapist verbal behaviour described above. Its originators felt that the new system should involve more detail with respect to the actual content of the family therapist's interventions. Very early in its development, it was decided that the application of this scale should involve little inference on the part of raters, and that descriptions of the categories should not include a lot of unnecessary jargon. It was intended that this scale would be one which could eventually be used in clinical settings holding a variety of theoretical and practical orientations concerning the practice of family therapy.
Assessment of Reliability
in Content Analysis Studies

To quote Waxler and Mishler (1966, p.35), "the degree to which confidence may be placed in the results of a study of interaction rests, in part, on the reliability of the measuring instrument."

Perhaps the area of greatest concern in the development of a new content analysis system is the extent to which it yields reliable results. Reliability studies have been carried out in a great variety of ways, and reports on the subject often have no common denominator. It seems obvious that when measuring devices, such as content analysis scales, involve subjective decisions, one must assess the degree of agreement between independent scorings. Thus, content analysis scales which to a greater or lesser extent involve inferential decisions, must be subjected to inter-judge consistency tests before they can be considered reliable tools for clinical research.

In assessing the reliability of an instrument such as the one in the present study, one must choose an index appropriate to the use to which that scale will be put in future research endeavors. That is, it must be decided just what it is about the coding system that should be reliably coded. Again, to quote Waxler and Mishler (1966, p.39), "if intergroup comparisons in category use are of primary interest, then an approach through category-by-category correlations may be most appropriate. On the other hand, if acts are to be treated separately...then act-by-act measures of reliability...would be most appropriate."
Lamontagne (1965), in her reliability study of Guttman and Spector's (1971) coding system of family therapy, decided to assess the reliability of the ratings of the individual units of coded material. She reasoned that in the future, the system in question might be utilized for testing hypotheses concerning one specific aspect of the interview; for example, the effects of the therapist's Drive statements on a family member's subsequent verbalizations. In her study, then, she used as her index of interscorer reliability, the percentage of agreement among judges with respect to their codification of individual units of speech.

The Chagoya-Presser Scale of the present study has been devised as a means of profiling therapists' behaviour during family interviews in terms of frequency of interventions falling into the categories involved. At this point, it is believed that the major focus of future studies utilizing this instrument will therefore not involve investigations requiring the more rigorous act-by-act reliability index as above. Thus reliability testing in this study will be based on a category-by-category comparison among judges resembling that used by Heinicke and Bales (1953) and Lanzetta, Wendt, Langham and Haefner (1956) in their studies utilizing the system of Interaction Process Analysis.
METHODOLOGY

As previously mentioned, the present work involved attempts to improve the existing C-P Scale and to test its reliability. A preliminary study dealing with consistency of therapists' behaviour as measured by the scale was also carried out in order to determine and assess some of the instrument's potential uses in further family therapy research.

Improving the C-P Scale and Assessing its Reliability

The audio-tapes coded in this study were of two types. Some (SF tapes) were of therapists interacting with the twenty-five minute simulated family video-tape described earlier. The others (T tapes) were of real conjoint family therapy sessions chosen randomly from among many collected in the past few years by our research team.

Two coders were used in this study: the author, and a research assistant in the team at the hospital. The latter had not been involved in the actual preparation of the scale, but was familiar with its earliest version, having been asked several months before to try it out on typed transcripts of family therapy sessions.

Procedure

During early stages of the present study, the author and Dr. Chagoya, the scale's senior author, carefully went over the existing categories, making a variety of revisions which, it was felt, would
facilitate the use of the scale. Names of many of the categories were changed, and several of the definitions were modified. Three categories were added to the original version, bringing the total number in the scale to twenty-five.

It was originally intended that coding with the C-P Scale would be done directly from audio-tape recordings utilizing the ten second unit method used previously in a study by Guttman et al. (in press). It was very quickly realized, however, during informal attempts at coding by the author, that this method was inappropriate for the task at hand. The C-P Scale focuses strongly on the meaning of therapists' statements, and ten second interval coding broke up verbalizations too much, rendering many of these fragments of speech impossible to code in any meaningful way. Thus, it was decided that the entire therapist speech, that is, anything said by the therapist between the utterances of family members, would serve as the unit coded. Even if during a particular intervention the therapist, for example, asked more than one question, that category, in this case, Therapist Asks Questions, would be counted only once for that intervention.

The two coders in this study spent a few sessions together listening to segments of SF and T tapes and discussing in which of the scale's categories each therapist intervention belonged. The coders found that in coding longer interventions on SF tapes it sometimes helped to write down what the therapist said, before attempting to code it. It was decided, therefore, that raters utilizing the C-P Scale should code, at their own discretion, either directly from the tape or as above. It was also decided that statements should be
coded one by one, ensuring that coding would be aided by contextual clues such as the family's verbalizations and non-content aspects of the therapist's speech.

It is to be remembered that during the recording of SF tapes, subjects stopped the video-tape machine when they made their interventions. Thus, therapists' verbalizations were recorded without background noise, and it was therefore easy to hear the remarks of the subjects involved. Tapes of family therapy sessions in vivo proved to be much more difficult to hear, due to the fact that family members and the therapist often spoke concurrently. It was decided that in order to ensure that coders were in fact coding the same material, written versions of the therapists' interventions were mandatory. Coding of T tapes was to be facilitated by utilizing typed transcripts of the therapist's verbalizations along with the audio-tapes.

Once the coders felt that they were well enough acquainted with the scale's categories and were in agreement as to their meaning, the formal reliability check was undertaken. Each of the two coders independently rated five complete SF tapes. Three of these had been used in an earlier study (Sigal et al., in press), and two contained the responses of two rather well-known American family therapists who had come to participate in a Symposium at the Jewish General Hospital. The tapes contained 44, 27, 25, 23 and 7 therapist interventions respectively. In addition, the coders also rated segments of three randomly chosen T tapes, using transcripts in addition to the audio recordings. Forty consecutive therapist interventions on each of
these tapes were coded.

For each rater, totals in the twenty-five categories were obtained for each of the interviews coded. Percentages were then calculated for each category per coded interview as follows:

\[
\frac{\text{no. of interventions per category}}{\text{total no. of interventions}} \times 100
\]

In order to meet normality assumptions of statistical tests, the percentage data were transformed using the formula: \( X^1 = \arcsin \sqrt[2]{X} \), \( X \) being the percentage calculated as above.

Those categories which consistently appeared very infrequently in the coding were omitted completely from the inter-judge reliability study. For the remaining categories, Pearson's product-moment correlation coefficients \((r)\) were obtained, using the transformed data from the eight coded interviews. Those categories which yielded coefficients of less than .707, the critical value at the 5% level of significance with six degrees of freedom, were re-evaluated by the two judges in order to discover the reason(s) for the discrepancies involved in coding. Appropriate changes were made in the definitions of those categories. Then the judges recoded the interventions in the eight interviews for these particular categories, and correlation coefficients were recalculated.
Consistency of Therapist Behaviour

Sample

Ten therapists in training served as subjects in this study. Each therapist had, after approximately two months of training in family therapy, been asked to view and interact with the simulated family video-tape described earlier (SF1). Between twenty and thirty weeks later, each therapist had again viewed and interacted with this same tape (SF2). The twenty SF tapes coded in this study, then, consisted of two for each of ten therapists who had 'interviewed' the video-taped family early and later in their first year of family therapy training. Of the ten therapists involved, five were psychiatric residents at various stages of their training, and five were professionals involved in a Mental Health Consultant training program. All were receiving supervised conjoint family therapy training with staff people at the hospital, and were, throughout the year, treating families using this approach.

Procedure

Therapist interventions on the twenty SF tapes were coded by the author, using the revised C-P Scale. Totals were obtained for each of the categories which had proven to be reliable, and these were converted to percentages and transformed as in the reliability study above.

To ascertain how consistent over time the therapists as a group were in the relative frequencies with which their interventions fell
into the various categories, Pearson's product-moment correlations were computed for each category for SF_1 versus SF_2. t-tests for correlated samples were also computed on this data as a means of determining whether in any of the coded categories, the behaviour of the subjects as a group changed significantly from SF_1 to SF_2. And finally, for each therapist an r was calculated to serve as a descriptive index in the comparison of the behaviour profiles obtained for SF_1 and SF_2.
RESULTS

The modified version of the Chagoya-Presser Scale, which resulted from discussion and coding attempts, is found in Appendix A. It consists of a set of coding rules and twenty-five operationally defined categories to describe the content of conjoint family therapists' verbalizations.

Reliability Study

Examination of the category totals for the eight interviews, as coded by the two judges, revealed that frequencies in categories $B_2$, $C$, $L_1$, $L_2$, $L_3$, $R$, $S$ and $T$ were consistently at or close to zero. These categories were eliminated from further study. It is, however, interesting to note that the only therapist among the eight coded in this study who was rated at all in $B_2$, Therapist Gives Tasks, was one of the American guests. He was also one of only two therapists who were scored at all in $T$, Therapist Lectures to the Family. It should also be noted that category $R$, Therapist Utters Facilitative Sounds, did not appear at all in SF tape coding, but did occur (in one case, 25% of the time) in T tape coding.

Fifteen of the seventeen categories for which inter-judge correlation coefficients were calculated from the transformed percentage data, proved to be very reliable. In all but categories $I$, Therapist Talks About Interaction, and $M$, Therapist Talks About the Here and Now, the obtained $r$ was .90 or higher (Table 1) and significant beyond .01.
### TABLE 1

**Correlation Coefficients:**
Reliability Study

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*p<.01

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The results of coding in categories I and M, which yielded $r$'s of .51 and .56 respectively, were examined, and discrepancies were noted. It was apparent that some of the differences in coding were due to careless omissions on the part of one or other of the coders. Others appeared to be due to the presence of words such as "family" and "everyone", which at times were included in I and at other times were not. It was agreed that such words did imply interaction, and therefore appropriate examples were added to the definition of category I.

Discrepancies in category M were due mainly to omissions from this category of interventions which had been coded in N, Therapist Talks About a Current Situation. It was agreed that in several of the discrepant statements, though a current situation was explicitly referred to, the here and now was also rather obviously involved in the therapist's intervention. This was then clarified in the expanded definitions of both categories M and N which appear in Appendix A. When the eight interviews were recoded for these modified categories, I and M, near-perfect ($r = .99$) and perfect ($r = 1.0$) inter-judge correlations were obtained respectively.
Consistency of Therapist Behaviour

The data based on the group of ten therapists, and the results of statistical procedures carried out on this data are found in Table 2. For both SF₁ and SF₂, the range and median of the percentages of interventions appearing in each category is included. A Spearman's \( \rho \), based on the medians for the seventeen categories, yielded a value of .823, which for 15 degrees of freedom, is significant beyond .01. That is, it was found that for the group, the relative frequencies of interventions falling into each category remained the same.

Of the product-moment correlations computed for each of the scale's reliably coded categories for SF₁ versus SF₂, only those for category J, Therapist talks About Feelings in the Family Without Specifying their Type, and K, Therapist Talks About Himself, Excluding Affect, were significant (\( p < .05 \)). The \( r \) for category B, Therapist Gives Instructions, approached significance, and a near-significant negative correlation was obtained for category I, Therapist Talks About Interaction.

The only significant \( t \) obtained (two-tailed, \( p < .01 \)) was for category A, Therapist Seeks Factual Information, while that for K, Therapist Talks About Feelings in the Family Without Specifying their Type, approached significance at the 5% level.

Table 3 shows the correlation coefficients which were calculated to serve as descriptive indices for each of the ten therapists, as a means of comparing their seventeen-variable profiles on SF₁ and
TABLE 2

Consistency of Therapist Behaviour:
SF1 vs SF2

<table>
<thead>
<tr>
<th>C-P Category</th>
<th>SF1 Range of %'s</th>
<th>Median %</th>
<th>SF1 Range of %'s</th>
<th>Median %</th>
<th>r</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>20-79</td>
<td>57</td>
<td>11-85</td>
<td>51</td>
<td>.12</td>
<td>.35</td>
</tr>
<tr>
<td>A1</td>
<td>0-29</td>
<td>8</td>
<td>0-9</td>
<td>0</td>
<td>.02</td>
<td>3.52**</td>
</tr>
<tr>
<td>B1</td>
<td>4-30</td>
<td>17</td>
<td>0-54</td>
<td>13</td>
<td>.60</td>
<td>.58</td>
</tr>
<tr>
<td>D</td>
<td>30-80</td>
<td>53</td>
<td>25-94</td>
<td>48</td>
<td>.28</td>
<td>.08</td>
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<tr>
<td>E</td>
<td>0-67</td>
<td>26</td>
<td>0-73</td>
<td>29</td>
<td>.44</td>
<td>.56</td>
</tr>
<tr>
<td>F</td>
<td>0-32</td>
<td>9</td>
<td>0-45</td>
<td>5</td>
<td>-.02</td>
<td>.26</td>
</tr>
<tr>
<td>G</td>
<td>0-30</td>
<td>14</td>
<td>0-38</td>
<td>10</td>
<td>.18</td>
<td>.19</td>
</tr>
<tr>
<td>H</td>
<td>0-20</td>
<td>5</td>
<td>0-22</td>
<td>10</td>
<td>.23</td>
<td>1.57</td>
</tr>
<tr>
<td>I</td>
<td>68-100</td>
<td>91</td>
<td>82-100</td>
<td>93</td>
<td>-.59</td>
<td>.44</td>
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<tr>
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<td>24</td>
<td>6-59</td>
<td>24</td>
<td>-.43</td>
<td>.32</td>
</tr>
<tr>
<td>J2</td>
<td>0-15</td>
<td>6</td>
<td>0-18</td>
<td>7</td>
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<td>.11</td>
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<tr>
<td>J3</td>
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<td>13</td>
<td>5-55</td>
<td>15</td>
<td>.67*</td>
<td>1.77</td>
</tr>
<tr>
<td>K</td>
<td>20-95</td>
<td>37</td>
<td>42-91</td>
<td>57</td>
<td>.68*</td>
<td>2.04</td>
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<tr>
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<td>77-100</td>
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<td>1.30</td>
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<td>0-18</td>
<td>6</td>
<td>-.16</td>
<td>.21</td>
</tr>
</tbody>
</table>

*p < .05
**p < .01

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SF_2'. These r's range from .53 to .92.

### TABLE 3

**Individual Profile Correlations:**  
SF_1 vs SF_2

<table>
<thead>
<tr>
<th>Therapist</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.76</td>
</tr>
<tr>
<td>2</td>
<td>.53</td>
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<td>3</td>
<td>.78</td>
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<tr>
<td>4</td>
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<td>.92</td>
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<td>7</td>
<td>.78</td>
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<tr>
<td>8</td>
<td>.92</td>
</tr>
<tr>
<td>9</td>
<td>.84</td>
</tr>
<tr>
<td>10</td>
<td>.67</td>
</tr>
</tbody>
</table>
DISCUSSION

Reliability of the C-F Scale

It appears that, with the adoption of revisions in some definitions, at least seventeen of the twenty-five categories of the Chagoya-Presser Scale can be reliably coded. Among the seventeen variables originally tested, the two judges in the present study achieved high levels of agreement in all but two. Pearson's $r$'s were, for fifteen categories, at .90 or above, and significant beyond .01. When categories I and M, which required expanded definitions, were recoded, extremely high coefficients were obtained ($r = .99$ and $r = 1.0$). These may be spuriously high values, since the raters were concentrating on those two categories only, and not on the usual twenty-five. However, it seems reasonable to assume that the new definitions for these two categories have made them as reliable as the other fifteen appear to be. This, of course, can be checked out in future studies involving the C-F Scale.

There are a number of reasons which may account for the consistently very low frequencies of interventions falling into the remaining eight categories. Examination of coding of the renowned American family therapist's SF tape revealed that some of his interventions did fall into some ($B_2$ and T) of these rather sparsely used categories. This finding lends support to the idea that some categories of the scale tap areas which may be stylistic components of some 'schools' of family therapy, and not of others. Our guest therapist, based on
a very small sample of behaviour, appears to practice a somewhat different brand of family therapy than that which is characteristic of Jewish General Hospital therapists. He seems to be more directive (Therapist Gives Tasks to the Family) and perhaps more authoritarian (Therapist Lectures to the Family) in his practice of family therapy. It stands to reason that others of the eight categories would prove more fruitful if therapists from a variety of centers were coded. Therefore, it would be premature to drop these categories from the C-P Scale on the basis of the present rather small-scale study.

Most coding for this study was done on SF tapes. The situational test involved is undoubtedly unrealistic in a variety of ways, which probably accounts also for the failure of some of the eight categories to appear very much in the coding to date. Category R, Therapist Utters Facilitative Sounds, is probably the best example of this. During recording of SF tapes, the simulated family kept talking no matter what, without requiring the gentle push of facilitative comments on the part of any therapist. And subjects interacting with the taped family could not be expected to stop the video machine in order to insert a mere "uh huh". Category R did appear in two of the three real therapy tapes coded in the reliability study, in one case comprising twenty-five percent of the therapist's interventions, which lends support to this reasoning.
Consistency of Therapist Behaviour

The results based on the $SF_1$ and $SF_2$ data for the ten therapists, which appear in Table 2, reveal some rather predictable findings. From $SF_1$ to $SF_2$, six or eight weeks later, it appears, based on the significant rho calculated on the medians, that the group as a whole did not change with respect to the relative frequencies with which the seventeen categories appeared. This may be an indication that even as early as two months into family therapy training, a general modus operandi, with respect to content of interventions, has been accepted by trainees, and that this is retained.

This latter statement is perhaps a rather global generalization, however. Not only are there obvious individual differences reflected in the wide response ranges, but within some of the categories there were marked inconsistencies from $SF_1$ to $SF_2$. In only two categories, $J_3$ and $K$, were significant correlations obtained for the group, and even in these categories, definite changes appear to have taken place over time. In the case of $J_3$, Therapist Talks About Feelings in the Family Without Specifying their Type, the upper limit of the range increased from 33 to 55%, and though the $t$ did not reach significance, there was an apparent tendency for therapists to refer more to family members' non-specified feelings. In $K$, Therapist Talks About Himself, Excluding Affect, the lower limit of the percentage range rose substantially (from 20 to 42%), as did the median (37 to 57%), pointing toward an increased tendency among therapists later in training to refer to themselves. These

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findings might have been predicted, as there is a strong emphasis, in the family therapy practiced at the Jewish General Hospital, placed upon the affective interaction among family members, and upon openness re self on the part of the family therapist.

The deflated upper limit of the range in category $A_1$, and the highly significant $t$ obtained for this category indicate a marked decrease in $SF_2$ among the therapists, to ask questions about specific non-affective matters. This finding again might have been predicted, since therapists in training in this setting are steered away from a history-taking approach to family therapy. Great emphasis is also placed upon an interactional approach to family therapy, which again comes through in the results of SF tape coding.

The elevation in category $I$, Therapist Talks About Interaction, of the lower limit of the range from $SF_1$ to $SF_2$, and the very high percentages obtained, reflect this emphasis. The rather high, though not quite significant, negative correlation obtained for this category, may be due in part to the narrow range of percents involved. In this narrow range of 18, and with an extreme upper limit such as the one obtained (100%), one would expect a shuffling of ranks among individuals, even though actual changes might be minimal. A large negative correlation might also be indicative of differential response among individuals to the training to which they are exposed.

In category $N$, Therapist Talks About a Current Situation, there was, for the group, an increase from $SF_1$ to $SF_2$, noted particularly in the lower limit of the range, which rose from 0 to 33%.
Again, it is plausible to assume that this is the result of training in the Jewish General Hospital setting, where novices are taught to consider and point out the fact that what is going on in the family during the therapy session is indicative of the family's day to day functioning.

Though the group of ten therapists as a whole remained rather stable with respect to the relative frequencies with which interventions fell into the seventeen categories, it is apparent that there were individual differences in this respect (see Table 3). Some of the therapists' profiles were rather stable from SF₁ to SF₂, as indicated by high correlation coefficients, and others were less so. Any of a number of reasons may account for this differential. A detailed look at individual therapists' profiles, which is beyond the scope of this paper, might reveal that those whose profiles changed substantially were those who in SF₁ least resembled the 'norm' for Jewish General Hospital family therapists. Or, perhaps those who did not exhibit stable profiles would prove to be generally inconsistent therapists, whose behaviour in the therapy situation will tend to fluctuate from session to session. Or these might prove to be the most inexperienced psychotherapists, those who haven't settled into a 'style' of conducting therapy. There are probably endless hypotheses such as these which might be offered. Only with the results of further studies will the reasons be revealed.
The Potential Utility 
of the C-P Scale

The present work has shown, at least tentatively, that the Chagoya-Presser Scale for Describing the Content of Family Therapists' Verbal Interventions is a reliable and potentially very useful content analysis system. Before undertaking any large-scale studies based on profiles obtained with the scale, one would be well-advised to again carry out reliability checks, using trained raters previously unfamiliar with the scale. It is reasonable to assume that the very high reliability obtained in this present study might have been due, in part, to the two coders' involvement in the development of the scale. It would be revealing, too, to code therapists trained in a variety of family therapy 'schools', to assess how well the scale reflects differences in orientation. Such a study would also shed light on the usefulness of those categories which did not appear in the profiles obtained in the present study.

The external validity of the present consistency study is undoubtedly limited in a number of respects. Not only is the sample size small, but the simulated family situational test tapes which were coded for this study may prove not to be at all comparable to the real therapy situation. This could be tested out in a study resembling that of Guttman et al. (1972), which showed that for some variables which they studied, the SF results were predictive of behaviour in real therapy, while for others this was not so.

Eventually, based on profiles obtained with the C-P Scale, some
basic styles of family therapy may be found to exist. Factor analyses may lead to the enunciation of certain family therapist 'types'. But before studies such as this are undertaken, it would be wise to do a large-scale consistency study, perhaps similar to the present one, but with experienced, practicing family therapists, rather than with novices as subjects. It remains to be seen whether family therapists do, in fact, display a characteristic style of intervention which is relatively stable from session to session, and with different families. Ultimately, and only once families and their interactional patterns are studied in depth, it will perhaps be possible to study the relationship between family therapist and family in treatment, with the aim of being able to predict the best possible matching to achieve positive outcome.
REFERENCES


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Appendix A

THE CHAGOYA-PRESSER SCALE FOR DESCRIBING
THE CONTENT OF FAMILY THERAPISTS' VERBAL INTERVENTIONS

RULES FOR CODING

1. Coding is to be done directly from recorded family therapy interviews. To aid in coding, the coder may write out the therapist's interventions. Or, if transcripts are available, these may be utilized.

2. Interventions should be coded one by one, in order, as they appear on the tape.

3. The unit to be coded is the single therapist speech, which is defined as anything the therapist says between the utterances of family members. However, when the content of the therapist's intervention changes suddenly, and it is perceived that something happened while he was speaking to make him change the content of his intervention, this should be considered a non-verbal interruption, and what follows should be coded as a new intervention.

4. Any one intervention can contain any combination of the scale's categories, but even if a category appears more than once in a given intervention, it is checked only once for that intervention.

5. It should not be decided that a given intervention belongs in a category because it is implied. An intervention should be classified into a category only when it is obvious to the coder what kind of comment the family therapist is making, or what its purpose is. Inferring should be avoided.
A - THERAPIST ASKS QUESTIONS

Check here any question. Include also interventions which are grammatically not in question form, but which, from their tone or context are apparent questions. e.g. "I wonder how that makes you feel when..."..."I wonder what it is that makes you feel this way."

A1- THERAPIST SEEKS FACTUAL INFORMATION

Check here any statement in which the therapist inquires about precise, defined data, or about details of a specific event, without the affect that such an event or such data provoke. e.g. "When were you born?"..."How many times a week do you go out?" Include questions about age, time, color of eyes, or precise data of that sort.

B1- THERAPIST GIVES INSTRUCTIONS

Check here any statement in which the therapist tells the family to do something specific during the session. These may be direct demands or ones which are rather indirect but nevertheless request that family members do something specific during the session. e.g. "Tell John how you feel"..."Give your father a chance to talk."... "Let's see if you can explain to your wife how you feel."..."Would someone like to console Susan?"

B2- THERAPIST GIVES TASKS

Check here any statement in which the therapist tells the family to do something specific between sessions. e.g. "This week I want you to keep your bedroom door locked."..."I'd like you to discuss at home what we have talked about today."
C - THERAPIST GIVES FACTUAL INFORMATION

Check here any statement in which the therapist tells the family about precise, defined data, or about details of a specific event, without the affect that such an event or such data provoke. e.g. "Next Monday the building will be closed."..."I am a psychiatrist, not a psychologist."

D - THERAPIST CLARIFIES MESSAGES

Check here any statement in which the therapist, without referring to motives, causes or intentions, talks about the meaning or sense of what family members express through behaviour, affect, or words. e.g. "So what you mean is that you feel pleased when she does that."..."What you are trying to say is..."..."You just made a pass at your mother."..."You seem very sad now." When in doubt as to whether to classify a statement in D or E, use D.

E - THERAPIST EXPLAINS MOTIVES, CAUSES OR INTENTIONS

Check here any statement in which the therapist talks about motives, causes or intentions in the behaviour, affect or words of family members. e.g. "Maybe you provoke your son because you enjoy fighting with him"..."You seem very sad now. Perhaps that is because of what your son said." When in doubt as to whether to classify a statement in D or E, use D.

F - THERAPIST REPEATS WORDS USED BY THE FAMILY

Check here any statement in which the therapist includes the exact words used by the family. The statement should contain a
G - THERAPIST TALKS ABOUT NON-VERBAL MATERIAL

Check here any statement about the presence of silence in the interview, about the style of verbalization ("You sound angry."), about movements, gestures and position, about other concomitants of speech, about facial expression, affective tone, and gross motor behaviour. e.g. "You look sad."..."Why are you sitting away from the rest of the family?" Do not include statements which are only implicit references to non-verbal material ("You feel regretful."). These are classified under D, Therapist Clarifies Messages. Exclude metaphors like "pat on the back", "sitting back", "getting between", "lying down and taking it". Include only those statements that refer to non-verbal behaviour which occurs during the interview.

H - THERAPIST TALKS ABOUT QUANTITY AND TIMING OF VERBAL BEHAVIOUR

Check here any statement in which the therapist mentions how much a family member talks, or when. e.g. "You always talk"..."You haven't said anything yet". If the therapist makes a statement such as "You interrupt your mother", this should not be included in this category because he is not saying how the member interrupts, i.e. the nature of the interruption is not specified. A statement such as "You talk so much that you are always interrupting your mother" should be included in H, I and M.
I - THERAPIST TALKS ABOUT INTERACTION

Check here any statement in which the therapist links, in any way, two or more family members that are present in the particular session. e.g. "You get depressed when your husband..."..."Jean laughed after you coughed."..."Why does Sheila scream when she talks to the family?"..."We are all getting tired of this session."..."This family seems very sad now."..."Ask him." (You ask him is implied).

J₁ - THERAPIST TALKS ABOUT DISTRESSING FEELINGS IN THE FAMILY

Check here any statement in which the therapist talks about unpleasant affect in family members. e.g. "You hate her when..."..."Nobody in this family likes this conflict." In this last example, the words "nobody likes" is equivalent to "everybody dislikes".

J₂ - THERAPIST TALKS ABOUT WELFARE FEELINGS IN THE FAMILY

Check here any statement in which the therapist refers to pleasant feelings in family members, or those that bring family members closer to each other. e.g. "You all love each other". Sometimes sadness can be included in both J₁ and J₂. e.g. "I noticed that when you talk about your dead child, you are closer to each other and share in the sadness."

J₃ - THERAPIST TALKS ABOUT FEELINGS IN THE FAMILY WITHOUT SPECIFYING THEIR TYPE

Check here any statement in which the therapist mentions affect in the family with no further elaboration. e.g. "You are not saying
what you are feeling."..."How do you feel?". At times, the word
"feel" is used to explore an opinion. e.g. "How do you feel about
John going to Central High?" This is not a reference to affect.
When the words "what do you think" or "you think" can be substituted
for the words "what do you feel" or "you feel", the statement should
not be included in J. Do not include statements such as "You are
smiling" which only imply affect.

K - THERAPIST TALKS ABOUT HIMSELF, EXCLUDING AFFECT

Check here any statement in which the therapist refers to him­
self using a personal pronoun (I, me, myself, mine) or his own name
e.g. "You think Dr. Chagoya is crazy", or when the therapist refers
to himself together with one or more family members, using pronouns
such as we, us, both of us. This category includes any statement in
which the therapist involves or includes himself, speaking about his
own interests, thoughts and actions, but not about his affect.
e.g. "If you were my son, I'd spank you"..."I think you're acting
silly to get attention." Exclude such facilitative comments as "I
see". Such interventions are classified in R only.

L₁ - THERAPIST TALKS ABOUT HIS OWN DISTRESSING FEELINGS

Check here any statement in which the therapist talks about his
own unpleasant affect. e.g. "I feel sad"..."I am angry."

L₂ - THERAPIST TALKS ABOUT HIS OWN WELFARE FEELINGS

Check here any statement in which the therapist talks about his
own pleasant feelings. e.g. "I love my wife, even though we fight at
times).

L - THERAPIST TALKS ABOUT HIS OWN FEELINGS WITHOUT SPECIFYING THEIR TYPE

e.g. "How do you think I feel?"

M - THERAPIST TALKS ABOUT THE HERE AND NOW

Check here any statement in which the therapist refers to something that is happening, has happened, or will or might happen in that particular session. e.g. "You are annoyed."..."You just said..."..."Tell her how you feel"..."How do you feel about what she did?" Often the therapist's statements about current situations also refer to situations occurring in the here and now. These should be checked in both M and N.

N - THERAPIST TALKS ABOUT A CURRENT SITUATION

Check here any statement in which the therapist uses the present tense to talk about an ongoing situation in the family, the home etc. e.g. "He never helps you". Often the therapist's statements about the here and now also point out current situations. When this is obvious to you, check both M and N. e.g. "There seems to be an alliance of the kids against the parents."..."They are all ganging up on you. How does it feel to be the scapegoat?"

P - THERAPIST TALKS ABOUT THE PAST

Check here any statement in which the therapist uses the past tense to talk about something that happened before the session (hours, days, years). e.g. "You felt hurt in those days."..."Why didn't you
Q - THERAPIST TALKS ABOUT THE FUTURE

Check here any statement in which the therapist talks about something that is going to happen or might happen in the future, after the session. e.g. "It will be hard for you to do this at home but..."..."Please call Dr. Jones tomorrow."

R - THERAPIST UTTERS FACILITATIVE SOUNDS

Check here any sounds or interventions of one or two words that indicate that the therapist is following the discussion. e.g. "Mm-hmm"..."So"..."Well". When this category is checked, no other one should be for that intervention.

S - THERAPIST USES SOCIAL NICETIES

Check here any statement in which the therapist uses convention-al words or phrases which show politeness, such as please, thank you, you're welcome, good morning.

T - THERAPIST LECTURES TO THE FAMILY

Check here any statement in which the therapist uses a general-ization about the human condition, life, morals, ethics etc. e.g. "Understanding and accepting are two different things"..."Dishonesty is a very bad policy."

U - UNSCORABLE

Check here any statement of the therapist's which you find
unscorable, that is, which you cannot fit into any of the above categories.