1976

COUNSELOR VARIABLES INFLUENCING THE OUTCOME OF THE DIRECTIVE PARENTAL COUNSELLING SYSTEM.

CHARLES T. CAPANZANO
University of Windsor

COUNSELOR VARIABLES INFLUENCING THE OUTCOME OF THE DIRECTIVE PARENTAL COUNSELLING SYSTEM

by

Charles T. Capanzano
M.A. University of Windsor, 1973

A Dissertation
Submitted to the Faculty of Graduate Studies
through the Department of Psychology
In partial fulfillment of the
requirements for the degree of
Doctor of Philosophy in Psychology
at the University of Windsor
Windsor, Ontario, Canada
1976

ABSTRACT

The present study was designed to determine the relative importance of a variety of counselor variables to the success of Directive Parental Counseling (D.P.C.), a parent training program recently described by Holland (1976). A second general purpose of this study was to assess the effectiveness of previously inexperienced D.P.C. counselors.

Twenty-four, third year, nursing students were trained in the D.P.C. technique in twelve, two-hour didactic sessions. During the intervention phase each counselor scheduled ten sessions with the mother of a child who had been referred to the D.P.C. program because of behavioral difficulties. Counselors also attended weekly group supervision sessions conducted by psychology graduate students experienced in the D.P.C. technique.

One family dropped out of treatment and one counselor was hospitalized. Of the twenty-two remaining families, thirteen were judged to be treatment successes by a rigorous criterion - a 60% decrement of the target problem behavior. The low treatment drop-out rate and the high average behavioral decrement (61.14%) compared favorably with other studies. There was also a significant change in the mother's perception of her child's problem behavior attributable to distractibility. There were no statistically

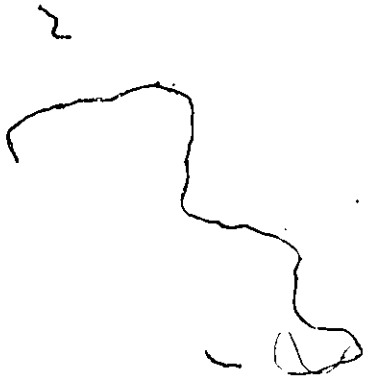
significant changes in the mother's attitudes towards a) acceptant and positive treatment of children; b) towards the family, and; c) towards internal-external control and in the mother's mood as measured by six scales. However, of sixteen scales measuring changes in the mother's mood or attitude, fifteen changed in the expected direction.

Of six counselor variables selected as a priori predictors of behavior decrement, three were found to be significant predictors (internal control, trust and emotional stability). In total, 17 of 117 counselor variables were significantly correlated with behavior percentage decrement. Successful counselors displayed more unconditioned regard; more affiliative and affectionate behavior and desire more control behavior. They value a sense of accomplishment, true friendship, wisdom, being capable and being responsible more highly than do unsuccessful counselors. However, unsuccessful counselors value family security, being courageous and being polite more highly than do successful counselors.

Of twenty-five family pre-test variables, only two were significantly correlated with behavior percentage decrement. The mother's satisfaction with both the therapy and the therpist was high.

Several factors which made this study more generalizable to clinical treatment programs than most other research

studies were discussed. The importance of therapist variables in behavior therapy and the utility of using paraprofessionals in mental health were also discussed.



ACKNOWLEDGEMENTS

The massive project described between the covers of this dissertation involved many hours of effort and toil by many people. I may have had to research pellet preferences in rats or a similar researchable (if irrelevant) topic had it not been for the generous financial support of the Laidlaw Foundation. I am particularly indebted to Dr. C. J. Holland and Dr. R. M. Daly who developed the D.P.C. system, obtained the research grant and offered continual support and assistance throughout the project. A night owl myself, I deeply appreciate the sacrifice these fine teachers and clinicians made on those early autumn mornings when they transformed third year nursing students into competent D.P.C. counselors. The fact that both scholars were on a sabbatical leave from the department makes their sacrifices even more noteworthy. In particular, I would like to laud my dissertation chairman, Neal Holland who had offered his time and energies when he was facing a serious life crisis. I have learned much from this inspiring and brilliant man. I also wish to thank the other competent members of my committee, Dr. Robert Fehr and Dr. Robert McDonald for their interest, involvement and willingness to provide assistance at any time. Their support and incisive comments were greatly appreciated.

Special thanks also goes to the other five psychology graduate student consultants for their enthusiasm, co-operation and needed emotional support in many phases of this project. Tony Fellbaum was particularly useful in helping me to select the assessment instruments used in this study and in providing me with tennis games to relieve the tension. Fred Meek's assistance in helping to recruit D.P.C. families was invaluable. The other consultants, Dennis Bellehumeur, Janet Fulgenzi and Alex Weinberger like Fred and Tony were a pleasure to work with. This complicated project could have been aborted at many phases had it not been for the co-operation and good humor of these competent, friendly individuals.

I also appreciate the co-operation that the nursing department has extended to us. Twenty-four eager nursing students are thanked for their enthusiasm in carrying out the parent training and their undaunted perserverance in collecting the data. Janet Rosenbaum, of the nursing department, was a helpful liason to the nursing department. Lila Comiskey and Sharon Girling of the nursing department are thanked for the supervision they provided throughout the program.

I also thank the many people who assisted in the referral process. Naida Hyde, William McDermott and Martin Girash at Regional Children's Center, Windsor Western

Hospital Center and Mike Stroud at Children's Aid Society of Essex County were particularly helpful.

I was also grateful for statistical and computer assistance provided by Hau Lei, Dr. Meyer Starr and Larry Starr. Mary Trussler also assisted in keypunching.

Bubbly Jocelyn Fleming deserves much praise for her management of the D.P.C. office. She was willing and able to transform scribbly scrawls into polished typed products on short notice. My dissertation typist, Sue Breeze also deserves honorable mention for her helpfulness and devotion to the project. Dorothy Adair, the clinical division secretary was also helpful throughout the project.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

A revolutionary way of conceptualizing aberrant human behavior was adopted at the beginning of the ninteenth century. Philippe Pinel in France, William Tuke in England and Benjamin Rush in America insisted that 'insane' people should be treated with kindness and dignity (Hobbs, 1964). Their difficulties were no longer considered as signs of moral depravity but as symptoms of medical disorder.

The mental health revolution was slower in changing the attitudes towards unacceptable and aberrant behavior of children. Initially, only grossly abnormal behavior was considered as warranting the intervention of mental health professionals. The child was seen as being morally obliged to adapt to the environment of his home.

Psychotherapy With Children

Kanner (1957) notes that child psychiatry is a twentieth century phenomena. In the first decade of this century there emerged several cultural trends favorable for the psychiatric consideration of children. Kanner notes four manifestations of this change: 1) Binet and Simon developed psychometric instruments which stressed the individual differences of children and

suggested that adult society should conform to the child's individual needs and abilities; 2) The popularization of the concepts of dynamic psychiatry, which viewed childhood events as precursors of later maladjustment, fostered an interest in studying the difficulties encountered in childhood; 3) The establishment of separate courts and separate legal criteria for juveniles fostered a desire to know why children were motivated to flout rules prescribed for them by adults; 4) The emergence of the mental hygiene movement and its emphasis on prevention set the stage for the development of special facilities for children with behavioral problems.

In the second decade of this century better community facilities for the adjustment of problem children were created (1957). Special education classes were developed for retarded or otherwise handicapped individuals. The juvenile courts were given the authority to remove children from homes in which they suffered from proven parental neglect or brutality. The child was no longer seen as being forced to conform to hostile family environments. In these cases, however, the tendency was to immediately remove the child from such homes. Parent training was rarely considered at this time. Instead there mushroomed a series of foster home placement organizations. The use of probation by juvenile courts as an alternative to incarceration also increased during

this period.

During the 1920's child psychotherapy was practiced almost entirely in community child guidance clinics. The emphasis was on the evaluation of the child's difficulties rather than treatment (Robinson and Bender, 1957). The child guidance movement was dominated by psychoanalytic thinkers. Conscious conflicts, situational stresses and realistic life situations were ignored in favor of a study of individual psyches, unconscious conflicts and irrational motivations (Ackerman, 1954). Brown (1975) notes that the arcane theorizing of psychoanalysis resulted in many failures and a tendency to blame all the problems upon the parents. Rarely were parents and children treated together.

In the 1920's children were less likely to be permanently institutionalized than they were in previous decades. Public assistance made it possible for many children who had previously been sent to orphanages to remain in their own homes or alternative foster homes. As this occured many institutions shifted from child care to providing psychiatric help for children with emotional problems. Eventually these centers evolved into residential psychiatric centers. Robinson and Bender (1957) cite several examples of such transitions. (Children's Service Center in Wilkes-Barre, Pennsylvania, the Cleveland Jewish Orphan Home, etc.). In the

1930's and 1940's these centers began to specialize in treatment of the child. Unfortunately treatment often occured in a 'vacuum'. The child was regarded as the problem and follow up work with the parent in the home was seldom carried out. During the 1940's and 1950's the use of milieu therapy - i.e., an emphasis on the therapeutic setting as an aspect of treatment; became increasingly popular (Robinson and Bender, 1957). During these decades there were basically two therapeutic alternatives: the child guidance clinic or the inpatient psychiatric setting. Both settings tended to ignore environmental and interactional phenomena. In the past decade, a third alternative, behavior therapy has become increasingly popular.

Behavior Therapy With Children

Behavior therapy is a term coined by Eysenck (1959) to denote a system of psychotherapy based on the explicit application of principles of learning to disorders of behavior. There were scattered reports of such application in the 1920's by Pavlov and his students in the Soviet Union and by students of J. B. Watson in the United States (Jones, 1924; Watson and Rayner, 1920). In 1938 Mowrer and Mowrer published their report on the classical conditioning treatment of enuresis with children (Mowrer and Mowrer, 1938). However, as Brady (1971) notes it was not until the 1950's that behavior therapy emerged as

a comprehensive and systematic approach to clinical problems.

The classical conditioning theory of Ivan Pavlov has been used by Wolpe (1958) as the theoretical rationale for his systematic desensitization technique. Classical or respondent learning is the modification of a naturally occuring reflex arc in which a neutral or conditioned stimulus is substituted for the natural or unconditioned stimulus (Werry and Wollersheim, 1967). With the exception of a few treatment programs aimed at eliminating enuresis (Martin and Kubly, 1955; Lovibond, 1964) and a few cases in which systematic desensitization was used with children (Tasto, 1969 and Montenegro, 1968) respondent techniques have not been used frequently with children.

Operant techniques are based on Thorndike's law of effect and on the operant theory of Skinner (1938). Operant learning involves the organism operating on the environment via his voluntary nervous system. What responses an organism makes is considered to be a function of the consequences or reinforcement which followed the same act on previous occasions. Operant conditioning has been applied to a variety of children's behavior. Fire-setting (Holland, 1969), toilet training (Madsen, 1965), withdrawal behavior (Allen et. al., 1965), aggressive behavior (Zeilberger et. al., 1968), encopresis (Conger, 1970), self-injurious behavior (Peine, 1972),

seizures (Zlutnick et. al., 1975), noncompliance (Forehand, et. al., 1974) and many other behaviors have been modified by operant technology. At present operant technology enjoys widespread useage in child treatment centers throughout North America. In particular, training facilities and schools for mentally retarded and autistic youngsters rely heavily on these techniques.

Brady (1971) notes the rapid increase in the number of articles and monographs on behavior therapy and implies that interest in this treatment modality is increasing. He believes that behavior therapy's emergence from the science of human behavior is an important reason for this increased popularity. This approach emphasizes objective observation and measurement. These characteristics have enabled behavior therapy to operate as an effective and efficient delivery system when compared with existing alternatives. Brady suggests that behavior therapy's emphasis on the scientific method will insure that further improvements will be made. With the self-critical demanding nature of the researcher, the behavior therapist constantly assesses the efficacy of his procedures and continues to look to the learning laboratory for new clinical applications.

Paraprofessionals As Therapists

While behavior therapists have reconceptualized psychopathology and psychotherapy in terms of overt

behavior, the systems that deliver these services have also been re-examined. In particular, the necessity of employing 'professionals' to address the multitude of mental health problems has been questioned by many (Hobbs, 1964; Guerney, 1969). With the increasing popularity of client-centered therapy and behavior therapy, there has been less of a need for professionals with intensive, lengthy and costly training. Guerney (1969) notes that these two therapies share certain characteristics which are amenable to the paraprofessional model: 1) Both have an ahistorical approach to the therapeutic task; 2) The basic set of principles of both therapies are simple, few in number and easily comprehended by most people, and 3) Both therapy systems rely upon patterns of behavior which can be specified, taught and measured with relative ease and reliability.

Guerney however, cautions that not everyone can become a successful mental health paraprofessional. The practitioner must have certain personal qualities such as a reasonably adequate intellect, patience, interpersonal sensitivity, self-control, and a strong motivation to help others. Given the necessary personal qualities a relatively short training period is still necessary to transform the lay person into a successfully functioning paraprofessional. Unfortunately there has been little research which has specified the attributes which are

necessary for a lay person to become a behavior change agent.

Several recent trends in mental health support the use of paraprofessionals. Mental health professionals are placing a greater emphasis on educational efforts designed to prevent mental and emotional difficulties. It is honed that money spent in drug addiction, alcoholism and other prevention programs in this year's budget will translate into decreases in the much more expensive treatment columns in future budgets. Paraprofessionals and volunteers can be readily employed in such volunteer efforts. There is also an increasing tendency to treat behavioral and emotional problems in the natural environment in which they occur. Institutionalization at medievial-like, remote, medicinally sterile, mammoth psychiatric hospitals and hospital-schools for the mentally retarded is becoming less common. The populations of institutions such as St. Thomas Psychiatric Hospital decreases yearly. Meanwhile, there has been a corresponding increase in outpatient services and short-term hospitalisation at such facilities as Windsor's Western Hospital Centre. Mentally retarded youngsters are also more likely to be cared for and trained in their community. There are too few 'traditional' mental health professionals (especially psychiatrists and psychologists) in the local community to effectively cope with this increasing work-

load. An increasing reliance on paraprofessionals has resulted.

Paraprofessional mental health workers have included carefully selected housewives (Rioch, 1966); college student volunteers (Reinherz, 1964); teenage peers (Perlmutter and Durham, 1965); teachers (Harris et. al., 1964) and parents (Holland, 1969). Nurses have also been used as therapists (O'Neal, 1972). The present study utilizes the skills and efforts of both nurses and parents.

Parents As Therapists

There is agreement that parents should be trained, but controversy over what type of training they should received (O'Dell, 1974). Nonbehavioral approaches include teaching parent skills such as insight (McNamara, 1963), communication techniques (Gordon, 1971) and warmth and empathy (Johnston, 1967). O'Dell has listed several advantages in using the behavioral approach in parent training: 1) People unskilled in sophisticated therapy techniques can learn the principles of behavior modification and carry out treatment programs; 2) Many persons can be taught at one time; 3) Behavior modification is based on empirically derived theory; 4) Only a short training period is usually required; 5) A minimum of professional staff can have more impact than in the one-to-one treatment models; 6) Many parents like a treatment model that doesn't assume sick behavior based on the medical

model; 7) Many children have well defined behavior problems which are conducive to behavioral treatment; 8) Behavior modification is well suited in dealing with problems in the natural environment; 9) Research demonstrates that parents are successful in carrying out behavior modification programs with their children.

Group treatment of parents began during World War II when personnel shortages were high. Until 1960, these groups utilized 'conversational' methods (O'Dell, 1974). During the early 1960"s behavior modification was applied to a variety of problem situations including parent-child relationships. O'Dell (1974) credits Pumroy (1965) as being the first investigator to specifically study the effects of teaching parents the principles of behavior modification. Ten of eleven experimental families reported behavioral change two months after the sessions. Other studies quickly followed. O'Dell (1974) has reviewed 70 such studies. In addition, there were many studies which his excellent review ignored (e.g., Nolan and Pence, 1970) and many studies which have been published since his review (e.g., Zlutnick et. al., 1975).

A variety of parent training approaches have been applied to virtually all child problem behavior, ranging from mild conduct problems to grossly psychotic behavior. In nearly all such programs the mothers are the primary object of training and bear the major responsibility for

carrying out the home programs. The home programs are usually aimed at the reduction of maladaptive 'surplus' behavior such as aggressive or hyperactive behavior. (Berkowitz and Graziano, 1972).

The training in such programs usually consists of operant conditioning approaches. A variety of training methods have been used. Parents have been trained individually and in groups, through lectures, assigned readings in programmed materials, group discussions, modeling and direct coaching. Telephones, audiotapes, videotapes, films, bug in the ear devices and various signal mechanisms have been used as training aides.

A review of the literature suggests that training parents in behavior modification techniques can lead to behavioral change in their children. The majority of the early reports of success were case studies. More recently, several large scale studies have been conducted. Walder and his colleagues (Walder et. al., 1972) have developed a successful training program which has been used with more than 50 sets of parents. Patterson (1974) has developed a sophisticated program which has been successfully used by many families. His approach aims to modify multiple classes of deviant child behavior. His research has been viewed by O'Dell (1974) as the most rigorous in terms of experimental methodology. Patterson has developed sophisticated observational and recording

techniques to validate the parent's reports of behavioral change.

Rose (1974) has taught behavior modification techniques in groups to both natural and foster parents of retarded children. The group leaders used programmed booklets, modeling and behavioral rehearsal, lecturing, discussion, weekly assignments and positive reinforcement. Following completion of training in eleven groups, 27 of the 33 families entering the program successfully modified 55 of the 58 behaviors for which plans were intitiated.

Recently Rinn, Vernon and Wise (1975) have presented the results of a three year program evaluation of their child management course. Over this time period over 1,100 parents were instructed in the principles of applied operant learning. The findings suggested that the course was effective. Eighty-four percent of the parents reported at follow-up that they had not sought further therapy for their problem child. Children whose parents completed the course were more likely to reach behavioral goals than children whose parents were placed in a no-training control group. Parents were satisfied with the course. The Rinn group found that the instructor's title and professional status did not affect the success of treatment. Two instructors, one titled Ph.D., the other M.A., were both previously described as popular, charismatic and informative. They were equally effective on all

treatment measures. Mira (1970) found that teachers, social workers, psychiatrists and parents were equally effective in acting as behavioral managers in a behavior modification program. These findings add further evidence that paraprofessionals and masters level personnel can be effectively and efficiently employed to implement behavioral programs as well as training parents in behavioral techniques.

Early research in this area was only concerned with the question of effectiveness: Can parents be trained to successfully modify their child's problem behaviors? Empirical data has repeatedly answered this question affirmatively. Researchers have become increasingly more stringent in the past decade but they have arrived at the same conclusions. Loose, uncontrolled case study information has been supplanted with highly controlled experiments with careful measurement. Reversal designs (reinforcement contingencies are reversed or witheld for a brief period and then reinstated), multiple baseline procedures (taking measurements also on behaviors which are not the target behavior of the program), control groups, observers to collaborate parent's report of behavior change and recording schemes have all been used by various researchers. Rigorous research has not changed the answer to the efficiency question.

There have been suggestions that attention to such

rigor is often unnecessary. For example, 46% of the studies reviewed by Macdonough and McNamara (1973) reported the use of unbiased observers. Training observers is costly and time consuming. Trained observers may also be unnecessary. There is evidence that parents can be very reliable observers. O'Leary, Turkewitz and Taffle (1973) found that the correlation between the parent's and the therapist's ratings of improvement for each problem was highly significant. Rinn and his colleagues (1975) also found that parents were reliable observers. Parents were asked to count the frequency of the specified behavior. Their results were compared with the recordings of trained observers. Eight visits were made to each of eight different homes. Seventy-five per cent of the observations coincided temporally.

Ferber, Keeley and Shemberg (1974) have reported problems in parent training procedures that utilized Patterson's very rigorous and expensive methodology. They found that despite attempts to structure observational sessions, families can and do constrain their interactions. Important target behaviors of the child are frequently not observed. Another difficulty was that changes in frequency counts failed to reflect the differential severity of problems. A 50% drop in high rate behavior such as noncompliance thus is not clinically equal to a 50% drop in low rate behavior such as fire setting. The

authors note that their findings raise additional questions about the meaningfulness of percentage change when target behaviors are combined both in terms of particular behaviors put in combination and in terms of of the number of responses combined. The Ferber group also are aware of the pitfalls of relying on simple 'codes' for classifying behavior. Target responses are embedded in the context of family difficulties. Specific codes obtained under specific conditions may not reflect change in a family's overall adjustment.

There are also indications that the emphasis on experimental rigor has retarded the exploration of other questions regarding parent training. Only recently have researchers formulated more sophisticated questions. For example Nay (1975) has asked not only whether parent training is effective, but "What type of parent training is most effective?" He gave instructions in time out procedures to 77 mothers. They were trained according to one of four instructional techniques: 1) written presentation, 2) lecture, 3) videotaped modeling, and, 4) modeling and roleplaying. Modeling and roleplaying in combination was found superior to the written presentation and lecture formats. There are many neglected areas in this field. O'Dell (1974) notes that studies tend to focus on the child's outcome behaviors and ignore descriptions of the parent and counselor behaviors that produce changed. The

counselor characteristics that may facilitate change have also been ignored.

Research in the natural environment is complex, time consuming and costly. Baer and his colleagues (1968) note that the experimental control required of applied studies has become less than that required of laboratory research because of the restraints that society puts on the manipulation of behavior for the sake of science.

The Nurse As A Behavior Modifier

Nurses have also recently participated in behavior modification programming. O'Neil (1972) has reported three studies in which she applied behavior modification techniques to nursing problems presented by three children with neurological disorders. In the first study, a program consisting of reinforcement and fading techniques was used to teach crutch walking to a five year old girl with cerebral palsy. O'Neil presents evidence that the techniques were effective in teaching motor skills to the handicapped girl. In the second study, two programs using reinforcement were used to teach a four year old mentally retarded boy to hold and manipulate objects. In the third study, nonverbal imitation training and reinforcement was used to improve attentiveness to instructions. O'Neil found that children complied with instructions more quickly following imitation learning. After presenting her experiences with behavior

modification, O'Neil concludes that this technology is a useful methodology for nursing intervention, since it is both "convincing and practical".

Kiernan (1973) has presented evidence that there is a substantial need for the development of the nurse as a trainer, teacher or therapist. Kiernan emphasizes the practical utilization of nurse therapists in hospital schools for the mentally retarded. In these facilities other professionals (e.g., occupational therapists, psychologists) are too few to cope effectively with the problems presented. Generally, residents in such settings are low in self-help and communication skills and show common problem behaviors. Kiernan convincingly argues that behavior modification techniques are valuable with many hospitalized patients. He suggests that the number of nurses at "mental subnormality hospitals" in Great Britain be increased and that finances and energy be devoted to the development of training programs in behavior modification.

The present study, will utilize nurses as didactic counselors. They will teach behavioral techniques to parents. Two nurses, Kyle and Savino (1973) have effectively utilized group instruction to teach parents behavior modification. Their program is an eight session, two hour per week course in behavioral principles and techniques. Usually four to seven families are

enrolled in each course. Classes include didactic material discussion and work on individual problems. After the parents are given a theoretical background they are asked to assess their children's behavior and evaluate the efficiency of the interventions they use. Each family is then asked to bring to class graphs of the target behavior's occurence during a specific time sequence, plus an anecdotal report that includes details about activities both before and after the target behavior. Kyle and Savino also employ visual aids, films, roleplaying and the behavior modification primer Living With Children (Patterson and Gullion, 1971). The last class is an evaluation session in which families discuss their expectations, attainments and disappointments. Evaluation sheets are completed. Follow-up assessments are conducted after one, three and six months. In assessing the 51 families who completed the course the authors have abstracted two factors which they feel are involved in changing a child's disruptive behaviors: 1) The willingness of the parents to accept the fact that they have a problem in their interaction with their child; 2) Their willingness to change. They report that "In all families...as the child's behavioral pattern changes, the parents' attitude changes too;" and a new and better relationship is built between parents and child.

Kyle and Savino's article is the only report known

to the author which describes an attempt to utilize nurses to teach parents behavior modification. Unfortunately, no quantitative evaluation of their success in this endeavor is presented. Their impressionistic report however, is encouraging.

The Directive Parental Counselling System

D.P.C. is a specific therapeutic technique designed to train parents as therapists for their children. This approach evolved from the systematic application of learning principles to the problems of childhood. The D.P.C. is described in detail by Holland and Daly (1975). While many clinicians are presently utilizing similar principles in their practice they rarely present a specific description of how their operations are carried out.

The core of the D.P.C. program is a 30 point teaching syllabus. Each point has prepared instructional materials, exercises and specific concepts or sub-points. The program designates specific operations which a counsellor follows in a clearly defined sequence until the training process is completed. Detailed operations are clearly delineated and continuing feedback is provided. A counsellor's manual (Holland and Daly, 1975) provides this complete description of D.P.C. technology. The purpose and usage of each point is described as well as descriptions of the potential problems which are encountered in applying each step and suggested solutions.

Holland's (1970) interview guide is the theoretical basis of the counsellor's manual. While explicitly stated, the manual suggests that it not be used mechanically. The counsellor still must rely upon his traditional skills in listening and communication and maintain an appropriate rhythm and pace in his delivery.

The parent(s) has an accompanying manual (Holland, 1974) which they utilize during the sessions and at home. Standard recording instruments and some instructional materials are placed in the manual. The parent and counsellor-instructor can use the manual as a springboard for discussion. Its most important function is as a source of reference for the parents.

Presented in Appendix A is a schematized overview of the D.P.C. procedure as outlined by Holland and Daly, (1975). The authors admit that their description is not a complete account of all the operations which might be performed in the D.P.C. counselling situation. Some flexibility and ingenuity will always be required from therapists. However, this general over-view does provide the reader with an example of a relatively replicable technique. In Appendix A the 30 points are listed as well as functional operations which must be executed at each point.

D.P.C. Research

The D.P.C. program has been used successfully for

approximately a decade. Brown (1975) found that the technique can be effectively applied in a group format by "experienced psychotherapists" who had a mean of 14.3 years of clinical experience. Parents taught in such groups were able to modify their children's target problem behaviors. Brown also found that the application of the D.P.C. program resulted in attitudinal changes and non-target-specific behavioral changes. Parents felt more positive towards their children and toward themselves as parents. The program was also helpful in shifting control of reinforcers for child behavior from sources outside the family to the parents. Brown noted that the D.P.C. program was not found to significantly influence the role perceptions the parents have of their spouses or their attitudes towards the total family unit.

Hyde (1975) found that the D.P.C. could be successfully applied by less experienced graduate trainers; psychology graduate students. They were described by Hyde as having minimal clinical skills and being previously untrained in behavior modification. Hyde's trainers met individually with their parents. Her results indicated that there were significant decreases in targeted problem behaviors and that these decreases were maintained over a three month period following the training program. Hyde found that there were significant changes in the parent's perceptions of child problem behaviors. However there was no significant

changes in parent-child relationship attitudes and the parent's perception of behavior change and personality adjustment. Since Brown (1975) found significant changes in these areas, the level of therapist training and experience may be a significant variable in effecting attitudinal changes. This experience does not seem to be as necessary for the effectance of changes in target behaviors.

Therapist Variables and Therapeutic Outcome

One of the most popular areas of clinical research continues to be the analysis of empathy, warmth, therapeutic genuineness and other therapist behaviors as relates to therapeutic outcome. Whitehorn and Betz (1954) studied the differences between successful and unsuccessful (or A and B type) therapists. They found that the successful therapist was warmer and attempted to understand the patient in a more personal, immediate and individualistic manner than the less successful therapist. They concluded that the personality, attitudes and interest of the therapist play a significant role in determining the effectiveness of the therapist.

In a recent review, Bergin and Suinn (1975) note that although research on the A-B variable persists, this area is plagued by ambiguities and poor studies. They point out that many studies using this framework are published and later seem trivial or misleading when the real

complexity of the phenomena under study becomes clear. For example; McNair, Callahan and Lorr (1952) have discovered that the type B therapist had significantly better therapy results than the type A therapist under one set of circumstances. They conclude that the relationship between therapist type and therapist results was dependent on the similarity of background and interest in patient and therapist.

Client centered therapists have emphasized the importance of three therapist characteristics: nonpossesive warmth, genuineness and empathy. Early evidence by Barrett-Lennard (1962), Truax (1963) and others strongly suggested the relevance of these three therapist conditions for success with counselling cases. However, Bergin and Suinn (1975) have recently concluded that the potency of these variables outside of highly specific client centered therapy is questionable. While some studies support the notion of a relationship between empathy and outcome (e.g., Barrett-Lennard, 1962) others fail to replicate this finding. They suggest that these conditions may be vital to positive change, but may not be measured appropriately. For example, in a number of studies showing no relationship between audiotape-rated empathy and outcome (the Truax scales) there were significant correlations between patient perceived empathy and outcome, usually as measured by the Barrett-Lennard Scales.

Knupfer, Jackson and Krieger (1959) related supervior's ratings of therapist's competence for forty psychiatric residents with the resident's own self-reports. The data suggested that therapists who were rated as highly competent were both more self-confident and more expressive as individuals. Combs and Soper (1963) also found high correlations between supervisor's rank orders and twelve aspects of the counselor's attitudes. "Good" counselors tended to assume the internal rather than the external frame of reference with others, to be people rather than thing-oriented, and to see people as able, dependable and friendly. However, Streitfeld (1959) found that ratings of self-acceptance and acceptance of other is not related to psychotherapeutic ability.

Gardner (1964) in reviewing several studies which attempted to correlate a large number of therapist personality variables with measures of the quality of the therapeutic relationship, concluded that positive results occured no more often than would be expected by chance. However, several tests such as the Comrey Personality Scales, the Profile of Mood States and the Chapin Social Insight Test which intuitively seem to be better predictors of clinical success have not been utilized in such research.

Behavior Modification and Therapist Variables

In any course of therapy there is uncertainty as to how much therapeutic effect is due to the client-therapist

relationship and how much to the actual technical aspects of the therapy. Systematic desensitization is more easily automated than most therapeutic techniques and thereby offers the opportunity to separate these components.

Lang and his associates have developed a Device for Automated Desensitization (DAD) which conducts therapy sessions. A comparison of the DAD with a live therapist conducting desensitization showed that the former was about as effective as the latter in producing fear reduction as measured by behavioral avoidance. Lang concluded that the specific program of instructions and not the therapeutic relationship was the viable aspect of the desensitization therapy. Krapfl (1967) also found that self-administered systematic desensitization (S. D.) produced the same amount of reduction in avoidance behavior as the standard, socially administered form.

However, in such automated procedures such as DAD, human contact is not totally eliminated. The subjects' initial sessions are conducted by a therapist. There is evidence that the presence of a therapist facilitates the progress of treatment. Lang (1969) reported that subjects who had human S.D. therapists reported less fear on a verbal measure after treatment than did DAD subjects.

Quirk (1973) also employed an automated desensitization procedure. He found that subjects who had less contact with their therapist needed more S.D. sessions than did subjects

who experienced S.D. with a human therapist present. Both groups eventually achieved the same level of fear reduction. Quirk suggests that a relationship facilitates S.D. but is not a necessary element of the process.

Donner (1970) believes that a therapist is necessary in S.D. to provide reinforcement to clients thereby maintaining their motivation to continue in the S.D. process. Clients may find the eventual elimination of their phobia as too delayed a reinforcer to maintain their behavior. Other investigators (Leitenberg, Agras, Barlow and Oliveau, 1969) have suggested that the major therapeutic benefit from S.D. was due to verbal reinforcement by the therapist for the small gradual successes of the client.

Many contend that the sensitivity of an astute clinician is often essential for successful therapy to occur. Paul (1969) notes that the construction of S.D. hierarchies is a nonoperationalized procedures which relies mainly on the clinical sensitivity of the therapist. The means of identifying central stimulus dimensions is according to Paul, "Still more art than technology."

There are indications that the therapist's beliefs affect the outcome of S.D. Wilkins (1973) believes that the therapist acts as a catalyst for the client's expectancy. He posits that the results of expectancy studies can be interpreted as evidence that the therapist

plays a considerably more active role in the outcome of S.D. therapy than was previously theorized. The therapist thus behaves differently towards high expectancy clients than he would towards low expectancy clients. Wilkins suggests that a very meaningful direction of future therapy is the identification of the therapist's manners and behaviors than may be controlled by the communication of lower client expectancies. Wilkins reported preliminary results which indicate the rate of therapist controlled progress through the hierarchy is slower for subjects who have been given low expectancy instructions.

There is also evidence that the characteristics of the therapist influence the outcome of S.D. This is still a relatively unexplored area. Marmor (1971) believes that therapists who are experienced as "help-giving" and powerful are more effective. No studies have been reported which have tested this hypothesis. Two attributes which have been examined experimentally are therapist warmth and the sex of the therapist.

Morris and Suckerman (1974) varied the amount of therapist warmth in an automated S.D. procedure. Subjects were assigned to one of three treatment conditions: Warm, automated subject group; cold, automated subject group and a no treatment control. All groups were equated with respect to pretest behavioral avoidance scores. The only procedural differences between the two therapy groups

were the manner in which the taped therapist verbalized the procedures. Subjects in the warm, automated therapist group improved significantly more than subjects in either of the other groups. There were no significant differences between the cold, automated therapist group and the control group. This relationship was maintained during a follow-up. This study suggests that therapist warmth is an essential element to successful S.D.

Geer (1973) has discovered that the sex variable influences the outcome of S.D. therapy. A significant therapist x subject interaction occured on the outcome of S.D. therapy with test anxious college students. Male therapists were significantly more effective with female subjects while female therapists were sometimes (but not significantly) more effective with male subjects than the male therapists were. Geer suggests that S.D. isn't immune to confounding by the personality variables of the client and the therapist.

The above studies suggest that personality and social variables affect S.D. Operant conditioning also seems affected by those factors. Homme (1972) has stated that it is preferable to use secondary reinforcers such as social reward. The reinforcing value of secondary reinforcers will partially depend upon the pertinent social and personality variables. There has been a paucity of research which has attempted to explore the

personality and social variables associated with the reward values of human reinforcers. It is also a truism that incentive and motivation affect all performance. Incentive to perform an interpersonal behavior is affected by the social and interpersonal context.

The effects of modeling procedures have also been shown to be controlled in part by social and personality variables. Bandura (1969) notes that intelligence, age, SES, apparent social and vocational competency, prestige and power all influence the effectiveness of a model.

The above studies suggest that the outcome of behavior therapy is enhanced when the optimal personality and social variables are present. Learning theory has been used to develop new clinical techniques. Since the therapeutic relationship is apparently crucial to therapy outcome, it may be fruitful to apply the theory and empirical findings of personality and social psychology. Kiesler (1966) has stated that it makes no sense to simply inquire if therapy is effective. A researcher must ask a more complex question: what combination of setting, client and therapist variables is optimal? The work of the Rogers group (e.g., Rogers and Dymond, 1954) was a beginning. Therapists who scored high on scales of accurate empathy, genuineness and warmth were more successful therapists than colleagues who scored lower on these scales. Thus Rogers' qualification would be that

therapy by empathic, warm and genuine therapists is effective. Other therapist variables must be examined. The present study attempts to determine the relative importance of a variety of counselor variables in a D.P.C. program in which nursing student counselors train parents to modify their children's inappropriate behavior.

Statement of the Problem

Although the parent training literature presents many descriptive reports of success in parents' learning to decrease their children's behaviors, the majority of these studies ignore describing the characteristics and qualities of the counselor who trains parents. Cost efficiency and mental health manpower conservation are heralded as some of the benefits of parent training programs. However, there is little data at present on the characteristics that would facilitate such parent training. It is generally accepted that Ph.D. level psychologists are not necessary for such programs. However, O'Dell (1974) and others assume that these programs can not be carried out successfully by everyone. Personal characteristics of the counselor are assumed to be important variables. One general purpose of this study is to determine the relative importance of a variety of counselor variables to the success of a parent training program.

A second general purpose of the present study is to examine the effectiveness of one parent training program,

the D.P.C., using nursing students as parent trainers. Currently with proposed reductions in North American provincial, state and federal budgets, there is an emphasis to provide effective, efficient, low-cost social and health services. The effective use of the psychologist as a consultant to less expensive parent trainers would significantly increase the number of families provided with help in a public health system which has limited resources. This study was designed to offer information and raise questions regarding the effectiveness of the D.P.C. as delivered by third year nursing students under supervision from clinical psychology graduate students.

Twenty-four families having at least one child with active behavior problems in the home comprised the client group. Behavior and attitude measures were administered pre and post experimentally to these families. The following specific hypotheses regarding the effectiveness of D.P.C. therapy were examined:

1) Parent training in D.P.C. will enable treatment group parents to significantly decrease those problem behaviors identified as specific targets in their children.

2) Parent training in D.P.C. should generalize and produce significant changes in the desired direction in the parents' attitudes towards their child's behavior and adjustment as measured

by the Walker Problem Behavior Checklist.

3) After the D.P.C. experience, the parents will have a more favorable attitude toward acceptant, positive treatment of children and a more favorable attitude towards the family.

4) The parent's mood adjustment will be significantly improved after participating in the D.P.C. program.

In addition, a variety of counselor variables will be empirically correlated with success in treatment as measured by a significant decrease in specified problem behaviors.

In the next six hypotheses it is predicted that specific counselor variables will be significantly positively correlated with therapy outcome as defined by target behavior frequency change:

5) The counselor's total mood adjustment as measured by the Profile of Mood States will be a significant predictor.

6) The counselor's social insight as measured by the Chapin Social Insight Test will also be a significant predictor.

7) The counselor's attitude toward external control as measured by the Rotter Internal-External Control Scale will also be a significant predictor of decrease in the frequency of the specified problem.

8) The counselor's trust as measured by the Comrey

Personality Scales will be a significant predictor of behavioral change.

9) The counselor's emotional stability as measured by the Comrey Personality Scales will also be significantly correlated with a decrease in the specified problem behavior.

10) The counselor's empathy as measured by the Comrey Personality Scales will be a significant predictor.

CHAPTER II

METHODOLOGY

The present study consisted of an experiment in which third year nursing students were trained in the principles and techniques of the Directive Parental Counseling System (D.P.C.). They were trained by two psychology department professors and six psychology graduate students. The nursing students (counselors) then trained parents in this system. The parents selected had a child who was referred to a local child mental health or other community social services agency because of behavioral difficulties.

Subjects

Twenty-four families having a child with active behavior problems in the home participated in this study. These children were referred by mental health specialists, family physicians and social services personnel. The families were assigned to the counselors randomly.

Twenty-four third year nursing students participated as counselors in this study as part of their course requirement for two required half-year nursing subjects (pediatric and psychiatric nursing). The counselors volunteered to participate in the program in lieu of completing a term project. At the outset of the program the nurses had no formal experience in psychotherapy or counseling. They

had had some experience in interviewing however. Twenty-three female counselors and one male counselor were employed. The mean age of the counselors was 21.79 years, the range 20 to 42 years.

Procedure

The experiment consisted of three phases: 1) The didactic phase, 2) The supervision phase, and 3) The intervention phase.

(1) Didactic Phase: Twenty-four third year nursing students received training in the D.P.C. system from Dr. C. J. Holland, Dr. R. M. Daly and six graduate student assistants. Twelve training sessions were held Wednesday mornings from 9:00 a.m. to 11:00 a.m. The didactic sessions commenced September 24, 1975 and ended on December 10, 1975. The teaching was generally didactic in nature, relying upon Directive Parental Counselling: A Parent's Guide by C. J. Holland as the main course reference. Each point in the 30-point system was discussed. Appropriate and inappropriate interviewing techniques were demonstrated through role-playing procedures. Typical conversational pitfalls and typical parental objections to behavior modification, baselining and behavioral contracting programs were also discussed. Case studies were used to give the students practice in using the system. Behavioral rehearsal was used in small groups to prepare the nursing students for their counseling experiences. Four nurses were randomly assigned to each of the six small

groups which were led by six psychology graduate students. Typically, a training session consisted of a 70 minute didactic presentation in a large group, a five minute recess and a 45 minute small group behavioral rehearsal experience.

Instruments were administered to the counselors at the beginning of the didactic phase. The graduate student consultants also evaluated the counselors at the end of the didactic phase. These measures yielded predictor variable scores.

(2) Supervision Phase: During this phase, the nursing students met weekly for an hour in a small group with their psychology graduate student supervisors. Ten supervisory meetings were scheduled in the time period January 12 to March 26, 1976. The specific times and places of these meetings were arranged by the counselors and the consultant-supervisor. Both general and specific concerns with counseling and the D.P.C. system were discussed.

(3) Intervention Phase: Concurrent with the supervisory phase the student taught the D.P.C. system to parents whose children were referred because of behavioral difficulties. Parents were seen individually in their own home. The identified problem child in some cases was given a medical examination in an attempt to determine if non-environmental factors were the primary determinants of the problem behaviors. All parents were informed of the general sequence

to be followed in the program. At the outset of the program they agreed to complete assessment instruments which they were told would be used to evaluate the effectiveness of the program.

The training program taught to the parents was based on the social learning principles and behavior change system described in Directive Parental Counselling: A Parent's Guide. Each set of parents will be given a copy of this manual to read and use throughout the program.

The parents learned the concepts, language, observation and data collection skills necessary to plan and carry out a behavioral change program. They were taught to identify one target behavior that would be appropriate to modify via the D.P.C. program. They were then given specific instructions regarding observing and counting the frequency of the target behavior in the home. Behavior frequency recording sheets were given to the parents in order to facilitate their data collection. Baseline data was then collected by the parents. The 30 points of the program and the social learning principles they entail were then discussed. Finally, at about the fourth or fifth week, depending upon the parent's progress, a specific program for changing the targeted behavior was developed and carried out by the parents. The parents made weekly frequency counts of the targeted behavior throughout the program.

Frequency counts of the targeted behavior at baseline,

during and after treatment, and tests measuring parent's perception of child behavior, parent's attitudes and the parent's mood were used to evaluate changes that resulted from the program. Only the parent implementing the program completed these assessment measures. In all treatment cases the mother implemented the program.

Measuring Instruments: Predictor Variables

Several instruments for the assessment of behavior and attitude change were used. The first fifteen measures described below were administered to all counselors at the beginning of the didactic phase. The next three measures were administered at the end of the didactic phase. These instruments were used to obtain predictor variables; i.e., variables that would be used to predict success in the D.P.C. Copies of all unpublished tests used in this study can be found in Appendix B. References for published instruments are given below.

(1) The Chapin Social Insight Test (CSIT): This test consists of 25 short paragraphs describing problems. The respondent is asked to choose one of four options which offers the most insightful or wisest course of action. F. S. Chapin, a sociologist, created the test. H. G. Gough (1968) has prepared a test manual. The corrected odd-even reliability coefficient of the Chapin is .75. Gough provides evidence that the Chapin test correlates highly with a variety of measures of interpersonal sensitivity.

(2) The Nurses Attitude Inventory (NAI): This survey consists of 70 multiple choice items. In devising the scale, Thurston and Brunclik (1959) chose items which would distinguish between successful and unsuccessful nursing students. Nine scales can be obtained: nursing, self, home-family, responsibility, others-love-marriage, academic, a validity scale designed to detect attempts to falsify in order to create a good impression and a validity scale designed to detect a tendency to create an unfavorable impression. A total score is also obtainable. Evidence has been presented that the total score is a signficant predictor of success in nursing school (Thurston, Brunclik and Feldhusen, 1970).

(3) The Family Scale (FS): Rundquist and Sletto's Family Scale is described by Shaw and Wright (1967). The scale consists of 21 statements for which the respondent chooses from the usual five Likert-type responses ranging from "strongly agree" to "strongly disagree". One scale is being measured: favorability of attitude toward the family. Test-retest reliability after a sixty-day interval was found to be .83; split-half reliabilities were found to be .84. Attitude scores on this scale have been found to be related to various family stresses (separation of parents, etc.).

(4) Survey of Opinions Regarding the Bringing Up of Children (SORBUC): Both this scale and the next one were

developed by Itkin to measure intrafamily attitudes. They are described by Shaw and Wright (1967). This scale consists of 26 standard Likert-type items and four multiple choice items. The scale purports to measure attitudes towards "acceptant, positive treatment for children". Reliability estimated by the split-half method was found to be .85. Little evidence of validity is available.

(5) ,Survey of Opinions Regarding the Discipline of Children (SORDC): This scale consists of 31 standard, Likert-type items and four multiple choice items. Split-half reliability was reported to be .95. This survey purports to measure attitudes towards strict control of children's activities.

(6) The Helping Attitude Inventory (HAI): Porter's Counseling Procedures Pre-Test (1950) has been adapted by Jones (1967). The revised instrument consists of twenty-five questions with five responses to each question. The respondent ranks alternatives in order of preferred responses. The instrument yields five response tendency scales: understanding, probing, interpretive, supportive and evaluative. These scales purport to measure preferences for given ways of responding to someone in a helping relationship. The mean estimated reliability of the scales as computed by the split-half method was .86 and ranged from .96 (understanding) to .71 (interpretive). Experienced counselors tend to have high understanding scale scores and

low evaluative scale scores when compared to other occupational groups (Jones, 1967).

(7) The Firo-B Test (FIROB): Schutz's Fundamental Interpersonal Relations Orientation-Behavior Test yields six scales: expressed and wanted behavior in the areas of inclusion, control and affection. The mean estimated reliability for the six scales as computed by the split-half method was .94 (Schutz, 1967). The mean test-retest reliability during a one month interval was .76. Both Firo tests consist of 54 statements for which the respondent must choose one of six alternatives.

(8) The Firo-F Test (FIROF): Schutz's Firo-F test purports to measure how an individual usually feels towards others. The test yields six scales: expressed and wanted feeling in the areas of inclusion, control and affection.

(9) The Internal-External Control Scale (I-E): Rotter's (1966) scale consists of 29 pairs of statements. The respondent must choose the statement he agrees with most. The scale purports to measure a generalized expectancy regarding the nature of the causal relationship between one's own behavior and its consequences. Internally controlled people believe that external events are contingent upon their own behavior. Externally controlled individuals believe that their fate is controlled by luck or other forces beyond their control. In various studies the split-half reliability of this instrument has ranged from .65 to .79. In the past decade there have been many validity studies in the

literature which have extended the predictive value of this instrument.

(10) The Rokeach Value Survey (RVS): Rokeach's (1970) instrument consists of a list of eighteen terminal values (such as happiness) and a list of eighteen instrumental values (such as loving). The respondent ranks items in each list in their order of importance as guiding principles in his life. Median test-retest reliabilities for college students with a two to four month interval between test and retest was .76 for the terminal values and .65 for the instrumental values. With a 14-16 month test-retest interval the terminal reliability was .69 while the instrumental reliability was .61. Rokeach (1973) has reported extensive research that has validated the scale as a useful measure of long-term and short-term change in values and attitudes. He has also provided normative data for groups broken down by sex, income, education, race, age and religion.

(11) The Comrey Personality Scales (CPS): The Comrey test consists of 180 items. The respondent chooses between seven responses. Eight personality scales (trust vs defensiveness, orderliness vs lack of compulsion, social conformity vs rebelliousness, activity vs lack of energy, emotional stability vs neuroticism, extraversion vs introversion, masculinity vs femininity, and empathy vs egocentrism), a validity check scale and a response bias scale are obtainable. Internal consistency reliabilities for the

personality scales range from .70 to .95. Comrey (1970) presents evidence from twelve factorial validity studies to support the use of his instrument.

(12) The Profile of Mood States (POMS): The POMS test consists of 65 adjectives which the respondent is asked to rate on a five point scale according to the degree to which the items are self-descriptive. A total mood disturbance scale and six sub-scales (tension, depression, anger, vigor, fatigue, confusion) are obtainable. The internal (split-half) reliability of the six sub-scales range from .87 to .95. The test-retest reliability (with approximately 20 days between testing) ranged from .65 to .74 for the scales (McNair, Lorr and Droppleman, 1971). Several validity studies are reported in the POMS test manual (McNair et. al., 1971).

(13) The D.P.C. Expectancy Scale (DPCES): This instrument was devised by the author for the present study (See Appendix B). It consists of four Likert-type items which must be responded to with one of five choices ranging from "strongly agree" to "strongly disagree". It purports to measure the respondent's belief in the D.P.C. as an effective treatment modality.

(14) The Social Desirability Scale (SDS): Marlowe and Crowne's scale (1964) purports to measure a need for social approval and a tendency to respond in socially desirable ways. It consists of 33 true-false items. The

internal consistency reliability was found to be .88. A test-retest reliability of .88 was obtained following a one month interval.

(15) The In-Training Evaluation Form (ITEF): This form was devised for this study (See Appendix B). In part I the counselor ranks himself in relation to three peers according to how successful she (he) will be as a D.P.C. counselor. Part II consists of nine bipolar adjectival statements: secure-insecure, steady-nervous, competent-incompetent D.P.C. counselor, competent-incompetent nurse, relaxed-tense, happy-sad, active-inactive, likeable-unlikeable and confident-unconfident. These items are rated on an eight-step scale according to how each applies to the counselor at the present time.

(16) The Verbal Behavior Indices (VBI): This instrument was also devised by the author for the present study (See Appendix B). The instrument is generalizable so that it could be used by the counselor to rate his own verbal behavior and by the supervisors to rate their counselors' verbal behavior. Part I is a modification of a verbal problem behavior checklist devised by Carter and Thomas (1973). The respondent checks off the verbal problems which apply to the subject being assessed. A total score is derived. Part II consists of two eight point scales regarding overall abilities to communicate and to listen.

(17) D.P.C. Knowledge Test (KT): A five question short

essay test was administered to the counselors at the end of the didactic training phase. The papers were given numerical grades on the standard 0 to 100 scale.

(18) Attitude Toward the Supervisor Scale (ATSS): Shaw and Wright (1967) have described and evaluated a scale created by Schmid, Marsh and Detter (1957). Subjects respond to each of fourteen items selecting one of five alternatives ranging from "strongly agree" to "strongly disagree". The scale purports to measure the extent that a respondent has a favorable attitude towards his supervision. The internal consistency reliability has been found to be .90.

In addition, the following scales were given by the supervisors at the end of the didactic sessions segment of the training program.

(1) Supervisor's Evaluation of the Counselor Form (SECF): This scale, also devised by the author for this study includes an item requesting the supervisor to rank the counselor being rated in relation to her (his) three peers in the supervision group. The form also has seven bipolar adjectives which compose eight-step scales. The supervisor rates the counselor on the following traits: predicted success as a D.P.C. counselor, empathy, regard, unconditional regard, congruence and willingness to be known.

(2) The Verbal Behavior Indices (see above).

At the end of the treatment phase the client (parent) completed the following test instrument which yielded counselor predictor variables:

The Barrett-Lennard Relationship Inventory (BLRI): Barrett-Lennard's (1962) scale consists of 89 statements describing counselor behavior. The client reponds to each item on a six-point scale, rating his (her) D.P.C. counselor. Five scales are obtainable: level of regard, empathic understanding, congruence, unconditionality of regard and willingness to be known. The internal consistency of the five scales as measured by the split-half method ranged from .82 to .93. Barrett-Lennard (1962) provides evidence that counselors independently identified as more competent scored higher on this instrument and that the client's perception of the counselor on these scales was significantly correlated to therapy outcome.

Finally, one behavioral index of committment to the D.P.C. was used. Nurses were given the opportunity to volunteer to speak in front of a nursing class in an attempt to elicit subjects for a related D.P.C. study.

Table 1 summarizes the counselor predictor variables examined in this study.

TABLE 1

Counselor Variables Tested As Predictors

Variable Code	Variable	Assessment Instrument
C1	social insight	CSIT
C2	attitude toward nursing	NAI
C3	attitude toward self	NAI
C4	attitude toward home-family	NAI
C5	attitude toward responsibility	NAI
C6	attitude toward others-love-marriage	NAI
C7	attitude towards academic pursuits	NAI
C8	tendency to try to make good impressions	NAI
C9	tendency to try to make bad impressions	NAI
C10	total score favorable nurse attitudes	NAI
C11	attitude towards the family	FS
C12	attitude towards acceptant treatment of kids	SORBUC
C13	attitude towards strict control of kids' actions	SORDC
C14	understanding response tendency	HAI
C15	probing response tendency	HAI
C16	interpretative response tendency	HAI
C17	supportive response tendency	HAI
C18	evaluative response tendency	HAI
C19	expressed inclusive behavior	FIROB
C20	expressed control behavior	FIROB
C21	expressed affection behavior	FIROB
C22	wanted inclusive behavior	FIROB
C23	wanted control behavior	FIROB
C24	wanted affection behavior	FIROB
C25	expressed inclusive feeling	FIROF
C26	expressed control feeling	FIROF
C27	expressed affection feeling	FIROF
C28	wanted inclusive feeling	FIROF
C29	wanted control feeling	FIROF
C30	wanted affection feeling	FIROF
C31	attitude re: internal vs ext. control	I-E
C32	importance of a comfortable life	RVS
C33	importance of an exciting life	RVS
C34	importance of a sense of accomplishment	RVS
C35	importance of a world at peace	RVS
C36	importance of a world of beauty	RVS

TABLE 1

(continued)

Variable Code	Variable	Assessment Instrument
C37	importance of equality	RVS
C38	importance of family security	RVS
C39	importance of freedom	RVS
C40	importance of happiness	RVS
C41	importance of inner harmony	RVS
C42	importance of mature love	RVS
C43	importance of national security	RVS
C44	importance of pleasure	RVS
C45	importance of salvation	RVS
C46	importance of self-respect	RVS
C47	importance of social recognition	RVS
C48	importance of true friendship	RVS
C49	importance of wisdom	RVS
C50	importance of being ambitious	RVS
C51	importance of being broadminded	RVS
C52	importance of being capable	RVS
C53	importance of being cheerful	RVS
C54	importance of being clean	RVS
C55	importance of being courageous	RVS
C56	importance of being forgiving	RVS
C57	importance of being helpful	RVS
C58	importance of being honest	RVS
C59	importance of being imaginative	RVS
C60	importance of being independent	RVS
C61	importance of being intellectual	RVS
C62	importance of being logical	RVS
C63	importance of being loving	RVS
C64	importance of being obedient	RVS
C65	importance of being polite	RVS
C66	importance of being responsible	RVS
C67	importance of being self-controlled	RVS
C68	trust	CPS
C69	orderliness	CPS
C70	social conformity	CPS
C71	activity	CPS
C72	emotional stability	CPS
C73	extraversion	CPS
C74	masculinity	CPS
C75	empathy	CPS
C76	validity check	CPS
C77	response bias	CPS
C78	tension	POMS
C79	depression	POMS
C80	anger	POMS

TABLE 1
(continued)

Variable Code	Variable	Assessment Instrument
C81	activity	POMS
C82	fatigue	POMS
C83	confusion	POMS
C84	total mood disturbance	POMS
C85	belief in D.P.C.'s effectiveness	DPCES
C86	need for social approval	SDS
C87	counselor's self-ranking	ITEF
C88	counselor's ranking by peers	ITEF
C89	security self-rating	ITEF
C90	steadiness self-rating	ITEF
C91	competency as D.P.C. counselor self-rating	ITEF
C92	competency as nurse self-rating	ITEF
C93	relaxed self-rating	ITEF
C94	activity self-rating	ITEF
C95	likeability self-rating	ITEF
C96	confidence self-rating	ITEF
C97	total verbal problems checked by counselor	VBI
C98	communication ability self-rating	VBI
C99	listening ability self-rating	VBI
C100	total verbal problems checked by supervisor	VBI
C101	supervisor's rating of communication ability	VBI
C102	supervisor's rating of listening ability	VBI
C103	knowledge of the D.P.C. System	KT
C104	attitude towards the supervisor	ATSS
C105	supervisor's ranking of counselor	SECF
C106	supervisor's rating of expected success	SECF
C107	supervisor's rating of empathy	SECF
C108	supervisor's rating of regard	SECF
C109	supervisor's rating of unconditional regard	SECF
C110	supervisor's rating of congruence	SECF
C111	supervisor's rating of willingness to be known	SECF
C112	client's rating of level of regard	BLRI
C113	client's rating of empathic understanding	BLRI
C114	client's rating of congruence	BLRI
C115	client's rating of unconditionality of regard	BLRI
C116	client's rating of willingness to be known	BLRI
C117	volunteering to elicit D.P.C. subjects	OBSERVATION

Measuring Instruments: Outcome Variables

The first five assessment instruments listed below were administered to the clients at the beginning of the D. P. C. counseling and at the end of the counseling. Pre-post test differences in the various scales served as outcome variables. The Therapy Attitude Inventory was administered once at the termination of the counseling. Its two scales were also outcome variables. All of the instruments listed below were completed by the parent who implemented the program.

(A) The Family Scale (see above).

(B) The Internal-External Control Scale (see above).

(C) The Survey of Opinion Regarding the Bringing Up Of Children (see above).

(D) The Profile of Mood States (see above).

(E) The Walker Problem Behavior Checklist (WPBIC): Walker developed this test in order to identify children with behavior problems. It is composed of 50 observable operational statements which yield information about a child's problem behavior on five dimensions: acting out, withdrawal, distractibility, disturbed peer relations and immaturity. A total score is also obtainable. If a child recieves a total score of 21 (T score of 60) or higher he is classified as disturbed. The split-half reliability coefficient obtained on the WPBIC is .98. The item validity indices on the 50 items vary from .03 to .67.

In contrasted groups validity, the difference between the means of the experimental and control subjects was significant beyond the .001 level.

(F) Therapy Attitude Inventory (TAI): This instrument was constructed by Eyberg and Johnson (1974) to assess parent's satisfaction with the process and outcome of the treatment program. It consists of eleven items which ask parents to rate statements on a five point scale ranging from dissatisfaction (or deterioration in condition) to satisfaction (or improvement). Responses were analyzed separately for the nine items relating to treatment outcome and for the items reflecting satisfaction with the therapist.

(G) Behavior Frequency: In addition, frequency counts of an identified problem behavior was taken throughout the treatment program. Changes in the problem behavior will be utilized as an additional outcome variable.

Table 2 summarizes the outcome variables which were examined. Unless otherwise specified, the variables refers to changes in the parent.

In addition, the Comrey Personality Scales, the Crowne Marlowe Social Desirability Scale and the D.P.C. expectancy form were given once. These scales and the outcome variables were analyzed as family variables predictive of success in the D.P.C. program (see Table 3).

TABLE 2

Outcome Variables

Variable Code	Variable	Assessment Instrument
01	attitude change towards the family	FS
02	attitude change towards internal-external control	I-E
03	attitude change towards acceptant treatment of kids	SORBUC
04	change in tension	POMS
05	change in depression	POMS
06	change in anger	POMS
07	change in activity	POMS
08	change in fatigue	POMS
09	change in confusion	POMS
010	change in total mood disturbance	POMS
011	acting out of child	WPBIC
012	withdrawal of child	WPBIC
013	distractibility of child	WPBIC
014	disturbed peer relations of child	WPBIC
015	immaturity of child	WPBIC
016	total behavioral disturbance of child	WPBIC
017	satisfaction with therapy	TAI
018	satisfaction with therapist	TAI
019	target behavior change	parent's recorded observation

TABLE 3

Family Predictor Variables

Variable Code	Variable	Times Administered	Assessment Instrument
F1	Family attitude	pre and post	FS
F2	internal-external control attitude	pre and post	I-E
F3	treatment of children attitude	pre and post	SORBUC
F4	tension	pre and post	POMS
F5	depression	pre and post	POMS
F6	anger	pre and post	POMS
F7	activity	pre and post	POMS
F8	fatigue	pre and post	POMS
F9	confusion	pre and post	POMS
F10	total mood disturbance	pre and post	POMS
F11	acting out of child	pre and post	WPBIC
F12	withdrawal of child	pre and post	WPBIC
F13	distractibility of child	pre and post	WPBIC
F14	disturbed peer relations of child	pre and post	WPBIC
F15	immaturity of child	pre and post	WPBIC
F16	total problem score (child)	pre and post	WPBIC
F17	target behavior frequency	pre and post	Observation
F18	trust	pre	CPS
F19	orderliness	pre	CPS
F20	social conformity	pre	CPS
F21	activity	pre	CPS
F22	emotional stability	pre	CPS
F23	extraversion	pre	CPS
F24	masculinity	pre	CPS
F25	empathy	pre	CPS
F26	validity check	pre	CPS
F27	response bias	pre	CPS
F28	social desirability	pre	SDS
F29	D.P.C. expectancy	pre	DPCES

CHAPTER III

RESULTS

The following hypotheses were tested:

(1) It was predicted that there would be a decrease in the frequency of targeted problem behaviors as a function of the Directive Parental Counseling parent training program. This was measured on a success-failure basis using an arbitrary criterion of a 60% decrease in frequency of target behavior before and after implementation of the program. The first two weeks established the base rate; the last two weeks provided the criterion data.

(2) It was further predicted that a generalization effect would take place in the mother's perceptions of and attitudes towards the child's behavior and adjustment as measured by the Walker Problem Behavior Identification Checklist. This prediction was tested by completing a multivariate analysis of variance of the pre-post treatment factor on the five subscales of this instrument (Acting out, Withdrawal, Distractibility, Disturbed Peer Relations and Immaturity). In addition, pre-post D.P.C. treatment differences in the total Walker Score was measured with a t test of differences.

(3) After the D.P.C. experience it was also predicted that mothers would have more favorable attitudes towards:

(a) Acceptant and positive treatment of children, as measured by a t test of differences between pre and post treatment scores on the Survey of Opinions Regarding the Bringing Up of Children

(b) their family as measured by a t test of differences between pre and post treatment scores on the Family Scale and

(c) controlling their environment and fate as measured by a t test of differences between pre and post treatment scores on the Rotter I-E Scale.

(4) The mood adjustment was predicted to be significantly improved after participating in the D.P.C. program. This hypothesis was tested by completing a multivariate analysis of variance of the pre-post treatment factor on the six scales of the Profile of Mood States (Tension, Depression, Anger, Vigor, Fatigue and Confusion). In addition pre-post D.P.C. treatment differences in the total Mood Disturbance Score was measured with a t test of differences.

It was further predicted that a variety of counselor variables would be empirically correlated with success in treatment as measured by a significant decrease in specified problem behaviors. Specifically, it was predicted that:

(5) The counselor's total mood adjustment as measured by the Profile of Mood States would be a significant predictor of treatment success.

(6) The counselor's social insight as measured by the Chapin Social Insight test would also be significantly correlated with treatment success.

(7) The counselor's attitude towards external control as measured by the Rotter-Internal-External Control Scale would also be a significant predictor.

(8) The counselor's trust as measured by the Comrey Personality Scales would be significantly correlated with treatment success.

(9) The emotional stability of the counselor as measured by the Comrey Scales would also be a significant predictor of treatment success.

(10) The empathy of the counselor as measured by the Comrey Personality Scale would be significantly correlated with treatment success.

(1) Analysis of Behavior Change

The mean frequency of targeted deviant behavior for each child at baseline and at conclusion of treatment is presented in Table 4. The pre-treatment baseline frequency is the total frequency of the deviant behavior as observed and recorded by parents during the first two weeks of the program. During this period, behavioral principles were discussed. A specific behavior change program was not yet implemented at this time. The post-treatment measure is the

TABLE 4

Behavior Frequency Scores For Selected Target Behaviors

S	Age	Sex	Target Behavior	Freq. Weeks 1 and 2 (x)	Freq. Weeks 9 and 10 (y)	Behavior Decrement[a]	Judged Outcome
1	8.0	F	Noncompliance	-	-	-	Dropped
2	8.5	M	Temper tantrum	9	11	-22	Failure
3	8.5	M	Noncompliance	9	0	100	Success
4	9.0	F	Noncompliance	24	16	33	Failure
5	4.0	M	Noncompliance	42	4	91	Success
6	5.0	M	Noncompliance	12	2	83	Success
7	6.0	M	Whining	38	1	97	Success
8	6.0	M	Whining	16	7	56	Failure
9	7.0	F	Whining	30	6	80	Success
10	4.0	F	Noncompliance	40	20	50	Failure
11	8.0	F	Noncompliance: sleeping	9	7	22	Failure
12	9.0	M	Noncompliance: sleeping	22	4	82	Success
13	4.0	F	Talking Back	-	-	-	Dropped
14	6.0	M	Inappropriate eating	8	12	-50	Failure
15	6.5	F	Temper tantrum	13	6	54	Failure
16	8.0	M	Fighting	50	0	100	Success
17	2.5	M	Fighting	21	5	76	Success
18	4.0	M	Noncompliance	31	8	74	Success
19	9.0	F	Talking Back	216	5	98	Success

TABLE 4 (continued)

Behavior Frequency Scores For Selected Target Behaviors

S	Age	Sex	Target Behavior	Freq. Weeks 1 and 2 (x)	Freq. Weeks 9 and 10 (y)	Behavior Decrement[a]	Judged Outcome
20	4.0	M	Fighting	22	9	59	Failure
21	8.0	F	Stealing	20	6	70	Success
22	6.0	M	Fighting	12	4	67	Success
23	8.0	F	Attention-getting	42	2	95	Success
24	3.5	M	Noncompliance	20	14	30	Failure

[a] $\frac{x-y}{x} \times 100$

total frequency of the deviant behavior during the final two weeks of the program. Treatment success is operationally defined as a 60% reduction from the baseline rate for the targeted behavior. This criterion follows the convention set by Patterson and his colleagues (Patterson, et al, 1972). To measure the percentage of reduction of each treatment problem behavior, the post-treatment total frequency was subtracted from the baseline rate, and the difference was divided by the baseline rate and multiplied by 100.

The results indicated that 22 of the original 24 families (91.67%) completed the Directive Parental Counseling Program with their nurse-counselor. Family one failed to complete any baseline data and eventually quit the program due to "time pressures". The counselor of family 13 was hospitalized in the beginning of the treatment program. This family completed the program with the counselor's consultant. Data from these two families were eliminated from further analyses.

The data indicated that thirteen of the 22 treatment cases analyzed were judged treatment successes in that they met the criterion. However, two cases increased the problem behavior frequency. The average percentage reduction in problem behaviors accross the 22 treatment cases was 61.14% with a range of -50% (i.e. an increase of 50%) to 100% (i.e. a total elimination of the problem behavior).

Of the 22 treatment cases 14 were boys and 10 were girls. Nine (or 64%) of the boys were judged to be successfully treated while four (or 40%) of the girls were judged to be successfully treated. Within the age range of this study (age 2.5 to age 9.0) age of the treatment child was not significantly correlated to treatment success as measured by the problem behavior percentage decrement (Pearson's r=.02). A visual inspection of Table 4 does not reveal any significant patterns between the type of target behavior and the treatment outcome. For example, of the nine cases in which noncompliance was the target behavior five were successful.

(2) Analysis of Parent Perception of Behavior Change

A summary of the results of the multivariate analysis of variance of the pre-post treatment factor on the five scales of the Walker Problem Behavior Identification Checklist is presented in Table 5. The means associated with the six scales comprising this test (Acting Out, Withdrawal, Distractibility, Disturbed Peer Relations, Immaturity) are presented in Table 6.

The results indicate that there is a significant change ($p<0.05$) in parent's perception of their child's problem behavior attributable to distractibility. A multivariate analysis of variance test for no overall pre-post effect (Hotelling-Lawley's Trace) yielded an F value of 2.45

TABLE 5

Summary of Multivariate Analysis of Variance of Walker Behavior Problem Checklist for Pre and Post-tests

Variable	Source	SS	df	MS	F	Probability F
Acting Out:	Pre-Post	6.10	1	6.10	.25	.63
	Case	776.48	20	38.82		
	Pre-Post x Case	489.90	20	24.50		
Withdrawn:	Pre-Post	7.71	1	7.71	1.42	.25
	Case	231.90	20	11.59		
	Pre-Post x Case	108.29	20	5.41		
Distractible:	Pre-Post	14.88	1	14.88	4.99	.04
	Case	324.48	20	16.22		
	Pre-Post x Case	59.62	20	2.98		
Disturbed Peer Relations:	Pre-Post	9.52	1	9.52	.68	.57
	Case	776.14	20	38.81		
	Pre-Post x Case	285.48	20	14.27		
Immaturity:	Pre-Post	.02	1	.02	.00	.95
	Case	340.00	20	17.00		
	Pre-Post x Case	130.48	20	6.52		

(with 5 and 16 degrees of freedom). The probability of obtaining an F value this large or larger by chance is .08. While only one scale changed significantly, an examination of Table 6 reveals that all scales changed in the expected direction. Mothers viewed their children as being less acting out, less withdrawn, significantly less distractible, having less disturbed relations with their peers, and being less immature.

Table 7 presents changes in several attitudes of the mother. This table reveals that one of the 22 treatment families failed to complete the Walker test. The t value of pre to post treatment differences (.96) failed to reach conventional statistical significance. However, the nonsignificant trend (a decrease in problem behaviors) was in the expected direction.

(3) Mothers' Attitudes

a) Attitude Towards Acceptant and Positive Treatment of Children.

The Survey of Opinions Regarding the Bringing up of Children (Children Survey #1) was completed by 21 families twice during the program. Table 7 presents data which indicates that while there was a tendency for mothers to become more acceptant and positive towards their children, this trend failed to reach conventional statistical significance.

TABLE 6

Pre-Post Test Changes

In

Walker Test[a]

Variable	Pre-Test Mean	Post-Test Mean
Acting Out	14.19	13.43
Withdrawn	2.81	1.95
Distractible	7.29	6.10
Disturbed Peer Relations	6.62	5.67
Immaturity	3.52	3.48

[a] n=22

TABLE 7

Pre-Post Test Changes

In

Mother's Attitudes

Scale	Number of Cases	Pre-test mean	Post-test mean	t value	Df	1-tail probability
Family Scale	20	58.8	55.8	.99	38	.16
Children Survey #1	21	107.95	112.05	-1.30	40	.10
Internal Control	22	9.45	9.32	.11	42	.46
Total Mood Score	22	45.00	35.00	.78	42	.22
Total Walker Score	21	34.86	30.62	.96	40	.17

b) Attitude Towards The Family.

The Family Scale was completed twice by 20 families. Data in Table 7 indicates that there was no significant differences between the pre-treatment and post-treatment scores on this scale. Higher scores on this scale indicate more negative feelings towards the family. There was a nonsignificant trend towards more positive feelings towards the family over time.

c) Attitude Towards Internal-External Control.

A higher score on Rotter's I-E Scale indicates that the subject is more externally controlled; i.e., he believes himself less in control of his environment and of his ultimate fate. Data in Table 7 indicates that there was no significant differences between the pre-treatment and post-treatment scores on this scale.

(4) Mother's Mood

A summary of the results of the multivariate analysis of variance of the pre-post treatment factor on the six scales of the Profile of Mood States is presented in Table 8. The pretest and posttest means associated with the six scales comprising this test (tension, depression, anger, vigor, fatigue and confusion) are presented in Table 9. The results indicate that there were no significant changes in the mother's mood as measured by these six scales. A multivariate analysis of variance test for no overall pre-post effect (Hotelling-

TABLE 8

Summary of Multivariate Analysis of Variance of Profile of Mood States for Pre and Post-tests

Variable	Source	SS	df	MS	F	Probability F
Tension:	Pre-Post	15.36	1	15.36	.67	.57
	Case	3011.91	21	143.42		
	Pre-Post x Case	482.64	21	22.98		
Depression:	Pre-Post	114.57	1	114.57	2.91	.10
	Case	6908.39	21	328.97		
	Pre-Post x Case	826.93	21	39.38		
Anger:	Pre-Post	2.75	1	2.75	.05	.82
	Case	1545.39	21	73.59		
	Pre-Post x Case	1103.75	21	52.56		
Vigor:	Pre-Post	90.20	1	90.20	2.65	.12
	Case	1424.93	21	67.85		
	Pre-Post x Case	715.30	21	34.06		
Fatigue:	Pre-Post	46.02	1	46.02	2.00	.17
	Case	1646.39	21	78.40		
	Pre-Post x Case	483.48	21	23.02		
Confusion:	Pre-Post	26.27	1	26.27	2.63	.12
	Case	981.73	21	46.75		
	Pre-Post x Case	209.73	21	9.99		

TABLE 9

Pre-Post Test Changes

In

Profile of Mood States[a]

Variable	Pre-Test Mean	Post-Test Mean
Tension	10.64	9.45
Depression	16.95	13.73
Anger	11.59	12.09
Vigor	13.18	16.05
Fatigue	13.18	11.14
Confusion	6.00	4.45

[a] n=22

Lawley's Trace) yielded an F value of 2.58 (with 6 and 16 degrees of freedom). The probability of obtaining an F value this large or larger by chance is only .06. While none of the scales changed significantly, an inspection of Table 9 reveals that five of the six scales changed in the expected direction. As a group, mothers were less tense, less depressed, less fatigued, less confused and more vigorous (the only positive mood factor on this test).

An examination of Table 7 reveals that the t value of pre to post treatment differences in the total mood disturbance score of the Profile of Mood States (.78) failed to reach conventional statistical significance. However, the trend was in the expected direction: a decrease in mood disturbance.

A Generalization Effect of the D.P.C. Program: Changes In Mothers' Moods and Attitudes

Tables 5 - 9 present data examining changes in the mother, as a result of the D.P.C. program which focuses on the child's behavior. Of the sixteen scales presented in these tables, fifteen changed in the predicted direction. A chi-square goodness of fit test performed on these findings and those trends expected by chance (eight), resulted in a X^2 value of 10.56 (one degree of freedom). This value is significant beyond the .005 level.

(5) Counselor's Total Mood Disturbance As a Predictor of Behavior Decrement

Labovitz (1970) and Tufte (1969) note that the Pearson correlation coefficient can be used with ordinal-level as well as interval-level data. Hence, percentage of behavior decrement (an interval-level variable) can be correlated with various counselor variables. The counselor's total mood disturbance score on the Profile of Mood States was found to be negatively correlated to the percentage of behavior change ($r = -.14$). Table 10 presents datum which indicates that this correlation is not statistically significant.

(6) Counselor's Social Insight As a Predictor of Behavior Decrement

Table 10 also presents data which indicate that the counselor's social insight (as measured by the Chapin Social Insight Test) is not significantly correlated with the percentage of behavior change ($r = .06$).

(7) Counselor's Internal Control As a Predictor of Behavior Decrement

An examination of Table 10 indicates that the counselor's orientation toward internal-external control (as measured by Rotter's I-E Scale) is significantly correlated with the percentage of behavior decrement. A larger score denotes external control. The obtained correlation (-.46) indicates that internally controlled counselors are more likely to be successful.

TABLE 10

Selected Counselor Characteristics Correlated with Percentage of Behavior Change During the D. P. C. Program

Hypothesis Number	Variables	Cases	Pearson r	Probability (one tail test)
5	Total Mood Score	22	-.14	.268
6	Social Insight	22	.06	.395
7	External Control	22	-.46	.015
8	Trust	22	.35	.053
9	Emotional Stability	22	.42	.027
10	Empathy	22	.31	.084

(8) Counselor's Trust As a Predictor of Behavior Decrement

Data presented in Table 10 also indicate that the counselor's level of trust (as measured by the Comrey Personality Scales) is significantly correlated with the percentage of behavior decrement. The obtained correlation (.35) indicates that more trusting counselors are more likely to be successful.

(9) Counselor's Emotional Stability As a Predictor of Behavior Decrement

An examination of Table 10 also indicates that the counselor's emotional stability (as measured by the Comrey Personality Scales) is significantly correlated with the percentage of behavior decrement. The obtained correlation (.42) indicates that emotionally stable counselors are more likely to be successful.

(10) Counselor's Empathy As a Predictor of Behavior Decrement

Finally, Table 10 indicates that the positive correlation between counselor empathy (as measured by the Comrey Personality Scales) and the percentage of behavior decrement failed to reach conventional statistical significance.

Counselor Variables As A Priori Predictors of Behavior Decrement: A Box Score

Of six counselor variables which were selected as predictors before the study was conducted, three were found

to be significantly correlated to the index of behavior decrement (Behavior Change/Baseline). However, all six counselor variables were correlated with the behavior decrement in the predicted direction. A chi-square goodness of fit test performed on these findings and those trends expected by chance (three), resulted in a X^2 value of 4.17 (one degree of freedom). This value is significant beyond the .05 level.

A variety of other counselor variables were correlated to behavior percentage decrement. These variables are described in Chapter II. Table 11 presents counselor personality, attitude, value and behavior variables which were significantly correlated to behavior percentage decrement. Three personality variables were significantly correlated with behavior percentage decrement. Besides trust and emotional stability (discussed above) unconditional regard is also predictive of counselor success. This variable appeared on the Supervisor Evaluation of Counselor Form.

Five attitudes were predictive of success. The I-E scale was discussed above. Three of the six scales on the Firo-B scales were significant predictors. Successful counselors express more inclusive (or affiliative) behavior as well as more affectionate behavior. They also desire more control behavior. Unexpectedly, the Nursing Attitude Inventory's Attitude Towards Responsibility Scale was negatively correlated to success in the D.P.C.

TABLE 11

Counselor Variables Significantly Correlated With Behavior Percentage Decrement

Variable Type	Variable	Test	Pearson's r	Cases	Significance level
Personality:	Trust	Comrey	.35	22	.05
	Emotional stability	Comrey	.41	22	.02
	Unconditional regard	SECF	.36	22	.05
Attitudes:	towards responsibility	NAI	-.35	22	.05
	expressed inclusive behavior	FIRO-B	.36	22	.05
	expressed affection behavior	FIRO-B	.37	22	.05
	wanted control behavior	FIRO-B	.39	22	.05
	External control	I-E Scale	-.46	22	.01
Values:	Accomplishment	Rokeach[a]	-.35	22	.05
	Family security	Rokeach	.36	22	.05
	True friendship	Rokeach	-.36	22	.05
	Wisdom	Rokeach	-.36	22	.05
	Capable	Rokeach	-.49	22	.01
	Courageous	Rokeach	.40	22	.03
	Polite	Rokeach	.44	22	.02
	Responsible	Rokeach	-.42	22	.03
Behavioral:	Volunteering to speak	Observation	-.52	22	.001

[a] On the Rokeach Value Survey a higher score indicates that the value has less importance. A negative correlation thus means that the value is actually positively correlated with behavior change.

The ratings of eight of the 36 values on the Rokeach Value Survey were significantly correlated to the major dependent variable in this study. Successful counselors value a sense of accomplishment, true friendship, wisdom, being capable and being responsible more highly than do unsuccessful counselors. However, unsuccessful counselors value family security, being courageous and being polite more highly than do successful counselors.

In total, 17 of 117 counselor variables were significantly correlated with behavior percentage decrement at or beyond the .05 level of significance. Chance alone would predict that only 5.85 variables would be significant. A chi-square goodness of fit performed between the observed number of significant correlations and those expected by chance resulted in a X^2 value of 20.30. This value is significant beyond the .001 level.

Family Variables As Predictors

Of twenty-nine family pre-test variables only two were significantly correlated with behavior percentage decrement. Chance would predict that 1.45 variables would be significant. An inspection of Table 12 indicates that children who were perceived as more withdrawn by their mother were less likely to show decrements in behavior during the D.P.C. program. Children who had a greater frequency of the targeted problem behavior during the baseline period were more likely to show

TABLE 12

Family Variables Significantly Correlated

With Behavior Percentage Decrement

Variable Type	Variable	Test	Pearson's r	Cases	Significance Level
Children: Pretest	Withdrawal	Walker	-.38	21	.05
	Behavior Frequency	Baseline Recordings	.35	22	.05
Children: Post-test	Acting Out	Walker	-.37	22	.05
	Distractibility	Walker	-.45	22	.02
	Disturbed Peer Relations	Walker	-.42	22	.02
	Immaturity	Walker	-.36	22	.05
	Total Walker Score	Walker	-.51	22	.005
	Behavior Frequency	Recordings Weeks 9 & 10	-.66	22	.001

a behavior percentage decrement.

Of seventeen post-test variables, six were significantly correlated with behavior percentage decrement. Chance would predict that .85 variables would be significant. A chi-square goodness of fit test performed between the observed number of significant correlations and those expected by chance resulted in a X^2 value of 26.77. This value is significant beyond the .001 level. Table 12 indicates that children who were perceived by their mother as being less acting out, less distractible, having less disturbed peer relations, being less immature and having a lower total problem scale score on the Walker Test were more likely to have decreased the frequency of the targeted problem behavior. The behavior frequency of the targeted behavior during weeks nine and ten was significantly negative correlated to behavior percentage decrement.

There were other indications that the D.P.C. program was successful. The Therapy Attitude Inventory (TAI) measured the mother's satisfaction with the treatment outcome and with the therapist on a five point scale. For the twenty-one families who completed this inventory, the satisfaction with therapy mean was 4.06 while the satisfaction with therapist mean was 4.29. Table 13 compares TAI scores to behavior decrement scores.

Of the eighteen other dependent variables (see Table 2) six

TABLE 13

Therapy Attitude Inventory and Behavior Decrement

Family	Treatment Outcome	Satisfaction With Therapists	Behavior Decrement[a]
2	3.87	4.00	-22
3	5.00	4.60	100
4	3.77	4.60	33
5	4.75	4.67	90
6	4.00	4.00	83
7	4.25	5.00	97
8	3.63	4.33	50
9	4.50	4.60	80
10	4.10	4.30	50
11	4.00	4.60	22
12	-	-	82
14	2.00	1.30	-50
15	4.80	5.00	54
16	4.50	4.30	100
17	3.75	4.67	76
18	3.38	4.25	74
19	3.00	2.67	98
20	4.63	5.00	59
21	3.50	4.00	70
22	5.00	5.00	67
23	4.50	4.30	95
24	4.38	5.00	30

[a] $\frac{x - y}{x} \times 100$

were significantly correlated with behavior percentage decrement. Chance would predict that .90 variables would be significant. A chi-square goodness of fit test performed between the observed number of significant correlations and those expected by chance resulted in a X^2 value of 24.74. This value is significant beyond the .001 level. An inspection of Table 14 indicates that satisfaction with both the therapy and the therapist was significantly positively correlated to behavior percentage decrement. Table 14 also reveals that the changes in the mother's attitude towards their child's acting out, distractibility and total problems as measured by the Walker test were all significantly negatively correlated with the behavior percentage decrement. The findings mean that scores on the Walker Problem Scales tended to decrease more when there were greater behavior percentage decrements. Table 14 also presents data which indicate that changes in the mother's vigor as measured by the Profile of Mood States was significantly positively correlated with behavior percentage decrements.

TABLE 14

Dependent Variables Significantly Correlated With Behavior Percentage Decrement

Variable Type	Variable	Test	Pearson's r	Cases	Significance Level
Mother's Attitude Towards Therapy	Therapy Satisfaction	T.A.I.	.51	21	.01
	Therapist Satisfaction	T.A.I.	.44	21	.02
Change In Mother's Attitude Towards Child's Behaviors	Acting Out	Walker	-.38	21	.05
	Distractibility	Walker	-.36	21	.05
	Total Walker Score	Walker	-.44	21	.02
Change in Mother's Mood	Vigor	POMS	.39	22	.03

CHAPTER IV

DISCUSSION

The parent training literature has demonstrated that parent training is an effective approach to child behavior change. One such parent training system, Directive Parental Counseling has been shown to be effective both when the therapists were experienced clinicians (Brown, 1975) and also when they were less experienced psychology graduate students (Hyde, 1975). The present study demonstrated that third year nursing students with no previous counseling experience could be trained to be effective D.P.C. counselors after only twenty-four hours of training in the technique. The present study evaluates an efficient comprehensive D.P.C. counselor training and supervision program which transformed young, inexperienced nursing students into proficient counselors. This study is a departure from the majority of studies in this research area which achieve their results through the use of highly trained, clinically experienced parent trainers.

The reduction in frequency of deviant behavior to 40% of baseline (a 60% reduction from the baseline rate) was the primary criterion used in this study to determine successful outcome. Thirteen of the twenty-two children in the treatment families met this criterion. These findings

compare favorably with those obtained by Hyde with more mature and experienced graduate students. While 60% of Hyde's treatment children were improved, only 55% of the treatment families showed improvement in the target child's target behavior. One of the families applied the D.P.C. program to a second child. In the present study 59% of the target children demonstrated the requisite decrease in target behavior.

The criterion selected in this study is the most rigorous standard reported in the research literature. Hyde (1975) notes that several researchers (e.g., Eyberg and Johnson, 1974) used only a 30% reduction criterion. The present findings seem even more impressive when one considers that most researchers work with only one target group. Most of Patterson's studies for example evaluate programs which treat only aggressive boys. The present study has focused on a wider range of behavioral problems and thus is more generalizable to the clinical setting.

Most studies in this area use screening interviews and other procedures which limit the number of treatment cases. Eyberg and Johnson (1974) for example reported that only 20-40% of the families interviewed were judged to be acceptable. Such selection procedures could serve to increase the success rate of the treatment evaluated by eliminating difficult cases. The present study accepted consecutive referrals for the D.P.C. program from all

referring sources. These selection procedures of this study would tend to increase the generalizability of the results obtained.

Data presented in Chapter III suggests that the Directive Parental Counseling System is an adaptable clinical workhorse that is able to modify a variety of behavioral problems for both boys and girls within the age range of 2.5 years to 9 years old.

Another consideration suggests that the present research is more generalizable to clinical treatment programs in child mental health agencies than most other studies in the area. Some studies do not report the number of cases which dropped out before treatment was completed (Johnson, 1967) while other studies report a high drop-out rate (Brown, 1975). Dropouts in most studies are excluded from the data analysis. This results in inflated success rates. To the knowledge of the author, the present study reports the lowest drop-out rate in the literature. Twenty-three of the twenty-four families remained in the program ten weeks and completed the pre and post-tests (96%). While the author deleted the drop-out case from further analyses he also deleted a treatment case which was successfully treated by the counselor's supervisor. The low drop-out rate in this study suggests that the success rate reported is a more accurate representation of the clinical utility of the treatment procedures in applied settings. Clients

who drop-out of treatment are not usually ignored in treatment services' evaluation procedures. Clients who unexpectedly drop-out without the consent of the therapist are often disatisfied with the therapy because they see little improvement. The present research suggests that the D.P.C. program is found to be a valuable product by mental health consumers. No formal reward system was used in this study to reinforce participation.

A fourth aspect of this study which makes it more generalizable to applied situations, is the minimal number of clinical personnel which were utilized. Many of Patterson's projects for example utilized trained behavioral observers who recorded the child's behavior frequency. Besides the difficulties already discussed by Ferber, Keeley and Shemberg (1974) involved in such procedures (see Chapter I above) the resources needed for their implementation are beyond the financial limitations of most mental health agencies. Non-research, clinical parent-training projects would rarely if ever use observers.

The absence of trained observers does not invalidate experimental findings. Previous studies have found parent's observations to be reliable (O'Leary et. al., 1973; Rinn et. al., 1975). The present study has demonstrated that behavior frequency decrements are significantly correlated to other indices of successful treatment. Table 14 shows that the mother's attitude towards the therapy, the mother's

change in attitude towards her child's behavior and the mother's change in mood are all significantly correlated to the child's problem behavior decrement as observed and recorded by the mother. These findings can be interpreted in two different ways. Mothers may in fact be accurate recorders of behavior frequency and behavior frequency decrements are significantly correlated to other dependent variables. Alternatively, mothers may be inaccurate recorders of behavior frequency. However, if such is the case, it must also be true that mothers who inaccurately recorded behavioral improvements tended to report more satisfaction with the therapy and an improved attitude towards their child's behavior than did parents who did not record such improvements. Some parents may have wanted to produce "good" results for the counselor and the experimenter. This tendency could have resulted in the high correlations observed between the various dependent variables. Such parents would score high on the Marlowe-Crowne Social Desirability Scale and on the response bias scale of the Comrey Personality Scales. Yet, the observed correlation between the behavior frequency decrement and the mother's social desirability was quite small ($r = .10$). These findings present difficulty for the second interpretation discussed above.

Since the counselors transmitted the testing data to the experimenter it is possible that they could have

altered the data to please the experimenter. However, the observed correlations between the behavior frequency decrement and the following validity checks were all insignificant: a) counselor's social desirability ($r = -.04$); b) counselor's response bias on the Comrey ($r = -.19$); c) counselor's validity scale on the Comrey ($r = -.19$); d) counselor's tendency to make a good impression on the Nurse's Attitude Inventory ($r = .16$); e) counselor's tendency to make a bad impression on the Nurse's Attitude Inventory ($r = .02$).

Positive changes in parent's perceptions of and attitudes towards the problem child and assessment of generalization effects were measured by the Walker Problem Behavior Identification Checklist, the Survey of Opinions Regarding the Bringing Up of Children, the Family Scale, the I-E Scale and the Profile of Mood States. The results obtained in this study indicated that only on one dependent variable (WPBIC Distractibility) was there a statistically significant difference in the desired direction between the pre-test and post-test scores.

Evidence that general clinical competence and competence in the D.P.C. system may result in significantly more change in extraconditioning variables is provided by Hyde (1975). On the Walker total problem score and seven other dependent variables Brown's (1975) treatment group obtained significantly better results than Hyde's group

who were treated by less experienced therapists. Except for the Walker test the present study used different measures of change. An analysis of the Walker test results indicates that the Brown group (treated by experienced therapists) decreased their mean total problem score 16.99 points while the less experienced Hyde group decreased their mean total problem score 11.28 points during the D.P.C. treatment program. The non-experienced group in this study only decreased their mean total problem score 3.80 points.

It is reasonable to assume that non-experienced nurses might be able to obtain results similar to those obtained by Brown if they would increase their clinical experience and their familiarity with conducting the D.P.C. training program. An empirical test of this assumption might be a valuable contribution to parent training research.

As noted above, behavior frequency changes for the non-experienced group were impressive as changes obtained with more experienced therapists (Hyde, 1975; Patterson, 1974). Thus extraconditioning variables seem more influenced by the characteristics of the therapist than does the specific conditioning variable which seems more technique-bound. Changing mother's attitudes and moods is more of an art and less of a technology than is changing the frequency of junior's problem behaviors.

Training professionals or paraprofessionals as

parent counselors is one method of increasing the availability of mental health services to the community. It is noteworthy that the student nurses were supervised by masters-level psychologists in groups of four. Only ten treatment sessions and ten group supervision sessions were required. This time compares favorably with Patterson's (1974) reported 31.5 hours per training program.

Another method of providing effective and economical service to families is to determine before treatment which families would likely be successful candidates for parent training. The present research was not able to detect many family variables which were good predictors. Children whose problem behaviors occured with a higher frequency during the baseline procedures were more likely to show a greater decrement in behavior. This is not an unsurprising result. It is easier to demonstrate a dramatic behavior change if the initial problem is more severe (i.e., occurs more frequently). Children who were less withdrawn (as rated by their mother on the Walker test) were more likely to show greater behavior decrement. Perhaps such children are less responsive to the social rewards which were used liberally during the application of the D.P.C. program.

Another method of providing an effective and efficient treatment service is to select mental health professionals who are more likely to be effective behavior change agents. The present study discovered seventeen

counselor characteristics which were predictive of success in parent training. The successful counselor is more likely to show high regard (feelings such as respect, liking and appreciation) consistently in his social interactions. The Comrey Scales indicate that the successful counselor is likely to be trust-worthy and believe in the basic honesty and good intentions of other people. He is also likely to be emotionally stable, i.e., free of depression, optimistic, relaxed, confident and stable in mood. The successful counselor is also more likely to express inclusive, affiliative and affectionate behavior. However, he is more likely to want more control in social situations than the unsuccessful counselor. The successful counselor is also more likely to be internally-controlled. He views himself as having reponsibility for his fate. Finally, the successful counselor has a different value hierarchy than does the unsuccessful counselor. Accomplishment, true friendship, wisdom, being capable and being responsible are valued more highly by the successful counselor than the unsuccessful counselor. The unsuccessful counselor tends to value family security, being courageous and being polite more highly than does the successful counselor.

This study has found several counselor attitudes, values and personality variables to be predictive of successful parent training. To my knowledge no other study in the behavior modification literature has found so many

counselor variables to be significantly correlated to treatment outcome. There is a need to replicate the present findings. It would also be useful to see if these variables are also predictive of successful application of other behavioral methods such as systematic desensitization and other treatment methodologies such as psychoanalysis, or Gestalt therapy.

The present findings suggest that behavior therapy is not merely a technology. Behavior therapy like other therapy techniques relies partly on the particular characteristics, experience, attitudes, skills and personality traits of the therapist. Behavior therapy may be a science but it is also an art.

Appendix A

Overview of the D.P.C. Program

POINT	PURPOSE
1. List the Problem	Assessment: A. Initiate the relationship with parents. B. Begin to teach them defining problems in behavioral terms. C. Obtain information to ascertain which problem to begin with. D. Gather information for assessment and decision-making purposes.
2. Select One: Two Aspects, #1 and #2 Points #10 through #18 are designed to decrease behavior which occurs too frequently (A#1). Points #19 through #30 are designed to increase behavior which occurs too infrequently (A#2).	Assessment: A. From this point of view, whatever problem is troubling the parent is always occuring <u>too frequently</u>. This will be labelled Aspect #1 of the problem behavior. Once specified it will be defined in behavioral terms. B. The other side of the coin is what the parents desire instead of A#1, and which is occurring <u>too infrequently</u>. This will be labelled Aspect #2 and when defined in behavioral terms it will become the goal behavior.
3. Estimate Strength	Assessment: A. Obtain objective, observational information concerning the frequency of A#1 and A#2. B. Obtain subjective estimate of effect of A#1 on parent(s).
4. Set Reasonable Goals for Two Aspects	Assessment: A. Decide with parent(s) what a decrease in A#1 entails. B. Decide with parents what appropriat increase in A#2 entails.
5. A.B.C.	Training: A. The parent(s) are instructed in the basic principles of learning which underlie the DPC system. Emphasis is placed on the A.B.C. paradigm utilizing the observations obtained by the parents.

POINT	PURPOSE
6. Know the Positives 7. Know the Negatives	Assessment: A. A thorough survey is made of the major reinforcing stimuli in the child's environment which can be employed in altering Aspect #1 and Aspect #2.
8. Making Words Matter 9. Making Rules	Training A. The major purpose of these points is to train parents to utilize the A.B.C. principles when communicating with their children.

NOTE: Points #10 through #18 contain the major techniques for decreasing Aspect #1 (the problem behavior). The counselor's goal is to guide the parents in selecting the specific procedures for their particular case from the following points.

ASPECT #1 — TOO FREQUENT

10. Where or When of A#1	Intervention: A. The counselor defines the antecedent, those conditions which preceed the A#1 behavior. The where and when of A#1 is defined.
11. Explore the Solution to A#1	Intervention: A. The counselor explores which of the three possibilities for decreasing behavior (i.e. punishment, loss, withholding) are appropriate for decreasing A#1.
12. Decrease Through Punishment, Loss, Withholding 13. Punishment 14. Loss 15. Withholding	Intervention: A. The three consequences are defined and the operations necessary for their execution are specified. B. The problems and potential effects of each consequence are explained to the parents.
16. Who Else Controls Positives	Intervention: A. A survey is made based on points #6 and #7 of the particular reinforcing agents and who controls the reinforcers. To obtain success these agents must be included in the program.
17. Sometimes vs. Never	Intervention: A. The concept of intermittent reinforcement and its effects on punishment, loss and withholding procedures are discussed.

POINT	PURPOSE
18. Decreasing Strategy Rehearse A.B.C.	Intervention: A. The parents are thoroughly trained via role playing, rehearsal, etc. in carrying out the chosen strategies for reducing A#1. Points #8 and #9 are very useful at this stage.

NOTE: Points #19 through #30 are the major techniques for increasing Aspect #2 (the goal behavior). The counselor's object is to guide the parents to utilize these methods to increase Aspect #2 while simultaneously decreasing Aspect #1.

ASPECT #2 — TOO INFREQUENT

19. Where or When of A#2	Intervention: A. The counselor defines the antecedent conditions (the where or when) which preceed the occurence of A#2. The parents will only deliver consequences under these conditions.
20. Explore for Solution to A#2	Intervention: A. The counselor begins to explore which of the possibilities for increasing behavior (i.e. reward or relief) is appropriate for this case.
21. Increase Through Relief or Reward	Intervention: A. The two consequences are defined and the operations necessary for their execution are carefully specified with the parent(s). B. The problems and potential effects of reward and relief are explained.
22. What is the Child Doing Right?	Intervention: A. A survey is made to establish how much of A#1 is already occurring. This is the starting point or baseline for A#1 behavior.
23. Immediacy 24. Step by Step 25. Bringing Behavior Out 26. Vary Type of Reward 27. More or Less 28. Not All the Time	Intervention: A. Points #23 through #28 contain the specific procedure which enhances the effectiveness of positive reinforcement procedures. They include immediacy of reward, shaping, chaining, prompt and fade techniques and intermittent reinforcement.

POINT	PURPOSE
29. Deprive	Intervention: A. Rarely the parent(s) is (are) required to place their child in a temporary state of deprivation in order to create circumstances where they can reward their child for A#2 behavior.
30. Increasing Strategy	Intervention: A. The parents are thoroughly trained via role playing, rehearsal etc. in carrying out the chosen strategies for increasing A#2. Points #8 and #9 are very useful at this stage. B. Charts, stars, tokens and other materials are constructed and utilized by the parents.

APPLICATION

The parents are now ready to perform the specific operations necessary for Aspect #1 and Aspect #2.

Appendix B

Unpublished Assessment Instruments

I.D.#_____ DATE:_____

READ EACH ITEM CAREFULLY AND UNDERLINE QUICKLY THE PHRASE WHICH BEST EXPRESSES YOUR FEELING ABOUT THE STATEMENT.

1. The Directive Parental Counselling (D.P.C.) Programme is a very effective treatment procedure that has been used successfully with many families.

   Strongly Agree Agree Undecided Disagree Strongly Disagree

2. The D.P.C. programme is an experimental procedure which perhaps may not be proven effective.

   Strongly Agree Agree Undecided Disagree Strongly Disagree

3. The D.P.C. programme will work with almost all families with children who have behavioral problems.

   Strongly Agree Agree Undecided Disagree Strongly Disagree

4. The D.P.C. programme will work with very few families.

   Strongly Agree Agree Undecided Disagree Strongly Disagree

D.P.C. Expectancy Scale

IN TRAINING EVALUATION FORM

Rank order each student in the group according to how successful you feel she (he) will be as a D.P.C. counsellor. Give a #1 for the counsellor you feel will be most successful, a #4 to the counsellor you feel will be least successful.

COUNSELLOR #	RANKING
	1
	2
	3
	4

Below are a number of adjectives or descriptive phrases arranged in pairs. The opposing descriptions in each pair are placed at the extremes of an 8-step scale. Please put one check mark for each adjective pair on the point of the scale which most closely corresponds to the way you feel at the present time.

SECURE	—	—	—	—	—	—	—	—	INSECURE
STEADY	—	—	—	—	—	—	—	—	NERVOUS
COMPETENT D.P.C. COUNSELLOR	—	—	—	—	—	—	—	—	INCOMPETENT COUNSELLOR
COMPETENT NURSE	—	—	—	—	—	—	—	—	INCOMPETENT NURSE
RELAXED	—	—	—	—	—	—	—	—	TENSE
HAPPY	—	—	—	—	—	—	—	—	SAD
ACTIVE	—	—	—	—	—	—	—	—	INACTIVE
LIKEABLE	—	—	—	—	—	—	—	—	UNLIKEABLE
CONFIDENT	—	—	—	—	—	—	—	—	UNCONFIDENT

VERBAL BEHAVIOR INDICES

ASSESSER:_____ DATE:_____

SUBJECT ASSESSED:_____ PERIOD OF ASSESSMENT:_____

DIRECTIONS: Check off all the verbal problems that you observed in the subject during the period of assessment noted above.

____	1. Over Talk	____	20. Overgeneralization
____	2. Under Talk	____	21. Undergeneralization
____	3. Fast Talk	____	22. Excessive Cueing
____	4. Slow Talk	____	23. Misrepresentation of Future Speech
____	5. Loud Talk	____	24. Misrepresenting Others
____	6. Quiet Talk	____	25. Misrepresenting Facts
____	7. Singson Speech	____	26. Avoiding Topics
____	8. Monotone Speech	____	27. Topic Shifting
____	9. Rapid Following	____	28. Persisting on a Topic
____	10. Slow Following	____	29. General Speech
____	11. Emotional Talk	____	30. Other-time Talk
____	12. Unemotional Talk	____	31. Detached Talk
____	13. Interruptions	____	32. No Positive Talk
____	14. Quibbling	____	33. Flattery
____	15. Overresponsiveness	____	34. Not acknowledging
____	16. Underresponsiveness	____	35. Too Much Acknowledging
____	17. Excessive Questioning	____	36. No Opinions
____	18. Pedantry	____	37. Too many Opinions
____	19. Dogmatic Statement	____	38. Too much Agreement

____ 39. Too Much Disagreement

____ 40. Choppy Talk

____ 41. Too Little Information Given

____ 42. Too much Negative Talk

____ 43. Too Little Negative Talk

____ 44. Illogical Talk

Rate the subject in terms of his(her) overall ability to communicate. Place a check on the following scale:

EFFECTIVE, GOOD COMMUNICATOR ___ ___ ___ ___ ___ ___ ___ ___ INEFFECTIVE, BAD COMMUNICATOR

Rate the subject in terms of his(her) overall ability to listen. Place a check on the following scale.

GOOD LISTENER ___ ___ ___ ___ ___ ___ ___ ___ BAD LISTENER

SUPERVISOR'S EVALUATION OF COUNSELOR FORM

Counselor No. #______________ Assessment Date ______________

1. Rank order each student in your group according to how successful you feel she(he) will be as a DPC counselor, Give a #1 for the counselor you feel will be most successful, a #4 to the counselor you feel will be least successful.
This counselor's rank is ________.

Below are a number of descriptive phrases arranged in pairs. The opposing descriptions in each pair are placed at the extremes of an 8 - step scale. Please place a check mark at the point of the scale which most closely corresponds to an accurate description of the counselor being assessed.

2.	Very Successful DPC counselor	___	___	___	___	___	___	___	___	Very Unsuccessful DPC counselor
3.	Very Empathic	___	___	___	___	___	___	___	___	No empathic understanding
4.	Very High Regard	___	___	___	___	___	___	___	___	Very Low Regard
5.	Unconditional Regard	___	___	___	___	___	___	___	___	Conditional Regard
6.	High Congruence	___	___	___	___	___	___	___	___	No Congruence
7.	Willing to be known	___	___	___	___	___	___	___	___	Evasive, Secretive

GUIDE TO SUPERVISOR'S EVALUATION OF COUNSELOR FORM

Item #1: This item is self explanatory. It refers to a ranking of the consultants in your group.

Item #2: This item refers to how successful you predict the counselor will be with her family.

Item #3: This refers to Roger's dimension of empathy. Degree of empathic understanding is conceived as the extent to which one person is conscious of the immediate awareness of another. It is concerned with experiencing the process and content of another's awareness in all its aspects.

Item #4: Regard refers here to the affective aspect of one person's response to another. Level of regard is the general tendency (at a given time) of the various affective reactions of one person in relation to another. High regard includes feelings like respect, liking, appreciation.

Item #5: This refers to the degree of constancy of regard felt by one person for another; the degree of variability in one person's expression. Conditional regard refers to more variability, unconditional regard refers to low variability.

Item #6: Congruence refers to genuineness, unity, honesty, directness and sincerity.

Item #7: This factor refers to the degree that a person is willing to self-disclose; i.e., is willing to let himself be known to another person. This refers to sharing of perceptions, feelings, etc.

REFERENCES

Ackerman, N. W. The Psychodynamics of Family Life: Diagnosis and Treatment of Family Relationships. New York: Basic Books, 1954.

Allen, K. E.; Hart, B.; Buell, J. S.; Harris, R. & Wolf, M. Effects of social reinforcement on isolate behavior of a nursery school child. Child Development, 1964, 35, 511-518.

Baer, D. M.; Wolf, M. M. & Risley, T. R. Some current dimensions of applied behavioral analysis. Journal of Applied Behavioral Analysis, 1968, 1, 91-97.

Bandura, A. Principles of Behavior Modification. New York: Holt, Rinehart & Winston, 1969.

Barrett-Lennard, G. T. Dimensions of therapist response as causal factors in therapeutic change. Genetic Psychology Monographs, 1962, 76, No. 43 (Whole No. 562).

Bergin, A. & Suinn. Individual psychotherapy and behavior therapy. In Rosenzweig, M. & Porter, L. (Eds.), Annual Review of Psychology Vol. 26. Palo Alto: Annual Review Company, 1975.

Berkowitz, B. R. & Graziano, A. M. Training parents as behavior therapists: A review. Behaviour Research and Therapy, 10, 1972, 297-310.

Brady, J. P. Behavior therapy: Fad or psychotherapy of the future? Presidential address, Fifth Annual Meeting of the Association for the Advancement of Behavior Therapy, September 5-6, 1971, Washington, D.C.

Brown, D. D. Directive Parental Counseling: An Appraisal of its Effects on Extra-conditioning Variables. Unpublished doctoral dissertation. Windsor, Ontario, 1975.

Bucher, B. D. Learning theory. In B. B. Wolman (Ed.) Manual of Child Psychopathology. New York: McGraw-Hill, 1972.

Chapin, F. S. The Social Insight Test. Palo Alto: Consulting Psychologist Press, 1967.

Combs, A. W. & Soper, D. W. The perceptual organization of effective counselors. Journal of Counseling Psychology, 1963, 10, 226-226.

Comrey, A. L. Comrey Personality Scales Manual. San Diego: Educational and Industrial Testing Service, 1970.

Conger, J. The treatment of encopresis by the arrangement of social consequences. Behavior Therapy, 1968, 1, 386-390.

Crowne, D. & Marlowe, D. The Approval Motive. New York: Wiley, 1964.

Donner, L. Automated group desensitization: A follow-up report. Behavior Research and Therapy, 1971, 8, 241-247.

Eyberg, S. M. & Johnson, S. M. Multiple assessment of behavior modification with families, effects on contingency contracting and order of treated problems. Journal of Consulting and Clinical Psychology, 1974, 42, (4), 594-606.

Eysenck, H. J. Learning theory and behavior therapy. Journal of Mental Science, 1959, 105, 61-75.

Ferber, H.: Keeley, S. M. & Shemberg, K. M. Training parents in behavior modification: Outcome of problems encountered in a program after Patterson's work. Behavior Therapy, 1974, 5, (3), 415-419.

Forehand, R.; Cheney, T. & Yoder, P. Parent behavior training: Effects of the non-compliance of a deaf child. Journal of Behavior Therapy and Experimental Psychiatry, 1974, 5, (3-4), 281-283.

Gardner, G. G. The psychotherapeutic relationship. Psychological Bulletin, 1964, 61, 426-237.

Geer, C. A. The sex variable in desensitization therapy. Dis. Abs. Int., 1973 (June), 33, (12-B), 6078.

Gordon, T. A. A New Model For Humanizing Families and Schools. Pasadena, California: Effectiveness Training Associates, 1971.

Gough, G. The Chapin Social Insight Manual. Palo Alto: Consulting Psychologists Press, 1968.

Guerney, B. G. Psychotherapeutic Agents: New Roles for Nonprofessionals, Parents and Teachers. New York: Holt, Rinehart and Winston, 1969.

Harris, F. R.; Wolf, M. M. & Baer, D. M. Effects of adult social reinforcement of child behavior. Young Children, 1964, 20, (1), 8-17.

Hays, W. L. Statistics. New York: Holt, Rinehart and Winston, 1963.

Hobbs, N. Mental health's third revolution. The American Journal of Orthopsychiatry, 1964, 34, (5), 822-833.

Holland, C. J. Directive parental counseling: The parent's manual. Behavior Therapy, 1976, 7, 123-127.

Holland, C. J. Elimination by the parents of fire-setting behavior in a seven year old boy. Behavior Research and Therapy, 1969, 7, 135-137.

Holland, C. J. Directive Parental Counseling: The Parents' Manual. Windsor: University of Windsor Press, 1974.

Homme, L. How To Use Contingency Contracting In The Classroom. Champaign, Ill.: Research Press, 1972.

Hyde, N. Directive Parental Counseling: An Empirical Study. Unpublished doctoral dissertation, Windsor, Ontario, 1975.

Johnston, R. Some casework aspects of using foster grandparents for emotionally disturbed Children, 1967, 14, (2), 46-52.

Jones, J. E. Helping relationship response tendencies and occupational affiliation. Personnel Guidance Journal, 1967, 671-675.

Jones, M. C. The elimination of children's fear. Journal of Experimental Psychology, 1924, 7, 383-390.

Kanner, L. Child Psychiatry. Springfield, Ill.: Charles Thomas, 1967.

Kiernan, C. Behavior modification and the nurse. Nursing Times, 1973, 69, (38), 149-152.

Kiesler, D. J. Some myths of psychotherapy research and the search for a paradigm. Psychological Bulletin, 1966, 65, 110-136.

Knupfer, G.; Jackson, D. D. & Kreiger, G. Personality differences between more and less competent psychotherapists as a function of criteria of competence. Journal of Nervous and Mental Disease, 1959, 129.

Krapfl, J. E. Differential ordering of stimulus presentation and semiautomated vs live treatment in the systematic desensitization of snake phobia. Unpublished doctoral dissertation, University of Missouri, 1967.

Kyle, J. R. & Savino, A. B. Teaching parents behavior modification. Nursing Outlook, 21, (11), 717-720.

Labovitz, S. The assignment of numbers to rank order categories. American Sociological Review, 1970, 35, 515-524.

Lang, P. J. The mechanics of desensitization and the laboratory study of human fear. In Franks, C. M. (Ed.), Behavior Therapy: Appraisal and Status. New York: McGraw-Hill, 1969.

Leitenberg, H.; Agras, S.; Barlow, D. & Oliveau, D. Conditions of selective positive reinforcement and therapeutic instructions to systematic desensitization therapy. Journal of Abnormal Psychology, 1969, 74, 113-118.

Lovibond, S. H. Conditioning and Enuresis. New York: Pergamon Press, 1964.

MacNamara, M. Helping children through their mothers. Journal of Child Psychology and Psychiatry, 1963, 4, 29-46.

MacDonough, T. S. & McNamara, J. R. Design criteria relationships in behavior research with children. Journal of Child Psychiatry and Allied Disciplines, 1973, 14, (4), 271-282.

Madsen, C. H. Positive reinforcement in toilet training of a normal child. A case report. In L. P. Ullman & L. Krasner (Eds.), Case Studies In Behavior Modification, New York: Holt, Rinehart & Winston, 1965.

Martin, B. & Kubly, D. Results of enuresis by a conditioned response method. Journal of Consulting Psychology, 1955, 19, 71-73.

Marmor, J. Dynamic psychotherapy and behavior therapy: Are they irreconcilable? Archives of General Psychiatry, 1971, 24, 22-28.

McNair, D. M.; Callahan, D. & Lorr, M. Therapist type and patient responses to psychotherapy. Journal of Consulting Psychology, 1962, 76, 425-442.

McNair, D. M.; Lorr, M. and Droppleman, R. Profile of Mood States Manual. San Diego: Educational and Industrial Testing Service, 1971.

Mira, M. Results of a behavior modification training program for parents and teachers. Behavior Research and Therapy, 1970, 8, 309-311.

Montenegro, H. Severe separation anxiety in two pre-school children successfully treated by reciprocal inhibition. Journal of Child Psychology and Psychiatry, 1968, 9, 93-103.

Morris, R. J. & Suckerman, K. R. Therapist warmth as a factor in automated systematic desensitization. Journal of Consulting and Clinical Psychology, 1974, 42, (2), 244-250.

Mowrer, O. H. & Mowrer, W. A. Enuresis: A Method for its study and treatment. Journal of Orthopsychiatry, 1938, 8, 436-447.

Nay, W. R. A systematic comparison of institutional techniques. Behavior Therapy, 1975, 6, (1), 14-21.

Nolan, J. D. & Pence, C. Operant conditioning principles in the treatment of a selectively mute child. Journal of Consulting and Clinical Psychology, 35, 265-268.

Nunnally, J. C. Psychometric Theory. New York: McGraw-Hill, 1967.

O'Dell, S. Training parents in behavior modification: A review. Psychological Bulletin, 1974, 8, (7), 418-433.

O'Leary, K. D.; Turkewitz, H. & Taffel, S. Parent and therapist evaluation of behavior therapy in a child psychological clinic. Journal of Consulting and Clinical Psychology, 1973, 4, (2), 279-283.

O'Neil, S. M. The application and methodological implications of behavior modification in nursing intervention. Dis. Abs. Int., 72-32915.

Patterson, G. R. Intervention for boys with conduct problems: multiple settings, treatments and criteria. Journal of Consulting and Clinical Psychology, 1974, 42, (4), 471.

Patterson, G. R. & Gullion, M. E. Living With Children. Champaign, Ill.: Research Press, 1971.

Paul, G. Outcome of systematic desensitization. In C. M. Franks (ed.), Behavior Therapy: Appraisal And Status. New York: McGraw-Hill, 1969.

Peine, H. The elimination of a child's self-injurious behavior. School Application of Learning Theory, 1972, 4, 4.

Perlmutter, F. & Durham, D. Using teenagers to supplement casework service. Social Work, 1965, 10, (2), 41-46.

Porter, B. H. An introduction to therapeutic counseling. Boston: Houghton Mifflin, 1950.

Pumroy, G. K. A new approach to treating parent child problems. Paper presented at the meeting of the American Psychological Association. Chicago, September, 1965.

Quirk, D. An automated desensitization. Advances in Behavior Therapy, Vol. 5. New York: Academic Press, 1973.

Reinherz, H. The therapeutic use of student volunteers. Children, 1964, 7, (4), 137-142.

Rinn, R. C.; Vernor, J. C. & Wise, M. J. Training parents of behaviorally disordered children in groups: A three years' program evaluation. Behavior Therapy, 1975, 6, 378-387.

Rioch, M. Changing concepts in the training of therapists. Journal of Consulting Psychology, 1966, 30, 4, 290-292.

Robinson, J. F. & Bender, L. Foreward to Robinson, J. F. (Ed.), Psychiatric Inpatient Treatment of Children. Washington: American Psychiatric Association, 1957.

Rogers, C. R. & Dymond, R. Psychotherapy and Behavior Change. Chicago: University of Chicago Press, 1954.

Rokeach, M. The Nature of Human Values. New York: The Free Press, 1973.

Rokeach, M. Value Survey. Sunnyvale, Calif.: Halgren Tests, 1967.

Rose, S. D. Training parents in groups as behavior modifiers of their children. Journal of Behavior Therapy and Experimental Psychiatry, 1974, 5, (2), 135-140.

Rotter, J. B. Generalized expectancies of internal versus external control of reinforcement. Psychological Monographs, 1966, 80, No. 1, (Whole No. 609).

Schmid, J.; Marsh, J. & Detter, H. M. Analysis of job satisfaction. Research Report AFPTRC-TN-59-30, March, 1951, ASTIA, Document No. 098935.

Schutz, W. C. FIRO-B Test. Palo Alto: Consulting Psychologists Press, 1957.

Schutz, W. C. FIRO-F Test. Palo Alto: Consulting Psychologists Press, 1967.

Schutz, W. C. The FIRO Scales Manual. Consulting Psychologists Press, 1967.

Shaw, M. E. & Wright, J. M. Scales For The Measurement of Attitudes. New York: McGraw-Hill, 1967.

Skinner, B. F. The Behavior of Organisms: An Experimental Analysis. New York: Appleton-Century-Crofts, 1938.

Streitfeld, J. W. Expressed acceptance of self and others by psychotherapists. Journal of Consulting Psychology, 1959, 23, 435-441.

Tasto, D. L. Systematic desensitization muscle relaxation and visual imagery in the counterconditioning of four year old phobic child. Behaviour Research and Therapy, 1969, 7, 409-411.

Thurston, J. R. & Brunclik, H. L. Nurses Attitude Inventory. Eau Claire, Wisc.: Nurses Research Associates, 1973.

Thurston, J. R.; Brunclik, H. L. & Feldhusen, J. F. Comprehensive Manual For Use With Nurse Attitude Inventory Forms I and II. Eau Claire, Wisc.: Nurses Research Associates, 1970.

Truax, C. B. Effective ingredients in psychotherapy: An approach to unraveling the patient-therapist interaction. Journal of Counselling Psychology, 1963, 10, 256-263.

Tufte, E. R. The Quantitative Analysis of Social Problems. Reading, Massachusetts: Addison Wesley, 1970.

Walder, L.; Cohen, S.; Breiter, D.; Warman, F. & Orme-Johnson, D. Parents as agents of behavior change. In S. E. Golann & C. Eisdorfer (Eds.) Handbook of Community Mental Health. New York: Appleton-Century-Crofts, 1972.

Walker, H. M. Walker Problem Behavior Identification Checklist. Los Angeles: Western Psychological Services, 1970.

Watson, J. B. & Rayner, R. Conditioned emotional reactions. Journal of Experimental Psychology, 1920, 3, 1-14.

Werry, J. S. & Wollersheim, J. P. Behavior therapy with children: A broad overview. Journal of American Academy of Child Psychiatry, 1967, 6, 346-370.

Whitehorn, J. C. & Betz, B. J. A study of psychotherapeutic relationships between physicians and schizophrenic patients. American Journal of Psychiatry, 1954, 3, 321-331.

Wilkins, W. Client's expectancy of therapeutic gain: Evidence for the active role of the psychotherapist. Psychiatry, 1973, 36, 184-190.

Williams, C. D. The elimination of tantrum behavior by extinction procedures. Journal of Abnormal Social Psychology, 1959, 59, 269.

Wolpe, J. Psychotherapy By Reciprocal Inhibition. Palo Alto: Stanford University Press, 1958.

Zeilberger, J.; Sampen, S. E. & Sloane, H. N. Modification of child problem behavior in the home with the mother as therapist. Journal of Applied Behaviour Analysis, 1968, 1, 47-53.

Zlutnick, S.; Mayville, W. J. & Moffat, S. Modification of seizure disorders: The interruption of behavioral change. Journal of Applied Behavioral Analysis, 1975, 8, (1), 1-12.

VITA AUCTORIS

1949	Born in Manhattan, New York, U.S.A. to Josephine and Salvatore Capanzano.
1955 - 1967	Educated at Plainedge Public School District, Massapequa, New York, U.S.A.
1967	Graduated from Plainedge High School, Massapequa, New York, U.S.A.
1971	Received Bachelor of Arts Degree Cum Laude (Psychology Honors Major) from Dartmouth College, Hanover, New Hampshire, U.S.A.
1971	Registered as a full-time graduate student at the University of Windsor.
1973	Received Masters of Arts Degree in Psychology, University of Windsor.
1973	Registered as a full-time graduate student in the Clinical Doctoral Program of the Department of Psychology at the University of Windsor.