

THE COMMUNICATION OF AFFECTS WITHIN
CLINIC AND NORMAL FAMILIES

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ABSTRACT

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by Michael Arthur Weiss

This study was undertaken in order to explore a question posed by family interaction: Can we differentiate between normal and clinic families with regard to the communication of negative and positive affects? Eight normal and seven abnormal families (four or five members each) participated in a semi-structured interview during which they interacted as a family in three task activities. Normal families had no known history of psychiatric disturbance or treatment and were obtained through labor union and church groups. The source of the abnormal families was the treatment waiting list of the Michigan State University Psychological Clinic.

It was predicted that the devised Rating Scale for the Communication of Affect (RSCA) would be able to distinguish between normal and clinic families, with the clinic families exhibiting lower scores on the positive affects and higher ones on the negative affects of the rating scale. Nine out of the thirteen items yielded inter-rater reliability coefficients that were significantly different from zero at

the .05 level (i.e. an r of .44 or greater). Five of the items yielded adequate inter-rater agreement ($r \geq .65$). The low reliability coefficients on a number of the items may be attributed to the very low incidence of these effects in the recorded communications.

The normal families were distinguished from the non-normal families by over-all pathology scores and a number of the individual items. The clinic families exhibited significantly more negative affects, such as depression, hostility, anxiety, confusion and double messages, whereas the non-clinics showed more positive communicational effects, such as happiness and dialogue, than did the clinics. Furthermore, the clinic families exhibited more extreme affective responses with a much more limited range of behaviors than did the non-clinic families.

Evaluation of the study's findings prompts the experimenter to suggest further research in the development of reliable rating scales as well as interactional tasks suited to the study of families.

Lucy R. Ferguson

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CHAPTER I

INTRODUCTION

Statement of the Problem

Recently there has been a large amount of research on the small group. Unfortunately very few of these studies have used the family as their focus and even fewer have studied the family group in any systematic manner. Therefore, there is a need to deal systematically with this most significant group--a group which, due to its prior common experiences and expectations of continued relations, can yield much more information of a heuristic nature to researchers than can any ad hoc group.

Of the relatively few studies in the past few years dealing with the family, most used time-saving techniques such as questionnaires or impressions of the observers. Although this may have been efficacious with regard to time, money and ease of experimental design, such devices allow such unwanted variables as interviewer and respondent biases (which subsume a whole host of other undesired variables) to intrude upon the scene. Direct observation of behavior of an interacting family when coupled with some objective rating schema will uncover its dynamics and will prove to be closest to the natural real-life situation.

The present study sought to study normal and clinic family interactions through the device of a rating scale developed to measure various effective modes of communication. It predicted that the rating scale would be able to distinguish between normal and clinic families. More specifically, the clinic families would exhibit lower scores on the "positive" affects and higher scores on the "negative" affects on the Rating Scale for the Communication of Affect (RSCA).

Relevant Literature

The Study of the Family as a Small Group

It is only very recently that psychology has joined psychiatry, anthropology, sociology and social work in the area of family interaction. Handel (1965) traces the notion of the "interaction concept" from a 1926 paper by Burgess in his plea for more systematic studies by psychological researchers in this all-important area. He decries the fact that psychology has been content to study the individual as if he functions in a vacuum.

While it is true that there have been many well-executed experiments done in the area of the small group, there arises the question of the heuristic value of many of these studies. Strodbeck (1954) asks how far we can generalize from the results obtained by many of these studies. He was seeking to test the appropriateness of certain

propositions concerning ad-hoc three-person groups in a study dealing with the father, mother and son as a three-person group. Strodtbeck favored the family over ad-hoc groups because of its prior common experience and expectations of continued relations--factors which make the experimental situation more like that of real life. In comparison with Mills (1953) Strodtbeck found that when the two most active members are in conflict, the stability is not as low for families as the former had found with ad hoc groups. Thus, it appears that many of the previous notions of the family which have been generalized from experiments on ad hoc groups may have to be modified accordingly.

To date the field of research on family interaction is in a rather amorphous and chaotic state. Framo (1965) states, "Despite the prodigious literature on the family, there is no body of formalized literature on systematic research on family dynamics with clearcut stands taken on issues and specific limits from which departures can be made" (p. 409). He also points to the unfortunate fact that there has been an extensive reliance by behavioral scientists upon questionnaires in family research. In addition the members of the family are usually seen separately rather than in the presence of other family members. Their conscious reports are subject to memory distortions and conscious and unconscious biases and falsifications.

Framo foresees much heuristic value of family research as he quotes from Hare (1955) "the study of small groups is a microscopic study of small cultures which has implications for the study of social systems, of cultures at large and of personality. The virtual omission of the family as a subject of systematic small-group investigation is singular indeed" (p. 412). Framo points out to us that there is a great wealth of knowledge to be gleaned by observations of interactional behavior within the family. He makes reference to the studies of Birdwhistell and Scheflen, who made very detailed microscopic analyses of interactional behavior by drastically slowing down film recordings.

In a study encompassing supplementary methods in family research Levinger (1963) provides an overview of the many techniques which have been utilized by past researchers in the area. He quotes Hill (1958) who examined marriage and family behavioral study techniques of 1945 to 1956. Of 422 studies, almost half used interviews, questionnaires or tests; a fifth utilized literary, legal or historical documents; one tenth of those studies were based on statistical summaries; one tenth were reliant upon the impressions of observers or upon various other unspecified methods; one tenth were ethnographic behavioral observation.

Levinger found that each of the above techniques had its merits. The questionnaire or interview is economic and focused. He states that competent judges avoid the

distortion of self-report. Behavioral observation yields a first-hand sample of interaction, although we receive no rich introspective data, Levinger points out. This method avoids distortions and gains insight into the functioning of the whole group. The observer can record action as it occurs and predict more directly future action. Problems of the respondents' unawareness or unwillingness to report the critical behaviors are greatly reduced. Levinger notes that it is also possible, unfortunately, for biases stemming from the subject's reactions to being observed and for the unrepresentativeness of the observed situation to distort the picture we obtain of the family in question.

Levinger sees the situational study technique of family research as being the best. It brings the family research closest to the usual mode of the scientific method while still remaining as close as possible to the real life situation. He adds that this is the most costly method in terms of time per subject. Also, without introspective report it may give misleading or unrepresentative impressions of family patterns. By virtue of the fact that it may influence the very process which is being studied it may produce artificial behavior on the part of the family members.

As soon as researchers began to realize that many of the older methods utilized in family studies would have to be supplemented by other techniques, a wealth of studies began to come into existence with regard to new devices for

family interactional experiments. Blood (1958) now has the observer taking notes on the spot. He believes that this will keep the observer active as he watches the family interacting in the home setting. This also enables the family to ignore the busy, non-participating reporter after a while. The observers concluded that volunteer families may be observed in this manner without causing a distortion in their behavior. Blood concludes that observation is a necessary adjunct to interviews and questionnaires.

Blood calls for the development and testing of observational categories to capture family interaction sequences. He decries the use of questionnaires in that they all too often leave unstudied little things that go on in family interactions which are more important than such classic questions as "When did your parents first explain to you about menstruation?"

In order to glean as much as possible with regard to the above-mentioned "little things that go on in family interactions" Strodtbeck (1951) made tape recordings in experimentally induced decision-making situations in order to be able to trace the role of each family member. He was studying mother-father interaction within three cultures (going from a mother-dominant Navajo to a father-dominant Mormon). The balance of power was revealed in the families who were instructed to reach a common consensus on problems about which they independently disagreed. The dominant

partner was judged to be the one who won the greater number of decisions.

Caputo (1963) has demonstrated the superiority of direct observation over a paper and pencil test in a very graphic fashion. Parents were instructed to discuss ten items of the Parent Attitude Inventory which they had previously answered in divergent fashion. He had derived relatively benign pictures of the parents' relationship from Osgood Semantic Differential data. However, analysis of the overt interaction of the parents revealed considerable antagonism and bilateral hostility.

In another early study attempting to demonstrate a significant relationship between family interaction and mental illness Jackson, Riskin and Satir (1961) sought to escape the trap of proving this in a retrospective manner. In their attempt to identify different patterns of family interaction and to relate these to the form of emotional disorder in the referred "patient," the authors utilized a communication theory approach. It was shown that the more disturbed families uttered a greater number of incongruent messages as compared to sequential disqualifications (i.e. "Yes" and then changing it to "No") than do normal families.

Riskin (1963) continued to seek out variables which could distinguish normal from pathologic families. He discusses covert and overt messages, with the former, an extreme form, indicating pathology. The experiment involved a series

of tasks, such as "Plan something you'd like to do as a family, etc." The specific variables on which the family was rated were: "clarity," "content," "agreement," "commitment," "congruency," "intensity," etc. It was found that in coalitions of any two members to the exclusion of a third, in families with schizophrenic children, the two are really not talking about the same thing although they seem to be. Riskin states that the healthier families exhibit what he terms "teamwork" or meeting in the middle of the road in coming to decisions. As many other researchers in the area, Riskin concludes by stating: "we do not have yet available adequate tools for evaluating the assumed relationships between family interaction and personality formation" (p. 348).

More recently a method was devised by Drechsler and Shapiro (1963) which compared clinical and statistical analyses of the same data in order to test hypotheses about a given family and to compare different families. The experimenters arbitrarily selected twenty-minute clinical samples to present in capsule form the family's characteristic pathology. In addition, from each family session, twenty one-minute segments were extracted at equal intervals and were scored independently for the number of times each person spoke to each other person.

The same authors had previously done research in the same area in a study which provided the family members with tasks to be completed without the presence of the

investigators (1961). They were to discuss together a family questionnaire of 20 items, containing factual as well as fantasy items (e.g. "Draw a diagram of the home with all the rooms." "What sort of thing does the family argue about?" "Describe how one special holiday is celebrated by the family." "What was the worst nightmare that each of you ever had?" "If each of you could change one thing about yourself and the other members of the family, what would you change?") Although this latter piece of research did not involve the sophisticated statistical methods of their later work, Drechsler and Shapiro had provided a setting where the family could act out its characteristic relationships and thereby reveal interactive patterns of which they were unaware.

Other investigators have decried the great difficulties encountered by researchers in this area, such as the lack of suitable methods for investigation and the paucity of coherent and specific theories which identify the critical variables and describe their presumed function. Farina, Storrs and Dunham (1963) used a "structured situational test" for assessing the effect of the relationships within the family on the behavior of the patient who is a member of that group. Each parent separately came to a solution of a hypothesized problem and then the family, consisting of the father, mother and son, arrived at a joint solution of that same problem. The patients consisted of two groups; "good

and "poor" premorbid. It was found that there was more conflict in the family interaction of poor premorbid and that the fathers were more dominant in the good premorbid group.

In another study involving abnormal and normal family groups interacting in task activities, Ferreira (1963) had each family member separately make his decision about three comparable neutral items (e.g. "If you were to take a trip to Alaska next month would you rather go by train, car or by boat") and to then order them in terms of his own preference. The second phase of the study involved the whole family deciding upon the same items with the awareness that the new ordering of the items would have to take into account the wishes of the other members.

Ferreira states that four broad categories of group decisions could be distinguished. They were "Unanimous," "Majority," "Dictatorial" and "Chaotic" decisions. In the Clinic Families it is often the child who decides what the family doesn't want, whereas in the Normal Families Ferreira noted that he found the greatest agreement between the preferences of the individual and those of the family.

Replicating his previous (1963a) finding concerning differences of spontaneous agreement between normal and abnormal families, and that abnormal families took more time to reach a joint decision which was often quite inappropriate with regard to the wishes of the individual family members, Ferreira (1963b) investigated some further phenomena cropping

up when normal families are compared with those in the clinic. In a family interactional activity, Ferreira states that the individual member in the Normal Families expects rejection in an amount that is commensurate with the amount that he tends to display. Ferreira likens this to the talionic, eye-for-an-eye principle. However, he notes that in the Abnormal Families, the principle can be stated more on the basis of "two eyes for an eye" or as "no tooth for a tooth."

One solution to the problem of the chaos in the field of family research is reported by Hill and Hansen (1960) at the University of Minnesota's Family Study Center. At this institution, there exists an inventory to codify substantive findings, research procedures employed and theoretical propositions derived from findings in family experiments. The authors have nicely categorized the various approaches to the study of the family and identify the discipline in which the conceptual framework was derived. The "Interactional" approach was developed in sociology and social psychology; the "Structure-Function" in sociology and social anthropology; the "Situational" in sociology; the "Institutional" in sociology and historical psychology; the "Developmental" in sociology and borrowing from rural sociology, child psychology and human development.

Another critic of family interaction studies, Haley (1964) states that the methods which have been used to date,

namely statistical, anthropological, individual and interactional are inadequate due to the fact that they must necessarily rely on the subjective reports of observers, inferential categories and the possibility of the raters possessing some common bias.

One of Haley's notions is that it is not important what the individual does, but to whom he responds. In his analysis of recorded speech, he discovered that the order of speaking and the patterns of order in abnormals showed non-randomness, whereas randomness of speaking order and patterns of order was exhibited by normal families. In normal families the interchange between mother and child was highest; that of father and child was least. In the abnormals the mother-father interchange was highest and that between father and child was least.

Another unusual method of studying family interaction sequences was devised by Riskin (1964). He had families plan something together which they could do with each other. His thesis was that significant incongruencies between body movements and vocal behavior can be found which will possess correlates in incongruencies between tonal and verbal behavior. He concluded that by just listening to family interactions, as does the average clinician, much valuable information on the family being studied is missed. Riskin believes that it is possible to make clinically meaningful and accurate descriptions of whole families and

the various members through the use of scales in blind interpretations of tapes.

The problem of studying the family remains a complicated one. For, as Ackerman (1957) states, "the moment we get absorbed in rigid statistical study we find ourselves counting the number of freckled mothers and fathers" (p. 74). The whole family should ideally be treated as an individual case study and should then be compared with others. It is necessary to have categories which can be applied universally. Referring to an early study executed by Moustakas, Sigel and Schalock (1956) he states it is also essential that the categories be comprehensive and objective. Situations should be as close to real life as possible. Ackerman (1957) cautions us on the problem of specification of bases for judgment in analysis of the data, i.e. the evaluation of actual life performances against a psychiatric model of "ideal" family and individual mental health. We must be aware that value judgments enter into the picture as well as do cultural biases.

A good deal of the research done in the area of family interaction has been executed so that we may gain insight and understanding into the ways in which families have come to be disturbed and how this disturbance is perpetuated within the family. Much of human responses to the behavior presented to them by their fellow humans is contingent upon the talion principle of "an eye for an eye a tooth for a tooth" as mentioned by Ferreira (1963b). In his study, the

payment was found to be two-fold in schizophrenic families in the case of negative responses and only half-fold in that of positive behavior. Thus it is not unexpected when two disturbed adults marry, that their progeny should help to maintain the vicious circle.

Ackerman (1953) noted that boys possessing problems with regard to conduct very often come from families where the parents are hostile or rejecting. He found that the child is not just a passive recipient of this hostility but is rather an active participant in the reinforcement of hostility within the family environment.

Raush, Dittman and Taylor (1959) showed that in groups of aggressive and normal boys that aggressive behavior generally begot aggression from others, whereas friendly behavior generally begot the same in return. This tends to be in line with the principle of reciprocal relations of Leary (1957) which holds that "interpersonal reflexes tend with a probability greater than chance to initiate or invite reciprocal interpersonal responses from the other person in the interaction that leads to a repetition of the original reflex" (p. 123). The unfortunate problem with disturbed families is, according to Leary, that they possess a narrow range of interpersonal behavior. They tend to repeat the same behavior which is for them a way of avoiding anxiety. It aids in minimizing conflict and provides for them the security of continuity and sameness. However, the price which

they must pay for this security is a restricted social environment with little opportunity for growth or change.

In a study of five hospitalized families, with each possessing a member judged to be schizophrenic, Brady's (1953) findings not only corroborate Leary but they demonstrate even more conclusively the absurd binds which abnormal families tend to get themselves into. Brady observed that the stereotyped roles in the disturbed families were like those in a medieval morality play where the "actors take allegorical roles and positions that are stereotyped and confined--one is Good, another Evil and a third Temptation" (p. 290).

A very early study in group behavior done by Kurt Lewin (1932) demonstrated very clearly some of the antecedent variables responsible for negative and positive affects existing within the group. Lewin set up two groups of children--one autocratic and the other democratic--to work together in the production of hand-crafted articles. A much higher state of tension was found to exist in the autocratic group along with about thirty-one times as much hostility as in the democratic group. On the other hand he found more praise and friendliness in the democratic group which led to a higher degree of constructiveness as judged by superior group products.

More recent studies, such as that of Bishop (1951) and Mackenzie (1968) point to the correlation between the

rigidity of roles in the group, extreme degree of negative affects and consequent lack of positive affects with psychopathology of that group. MacKenzie demonstrates that in a normal group of families more friendly responses were sent than in a matched clinic group. The behavior in the abnormal group also tended to be more extreme, thus pulling more extreme responses. The normals tend to show a wider repertoire of responses than do the clinic families. Bishop found that children reflected directly in their own behavior the mother's use of directing-interfering-criticism, strong stimulation and suggesting types of control and also the tendency toward nonacceptance of stimulations. She also noted that as the child becomes more familiar with a "neutral adult" in the experiment, his behavior approached that displayed toward the mother.

Thus, we see that the disturbed families tend to restrict their behaviors to a much greater extent than do the normal families. Unfortunately when certain types of behavior are negatively reinforced between mother and father, the children do not always play the game well, or perhaps they play it too well, for sometimes the parents may not even realize which behaviors in the children they are reinforcing. We all know of the mother who believes that she is negatively reinforcing aggressive behavior in her child when she slaps him in the face and says, "I don't ever want to see you hitting anybody again, Johnny!" Unfortunately for

the disturbed family, Johnny adopts his mother's behavior and contributes to the general pool of negative, destructive behaviors within the family. It is not very often in a disturbed family that parents transmit positive behaviors to the children since they themselves show little such behavior.

CHAPTER II

METHOD

Subjects

The data for this study were gathered by Marv Moore for his doctoral dissertation, carried out in 1966 at Michigan State University. Dr. Moore was kind enough to provide this experimenter with a series of taped family interactions.

The families in the study were comprised of four- or five-member units (both parents and two or three children) meeting the following criteria for acceptance: (1) all families had lived together for at least four uninterrupted years previous to participation in Moore's project; (2) the families had at least one male child between 8 and 13; (3) children ranged in age from 5 to 18 years old; and (4) they met the criteria listed below for inclusion in one of the two samples studied.

The sample groups were defined by Moore in the following manner: Normal group, consisting of 8 families where none of the members had ever received, or had ever been recommended to receive, any type of psychiatric treatment for an emotional or nervous disturbance. Moore obtained the sample of normal families from two sources. He states

that three of the families volunteered as a result of his solicitation of subjects at labor union meetings in the Lansing area. The five other family units volunteered after they had been recommended by their minister as representing the "most emotionally mature" families in his congregation. Each of the normal families received \$20.00 as payment for their cooperation in the two interviews. Clinic group, consisted of 8 families waiting for psychotherapy at the Michigan State University Psychological Clinic, the treatment to involve both parents and sometimes one or more children; none of the families received any treatment during the course of Moore's study. All clinic families selected for Moore's experiment had arranged for psychotherapy with the clinic as a result of a male child between age 8 and 13 having been referred for underachievement and/or lack of behavior control in school. The clinic families, unlike the normals, were not paid for their cooperation due to the fact that the treatment agreement at the clinic at Michigan State University is that families participate in some ongoing research project; there is no clinic fee.

The present study had been initiated with the hope of utilizing the first interview for each of the sixteen families. Unfortunately some of the tapes of both the first and the second interviews were missing with no possible hope of their retrieval. Therefore a method had to be devised to provide a reasonable sample size as well as a sample that

would retain the original normal-clinic differences as found in Moore's study. It was decided to combine data from first and second interviews where both were available, otherwise to use whichever was available.

The problem was that while Moore had found no differences between the behaviors exhibited by the clinic families in the first and second interviews he had found a significant difference between the normal families' first and second interviews with regard to the behavior which he was studying. The latter finding Moore attributed to a favorable practice effect; the normal families were able to profit from their first interview experience and hence perfect smoother ways of carrying out the second interview. Therefore while the present study utilized a completely different rating scale for affect, the experimenter had to decide whether or not he would be justified in combining first and second interviews in order to provide a reasonable sample size for himself.

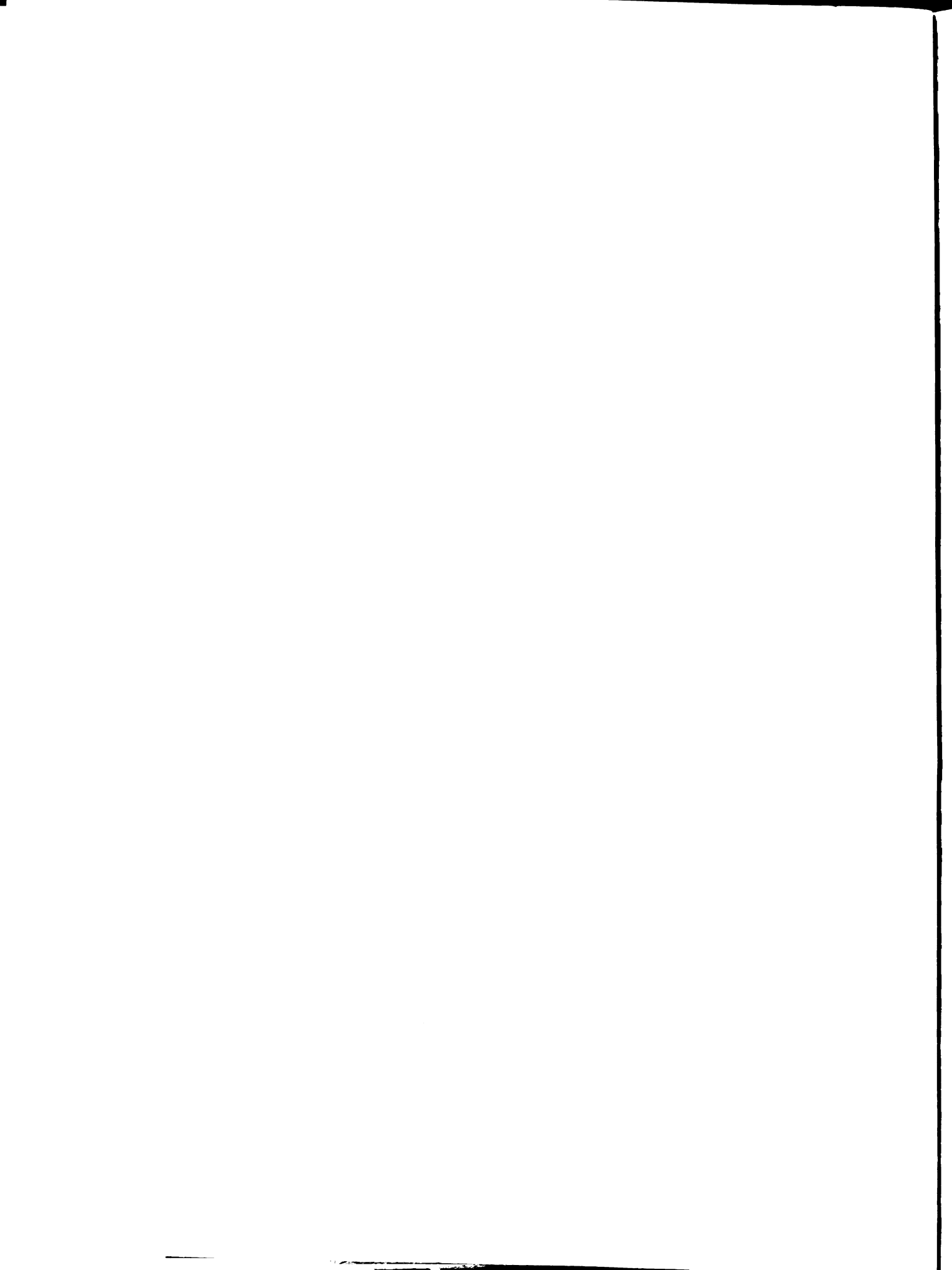
In essence the problem was one of devising a legitimate method of combining the two interviews. After all of the first interviews had been listened to and rated (there were thirteen out of Moore's sixteen remaining, 7 normal and 6 clinic) the experimenter rated the second interviews (there were eight out of the fifteen remaining, 4 normal and 4 clinic; of Moore's original sixteen families who had appeared for the first interview one had refused to show up

for the second interview). Finally, a sample of fifteen families emerged--eight normals and seven clinics. Scores received by the families were pro-rated so that a composite score was arrived at for each of the fifteen families. No significant differences were found with regard to the affects measured in the first and second interviews. Where the first and second interviews for a family still existed on tape the scores for each of the thirteen items on the scale were averaged. Where only the second interview existed (in one normal and one clinic family) the score for the second interview is that which was reported.

Thus, there were a total of 15 families included in this project, 8 normal and 7 clinic. Inspection of Table 1 shows that the two groups are essentially similar with respect to composition, except that the mean level of the fathers' education is 1.4 years higher in the Clinic sample. For this small a sample, the difference is not significantly different from chance expectation.

Table 1. Comparison of normal and clinic family groups on several composition criteria.

	Mean years of completed education		Mean number of children per family	Mean age of children per family
	Father	Mother		
Normal Family Group	12.8	12.3	2.3	10.2
Clinic Family Group	14.2	12.3	2.6	10.6



The Interviewing Procedure

Moore began the family interviews by greeting the families and obtaining some very global facts about them. This aided in establishing rapport between himself and his subjects. He then introduced the family to the first conjoint task. Preliminary remarks made by Moore include reiterating that there would be two raters who would be viewing them through the one-way mirror, and also that the purpose of the study was to provide information which would hopefully increase our skills in aiding families.

While Moore's experiment involved the family's participation in nine tasks, taking approximately one and one-half hours to complete, the present study has utilized only three of those tasks with a total time of about one-half an hour.

The tasks on the interview schedule occurred as follows:

Task 1: Moore spent enough time with each family member so as to ask him the question, "At this point in time what changes would you like to see made in your family, as a whole or in any particular members?" While the family members were reporting this information to the experimenter the remaining family members waited in an adjoining room with the instructions not to discuss the question among themselves. After all members had reported to the experimenter

the family met again conjointly and carried out the following instructions: "Discuss among yourselves the question I have just asked each of you separately; you may discuss any aspect of the question you wish. The only specific request I wish to make is that at some point you talk about specific steps you might take as a family to bring about any of your desired changes. You will have about four minutes, or more if you need it. I will not take part in your family discussion, but will remain quietly in the room."

The present study utilized only that part of the task which involved the family as a whole discussing the changes they reported and how they would like to bring them about. The reason is that here we are attempting to devise a rating scale to be used on interactions in which the entire family participates.

Task 2: The whole family was instructed: "Plan an activity you could all do together; it should be something you might actually do. I will leave the room for four or five minutes; choose one person to summarize your plans for me when I return." In Moore's study, first the father, mother and children; then the father and the children excluding mother; mother and the children excluding father; and husband and wife excluding the children all planned activities (with Moore present in all but the first). Again, the present study, due to the fact that it is interested in

family units, did not rate the task planning activity in which only the father and mother participated.

Task 3: The parents received a proverb: While the cat's away the mice will play (First interview). In the second interview the proverb was: A rolling stone gathers no moss. The experimenter asked them to discuss the meaning of the proverb between themselves with the fact in mind that they would be required to teach it to their children. When the latter was accomplished the interviewer requested the parents to retrieve the children so that they might be taught the proverb's meaning. The present study rated only that family interaction which came about as the parents attempted to communicate the proverb's meaning to their children.

The Rating Scale

The rating scale was developed by this experimenter in conjunction with Lennard Leighton, a student at Michigan State University. It grew out of a series of observations made by these two students who listened to many taped interviews of family interactions.

After having listened to the tapes and having noted a series of variables on which the families could be rated, the two of us examined the items which we had selected. Many of these original items (there were over forty of them in all) were subsumed under more global categories. With the help of Dr. Lucy Ferguson of Michigan State University,

other categories were added and some of the categories which were drawing a great deal of data were broken down into smaller ones. Thus, in the end, a group of thirteen items made up the final version of the Rating Scale for the Communication of Affect (RSCA).

Due to time limitations the experimenter could not afford to train other raters. Therefore all families were rated by the experimenter himself and Lennard Leighton. This may well have introduced some bias into the results, since both raters had knowledge of and investment in the hypotheses, and it proved difficult not to be aware of which group a family belonged to. In addition, the raters being clinical psychology students may have exhibited a bias toward looking for pathology in all families. The raters gave each family a check mark whenever one of the items on the RSCA was exhibited in one of the measured family interaction sequences. Thus, the data for each family could be broken down into the three tasks and each task was scored for any of the thirteen items on the RSCA which occurred. All tapes were rated in random order and the raters presumably did not know to which group any of the families belonged.

The scores for the families on the RSCA are the averages of the two raters. Pearson product-moment correlations were utilized in comparing the scores assigned to the families by the two raters.

Rating Scale for the Communication
of Affect (RSCA)

I. POSITIVE AFFECTS

1. HAPPINESS: Marked examples of total family enthusiasm, spontaneity, genuine group laughter and vocal inflections. This is to be contrasted with examples of laughter which is sarcastic and biting, e.g. laughing at, not with, and/or which involves only one or two family members.
2. AFFECTION: Manifested as a positive, warm feeling toward others; an appreciation and pride of others within the family. Involves either verbal report, such as "I like you" and/or such behaviors and statements from which affection can be inferred.
3. EMPATHY: Marked examples of one family member asking for and truly wishing to hear and respect the opinions of another member of the family. Involves genuine respect and understanding of another person's feelings, wishes and opinions, e.g. "I know how you feel."
4. POSITIVE
VALUE
JUDGMENTS: Involves the placing of positive values on the ideas of oneself or of others or, in a similar manner, upon the worth of various objects. Examples are, "I like that," "That's good."
5. DIALOGUE: This is in regard to how the various members of the family impart knowledge to each other. Involves a democratic mode of the communication of ideas. Involves the Socratic notion of a sharing of ideas and opinions with neither side "right" or "wrong." Each is willing to respect the ideas and opinions of the other until a common ground is reached.

II. NEGATIVE AFFECTS

6. DEPRESSION: Often manifested as very vocal sighs or groans on the part of the members of the family. Involves also at times crying, complaining, apathy and inappropriate silences.
7. HOSTILITY: Is very much the opposite of Affection. Involves the utilization of critical and disrespectful commands, such as "shut up!" Also, curses, mocking tones, sarcasm, destructive criticism, rejection, ignoring other family members, bitterness and resentment.
8. ANXIETY: Often involves long silences which have been induced by parents as a result of severe, negative criticism, especially of the children. Involves themes of fear, guilt. Manifested often by feelings of tenseness, agitation, nervous laughter, extreme defensiveness of self and of family.
9. CONFUSION: Lack of continuity, lack of understanding, interruptions, ignoring other's ideas in favor of oneself, complete noise and chaos, going off on topics which are tangential to the family task to be completed.
10. DOUBLE MESSAGES: Is essentially a failure of communication in the extreme sense. Examples are, "I don't give you too much housework to do Johnny, now do I?" Saying one thing and meaning another. Leaves the recipient of the message in an extreme bind.
11. APPROPRIATE ANGER: Involves loss of control in a situation in which anger is warranted. However, implies that there existed other, less negative ways, in which to respond to the frustrating situation.

12. NEGATIVE
VALUE
COMMENTS: Involves the placing of negative values upon the ideas of oneself or of others or, in a similar manner, upon the worth of various objects. Examples are, "That stinks," "That's no good," "I don't like that."
13. PREACHING: Involves an autocratic mode of the communication of beliefs and opinions. The sender is unwilling to respect the ideas of the receiver should they be contrary to his own. The speaker is like Moses, trying to sway his audience in an autocratic manner.

CHAPTER III

RESULTS

Inter-Rater Reliability

The rating scale for the Communication of Affect (RSCA) contained 13 items on which the fifteen clinic and non-clinic families were rated as they participated in the task. The inter-rater reliability coefficients (Pearson r 's) were calculated for each of the scale items on the RSCA using the total number of judgments (see Table 2); the number of paired observations for each reliability coefficient consisted of all families in the study (15). The final data analysis was derived from pooled judgments scores (rater 1 + rater 2) on those items where the inter-rater reliability coefficients were found to be significantly different from zero when $p = .05$ (i.e. an r of .44 or greater). The negative items were judged far more consistently than were the positive ones (i.e. a mean inter-rater reliability of .22 for the positive items as compared with .66 for the negative ones.) It will be noted in the next section that even some of the less consistently rated items differentiated between the two groups of families. The low inter-rater agreement on some of the items seems related to the very low occurrence

of these affects. (See Table 6 where total scores of each group on each item are reported.)

Table 2. Inter-rater reliability for items of the Rating Scale for the Communication of Affect.

RSCA Item Label	r Across All Tasks	
<u>Positive Items</u>		
HAPPINESS	.59	
AFFECTION	.49	
EMPATHY	.21	
POSITIVE VALUE JUDGMENTS	-.09	
DIALOGUE	-.08	$\bar{r} = .22$
<u>Negative Items</u>		
DEPRESSION	.66	
HOSTILITY	.87	
ANXIETY	.44	
CONFUSION	.92	
DOUBLE MESSAGES	.89	
APPROPRIATE ANGER	.45	
NEGATIVE VALUE JUDGMENTS	.30	
PREACHING	.77	$\bar{r} = .66$

Referring to tables 3 and 3A, to test for negative halo effect, an all-too-frequent contaminant of studies,

Table 3. Intercorrelations of Positive RSCA items.

	HAP.*	DIALOG.*	EMPATH.	AFFEC.	POS. VAL.
HAP.*	XX	.69	.25	.70	.87
DIALOG.*		XX	.71	.77	.34
EMPATH.			XX	.81	.35
AFFEC.				XX	.42
VAL.					XX

*Item which significantly discriminated between normal and clinic families at least at the .05 level.

Table 3A. Intercorrelations of Negative RSCA items.

	DEP.*	HOST.*	ANX.*	CONF.*	D. MESS.*	APP. ANG.	NEG. VAL.	PREACH.
DEP.*	XX	.92	.35	.67	.07	.32	.37	.24
HOST.*		XX	.47	.79	.28	.52	.82	.21
ANX.*			XX	.76	.07	.14	.16	.06
CONF.*				XX	.22	.77	.54	.49
D. MESS.*					XX	.05	-.06	.18
APP. ANG.						XX	.21	.37
- VAL.							XX	.01
PREACH.								XX

*Item which significantly discriminated between normal and clinic families at least at the .05 level.

intercorrelations of negative and of positive items were calculated. The mean intercorrelation within the positive items was .59 and was .35 within the negative items. Thus, no strong negative halo effect seems to have been present.

Test of Hypothesis

The hypothesis stated that the RSCA ratings in the three task sequences would differentiate normal and clinic families. It was also hypothesized that the normals would score higher on the positive items and that the clinic families would score higher on the negative items of the RSCA. These hypotheses were tested in various ways.

Since the normal and clinic families participated in three task activities, i.e. Changes, Planning an Activity and the Proverb, and were judged by the RSCA, which contains items with regard to both positive and negative affects, over-all pathology scores could be arrived at for the three tasks as a whole and within the separate tasks. The results of these comparisons are presented in Table 4.

Looking across the three tasks (Table 4), it can be seen that the combined negative and positive items on the RSCA nicely differentiate the non-clinic from the clinic families. With regards to the negative items, the t ratio of 3.15 ($p = .01$ with 13 d.f.) shows a highly significant difference with the clinics exhibiting more negative effects. The ratio of 2.16 for the positive items ($p = .05$ with 13

d.f.) indicates the significant difference between the families once again, with the non-clinics demonstrating more positive affects than the clinics.

Table 4. $\bar{X}$'s and t ratios between groups and within task categories for positive and negative items of the RESCA.

Task Category	Item Polarity	$\bar{X}$ Normal	$\bar{X}$ Clinic	t ratio
Across Tasks	Positive	8.44	2.50	2.16*
Across Tasks	Negative	5.06	22.07	3.15**
Changes	Positive	2.87	.71	2.45*
Changes	Negative	.69	4.50	3.46**
Activity	Positive	4.33	1.50	1.99
Activity	Negative	3.56	14.87	3.62**
Proverb	Positive	1.31	.29	2.17*
Proverb	Negative	.81	2.71	1.38

*p = .05.

**p = .01.

Within the separate tasks, the hypothesis of a significant difference between normal and clinic families with regard to positive and negative affects is further substantiated. In the Changes task the t ratio of 3.46 ($p = .01$ with 13 d.f.) for the negative items and the t ratio of 2.45 ($p = .05$ with 13 d.f.) for the positive items establishes

the validity of that hypothesis as does the t ratio of 3.62 ($p = .01$ with 13 d.f.) for the negative items within the Activity task and the t ratio of 2.17 ($p = .05$ with 13 d.f.) for the positive items within the Proverb task. The t 's of 1.99 for the positive items of the Activity task and 1.38 for the positive items of the Proverb task were in the predicted direction but non-significant. Hence the hypothesis of a significant difference between the families along the lines of positive and negative affects has been substantiated.

Table 5 demonstrates further the differences between the non-clinic and clinic families, this time with regard to each of the thirteen items of the Rating Scale for the Communication of Affect (RSCA). Seven of the 13 items have distinguished the families at the .05 level or better. A greater percentage of the negative items than positive ones have distinguished the two groups (respectively, 5 out of 7 as compared with 2 out of 5).

Table 6 shows the rather extreme affects exhibited by the clinic families as opposed to the more moderate extent and range of affects manifested by the non-clinics. More specifically, the positive affects were rare and limited in range in the clinic families and were moderate and showed a fairly wide range in the non-clinic group. With regard to the negative affects, the clinics showed a great deal as well as a great deal of variance. The non-clinics however exhibited a moderate amount and tended to vary much less than did the clinics.

Table 5. T ratios between groups on each item of the RSCA.

RSCA Item Label	Normal Means	Clinic Means	t ratios
<u>Positive Items</u>			
HAPPINESS	1.1	3.30	2.78*
AFFECTION	.29	1.00	1.69
EMPATHY	.06	1.00	2.02
POSITIVE VALUE JUDGMENTS	.57	1.00	1.18
DIALOGUE	.36	2.00	2.88*
<u>Negative Items</u>			
DEPRESSION	3.07	.31	3.38**
HOSTILITY	4.57	.19	2.43*
ANXIETY	1.64	.25	3.07**
CONFUSION	6.00	1.63	3.38**
DOUBLE MESSAGES	1.14	.19	3.03**
APPROPRIATE ANGER	1.14	.56	.71
NEGATIVE VALUE JUDGMENTS	1.93	.63	1.71
PREACHING	2.51	1.31	1.78

*p = .05.

**p = .01.

Only four items, CONFUSION, APPROPRIATE ANGER, PREACHING and POSITIVE VALUE JUDGMENTS, give us group variances which do not lead to F ratios significant at the .05 level. The other nine items have divided the clinic and non-clinic groups along two different continua. This was to be expected to a large extent with these items since we are dealing with two very dissimilar groups.

A more microscopic treatment of the data which compared the scores of the two groups for each item and within

Table 6. Raw scores, means, standard deviations and F ratios of the clinic and non-clinic families on the 13 items of the RSCA.

RSCA Item Label	Clinic		Non-clinic		F Ratio
	Total Score	Mean	Total Score	Mean	
<u>Positive Items</u>					
HAPPINESS	7.5	1.1	26.0	3.30	4.87*
AFFECTION	2.0	.29	8.0	1.00	15.80*
EMPATHY	0.5	.06	8.0	1.00	7.35*
POSITIVE VALUE JUDGMENTS	4.0	.57	8.0	1.00	1.02
DIALOGUE	2.5	.36	16.0	2.00	6.75*
<u>Negative Items</u>					
DEPRESSION	21.5	3.07	2.5	.31	17.00*
HOSTILITY	32.0	4.57	1.5	.19	150.0 *
ANXIETY	11.5	1.64	2.0	.25	20.0 *
CONFUSION	42.0	6.00	13.0	1.63	3.43
DOUBLE MESSAGES	8.0	1.14	1.5	.19	20.8 *
APPROPRIATE ANGER	8.0	1.14	4.5	.56	1.9
NEGATIVE VALUE JUDGMENTS	13.5	1.93	5.0	.63	6.9 *
PREACHING	18.0	2.57	10.5	1.31	2.36

*Indicates a difference in the variances of the clinic and non-clinic distributions significant at the .05 level.

Table 6. Raw scores, means, standard deviations and F ratios of the clinic and non-clinic families on the 13 items of the RSCA.

HSCA Item Label	Clinic		Non-clinic		F Ratio
	Total Score	Mean	Total Score	Mean	
<u>Positive Items</u>					
HAPPINESS	7.5	1.1	26.0	3.30	4.87*
AFFECTION	2.0	.29	8.0	1.00	15.80*
EMPATHY	0.5	.06	8.0	1.00	7.35*
POSITIVE VALUE JUDGMENTS	4.0	.57	8.0	1.00	1.02
DIALOGUE	2.5	.36	16.0	2.00	6.75*
<u>Negative Items</u>					
DEPRESSION	21.5	3.07	2.5	.31	17.00*
HOSTILITY	32.0	4.57	1.5	.19	160.0 *
ANXIETY	11.5	1.64	2.0	.25	20.0 *
CONFUSION	42.0	6.00	13.0	1.63	3.43
DOUBLE MESSAGES	8.0	1.14	1.5	.19	20.8 *
APPROPRIATE ANGER	8.0	1.14	4.5	.56	1.9
NEGATIVE VALUE JUDGMENTS	13.5	1.93	5.0	.63	6.9 *
PREACHING	18.0	2.57	10.5	1.31	2.36

*Indicates a difference in the variances of the clinic and non-clinic distributions significant at the .05 level.

each task category (a total of $13 \times 3 = 39$ t tests) showed very few significant differences due to the small sample size. All were in the predicted direction but only eight of the 39 were significant. For fear of committing a type I error due to the small sample size and extreme paucity of scores making up the differences being tested, those t ratios are not reported here.

CHAPTER IV

DISCUSSION

Inter-Rater Reliability

Some interesting findings arise with regard to the reliability between the two raters.

Across all categories the raters arrived at higher correlations with regard to Negative affects (a mean r of .66) as compared with Positive affects (a mean r of .22). This suggests some sort of rater bias in the judging of the families. One would suspect the presence of a negative "halo" effect. However, the mean intercorrelations among the negative and positive items as seen in Tables 3 and 3A (.59 and .35 respectively) cause us to reject the halo effect notion. The fact that eight negative items as compared with five positive ones were put into the scale to begin with does demonstrate this "clinician's bias."

It was noted that those items on the scale which were most objectifiable and identifiable in family interaction sequences, such as APPROPRIATE ANGER and HOSTILITY (identified quite readily in most cases as verbal statements, loud noises, etc.) and EMPATHY (very few occurrences, but

pronounced when they did occur) were most obvious. The more amorphous items, such as DIALOGUE and PREACHING, which often involved the subjective opinions of the raters, were less reliable. This latter finding calls for scale items which are less subject to rater biases and interpretations. On the scale as it now exists the negative affects are most readily identifiable and less subjective, thus yielding higher reliability.

With regard to the positive items it was noted that many of these items were not manifest to any great extent in either the clinic or non-clinic families. HAPPINESS, which yielded the highest reliability of all the positive items (.59) was also the one which was exhibited the greatest number of times. This item also was able to differentiate between the two groups. This finding points to the need for further research in the area of positive affects. Specifically, the question is how can we get a more adequate sample of family interaction in which we can find positive affects. Since it is true that very often individuals exhibit positive affects very subtly, such as by facial gestures, further researchers in this area might rely upon video tapes, rather than just audio as used in the present study. Also, longer duration of interaction as well as different tasks which would be better suited to pulling positive affects might be used.

Hypothesis

The experimental hypothesis that normal and clinic families could be differentiated with regard to the communication of affects was confirmed. More specifically, the hypothesis that the Clinic families would demonstrate more negative affects, as judged by the Rating Scale for the Communication of Affect (RSCA) and that the non-Clinic families would demonstrate more positive affects on the basis of the same scale, was also confirmed.

As can be noted with reference to Table 2, the negative items on the scale have differentiated the families in most cases much more effectively than did the positive items. This was the case across tasks, within the Activity task and within the Changes task. Again, this may have been due to the fact of the "negative halo effect" biasing a rater against a family already beleaguered by negative affects. However, the higher average intercorrelation of positive items causes us to reject possibility of a negative halo effect. Referring to Table 3 the mean intercorrelation between negative items which differentiated between groups was 46 as compared with 20 for non-discriminating items. However, with positive items, the mean r 's of .69 and .53, respectively show less of a disparity. This may have been due to the fact that many of the negative items on the rating scale which were found to be statistically significant, such as DEPRESSION, HOSTILITY, ANXIETY, CONFUSION and DOUBLE MESSAGES

were much more noticeable in the family interaction sequences--if only in terms of decibels--than were the positive affects which turned out to be significant, such as HAPPINESS and DIALOGUE. They were also more reliably rated.

Taking the separate items into consideration, it is found that 2 out of 5 of the positive items (40%) were statistically significant, whereas 5 out of 7 (over 71%) of the negative items of the rating scale were statistically significant in differentiating the Clinic from the Non-Clinic families. Referring to the raw scores used in the calculation of the t tests (see Table 6), it appears that the positive items were not exhibited very many times by the families as a whole. The positive affects which turned out to differentiate significantly were also the items which received the highest raw scores, i.e. HAPPINESS and DIALOGUE with raw scores of 33.5 and 18.5 respectively for Clinics and Non-Clinics combined. It appears as if the other positive affects just did not appear often enough to yield significant differences. This may again be due to the fact that the tasks were just not representative to a great enough extent of real life situations which would pull such affects from the families.

With regard to the negative affects a similar finding appears. DEPRESSION, HOSTILITY and CONFUSION were manifest many more times by the families than were the non-significant items. However, DOUBLE MESSAGES and ANXIETY,

which did differentiate significantly, were not manifest to any greater extent than were the non-significant items.

The significant differences found for the negative items substantiate Ackerman (1958), who found that boys possessing conduct problems often came from families where the parents were hostile and rejecting. The Clinic families in this study were referred to the Michigan State University Clinic due to the fact that they all had a male child who in school was found to be an underachiever and/or who exhibited lack of behavioral control. The Clinic families demonstrated significantly more hostility than did the Non-Clinic families. Ackerman also reported that the child in an abnormal family is not just a passive recipient of the hostility but is rather an active participant in the maintenance of this hostility within the family. The domineering parents in the Clinic families often did not allow any hostility to be directed at them by the children--although they themselves exhibited a good deal of it in their interactions with them. The prohibition of reciprocal behaviors may have led to depression, anxiety and confusion.

The highly significant difference between the families with regard to confusion tends to demonstrate Leary's (1957) thesis that disturbed families tend to repeat the same behavior, thus providing security--but at the price of restricting their social environment. This formulation may be illustrated by the attempts of the parents in the Clinic

families to limit their children's behavior. The parents tended to become angry quite often with the behavior of their children (as shown by the significant t scores for HOSTILITY). Frequently this occurred due to the fact that the children would not conform to attempts of their parents to limit their behavior. When they came into conflict with their parents on this account, confusion became the keynote.

The periods of confusion were often reminiscent of Brody's (1959) statement, that the medieval play begins with the "actors taking all-egorical roles and positions that are stereotyped and confined--one is Good, another Evil and a third Temptation" (p. 380). In Clinic families the players often do not know who is playing what part. Therefore, CONFUSION, ANXIETY, DEPRESSION, HOSTILITY and DOUBLE MESSAGES is the resultant.

Referring to Table 6, it can be seen that the rather extreme raw scores of the Clinic families is evidence of the limiting of behavior. The lack of positive affects in the Clinics, i.e. less HAPPINESS and DIALOGUE, substantiates the findings of MacKenzie (1968) who found a correlation between role rigidity in the group with the extreme degree of negative affect and consequent lack of positive affect. MacKenzie is again substantiated with regard to the extreme responses of Clinics as contrasted with the wider, less extreme range of responses in the Non-Clinics. The extreme degree of affects as well as the limited range of the Clinics

is shown in Appendix B which contains the total scores for the families. On the positive items of the rating scale, the very low mean scores achieved by the clinics and the small standard deviations from the means shows the uniform lack of positive affects within the Clinic families. On the other hand, the Non-Clinic families showed a moderate amount of positive affects as well as a moderate amount of variability.

With regard to the negative items on the scale, the Clinic families have exhibited a great amount of affect with a very broad variance. The Non-Clinic families show a moderate degree of negative affects with a much less broad variance. Thus, overall, the Clinics have restricted their affects to the negative side of the continuum with a wide range of those affects within the families. It was as if some families could be considered confusion-ridden families, with few of the other negative affects, while others could be depicted as Hostility-ridden. The Non-Clinic families, on these same affects, have scored in the much more moderate range. All of the families have exhibited a few of the negative affects, but to a much less extreme degree than did the Clinic families.

The only items which have produced a normal distribution for both the Clinic and Non-Clinic families to be compared along a continuum were POSITIVE VALUE JUDGMENTS, CONFUSION, APPROPRIATE ANGER and PREACHING. However as

Hayes points out in Statistics For Psychologists (1963), "Once again, however, the test of equality of variances is quite sensitive to nonnormality, although this apparently makes little difference in tests concerning means. Therefore, one can easily do himself a disservice if he interprets a significant result from a test of variances as a prohibition against the use of a test of means" (p. 352). Thus, it seems as if nine scale items have broken the two groups into different continua, with different means and standard deviations. One might expect this due to the fact that one has no right to make the assumption that the items on the scale should produce one single normal curve for two very dissimilar groups. Of the four non-significant F ratios, only one, i.e. CONFUSION, yielded a significant t score. This item tended to produce a great number of responses in both groups, thus providing evidence that it is common to both Clinic and Non-Clinic families. This item, as well as the other three which provided non-significant F ratios, are all less extreme in their nature than many of the other items. Thus, both groups together yielded a normal curve, giving evidence for the existence of these affects in both normal and abnormal families.

The present study has yielded findings which should serve as a spur toward further research in the field of family interaction. Of prime importance in the study of families is the development of reliable and valid rating

scales. The present study has demonstrated reasonable, but definitely not excellent, inter-rater reliability. It has in some cases fallen into the pitfall of subjective rater biases. Further research in this area should pay careful attention to the development of scale items which are easily objectified.

Also of much importance in the study of family interaction is the establishment of tasks for the family which will prove to be as close as possible to the real life situation which the family will be immersed in upon leaving the experimental setting. While the Activity task in this study proved to be particularly well-suited for the above purpose, the Changes task and especially the Proverb task were often artificial enough to constrict family members to such an extent that family interaction could not be assessed very effectively.

Finally, it is hoped that the present Rating Scale for the Communication of Affect, since it has been demonstrated to differentiate significantly Clinic from Non-Clinic families, will be appropriately modified so that it shall prove to be even more effective in studying the dynamics of the modern family.

CHAPTER V

SUMMARY

This study was undertaken in order to explore a question posed by family interaction: Can we differentiate between normal and clinic families with regard to the communication of negative and positive affects? Eight normal and seven abnormal families (four or five members each) participated in a semi-structured interview during which they interacted as a family in three task activities. Normal families had no known history of psychiatric disturbance or treatment and were obtained through labor union and church groups. The source of the abnormal families was the treatment waiting list of the Michigan State University Psychological Clinic.

It was predicted that the devised Rating Scale for the Communication of Affect (RSCA) would be able to distinguish between normal and clinic families, with the clinic families exhibiting lower scores on the positive affects and higher ones on the negative affects of the rating scale. Nine out of the thirteen items yielded inter-rater reliability coefficients that were significantly different from zero at the .05 level (i.e. an r of .44 or greater). Five of the items yielded adequate inter-rater agreement ($r \geq .65$).

The low reliability coefficients on a number of the items may be attributed to the very low incidence of these affects in the recorded communications.

The normal families were distinguished from the abnormal families by over-all pathology scores and a number of the individual items. The clinic families exhibited significantly more negative affects, such as depression, hostility, anxiety, confusion and double messages, whereas the non-clinics showed more positive communicational affects, such as happiness and dialogue, than did the clinics. Furthermore, the clinic families exhibited more extreme affective responses with a much more limited range of behaviors than did the non-clinic families.

Evaluation of the study's findings prompts the experimenter to suggest further research in the development of reliable rating scales as well as interactional tasks suited to the study of families.

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APPENDICES

APPENDIX A

Specification of families sampled in this study; families 1-8 are the Non-Clinic group and families 9-15 are the Clinic group.

Family Number	Father		Mother		Children	
	Occupation	Education	Occupation	Education	Sex	Age
1	Tool and Die Maker	12	Housewife	12	M	11
					M	14
2	IBM Programmer	14	Housewife	14	M	5
					M	9
3	Personnel Director, Mich. Dept. of Social Service	12	Housewife	12	M	7
					M	10
					F	12
4	Labor Union Leader	12	Housewife	12	F	6
					F	7
					M	8
5	Bricklayer	12	Housewife	12	F	10
					M	15
6	Accountant	16	Housewife	12	M	15
					M	17
7	Postal Clerk	12	Secretary	12	M	12
					F	16

8	Insurance Salesman	12	Housewife	12	F M	6 7
9	Machinist	12	Housewife	12	M F M	7 9 12
10	Graduate Student	17	Housewife	13	M F	11 13
11	Pet Store Manager	15	Housewife	12	M M	7 12
12	Mechanical Engineer	17	Housewife	14	M M	8 12
13	Cartographer	13	Housewife	11	M M M	9 12 13
14	Graduate Student	16	Secretary	12	M M M	8 11 13
15	Factory Worker	12	Housewife	12	M M M	7 9 13

APPENDIX B

Total Scores for RSCA Items: Clinic versus Non-Clinic Families.

Families	RSCA Items									
	HAP.	APP.	FMP.	+VAL.	DIA.	DEP.	HOST.	ANX.	CONF.	D. APP. MESS. AMG. VAL. PREACH.
<u>Non-Clinic</u>										
1	3.5	0.5	1.5	2.0	1.5	0.0	0.0	0.0	0.0	1.0
2	2.5	0.0	0.0	1.0	2.0	0.0	0.0	0.0	0.5	0.0
3	1.5	0.0	0.5	0.5	0.5	0.5	1.0	0.0	4.5	1.0
4	3.5	3.0	3.0	0.5	4.5	0.0	0.5	1.0	5.5	1.5
5	7.0	1.0	0.0	1.5	1.0	0.5	0.0	0.5	2.0	1.5
6	3.0	0.5	0.0	1.0	3.0	0.0	0.0	0.0	0.5	2.5
7	3.0	2.0	2.5	3.0	3.0	1.5	0.0	0.5	0.0	0.5
8	2.0	1.0	0.5	1.0	0.5	0.0	0.0	0.0	0.5	2.5
<u>Clinic</u>										
9	0.5	0.0	0.0	0.0	0.5	3.5	7.5	3.5	13.0	4.0
10	6.0	1.0	0.0	2.5	1.5	0.0	0.0	1.0	0.5	0.0
11	0.0	0.0	0.5	0.0	0.0	2.0	2.0	1.5	5.0	5.0
12	0.5	0.5	0.0	2.0	0.5	1.0	1.0	3.0	5.0	4.5
13	0.0	0.5	0.0	0.5	0.0	5.5	4.5	0.5	4.0	2.0
14	0.0	0.0	0.0	0.0	0.0	6.0	4.5	0.5	6.0	1.5
15	0.0	0.0	0.0	0.0	0.0	3.5	12.5	1.5	8.5	1.0

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