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## The Process and Outcome of Child Psychotherapy

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THE PROCESS AND OUTCOME OF  
CHILD PSYCHOTHERAPY

by

Shelly J. Smith

A Dissertation Submitted to the Faculty of the  
Graduate School of Loyola University of Chicago  
in Partial Fulfillment of the Degree of  
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## VITA

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## CHAPTER I

### INTRODUCTION

Over the past two decades there has been a dramatic increase in the number of studies examining the process and outcome of psychotherapy with adults. Based on a consensually stated need that was documented in the 1960's, these studies have gone beyond the question of whether psychotherapy works to explore variables that contribute to the effectiveness of psychotherapy. Some of these variables include therapist characteristics, client characteristics, duration of treatment, and process elements. In contrast to the adult therapy literature, there has been a paucity of well designed and executed studies on psychotherapy with children. In reviewing the literature in the area, Barrett, Hampe, and Miller (1978) note the inadequacy of psychotherapy research with children, and comment on the factors that contributed to this lack of research in the area. They suggest that there has been an emphasis on advocacy and large scale environmental interventions, diminishing the focus on individual clients and their response to treatment. In addition, they conclude that child

clinicians have not responded to Eysenck (1952) and Levitt's (1957) controversial findings that psychotherapy is no more effective than no treatment.

Barrett et al. (1978) emphasize that there has been a "general drop in interest in the specific variables that cause and ameliorate emotional disorders" (p. 412).

## CHAPTER II

### REVIEW OF RELATED LITERATURE

Other researchers and clinicians concerned with child psychotherapy second the views of Barrett, Hampe, and Miller. Cass and Thomas (1979) discuss the longstanding focus on efficacy in child therapy research, and discuss the problems inherent in this approach due to the complexity of assessing treatment outcome and the limitations of examining outcome without process. Recently, two in-depth meta-analyses of child psychotherapy outcome reached the consensus that child therapy is significantly more effective than no treatment (Casey & Berman, 1985; Weisz, Weiss, Alicke, & Klotz, 1987). Yet the need to determine what therapeutic techniques and theoretical approaches are being used in treatment of children continue to be sounded in a variety of circles (Phillips, 1987; Snow & Paternite, 1986). Thus, questions around, "Which set of procedures is effective when applied to what kind of patients with which sets of problems and practiced by which sort of therapists?" (Barrett, Hampe, & Miller, 1978) are central to the study of psychotherapy with

children at present.

### Historical Overview

In examining current research practices relating to child psychotherapy, it is helpful to briefly review the historical antecedents of the research in the field. The development of child psychotherapy has been linked to the child guidance movement early in this century, which emphasized interdisciplinary collaboration of psychiatry, psychology, and social work, as well as program evaluation (Rie, 1971). It was the focus on program evaluation within the mental hygiene approach that provided a rationale for early research on child psychotherapy. During the 1930's a great deal of research evaluating the outcome of therapy with children occurred. Based on a variety of studies, Witmer (1935) concluded that psychotherapy for children was very beneficial, with the chance for improvement in functioning as great as eight in ten.

Following this period, little empirical outcome investigation was done (Barrett, Hampe, & Miller, 1978) other than a few observational studies examining various forms of play therapy (Moustakes, 1955). In the late 1950's, Levitt (1957) began a series of investigations that evaluated the results of child psychotherapy. Using studies done mainly in the 1930's, with additional

sources from the 1940's and 1950's, Levitt went on to look at the baseline for improvement of children with problems who did not receive treatment. He concluded that with treatment, 78.22% of all children improve, while without treatment, 72.5% of all children improve (Levitt, 1957). Levitt's analysis of this data would suggest that psychotherapy is no more successful than the passage of time in alleviating problems in children. As Barrett, Hampe, and Miller (1978) point out, however, responses to his arguments were slow and sporadic in coming. Unlike the response to Eysenck's challenges to the efficacy of psychotherapy with adults, very little research was undertaken to address Levitt's claims. Instead, interest was focused on work in community mental health centers, child advocacy, and public policy, According to Barrett, Hampe, & Miller (1978) "Mental health professionals went about building institutions and developing programs to deal with disturbed children rather than tackling the question of the effectiveness of child psychotherapy" (p. 429). In addition, the lack of research has had no impact on the use of services for children. Even without adequate research, parents' utilization of mental health services for their children has continued to increase (Silver &

Silver, 1983). The combination of these factors has contributed to the dearth of studies on psychotherapy with children.

### Methodological Issues

Noting the paucity of research on child psychotherapy, a call has been made for increased research in the area, and guidelines to structure such research have also appeared (Mannarino, Michelson, Beck, & Figueroa, 1983). Several recommendations have been made to address methodological concerns pertaining to child psychotherapy research. Cass & Thomas (1979) highlight issues such as the child's developmental status, kinds of problems, diagnosis, and age, in addition to therapeutic factors such as frequency of sessions, duration of treatment, type of treatment, and characteristics of the therapist in describing variables that are typically neglected in child psychotherapy research. Similarly, methodological concerns are raised by Shaffer (1984) who discusses sample selection, therapist's characteristics, measurement of outcome, and duration and specification of treatment. Thus, concerns regarding generalizability of findings, sampling procedures, process and outcome measurement, and therapy evaluation are central in examining work on child psychotherapy.

Generalizability. A major methodological issue in the area relates to the generalizability of current studies. At present, much of the literature is comprised of clinical case studies, limiting the extent to which inferences can be made to a broader population (Shaffer, 1984; Tramontana, 1980). McDermott & Harrison (1977) note that

much of the literature in the field is devoted to single or groups of cases that demonstrate a particular method or technique which has been successful in solving the particular problems of a child or group of children. Any practitioner can cite cases which would in his mind demonstrate the efficacy of psychotherapy. (p. 32)

The need for comprehensive, ecologically valid research is exacerbated by the fact that existing research typically focuses on one particular theoretical approach or diagnostic category. It is especially notable that in recent years there has been a surge of research on child behavior therapy. Johnson et al. (1986) state that, "There has been more research evaluating the effectiveness of child behavior therapy than is available on any other approach to the treatment of child behavior disorders," (P. 180), while Ollendick (1986) reports that a selective review of the literature in 1981 revealed over 1000 studies related to the behavioral treatment of children and adolescents. In



contrast, Barrett et al. (1978) reported only two psychoanalytic research projects and six client-centered studies over the past 30 years. This discrepancy is so pronounced that the only chapter reviewing child psychotherapy in the latest edition of the Handbook of Psychotherapy and Behavior Change (Garfield & Bergin, 1986) concentrated exclusively on behavior therapy. While there is nothing inherently negative in the relative abundance of studies on child behavior therapy, it is significant that recent surveys suggest that behavior therapy is not the most widely used treatment for children (Silver & Silver, 1983; Milam et al., 1982). Instead, psychodynamic and family approaches are used more frequently in work with children. Clearly, empirical studies which do exist on child psychotherapy do not provide an adequate evaluation relevant to current practices.

As noted in Shaffer (1984), a large proportion of published psychotherapy research has employed a single case or within-subject format. A reversal (ABAB) design in which treatment is discontinued then re-instated is often used in such studies. While this design is useful with symptoms that are expected to recur immediately after treatment is discontinued, it is inappropriate for

a good deal of the work done in regular clinical practice where more lasting change is expected. Other authors also discuss the limitations of single case studies in that they rarely provide adequate evaluation of the comparative effectiveness of several treatment procedures or of the applicability of procedures to a broad population of children (Johnson et al., 1986; Yule, 1977).

Sampling. A second area of methodological concern relates to sampling procedures and the population studied. Barrett et al. (1978) note the importance of considering diagnosis and developmental level of the child when investigating the process and outcome of psychotherapy. For a variety of reasons, however, these factors have not been accounted for adequately. According to Shaffer (1984), few child psychotherapy studies employ sufficient sample sizes to take such patient characteristics into account. Rutter (1983) echoes concerns about examining treatment within the context of the disorder under treatment, and adds that other personal variables such as developmental level may interact with diagnostic category to influence treatment effectiveness. Difficulties around measurement of personal variables and diagnostic categorization with

children further complicates the use of these variables in psychotherapy research (Rutter, 1977). Achenbach and Edelbrock (1978) review extensive problems in developing reliable classifications systems for child psychopathology, and suggest that at present, most empirical evidence support the use of broad categories of disorders (e.g. "externalizers" and "internalizers"). Unfortunately, current research rarely employs even this level of diagnostic specification. Even when diagnostic category is included in behavioral research, the aforementioned use of single case designs limits the generalizability of results to that population (Ollendick, 1986). In other studies, a particular population or diagnostic category may be overrepresented. For example, a large body of research exists on institutionalized children (McDermott & Harrison, 1977) and on juvenile delinquents who have come in contact with the courts (Barrett, Hampe, & Miller, 1978; Rutter, 1982). Finally, Mannarino et al. (1982) discuss practical considerations in obtaining representative clinical populations for study. In their own comparative treatment study in a community mental health center, they found it difficult to get referrals other than those children considered hard-to-treat cases

without constant administrative support and involvement.

Process and Outcome Measures. The measurement of process and outcome constitutes yet another methodological issue in psychotherapy research with children. Instruments designed to measure the therapy process with children have been sorely lacking. Attempts were made in the early 1970's to develop parallel instruments to those used in adult psychotherapy research (Wright, Truax, & Mitchell, 1972), yet these efforts were not pursued with the rigor that was seen in work on adult psychotherapy. It is worthy of note that few child therapy studies have appeared using these instruments. It may well be that the use of newer therapies such as behavior therapy and family therapy diminished the belief in the relevance of process measures in child treatment (Barrett, Hampe, & Miller, 1978). There have also been concerns that measures should tap a generic set of procedures (Miller, Barrett & Hampe, 1974) but again, such procedures have not materialized.

Further, questions have arisen regarding the child's ability to understand the therapy process. At present, standardized procedures for examining the child's evaluation of the therapy process have not been

developed. Recently, however, legal concerns regarding a child's capacity to consent to treatment has stimulated interest in the child's perception of the therapy process. Research has examined the ability of children to weigh the benefits and risks of psychotherapy to evaluate their capacity to consent to treatment. Results suggest that children as young as age ten do not differ significantly from older children and adults in their ability to identify the potential advantages and disadvantages of psychotherapy (Kaser-Boyd, Adelman, Taylor, & Nelson, 1986). Other researchers have touched upon the relationship between preparation for and attitudes towards psychotherapy. Examining both children receiving therapy and children who have never been in therapy, studies have documented that children as young as age six generally have highly positive expectations for psychotherapy outcome, and that these expectations become more positive when children are provided information geared to prepare them for treatment (Bonner & Everett, 1982; Bonner & Everett, 1986). As yet, however, it is unclear how these attitudes influence the outcome of therapy. Given the ability of young children to meaningfully describe their expectations for psychotherapy, one would assume that

children possess relevant attitudes and perceptions regarding the therapy process. Unfortunately, this variable has not been explored. Further, children's perceptions of outcome during and subsequent to their own treatment have not received investigation. Several authors cite the need for reliable, standardized outcome measures, which include measures obtained from the child (Barrett, Hampe, & Miller, 1978; Shaffer, 1984; Johnson et al., 1986), and the need to look beyond symptom relief in measuring the outcome of therapy (Shaffer, Briesmeister, & Fitton, 1984).

#### Therapy Evaluation - Treatment Models

In turning to the evaluation of treatment models, it is worthwhile to explore current models which describe the type of relationship-oriented, individual child psychotherapy that is commonly practiced. As noted by Johnson et al.(1986) the psychodynamic models of psychopathology have provided the theoretical foundation for much of the clinical work with children during the past three decades. In addition to examining intrapsychic conflict and blocks in development, this treatment often incorporates a problem-oriented focus. (Johnson et al., 1986,). During the session, the child is encouraged to express thoughts, feelings, and

fantasies through verbalizations or through play. Following the work of Anna Freud, current dynamic therapies recognize the expression of situational as well as intrapsychic concerns in the child's play and speech. In essence, the aims of therapy under this model are to provide the support and insight necessary for the child to overcome blocks in the path of development (Shapiro & Esman, 1985; Dare, 1977). These developmental blocks, which emerge as psychological symptoms, may arise from intrapsychic conflicts, environmental forces, or a combination of these factors. In any event, the task of the therapist is to establish a relationship with the child in order to provide a foundation for the work of the therapy. Through this relationship, the therapist should be able to help the child better understand his or her feelings and concerns. With this understanding, the "child incorporates the explanation into his evolving belief system and can then operate in accord with it to change his behavior (Shapiro & Esman, 1985, p. 920)." In other words, through support and insight the child should be better able to resume adaptive development. Finally, current psychodynamic therapy focuses on the resolution of a specific set of problems, and when they are resolved treatment is terminated (Johnson et al., 1986).

Integrative Models. Further writings on individual psychodynamic psychotherapy highlight the common elements of the application of the theory to techniques based on other approaches. As stated in McDermott and Harrison (1977):

Despite this plethora of theories one cannot help but note the commonality in the procedures and practices within child psychotherapy pointed out three decades ago (Witmer, 1946). Much of the theoretical position-taking occurs about the most abstract concepts, those the furthest removed from the actual data of observation and which are least significant for clinical theories and clinical practice (Waelder, 1962). What we do in the clinical hour, what we think we do, and how we then conceptualize it brings the data to a refinement which may distort the commonality of what many psychotherapists actually do with children. (p. 32)

Blom (1977) proposes the use of multiple paradigms which combine attention to feelings, relationships, and other inner forces of children and their families as well as the development of skills, competencies, and alternative behaviors. Several authors cite recent efforts to integrate aspects of psychodynamic and family therapies (Steinhauer, 1985; Malone, 1979). The ability to draw parallels between the technical aspects of a variety of theories has led to proposals that more generic models of the practice of psychotherapy be developed and adopted. Such a generic view could account for general



or non-specific factors facilitating behavior change that have received a great deal of attention in the literature on adult psychotherapy (Barrett, Hampe, & Miller, 1978). Adelman and Taylor (1985) highlight common themes in several theories in terms of tasks of intervention, which are central to understanding the process of psychotherapy. They propose a "scholarly eclecticism" which is equivalent to building new models based on commonalities in current work, and highlight the advantages of more broad-based models in refining research strategies. As will be noted later, their comments parallel arguments presented by researchers in adult psychotherapy.

In sum, recent literature concerning child psychotherapy research emphasizes the need for further work in the area. Calls have been made for studies with higher generalizability of findings, more thorough and in-depth measurement of process and outcome, and an improved model for evaluating and understanding child therapy which includes a broad-based theoretical model.

#### Models of Adult Research

The questions already highlighted regarding research on child psychotherapy point to the need to look to adult psychotherapy research for models and

guidelines. As previously noted, Eysenck's (1952) argument that psychotherapy is no more effective than no treatment spurred a flurry of outcome studies with adults. Since that time, evidence on the general effectiveness of psychotherapy with adults has continued to accumulate (Bergin, 1971). Given the conclusion that "psychotherapy works", several authors point to the need to move beyond global questions of outcome to examine questions relating to what client benefits most from which kind of therapy under which conditions (Lambert, Shapiro, & Bergin, 1986). More specifically, discussions of adult psychotherapy are stimulating progress in the areas of improved methodological rigor (Kazdin, 1986; Fiske, 1979), and a further examination of the relationships between process and outcome (Orlinsky & Howard, 1986; Rice, 1979).

### Methodological Issues

In the area of methodological concerns, several issues have recently been raised regarding adult psychotherapy research. Overall, many of the concerns can be grouped according to generalizability or external validity issues and the adequacy of current measurement practices.

Generalizability. Kazdin (1986) has highlighted

the methodological advantages and disadvantages of research done in a variety of conditions which are delineated according to the extent to which they resemble actual treatment of clients in clinical settings. He distinguishes between clinical trials, which are done in actual clinical settings and highly resemble average treatment, and analogue studies, which are done under laboratory conditions and only slightly resemble average treatment. Typically, research done in clinical settings is hampered by methodological compromises due to practical and ethical constraints, yet effects which emerge from this research are seen as clinically relevant due to high external validity (Parloff, 1986). Analogue studies offer more clear-cut results due to fewer methodological problems, but raise questions regarding generalizability to clinical settings. Kazdin (1986) notes that most contemporary research falls in between categories of analogue research and clinical trials, and goes on to discuss strategies to maximize feasibility, experimental control, and generalizability. Most current recommendations revolve around improving the precision of measurement instruments and data collection within actual clinical settings (Parloff, 1979).

A further limitation of the generalizability of several current studies reflects the fact that the effects of time are overlooked. Numerous references in recent literature highlight the importance of the sequence of therapy sessions on outcome (Howard, Kopta, Krause, & Orlinsky, 1986) while another body of literature has emerged pertaining to the relevance of stage in treatment on therapy process (Mann, 1976). Despite these developments, most current studies focus on average process dimensions over time, or examine sections of single therapy sessions (Windholz & Silberschatz, 1988).

Treatment Implementation. An essential aspect of the precision of clinical studies relates to the extent to which treatment is actually implemented as intended, sometimes referred to as treatment integrity (Quay, 1977; Yeaton & Sechreat, 1981). Kazdin (1986) describes several steps to insure treatment integrity, which include comprehensive training on the specific treatment, supervision and feedback on actual sessions, and assessment of whether or not the treatment is practiced as planned. The assessment phase of this evaluation may be enhanced by the use of current technology such as videotaping and audiotaping. Fiske

(1979) also discusses methods of evaluating the treatment process which include more direct observation and the use of multiple levels of data coding procedures. The levels of coding may range from global ratings of therapist conceptualization of a problem to molecular rating of therapist and client speech patterns. According to Fiske, the combination of these methods provides a more in-depth view of psychological treatment than exists in most current studies, which often employ one point of observation and one level of data analysis.

Measurement of Outcome. Further, many authors agree on the need for multiple levels and sources for the evaluation of outcome. Strupp (1979) has outlined multiple outcome criteria which include perception of client functioning according to the therapist's perspective, the client's perspective, and the community's perspective. His views have been seconded by numerous researchers (Fiske, 1986; Kazdin, 1986; Parloff, 1986). A number of well-standardized outcome measures have been developed over recent years, but these measures are generally geared to examine the therapist's perspective (Lambert, Shapiro, & Bergin, 1986). Given the wide range of complaints that clients bring to therapy, it has also been suggested that

outcome be examined on several levels, extending past the typically used symptom change measures (Strupp, 1986). When symptom change is employed, several sources highlight the importance of looking at residual change over time rather than relying on change between simple pre- and post-measures (Jones, Cumming, & Horowitz, 1988).

### Specific and Nonspecific Factors

Beyond specific recommendations regarding treatment evaluation, recent controversy has arisen surrounding the elemental aspects of psychotherapy. Arguments have developed, in part, because very few studies have demonstrated a difference in the effectiveness of a whole range of therapeutic approaches (Lambert, Shapiro, & Bergin, 1986). Given the lack of differences, Frank (1971) has addressed these concerns by stating that all effective therapies have in common critical but nonspecific therapeutic elements which account for the observed therapeutic effects. After more than a decade of conflict in the literature around which factors should be considered specific and which should be considered nonspecific, recent approaches have been developed to integrate these concepts. (Orlinsky & Howard, 1982). Karasu (1986) remarks that "All

psychotherapies use some combination of affective experiencing, cognitive mastery, and behavioral regulation as therapeutic change agents " (p. 693). He recommends that specific change agents, or techniques, be studied, in contrast to current comparative studies, which compare different schools of psychotherapy. Other authors highlight the need to focus on improving the specificity of the descriptions of what is done in therapy (Parloff, 1986; Strupp, 1986).

In order to examine therapy more thoroughly, new theoretical systems for describing behavior change have been developed which aim to resolve the specific-nonspecific factors controversy. One such model has been developed by Howard & Orlinsky (1986). They describe a generic model of psychotherapy in which there is an "empirically based generic understanding of psychotherapy, concerned with active ingredients rather than brand names." (p. 312). Under this model, there are five conceptual elements of the therapeutic process, which include 1) the therapeutic contract, 2) therapeutic interventions, 3) the therapeutic bond, 4) patient self-relatedness, and 5) therapeutic realizations. Within each element, descriptions of therapist and client thoughts, feelings, and behaviors

are provided that are not tied to specific theories. For example, within the "therapeutic bond" section, descriptions of therapists feelings of attachment to the client, investment in client change, and belief in positive prognosis are provided. Correspondingly, client feelings of attachment to the therapist, trust in the therapist, and involvement in collaborative efforts for change are described. The advantage of such a model is that different schools of psychotherapy could use the same language to investigate empirically what occurs in the therapy process that is beneficial to clients. The development of this pan-theoretical model seems to parallel a current trend towards eclecticism and integration of theoretical orientations cited in Garfield & Bergin (1986), and its use holds promise for more specific, relevant, and understandable research.

#### Process in Relation to Outcome

In addressing the need for clinically relevant psychotherapy studies, a body of research has developed which examines therapy outcome in relation to process (Orlinsky & Howard, 1978; Parloff, Waskow, & Wolfe, 1978). This research has increasingly addressed questions around the interactions of clients and therapists within the therapy session that lead to



change, although most of the research is too broad based to be considered more than suggestive (Rice & Greenberg, 1984). Orlinsky & Howard (1986) summarize over 1100 studies which compare therapy process and outcome. In doing so, they chose studies done with real clients in actual treatment setting. Studies evaluated process via client report, therapist report, and/or observer rating, and measured outcome through client report, therapist report, independent rater report, and/or normative score. The authors highlight the advances in interpretation of effects in studies that examine process and outcome from a variety of perspectives. A few of the pertinent findings gleaned from the summary are as follows:

1. A collaboration of therapists and clients on sharing initiative and responsibility was positively related to outcome.

2. Confrontation, interpretation, and exploration were positively related to outcome, while reflection, giving support, giving advice, and therapist self-disclosure show little differential relation to outcome.

3. In terms of patient participation, the experience of negative affect, the immediate expression of affect, and the occurrence of affective discharge

were associated with positive outcome.

4. Therapist engagement, credibility, and confidence were associated with better outcomes.

5. Patient engagement and motivation were related with good therapeutic outcome.

6. Therapist and patient warmth and acceptance, particularly when viewed as reciprocal affirmation, were strongly linked to positive outcome.

7. Patient openness versus defensiveness was positively correlated with outcome.

The authors conclude that a wider range of outcome measures should continue to be employed in future studies, and outcome should be measured at several points in the therapeutic process. In addition, process should be studied from several perspectives, and results should be reported in a manner that represents various viewpoints rather than as a definitive specific therapy. They focus on the usefulness of quantifying the clinician's experience in therapy, and expanding the understanding of the process of therapy to include the client's perspective and nonparticipant perspectives.

#### Present Study

The present study examines the process and outcome of individual psychotherapy with children. The study was

designed to follow several methodological guidelines established in the literature, most of which revolve around generalizability of findings and adequacy of measurement. Several aspects of this study serve to maximize its external validity. The study was set in an existing community mental health center, and subjects consist of actual clients and their therapists. Thus, the study qualifies as a clinical trial, in Kazdin's terms (1986). Treatment implemented by the therapists followed a broadly-defined psychodynamic model, and a combination of verbal and play therapy was used. This form of treatment parallels treatment commonly practiced in child clinical settings (Silver & Silver, 1983). The study also examines a wide range of client psychopathology rather than one diagnostic group, again increasing the generalizability of findings.

Several recommendations for increasing experimental rigor have been addressed in the design of the present study, as well. Psychotherapy process was measured according to a widely used and well standardized instrument in adult psychotherapy research that is applicable to a variety of theoretical orientations (Orlinsky & Howard, 1975). This instrument was adapted for use by therapists and child clients,

thus providing multiple measure of the therapy process, as suggested in the literature (Orlinsky & Howard, 1986). Psychotherapeutic outcome was measured using a standardized instrument for children, which was completed at several points by the therapist. Again, this procedure meets the recommendation that multiple sources of outcome be employed (Strupp, 1986; Lambert, Shapiro, & Bergin, 1986). Finally, the study includes multiple therapists, multiple clients, and multiple sessions to provide material for analysis on these variables (Kazdin, 1986; Luborsky et al., 1986), and to limit the bias that would result in a single source of data in each area.

Beyond the typical examination of process and outcome variables, this study included an investigation of the changes in these variables over time. Cases were examined at differing points in treatment, and were followed for a three month period. Process and outcome were measured at several points in time to provide a more thorough exploration of potential fluctuations in process in treatment.

In general, the following hypotheses were developed, based on the assumption that the process of child therapy can be measured in a meaningful way, which

includes a measurement of the child's perception of the treatment process. Anticipated results were:

1. Both the child and adult instruments would produce internally consistent scales parallel to the scales produced on the adult instruments.

2. There would be agreement between child and therapist reports on basic process variables, including therapist warmth, therapist acceptance, therapist structuring the session, and on measures of positive affect.

3. Therapist positive affect would be related to positive outcome.

4. Therapist use of structuring the session would relate to promoting insight.

5. Therapist use of communicating warmth and providing acceptance would relate to promoting catharsis.

6. The child's report of positive and negative feelings would relate to the perception of the same feelings in the therapist.

7. Therapists would employ more directive techniques and goals, such as structuring the session and promoting insight, with externalizing clients. These clients would also perceive these variables more

frequently in their therapists.

8. Therapists would employ more supportive techniques and goals, such as communicating warmth, providing acceptance, and promoting catharsis, with internalizing clients. These clients would also perceive these variables more frequently in their therapists.

9. The child client's expression of feelings, whether through play or through verbalizations, would be associated with positive outcome.

## CHAPTER II

### METHOD

#### Setting

The study was conducted at the Charles I. Doyle, S.J. Center, a community mental health clinic operated by Loyola University of Chicago. The clinic provides outpatient psychotherapy to children, families, and parents in an ethnically diverse, middle and lower class urban neighborhood and is a training site for graduate students in psychology and social work. The clinic operates on a sliding fee scale, and most referrals come from area schools, churches, and community agencies.

Therapists at the Doyle Center use a broad-based psychodynamic model very similar to that described in the literature (Silver & Silver, 1983; Mishne, 1984). A combination of verbal and play therapy is employed, with an emphasis on building a caring therapist-client relationship, facilitating the expression of feelings, increasing the child's self esteem, and encouraging more adaptive behavior. Besides receiving weekly supervision to facilitate the implementation of these strategies,

therapists receive small group didactic presentations on various therapeutic techniques.

### Subjects

Subjects consisted of both therapists and their child clients. Children eligible for the study were clients between the ages of six and twelve who were receiving individual therapy. Each child had received a diagnostic evaluation at the clinic and was recommended for individual treatment. The author met with all of the therapists in the agency and informed them of the eligibility requirements. If the therapist was treating an eligible child, the therapist contacted the parents of the child to request permission for the child's participation. The child was also asked to consent to participation. When permission was obtained, the author was notified and data collection for that subject began. Thus, all of the children in the study had parental permission for their participation.

Of 29 child clients who were eligible for the study, 20 children served as subjects. Four child subjects were lost due to lack of parental permission, two children declined to participate, one child asked to discontinue participation following the first interview, and two children terminated therapy before data



collection was completed.

The final subject sample consisted of 13 boys and 7 girls. Mean age was 8.9 (S.D.= 1.7). Children were in individual therapy for a variety of school and family problems. Six of the subjects had been in therapy for more than 1.5 years; eight subjects had been in treatment between six months and 1.5 years, while the remaining six subjects had been in therapy for less than six months prior to the beginning of the study. Five subjects in the sample also received adjunct family therapy in addition to their individual sessions, while another five subjects' mothers received individual therapy.

DSM III-R diagnoses of subjects included oppositional personality, conduct disorder, separation anxiety disorder, overanxious disorder, attention deficit disorder with hyperactivity, and parent-child problems. For the purpose of this study, diagnoses were collapsed into two categories identified by Achenbach (1979): "externalizers" and "internalizers." These categories reflect whether the disorder results in an overt, acting out of problems, such as in hyperactivity or conduct disorder, ("externalizers,") or whether the disorder results in symptoms that suggest holding

problems within, such as in overanxious disorder or separation anxiety disorder, ("internalizers"). In three cases the diagnosis, parent-child problems, did not fit into one of these categories. In these cases the therapists were interviewed and asked to describe the child's problems more specifically, and these children were categorized based on this information. Overall, 10 subjects were labeled "externalizers" and 10 were labeled "internalizers." There were no significant differences in gender or age in the composition of the two groups.

Fifteen therapists also served as subjects in the study. Five therapists had two child clients who were participating in the study, and the remaining therapists each had one client involved. All therapists who had child clients participating in the study were asked to serve as subjects, and all therapists agreed to participate as well. Twelve of the therapists were female, and three were male. The group was comprised of ten graduate students in psychology and five graduate students in social work who were supervised by four Ph.D. level psychologists and four MSW level social workers, respectively. Eight of the students had one year or more of clinical experience children, while the

remaining seven students had less than one year of clinical experience.

### Examiners

Five examiners were used in the study to administer the child instrument. Four were undergraduate students and one was a graduate student. Two of the undergraduate students received academic course credit for their participation in the study. Each had at least three months experience in working with children and was trained through live demonstrations to administer the instrument. In addition, child interviews were taped and listened to by the author to guarantee standard administration and to facilitate supervision.

### Measures

Two measures were adapted and employed to examine two perspectives of the therapist's goals, techniques, and therapist and client affect during the session. A third measure completed by the therapist was also used to provide a general assessment of client functioning. All measures were pilot tested prior to the implementation of the study (see Procedures). The measures and perspectives to be examined are as follows:

1. Therapist report (TR). In order to measure therapists' perceptions, four subscales of the Therapy

Session Report for therapists (Orlinsky and Howard, 1975) were adapted for use. On the original instrument, responses to 152 items are obtained along three-point Lickert scales ("none, some, a lot"). Items are designed to address 10 aspects of a therapist's experience during a session, six of which focus on the client and four of which focus on the therapist. For the purpose of this study, four aspects of the therapist's experience were selected for examination: a) the therapist's affect during the session (T-Affect), b) the therapist's goals for the session (T-Goals), c) the therapist's perception of his/her interpersonal behavior during the session (T-Behavior), and d) the therapist's perception of the client's affect (TC-Affect).

The first modification of the TR involved a decision to use the same items to measure client and therapist affect in the TR. On the original instrument, different affect adjectives are used to measure client and therapist affect. In order to provide a form parallel to the child report, the same items were used to measure client and therapist affect in the TR. Secondly, in adapting the TR a few new items were added to make the instrument relevant for child therapy. Two items were added to the section pertaining to therapist

goals and four items were added to the section pertaining to therapist behavior. Two of these items related to the use of play therapy and paralleled items in the adult instrument regarding client verbal expression, while the remaining four items concerned the therapist's attempts to engage the child in a collaborative relationship or offer direct support or nurturance, areas that have been reported to be important in the child therapy literature (Blom, 1977). Thus, in the adapted instrument, T-Affect included 33 items, T-Behavior consisted of 16 items, T-Goals was comprised of 12 items, and TC-Affect included 33 items. The adapted TR was designed to yield the same subscales as the original measure. Higher scores on each scale reflect higher levels of the construct being measured. Appendix A contains the adaptation of the TR. Items preceded by asterisks represent new items designed expressly for this study.

2. Client report. Four subscales of Orlinsky and Howard's (1975) measure of client perception of the therapy process, the Client form of the Therapy Session Report were adapted for use with children. The Client form of the Therapy Session Report parallels the Therapist Form of this instrument. The original

instrument also contains 152 items which are followed by 3 or 4 response alternatives ("none, some, a lot"; or "slightly, some, pretty much, very much"). This measure examines the client's feelings, the client's perceptions of the therapist's feelings, content areas covered, client's perceptions of their own interpersonal behavior, client's perceptions of the therapist's behavior, client's goals for the session, and a general evaluation of the session.

The modified measure in the present study (CR) concentrated on four dimensions of the child's experience. In relation to the child, the CR assessed the child's Affect (C-Affect), and the child's Goals for the session (C-Goals). In relation to the therapist, the CR examined the child's perception of therapist's Affect (CT-Affect), and the child's perception of therapist's Behavior (CT-Behavior). The modified CR employed a combination of open-ended questions, forced choice items, and Q-sort items. (The CR is presented in Appendix B).

Three sections measured the child's response through the use of the Q-sort technique (C-Affect, CT-Affect, and CT-Behavior). The Q-sort technique has been shown to be useful in eliciting children's responses to

questions about their feelings and perceptions of interpersonal behavior (Sines, Pauker, & Sines, 1974). Both the C-Affect and the CT-Affect sections were covered by 14 items presented in a Q-sort format which asked subjects to either agree or disagree with each item and sort their responses accordingly. Based on the results of the pilot study, both the C-Affect and CT-Affect sections were modified to allow the child three choices to indicate the extent to which he/she experienced a particular emotion. For example, subjects were given cards with words such as "scared" or "liked" and were asked to place them in one of three piles indicating they experienced the feeling, "A lot," "A little," or "Not at all." The measure of CT-Behavior employed a Q-sort format and included 21 items to which subjects had three sorting alternatives. For example, subjects were given a statement such as "Today my therapist listened to me," and were asked to place this item on one of three stacks labeled, "not at all," "a little," or "a lot." The above three sections of the CR (C-Affect, CT-Behavior, and CT-Affect) were designed to produce scales parallel to those in related sections on the TR (see Results). Higher scores on each scale reflect higher levels of the construct being measured.

The section pertaining to the child's aims for the session (C-Goals) did not use a Q-sort technique, and was designed to provide descriptive information. Because little was known about children's ability to comment meaningfully on the process of therapy, the decision was made to vary the format of the instrument to include a section which was more exploratory in nature. Eight items were included in the C-Goals section, five using open ended questions and three using forced choice items. These items required verbal responses rather than the sorting of response cards. The items were read to the child at the end of the designated sessions, and the child's response was recorded verbatim.

3. Assessment of client functioning. The Brief Psychiatric Rating Scale (BPRS) developed by Overall & Pfefferbaum (1982) was administered to therapists to evaluate the child's general level of functioning at different points during the study. (See Appendix C.) This measure is similar to the Brief Psychiatric Rating Scale for adults (Overall & Gorham, 1962) and consists of 21 symptom descriptions which are rated on a 7-point scale ranging from not present to extremely severe. The scale yields seven separate scores representing symptom



clusters such as behavior problems, depression, and thinking disturbance, and these factors have been demonstrated to be highly reliable ( $r > .816$ ; Gale et al., 1986). Higher scores on this instrument reflect higher levels of observed disturbance.

### Procedure

Pilot Testing. The TR and the CR were pilot tested with a sample taken from Doyle Center staff and clients. Five therapists completed the TR and the CR was administered to five child clients after two separate sessions. Whenever the CR was administered, CR items were read to the child by the examiner immediately following the session under study, and the child was asked to respond to the sorting technique or give a verbal response, depending on the question. Examiners and therapists were interviewed following the piloting procedures to examine the efficiency of the procedure. Responses were examined, and two major procedures were used to evaluate the items: 1) Examiners were asked to rate the items for their understandability and feasibility in use with children, and 2) the distribution of responses was inspected. Results suggested that both instruments were understandable and feasible for use with child clients and their

therapists. On the CR, however, children's responses revealed that there was no variability on items measuring children's perceptions of affect in sessions. Since raters observed that children sometimes struggled in choosing between the two alternatives, a decision was made to provide three alternatives in this section. Thus, the final version of the CR provided three levels of agreement, "Not at all," "A little," and "A lot," for each section that employed the Q-sort technique.

Formal Data Collection. Following the pilot period, each treatment case was studied over a three month period. During this period, most therapists completed the TR after every other session for a total of six sessions representing 12 weeks in treatment. In nine of the 20 cases, however, the child missed one of the sessions scheduled for data collection. Due to the need to complete data collection in a timely fashion, data collection was rescheduled for the following week. Thus, in nine cases three of the six sessions examined occurred consecutively. Each of the six sessions under study was also audiotaped, but data from the audiotapes are not reported here.

At six points during the study corresponding to the same session that the TR was completed, an

independent examiner administered the CR to the child client immediately after a therapy session. Again, when possible the data were collected biweekly over a 12 week period, but in nine cases three consecutive sessions were examined. On the average, the CR took 10 minutes to administer and score. The open ended responses were recorded verbatim, and later coded to facilitate comparison to therapists' responses. Thus, categories of responses were developed based on the subscales of this section of the TR. Coding reliability was assessed on a sample of twenty sessions which were coded by four different raters. Inter-judge agreement was 92% with the author's coded responses serving as the standard. Finally, therapists completed the BPRS at the same six times that they completed the TR.

## CHAPTER IV

### RESULTS

Given the nature of this study, which included both exploratory and replicative aspects, data analysis was conducted in four major phases. The preliminary phase focused on examining the variables measured by the therapy process instruments, the CR and the TR. This examination included computing the internal reliabilities of each scale on both instruments, as well as testing the distribution of responses on items yielding discontinuous data. Secondly, the relationship among scales of each instrument and correspondence between the two instruments was investigated. The third stage of data analysis involved measuring the change in process variables in each diagnostic group over time. This process was completed by testing for main effects for time and diagnostic group, as well as for an interaction between the two. Finally, the fourth stage involved investigating symptom change, or outcome. Patterns of symptom change were explored, followed by an examination of process variables which are associated

with change. Each stage of data analysis is described in detail below.

### Instrument Reliabilities

The first level of data analysis involved examining the reliability of the CR and TR subscales. Because the sample was too small to employ factor analytic procedures, it was hypothesized that items would fall in the same subscales as in the adult studies (Orlinsky and Howard, 1975). Accordingly, Cronbach's alpha procedure was employed to test the internal consistency of each subscale. Item-whole correlations for each subscale were calculated, and any item which correlated below .20 with the total scale was eliminated.

### Child Report

The CR was designed with three sections which yield subscales: C-Affect, CT-Affect, and CT-Behavior. Cronbach alpha reliabilities and retained items for scales in each section are shown in Table 1. Two subscales within both the C-Affect and CT-Affect sections, positive and negative affect, were examined for internal consistency. Results of this analysis suggest that within both sections, subscales measuring positive and negative affect were sufficiently reliable (alpha ranged from .75 to .83). Three subscales

Table 1

Scale Reliabilities for the Child Report

Section	Scale	Items Retained	Alpha
C-Affect	C-Positive Affect	1,3,5,7,11,12	.75
	C-Negative Affect	2,4,6,9,10,13,14	.76
CT-Behavior	CT-Warmth	1,2,3,4	.82
	CT-Structuring	7,11,12,13,18	.68
	CT-Acceptance	14,15,16,17	.72
CT-Affect	CT-Positive Affect	1,3,6,8,10,12	.86
	CT-Negative Affect	4,5,7,9,11,13,14	.83

within T-Behavior were tested for internal consistency: communicating warmth (CT-Warmth), acceptance (CT-Acceptance) and structuring the session (CT-Structuring). All three subscales emerged with adequate internal consistency within this section. Reliabilities ranged from .68 to .82. Interestingly, the three items which were eliminated from the CT-Structuring scale related to the therapist structuring the activities of the session, while the five that remained pertained more to the therapist influencing what was talked about in the session.

#### Therapist Report

The TR was comprised of four sections: T-Goals, T-Behavior, T-Affect, and TC-Affect. In the T-Goals section, five subscales were tested for internal consistency, which included T-Catharsis, T-Insight, T-Encouraging Independence, T-Control Vs. Support, and T-Enhancing the Relationship. A list of the scales and items which were retained and Cronbach alpha reliabilities for each scale are presented in Table 2. Three of the original subscales achieved acceptable levels of internal consistency. These were T-Catharsis ( $r = .74$ ), T-Insight ( $r = .80$ ), and T-Encouraging Independence ( $r = .78$ ). The T-Encouraging Independence

Table 2

Scale Reliabilities for the Therapist Report


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Section	Scale	Items Retained	Alpha
T-Goals	T-Catharsis	3,4,8	.74
	T-Insight	5,12	.80
	T-Encourage Independence	7,9,11,16	.78
T-Behavior	T-Warmth	2,7,9,11	.61
	T-Structuring	1,5,12	.76
	T-Acceptance	3,4,6,10	.73
T-Affect	T-Positive Affect	1,3,6,7,8,10,15,18,22,26,29	.74
	T-Negative Affect	2,4,11,13,14,16,17,20,23,25,28,30,31	.85
TC-Affect	TC-Positive Affect	1,7,10,15,18,22,26,29	.80
	TC-Negative Affect	2,5,9,11,12,13,14,16,17,20,21,23,24,25,28,30,31	.88

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subscale was designed with only three items, and was sufficiently reliable when examining these items ( $r = .72$ ). By adding an item from a scale which was not found to have adequate internal consistency (Control vs. Support) the reliability of the scale was improved. Due to the face validity of the item, it was retained under this subscale.

In the T-Behavior section, which was comprised of three subscales, two subscales were judged to fall within the range of adequate internal consistency. These included acceptance (T-Acceptance), and structuring the session (T-Structuring). Reliability levels were .78 and .74, respectively. Although slightly below acceptable levels of reliability ( $r = .61$ ), a third subscale, communicating warmth (T-Warmth) was nonetheless retained.

On the original measure, the T-Affect and TC-Affect sections are comprised of 18 separate scales, with nine subscales in each section. When internal consistency tests were computed on these scales, many of which contained only one or two items, only five scales achieved adequate internal consistency. Based on a precedent in the literature (Orlinsky & Howard, 1986), all items within both the T-Affect and TC-Affect

sections were grouped according to Positive and Negative Affect. When internal consistency was tested in this manner, each subscale fell within an acceptable range ( $\alpha$  ranged from .74 to .88).

In sum, the first hypothesis was confirmed through an analysis of the internal consistency of the CR and the TR. The five subscales of the CR were all found to have adequate internal consistency ( $\alpha > .70$ ). These scales included C-Positive Affect, C-Negative Affect, CT-Warmth, CT-Acceptance, CT-Structuring, CT-Positive Affect, and CT-Negative Affect. A total of seven items were eliminated from the adapted instrument to achieve its final form, which is presented in Appendix C. Twenty-six subscales of the TR were tested for internal consistency. Ten of these subscales were judged to have adequate internal consistency: T-Catharsis, T-Insight, T-Encouraging Independence, T-Warmth, T-Acceptance, T-Structuring, T-Positive Affect, T-Negative Affect, TC-Positive Affect, and TC-Negative Affect. Of the sixteen subscales that were eliminated, fourteen came from the T- and TC-Affect sections as a result of using a more global and reliable measure of affect. A total of 12 items were eliminated in the TR. It is notable that these preliminary findings indicate that the CR and TR

provide adequately reliable measures of several dimensions of the therapy process. Further, these dimensions are strikingly similar to those examined in adult therapy studies.

### Analysis of Open-ended Questions

Because the section examining Goals of the Session on the CR was designed to employ open-ended and forced-choice questions, statistics designed for continuous variables were not appropriate for analysis of this section. Instead, the Chi-Square procedure was used to examine the distribution of responses for each question. (A list of questions and possible responses are available in Appendix D.) Responses at each of the six time periods were analyzed. A list of significant chi-squares is presented in Table 3. Following the emergence of a significant Chi Square, data were inspected to indicate which response contributed to the finding. On question 1, which related to reason for attending therapy, five response alternatives were possible. A significant chi was obtained on one occasion, at time four ( $\chi^2 = 11.5$ ,  $p = .021$ ). Inspection of the data suggested that the response indicating that that the child comes to therapy because it helps with problems (response #2) was given more frequently than other

Table 3

Time Periods Yielding Significant Response Differences  
on the Child's Goals Section of the CR

Question	Time	<u>X</u>	<u>p</u>
1	4	11.5	.021
2	1	12.4	.002
	2	22.0	.000
	3	17.8	.003
	4	11.2	.011
	5	12.4	.002
	6	16.6	.005
4	1	13.2	.004
	2	10.8	.013
	3	13.2	.004
	4	21.6	.000
	5	6.7	.035
	6	10.0	.040
5	1	11.5	.021
	2	17.8	.003
	3	13.0	.023
	4	16.0	.003
	5	12.9	.045
	6	12.9	.045
6	2	19.9	.000
	3	19.9	.000
	4	7.2	.007
	5	9.7	.008
	5	9.7	.008
	6	12.8	.000
7	1	5.0	.025
	2	7.9	.019
	5	7.9	.019
8	1	9.1	.011

responses (50%). Question two, which pertained to the problems the child wanted to work on in the session, yielded significant results on all six occasions ( $\chi^2$  ranged from 11.2 to 22.0;  $p$  ranged from .011 to .001). In each case, the largest group of children answered, "None," (between 50% and 70%) which was coded as response #1. This finding must be interpreted with caution, however, because at three time periods there were greater than four response categories, producing expected frequencies of less than four per cell.

Looking at question three, which related to the child's perception of how therapy helps with problems, no significant differences emerged between responses. Five responses were given to this question, thus it was expected that 20% of subjects would endorse each possible response. While only 5% of subjects chose response #3, which pertained to the child stating that the relationship with the therapist was what helped with problems, other responses were distributed fairly evenly among the remaining four alternatives (endorsement ranged from 10% to 40%). On question four, however, significant differences at each time period were found ( $\chi^2$  ranged from 6.7 to 21.6;  $p$  ranged from .040 to .004). This question asked children to describe what

they like best about therapy, and the answer given most frequently was response #2, "playing" (45% to 60%). Similarly, when asked to describe the worst thing about therapy in question five, the response, "Nothing," (#1) was given most frequently (40 to 55% of subjects), yielding significant  $\chi^2$  on five occasions ( $\chi^2$  ranged from 11.5 to 17.8;  $p$  ranged from .005 to .003). On this question, however, more than four categories were represented at each time period, limiting the interpretation of significant findings.

Questions six, seven, and eight employed a forced choice rather than an open-ended format. Questions were designed with two response choices, but in seven instances subjects insisted that they had equal inclinations towards both alternative, yielding a third response choice on seven separate analyses. Chi-square analyses of question six revealed significant differences at five time points ( $\chi^2$  varied from 7.2 to 19.9;  $p$  ranged from .008 to .000). This question related to whether children would rather leave therapy early or stay late in therapy. Children were more likely to choose the latter (65% to 90%). Question seven asked children whether they would rather talk about problems or talk about other things. At three

time periods significant  $\chi^2$  were obtained ( $\chi^2$  valued from 5 to 7.9,  $p$  ranged from .025 to .019), and children were more likely to choose talking about other things (55% to 75%). Interestingly, however, probability estimates varied widely on the remaining time periods, from  $\chi^2 = 0$  to .8, with  $p$  ranging from .37 to 1.0. Finally, on question eight, which inquired whether children would rather come to therapy or stay at home and play, difference emerged at time one only ( $\chi^2 = 9.1$ ,  $p = .011$ ), with children responding that they would rather come to therapy (60%).

In seven of eight items within the C-Goals section, significant  $\chi^2$  's were obtained, suggesting that there is a differential pattern of responses for children in therapy. In six of these questions, the significance emerged in at least half of the three time periods, as well.

By examining the frequencies of various responses when significance was achieved, a general pattern of findings can be described. Children stated that they come to therapy because it helps with their problems; they would prefer to stay beyond their 50-minute hour rather than have to leave before their time is up, and they would rather come to therapy than stay at home and

play. Yet the aspects of therapy that seem most rewarding appear to relate more to enjoying time with a special adult than to solving problems. Hence, children rate playing as their favorite aspect of therapy. They typically do not identify particular problems that they wanted to work on in the session, and they would rather talk about other things than talk about problems. While the format of this section limits the possibilities for statistical analyses, the responses in most of this section are especially notable since they came directly from the children themselves.

#### Correlational Analyses of Subscales

The next set of hypotheses, which pertained to the relationships among various subscales within and between Child and Therapist reports, were tested using Pearson Product Moment Correlations. In order to summarize data from the six time periods, average scores were calculated for each subscale. Correlations were then performed on the average scale scores. Correlations were calculated for all scales within each instrument, and between the subscales of the Child and Therapist Reports.

#### Within Instrument Subscale Correlations

Child Report. In the CR, a number of strong



interrelationships emerged among the scales. The correlations between these subscales can be viewed in Table 4. The first major pattern of correlations centered around the Affect scales. As expected, C-Positive Affect was significantly correlated with CT-Positive Affect ( $r = .85, p = .000$ ), and there was a strong positive relationship between C-Negative Affect and CT-Negative Affect ( $r = .93, p = .000$ ). Further, C- and CT-Positive Affect were negatively related to both C-Negative Affect and CT-Negative Affect ( $r > -.62, p < .002$ ). Secondly, within the CT-Behavior section, two of the three subscales showed a positive relationship with each other, while the third subscale was negatively related to the first two. CT-Warmth and CT-Acceptance emerged as related subscales ( $r = .43, p = .029$ ), while the latter was negatively correlated with CT-Structuring ( $r = -.79, p = .000$ ).

Further, Positive and Negative Affect subscales were related to the Behavior subscales listed above. Both Positive Affect subscales were positively correlated with CT-Warmth and CT-Acceptance ( $r > .47, p < .018$ ), while both scales were negatively associated with CT-Structuring ( $r > .66, p < .001$ ). Finally, Negative Affect scales were positively related to CT-

Table 4

Scale Correlations within the Child Report

Scale	2	3	4	5	6	7
1. C-Positive	-.71***	-.67***	.70***	.47*	.85***	-.62***
2. C-Negative		.64***	.82***	.46*	.70***	.93***
3. CT-Structuring			.79***	-.28	-.62**	.63***
4. CT-Acceptance				.43*	.71***	.75***
5. CT-Warmth					.57**	-.29
6. CT-Positive						-.55**
7. CT-Negative						

\* $p < .05$ \*\* $p < .01$ \*\*\* $p < .001$

Structuring ( $r > .63$ ,  $p = .001$ ) and negatively related to CT-Acceptance ( $r = -.75$ ,  $p = .000$ ). In general, then, the relationships among the subscales of the CR are suggestive of two experience clusters, either positive or negative, which are comprised of feelings, perceptions of therapist's feelings, and types of therapist behaviors. The "positive" cluster includes C- and CT-Positive Affect, CT-Warmth, and CT-Acceptance, while the "negative" cluster would include C- and CT-Negative Affect and CT-Structuring.

Therapist Report. Several significant relationships were evident between subscales of the TR, as well. Correlations among the scales of the TR can be viewed in Table 5. Within the T-Goals section, all of the subscales were found to have a significant positive correlations. These scales included Catharsis, Insight, and Encouraging Independence ( $r$  ranged from .71 to .46,  $p$  from .000 to .021). Looking at the T-Behavior section, however, none of the subscales was significantly related. This suggests that therapists may have several aims or goals for a particular session, yet may choose to focus on only one type of technique or behavior in implementing these goals.

In the Affect subscales, the strong

Table 5

Scale Correlations within the Therapist Report

Scale	2	3	4	5	6	7	8	9	10
1. T-Catharsis	.71***	.46*	.42*	.47*	.40	.15	.29	.62**	.40
2. T-Insight		.55**	.35	.35	.12	.08	.02	.30	.44*
3. T-Encouraging Independence			.56**	.60**	-.11	.27	.15	.15	.64**
4. T-Structuring				.31	.05	.03	.08	-.03	.42*
5. T-Acceptance					.11	.15	.37	.30	.61**
6. T-Warmth						.15	-.18	-.15	-.15
7. T-Positive							.14	.69**	.20
8. T-Negative								.20	.50*
9. TC-Positive									.20
10. TC-Negative									

\* $p < .05$     \*\* $p < .01$     \*\*\* $p < .001$

interrelationships among scales that emerged on the CR were not found on the TR. While T- and TC-Positive Affect and T- and TC-Negative Affect were related ( $r$ 's  $> .50$ ,  $p$ 's  $< .012$ ), the Positive and Negative Affect scales did not show the consistent negative correlations that were evident between these scales in the CR. It appears that the polarities between positive and negative experience that were suggested in the child measure were replaced by more diverse relationships in the therapist measure.

A variety of relationships were found among subscales of the Affect, Behavior, and Goals section. Subscales from the T-Goals section were most frequently related to other subscales. Catharsis, for example, was correlated with T-Structuring, T-Acceptance, TC-Positive Affect, and TC-Negative Affect ( $r$  ranged from .40 to .62;  $p$  ranged from .002 to .042). These findings in part confirmed hypothesis five, which predicted a relationship among communicating warmth, providing acceptance, and promoting catharsis. Insight was related to TC-Negative Affect ( $r = .44$ ,  $p = .025$ ). Encouraging Independence was associated with several other scales, including T-Structuring, T-Acceptance, and, interestingly, TC-Negative Affect ( $r$  ranged from .56 to

.64;  $p$  ranged from .005 to .001).

In summary, several subscales of the CR were found to be interrelated. Positive Affect scales and two CT-Behavior scales, CT-Warmth and Acceptance, were related, while Negative Affect scales and the remaining CT-Behavior subscale, CT-Structuring, were related; subscales in these clusters were negatively related to subscales in the other. This pattern suggests a global trend towards the identification of positive and negative experiences by the child in describing therapy. On the TR, however, broad positive and negative experiences did not emerge. The therapists endorsement of Positive or Negative Affect related to their perception of these feelings in their clients, but there was no inverse relationship between Positive and Negative Affect in this instrument. All of the goals described by the therapists were interrelated, yet none of this self-reported behaviors were related. Finally, providing catharsis was associated with several variables such as structuring the session and providing an acceptance, while providing insight was associated with encouraging independence and observing child negative affect.

#### Between Instrument Subscale Correlations

The next stage of data analysis involved

correlating the scales of the CR and TR. It was predicted that there would be agreement between child and therapists views of positive affect and therapist behavior. The Pearson Product-Moment correlations revealed fewer significant relationships between measures than predicted. Correlations among CR and TR scales are presented in Table 6.

Looking at similar dimensions of therapy, there was a significant correlation between the T-Positive Affect and CT- Positive Affect scales ( $r = .47$ ,  $p = .019$ ), and there was a nonsignificant trend for the C-Positive Affect and the T- Positive Affect to be related ( $r = .36$ ,  $p = .061$ ). In addition, both T-Warmth and CT-Warmth were related ( $r = .53$ ,  $p = .008$ ). These findings did not confirm hypothesis six, however, which stated that the child's affect would related to perception of the same affect in the therapist.

Other correlations suggest more complex relationships between the therapist and child's experience of therapy. Interestingly, there was a negative relationship between CT-Acceptance and T-Insight ( $r = -.38$ ,  $p = .047$ ). Similarly, the CT-Negative Affect was related to T-Encouraging Independence ( $r = .43$ ,  $p = .029$ ). Finally, although

Table 6

Scale Correlations between the Child Report and the Therapist Report

CR Scale	1	2	3	4	5	6	7	8	9	10
1. Self Positive	.36	.24	.22	.12	-.12	.05	.10	.23	-.13	-.03
2. Self Negative	-.30	-.21	.13	.11	.04	-.29	.06	.25	.01	.23
3. Structuring	-.21	.04	-.12	.20	.02	-.09	.22	.18	-.02	.26
4. Acceptance	.34	.18	.02	-.01	.03	.28	-.01	-.38*	-.01	-.10
5. Warmth	.19	.08	.22	-.04	.53**	.21	-.09	-.29	.11	-.06
6. Other Positive	.46*	.08	-.01	.11	.17	.30	-.16	-.32	-.05	-.33
7. Other Negative	-.13	-.15	.18	.31	.07	-.18	.07	.29	.12	.43*
8. Insight										
9. Cartharsis										
10. Encouraging Independence										

Note. Scales #8, 9, and 10 were included only on the TR, thus correlations are not listed under the CR section.

\* $p < .05$     \*\* $p < .01$     \*\*\* $p < .001$



none of the relationships was significant, it is interesting to note that the CT-Structuring was negatively related to several scales on the TR, including T-Structuring, T-Catharsis, T-Positive Affect, and TC-Positive Affect ( $r$  ranged from  $-.02$  to  $-.21$ ).

Thus, an examination of the correspondence of Child and Therapist reports revealed several intriguing results. There were basic agreements between client and therapist perceptions of therapist's positive affect and warmth. In addition, there was a trend for the therapist's and the child's experience of positive affect to be related. In other areas, more negative experiences of the child, such as an increased perception of therapist's negative affect and a decrease in perception of therapist's acceptance, were associated with the therapist's report of activities that are not inherently negative, encouraging independence and promoting insight. The agreement evident on the therapist positive affect and warmth scales suggest that child clients are especially tuned in to these aspects of the therapist's experience. It appears that in many other areas, clients and therapists experience aspects of the therapy hour differently. It is notable that there was more agreement on therapist feelings than on

client feelings. Such data may suggest either that children may conceal some of their true feelings, or that therapists may be unaware of the client's emotions. Further, it seems that the therapist's attempts to promote autonomy during the therapy hour may be experienced by the child as the therapist withdrawing acceptance or expressing negative feelings.

#### Analysis of Diagnostic Group Differences over Time

Following the preliminary analyses reported above, the next step in data analysis was to examine the degree of change in responses of both diagnostic categories, externalizers and internalizers, over time. A repeated measures Analysis of Variance (ANOVA) was used to calculate differences between the two groups over the six time periods. Scores in this analysis consisted of the data from the CR and TR subscales. When significant differences were found, post hoc  $t$ -tests were performed between time periods to indicate the points at which variations occurred.

#### Child Report

Because the Goals section of the CR consisted of discontinuous data, it was not possible to test for response differences over time. To examine differences over time in other sections, repeated measures ANOVAs were computed on each of the subscales of the CR

across the six time periods. This test revealed that subjects responded differently at different time periods on several subscales. A summary of significant differences at various points in time are presented in Table 7.

Significant differences were achieved on both C-Positive and C-Negative Affect scales ( $F = 2.66$ ,  $p = .03$ ;  $F = 18.86$ ,  $p = .0000$ , respectively), indicating that children's emotional experiences during therapy varied from session to session. Post hoc  $t$ -tests indicated that within the CP-Affect scale, differences were evident between times one and two, times two and three, and times two and five. The trend seen in these differences is for positive affect to decrease after the first session, then increase in following sessions. Post hoc analyses of the CN-Affect scale revealed that there were differences occurred mainly between time one and other periods and time two and other periods ( $p$  ranged from .000 to .05); time one differed from times two and six, while time two also differed from time three, four, five, and six. In addition, time three differed from time five ( $p = .04$ ). These differences appear to be due to a rise in negative affect in the second session, which decreased thereafter.

Table 7

Change in Child Report Scales over Time

Scale	F	Time	Mean
C-Positive Affect	2.66*	1	10.15 a
		2	8.15 abc
		3	10.20 b
		4	9.30
		5	9.90 c
		6	8.85
C-Negative Affect	19.47***	1	1.35 a
		2	6.50 bcdf
		3	2.50 bg
		4	2.35 c
		5	1.65 dg
		6	2.75 af
CT-Acceptance	15.37***	1	6.05 abc
		2	4.35 adefg
		3	6.80 bd
		4	6.50 e
		5	6.90 cf
		6	7.00 g

Note: Means sharing the same superscript are significantly different ( $p < .05$ ).

\* $p < .05$

\*\* $p < .01$

\*\*\* $p < .001$

In the CT-Behavior section, CT-Accepting Manner was the only subscale on which significant differences were evident over time ( $F = 15.37$ ,  $p = .000$ ). Within this scale, a pattern similar to the one found in CN-Affect emerged; time one was found to differ from times two and five, while time two differed from time three, four, five, and six ( $p$  ranged from .000 to .018). Again, there was a drop in CT-Acceptance in session two, which increased in subsequent sessions. Interestingly, although there were strong correlations found between C-Affect and CT-Affect subscales, neither CT Positive Affect nor CT Negative Affect were found to differ significantly over time.

In summary, the areas most variable over time were child positive and negative affect, and the child's perception of the therapist's accepting manner. In general, times one and two differed most frequently from other time periods, perhaps indicating a transition in therapy or a transition in the response to the experimental process.

In contrast to the differences found in subjects responses over time, there were no differences found in children's responses between diagnostic groups. Further, no interactions between diagnostic group and time were

found on the CR. It appears that variations in subjects responses on the CR are more reflective of changes in the child's experience over time than of the problems that brought the child to therapy.

### Therapist Report

Each of the subscales of the TR were examined over the six time periods by diagnostic group through the repeated measures ANOVA procedure, as well. As with the CR, when a scale revealed significant variation over time, post hoc  $t$ -tests were used to determine at which time periods there were significant differences. The results of planned and post hoc analyses of change over time are presented in Table 8.

Examining the T-Affect section, no differences were found over time in the T-Positive Affect scale nor in the T- Negative Affect scale. In contrast, differences were evident in each section of T-Goals, including T-Catharsis ( $F = 3.11, p = .0187$ ), T-Insight ( $F = 2.43, p = .034$ ), and T-Encouraging Independence ( $F = 5.71, p = .001$ ). Within T-Catharsis, significant differences were found between time one and times three, four, five, and six, as well as between time two and five ( $p < .04$ ). These findings indicate that therapists tended to increase their endorsement of T-Catharsis over

Table 8

Change in Therapist Report Scales over Time

Scale	F	Time	Mean
T-Catharsis	3.11*	1	2.55 abc
		2	3.15 d
		3	3.30 a
		4	3.15 e
		5	3.80 bde
		6	3.50 c
T-Insight	2.43*	1	1.45
		2	1.10 abc
		3	1.50
		4	1.75 a
		5	1.80 b
		6	1.70 c
T-Encouraging Independence	5.71***	1	1.95 ab
		2	1.50 cdef
		3	2.25 cgh
		4	2.80 d
		5	3.25 aeg
		6	3.20 bfh
T-Structuring	2.52*	1	2.55 a
		2	2.55 b
		3	2.90
		4	2.85
		5	3.35 ab
		6	3.15

Note: Means sharing same superscript are significantly different ( $p < .05$ ).

\* $p < .05$

\*\* $p < .01$

\*\*\* $p < .001$

time. Variations over time in T-Insight occurred between time two and times four, five and six. There was an increase in use to T-Insight following time two. Finally, within T-Encouraging Independence, significant differences were evident between the following times: one with five and six; two with three, four, and five; and three with four and five ( $p < .047$ ). Each of these differences reflects an increase in T-Encouraging Independence.

In the T-Behavior section differences emerged over time in the T-Structuring subscale ( $F = 2.52$ ,  $p = .0333$ ). These differences were seen between time five and times one and two ( $p < .012$ ), and indicate a general increase in the use of T-Structuring. Unlike the CR, differences did not emerge on T-Acceptance. Similarly, no significant time effects were found in the TC-Affect subscales, TC-Positive Affect and TC-Negative Affect.

To summarize, on the TR the subscales which reflected significant change over time related to the therapist's goals for the session, with the addition of the subscale which examines the therapist's attempts to structure the session, concerned more with the therapist's behavior. There was no specific pattern which described the time points at which differences



were likely to occur, although the general trend was for early sessions to contrast most with other sessions. As in the CR, this may suggest a transitional point following the first two sessions, or may be an artifact of the experimental process.

On the TR, there were significant main effects for diagnosis on two subscales, T-Positive Affect and TC-Positive Affect ( $F = 4.79, p = .042$ ;  $F = 4.76, p = .043$ , respectively). In both instances, higher levels of positive affect were evident in therapists treating Externalizers. In addition, interactions between time and diagnosis were evident on the TR. Graphs of these interactions are presented in Figures 1 and 2.

One interaction occurred on a scale which had previously revealed a main effect for time, T-Catharsis ( $F = 2.61, p = .03$ ). An interaction was also observed on T-Warmth ( $F = 2.51, p = .035$ ). Within T-Catharsis, therapists treating Externalizers tended to hold the rate of promoting catharsis steady over time, while those treating Internalizers increased the rate of promoting catharsis over the six sessions.

Within T-Warmth, therapists treating Internalizers were initially less warm towards their clients; warmth increased, but the pattern of exhibiting warmth was more

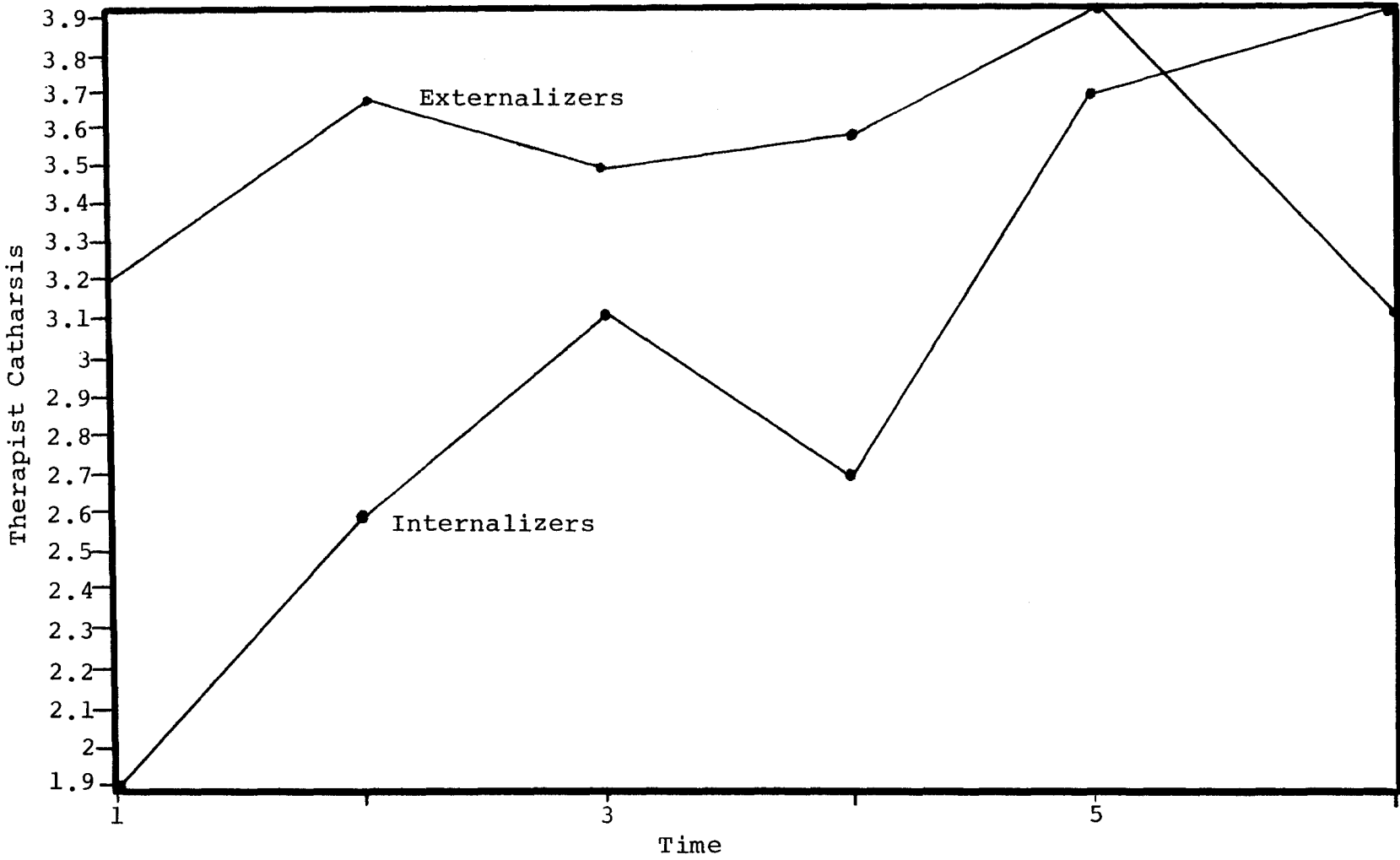


Figure 1. Therapist Catharsis by Diagnostic Group over Time

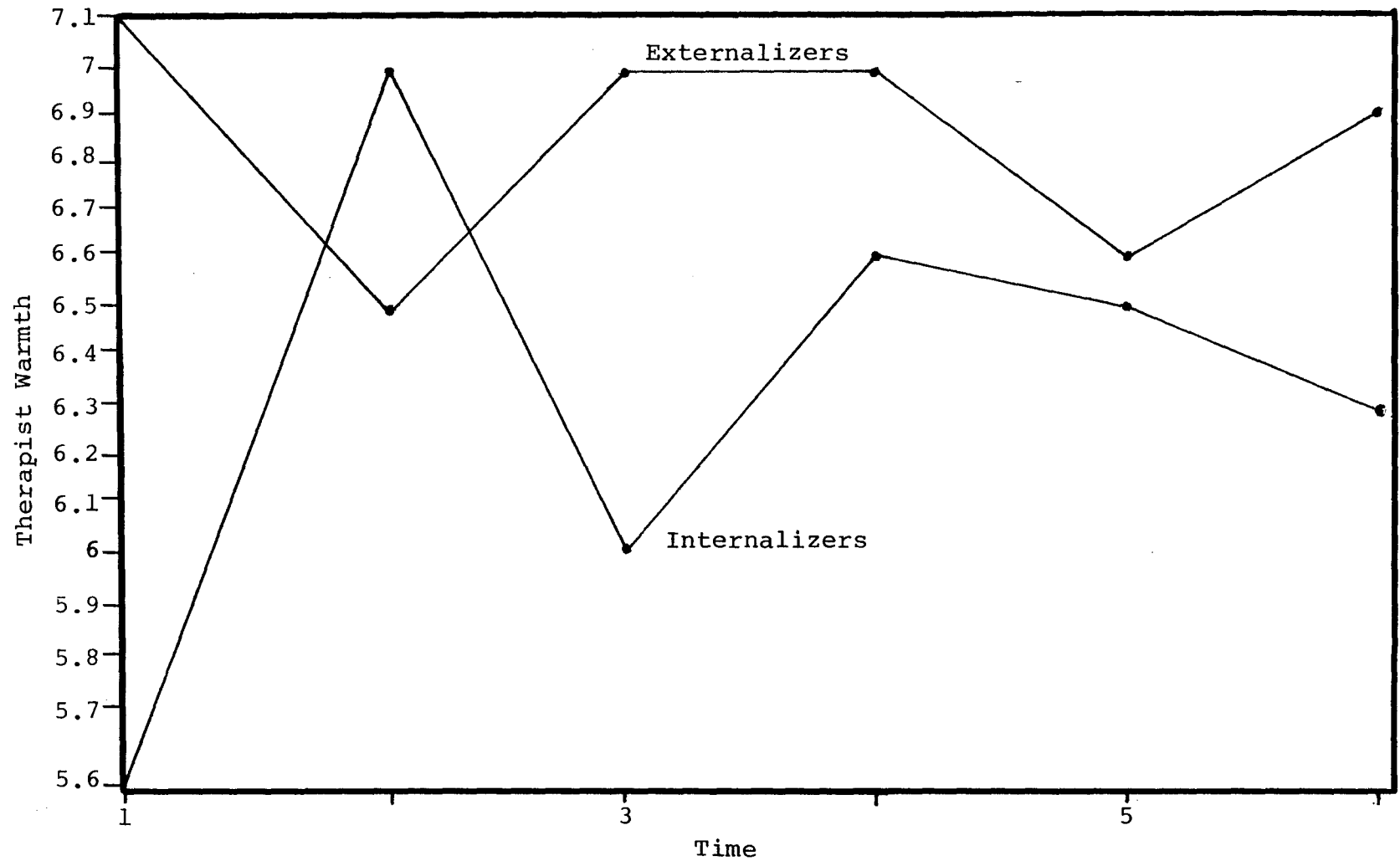


Figure 2. Therapist Warmth by Diagnostic Group over Time

variable than with Externalizers and was declining at the sixth session. Initially, therapists reported more warmth with Externalizers; this dropped below the rate with Internalizers after the second session, but rose after the third session and remained more steady over the remaining three sessions. These findings suggest that therapists feel more positive and note more positive feelings in Externalizers than with Internalizers. The therapists' goals relating to catharsis varied over time depending on the diagnosis of the client, with therapists gradually encouraging more catharsis in Internalizers and maintaining a steady rate of encouraging catharsis in Externalizers.

Interestingly, therapists tendency to communicate warmth to Internalizing clients varied between sessions, while after an initial drop with Externalizers they tended to maintain a steady rate of communicating warmth.

#### Analysis of Outcome

The final phase of data analysis involved examining various aspects of therapy outcome. The initial step taken in examining the rating scale was to look at symptom changes between the beginning and end of the study. Student's  $t$ -test was used to look for

significant differences in scores on the subscales of the BPRS between time 1 and time 6. Client's symptoms were expected to decrease over time in treatment, thus a one-tailed test of significance was employed. Of the seven subscales of the BPSR, significant symptom change was evident on three subscales. These scales included Thinking Disturbance ( $\underline{t} = 1.69, p = .05$ ), Motor Agitation ( $\underline{t} = 3.63, p = .001$ ) and Organicity ( $\underline{t} = 2.54, p = .01$ ). Other subscales, which include Behavior Problems, Depression, Withdrawal, and Anxiety were not significantly different between time 1 and time 6. With the exception of the Withdrawal subscale, however, symptoms decreased in every subscale during the period of study. Next the symptom scales were collapsed to examine the overall symptom change between time 1 and time 6. There was a significant decrease in composite symptom scores between time 1 and time 6 ( $\underline{t} = 2.91, p = .005$ ).

In order to look more closely at change over time in the BPRS, a repeated measures ANOVA was computed on each of its subscales. As expected, significant differences emerged within the Motor Agitation and Organicity subscales over time ( $F = 2.87, p = .0186$ ;  $F = 3.65, p = .0046$ , respectively). Further, changes

emerged using this procedure with the composite symptom scores ( $F = 2.43$ ,  $p = .04$ ). Post hoc  $t$ -tests were used to examine the points at which variations occurred. Results revealed differences between time one and times five and six, suggesting improvement between the beginning and end of the study. Thus, these tests confirmed the general trend for symptoms to decrease over three months of therapy.

In order to gauge differential change according to diagnostic group, repeated measures ANOVA's were also calculated for symptom change by group. There were no main effects for group in the symptom scale or in the composite change score. However, significant interactions between time and diagnostic group were found on two variables. Graphs of these interactions are presented in Figures 3 and 4. On Motor Agitation ( $F = 2.52$ ,  $p = .03$ ), internalizers began with lower scores which increased slightly, then decreased; externalizers exhibited high scores initially which declined, then rose at the last session. Looking at the total symptom change ( $F = 4.13$ ,  $p = .002$ ), internalizers again began with a lower initial score which rose, then began to fall following the last two session. Externalizers' symptoms declined steadily until the last session, when

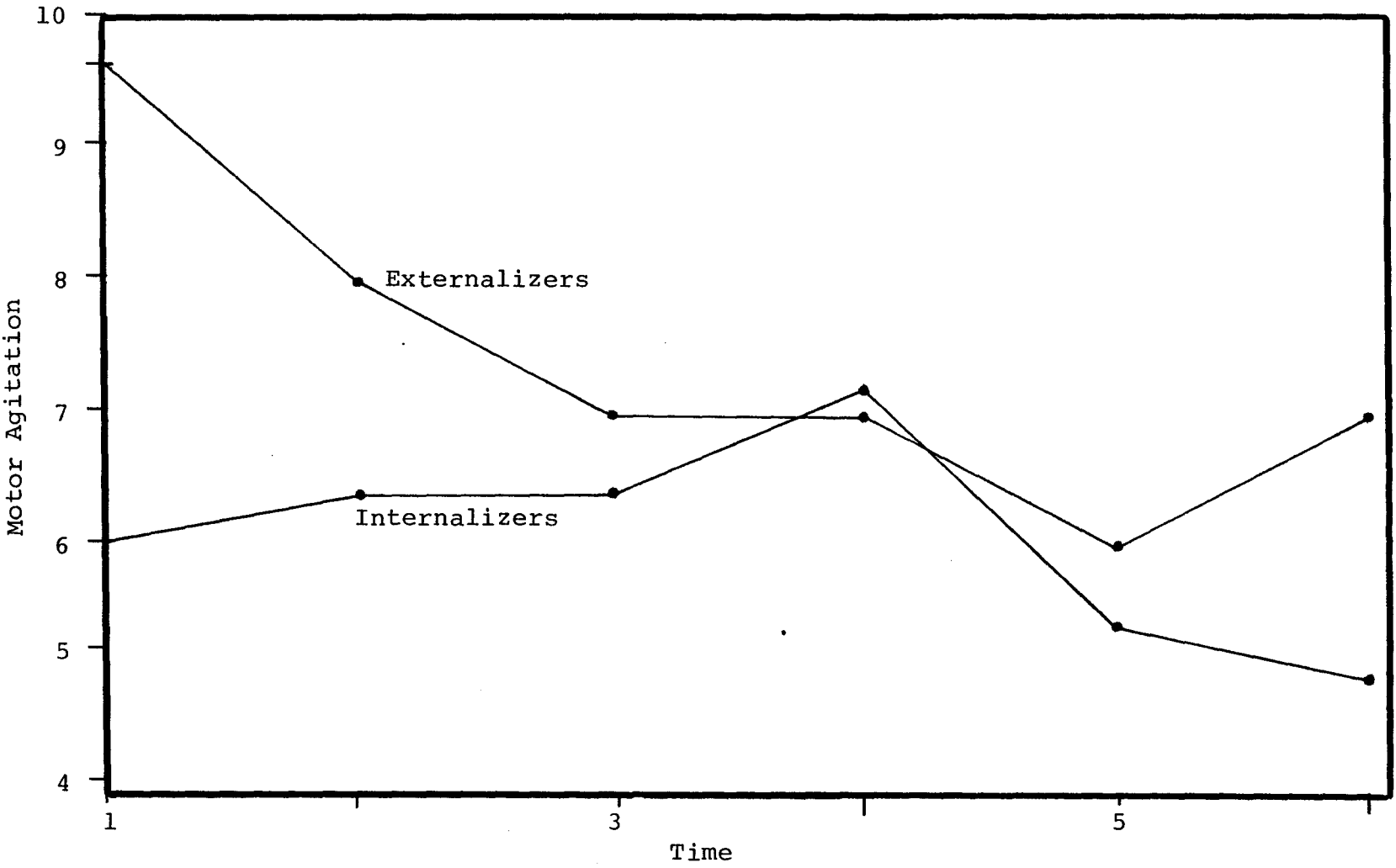


Figure 3. Motor Agitation by Diagnostic Group

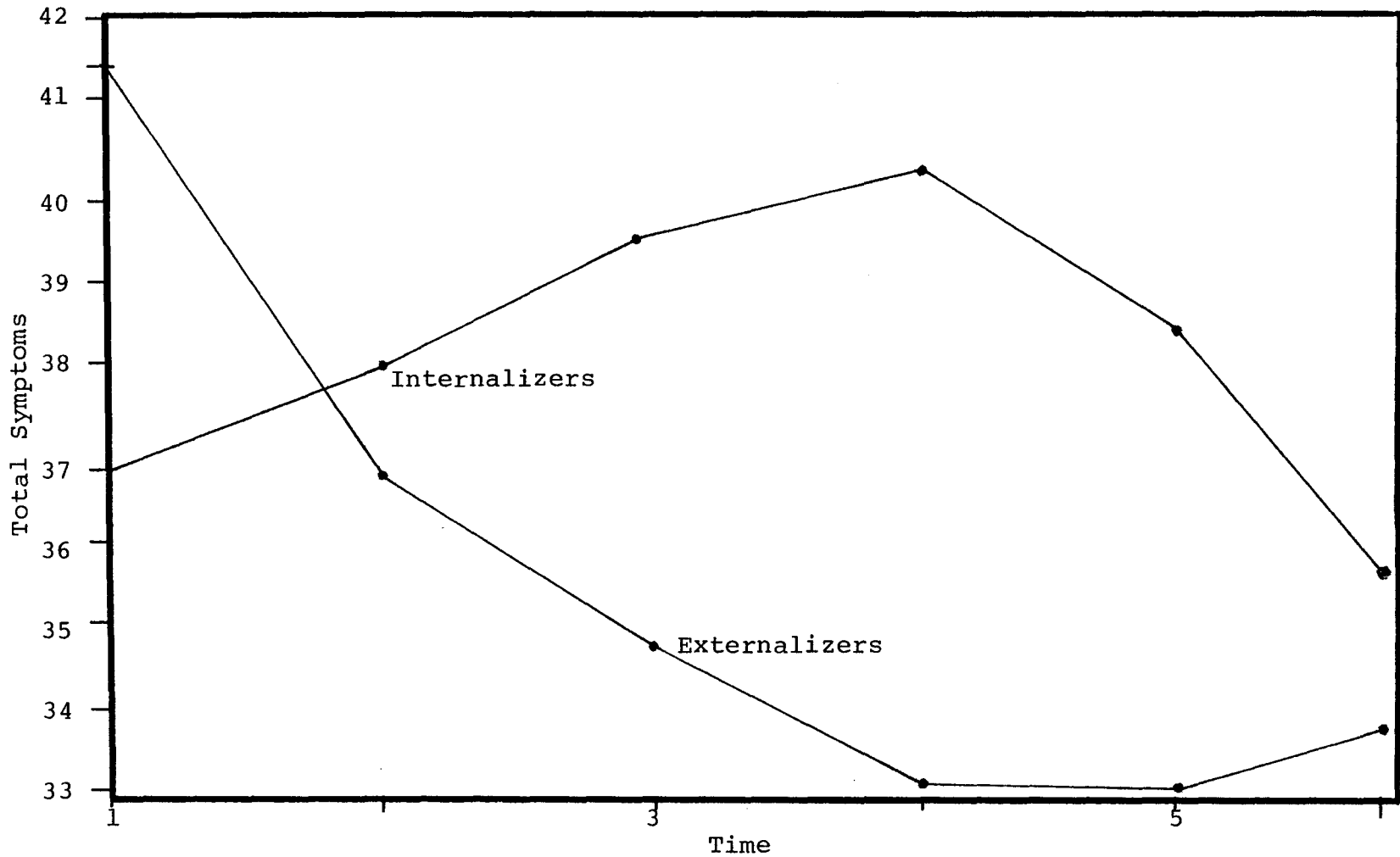


Figure 4. Total Symptoms by Diagnostic Group over Time



they rose slightly.

The final analyses related to examining the process variables that were associated with positive change over time. In order to examine positive change, a symptom change score was calculated for each individual by using the difference between compositive symptoms on time 1 and time 6. To account for change that was due to regression toward the mean, a regression equation was calculated to determine the expected difference between time one and six. A residual score was then computed between the actual difference and expected difference. This residual score was used to represent change over time. Fifty per cent of all subjects showed positive change over time, with residual change scores ranging from 1.07 to 13.67. The remaining 50% of subjects did not show more positive change more than was expected over six points in time. Residual change scores of these subjects ranged from -.59 to -17.83. Due to the natural split evident in the data between half of the subjects whose residual change scores improved over time and the other half whose scores did not, a decision was made to group subjects according to change score. Both the Low Client Improvement and the High Client Improvement group were

comprised of 10 subjects.

In order to examine the effects of time in differences between high improvement and low improvement individuals on process variables, repeated measures ANOVA's were calculated on each process variable between the two groups. It was notable that there were no significant main effects for change group on any of the process variables. Further, there were no significant interactions between change group and time on the CR, which disconfirms hypothesis nine. Instead, significant interactions were found between change group and time on three subscales of the TR: T-Encouraging Independence ( $F = 3.28, p = .01$ ), T-Positive Affect ( $F = 2.81, p = .02$ ), and TC-Positive Affect ( $F = 2.80, p = .02$ ). Graphs of these interactions may be viewed in Figures 5, 6, and 7.

A closer examination of T-Encouraging Independence suggests that in the high change group, therapists began with slightly higher levels of encouraging independence which gradually increased, then dropped following the sixth session. In the low change group, therapists dropped their level of encouraging independence following the second session, then increased their use of this variable dramatically in the sixth session. The Positive Affect scale reveals a less complex

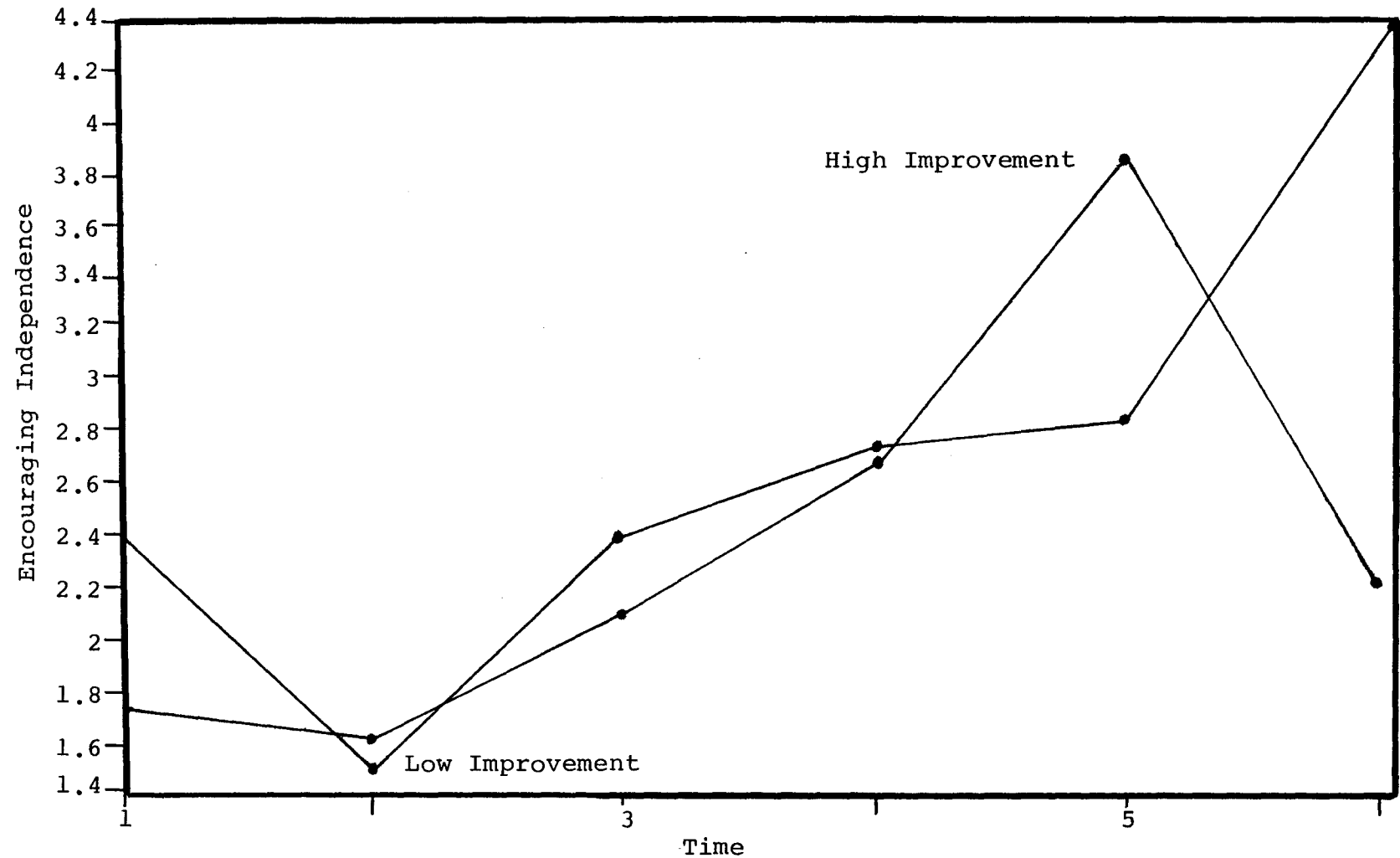


Figure 5. Therapist Encouraging Independence by Client Improvement over Time

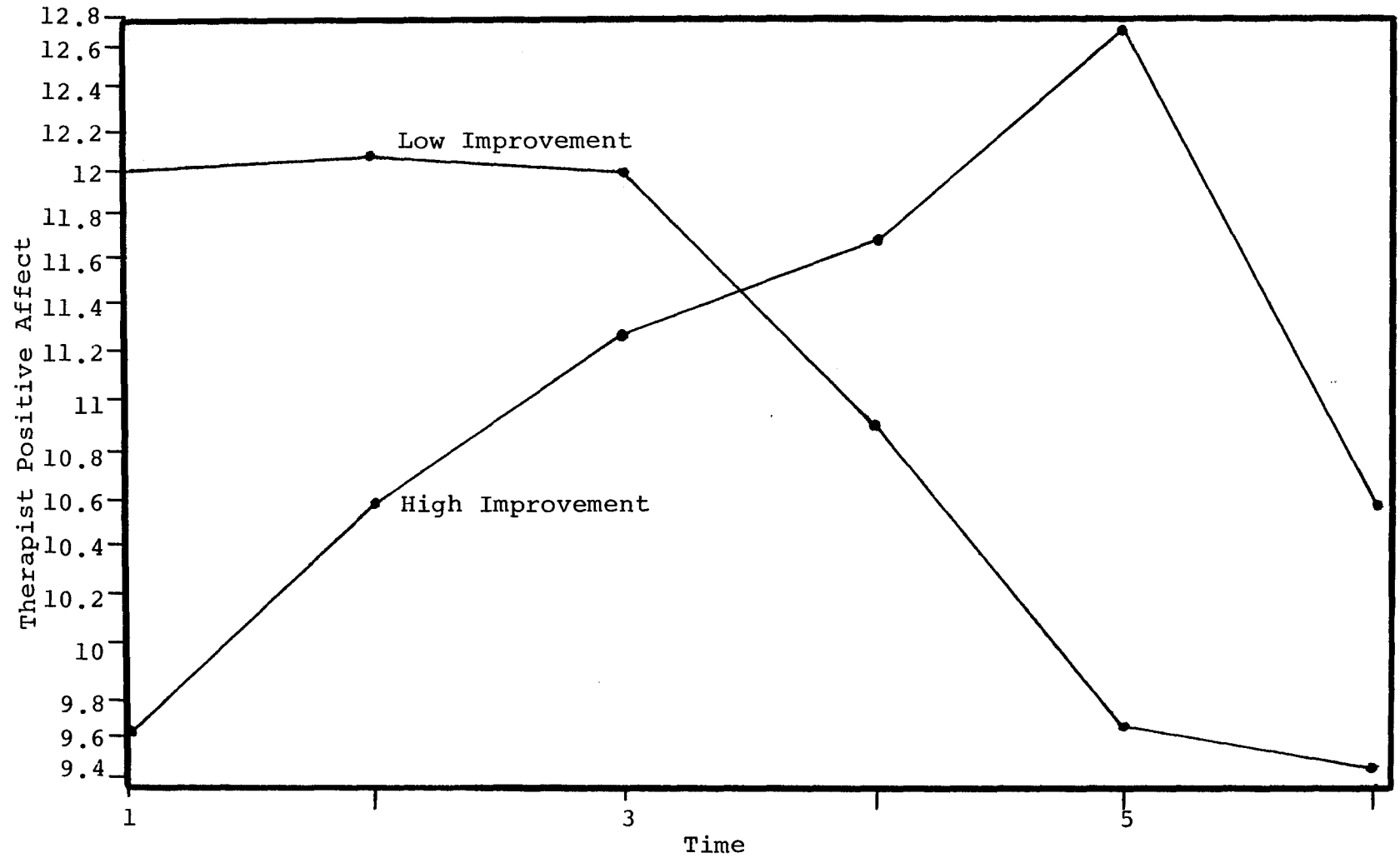


Figure 6. Therapist Positive Affect by Client Improvement over Time

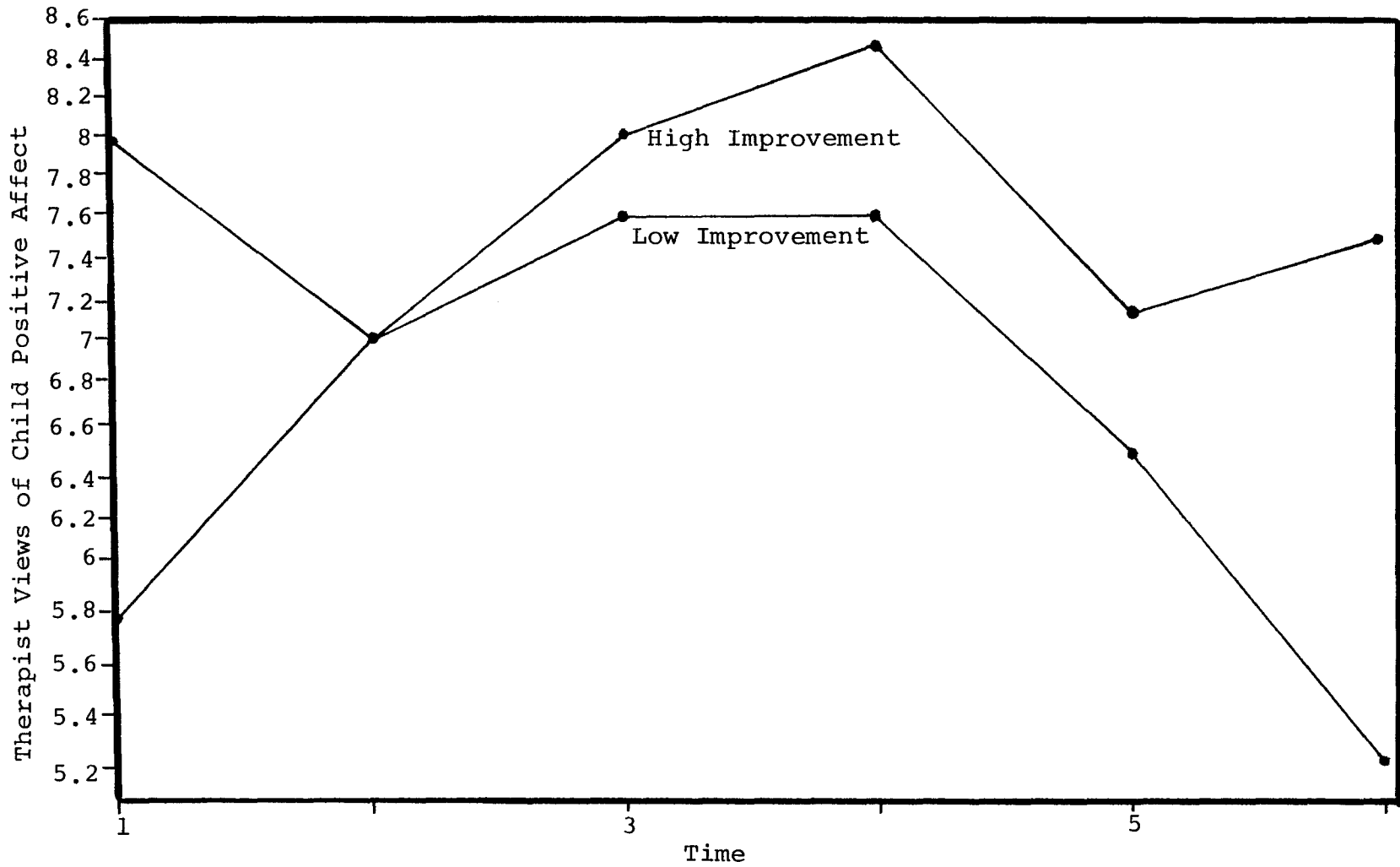


Figure 7. Therapist Views of Child Positive Affect by Client Improvement over Time 84

interaction. Whereas at time one therapists reported of more positive feelings in the low than the high change group, there was an increase in positive feelings reported in the high change group, and a concurrent drop in positive feelings in the low change group over time. Similarly, on the TC-Positive scale, compared to the high improvement group, therapists in the low improvement group perceived higher levels of client positive feelings at time one. However, scores for therapists in the latter group decreased over time, while perception of positive feelings in the high change group increased. This finding confirms, in part, the hypotheses that the client's expression of feelings is related to positive outcome.

In sum, child subjects in this study exhibited significant change over three months. Changes were evident in measures of general symptom decrease, as well as on three specific symptom clusters, motor agitation, thinking disturbance, and organicity. When correcting for the effect of initial symptom level, residual change remained significant. Looking at process variables associated with outcome, no single, clear picture emerges. Therapists tended to decrease their level of encouraging independence with the high change group,

while they varied widely and finally increased encouraging independency in the low change group. In addition, it seems that in individuals who show positive change, therapists observe and experience increasing levels of positive affect, while this pattern is reversed for individuals who do not exhibit positive change.

## CHAPTER V

### DISCUSSION

Before discussing the major conclusions and implications drawn from this study, the principal limitations of the study should be mentioned. First, a major limitation relates to the small sample size. With only 20 cases, it was impossible to answer several questions of interest. For example, neither instrument could be factor analyzed to confirm the factor structure of the TR and CR. In addition, analyses were performed according to diagnostic group and to client improvement group, but the sample was too small to look at both variables simultaneously. Similarly, while the effect of time was important in several instances, the sample could not be split into groups according to stage in treatment due to the limited number of subjects.

Second, the only outcome measure employed was completed by the therapists providing the treatment. Clearly, the therapist's view of the child's level of functioning is an important variable for study. Yet without other descriptions of the child's functioning,



it is difficult to estimate the extent to which therapist bias may have contributed to current findings.

The third area of concern involves the limitations of self report measures. The process measures used in the study relied solely on self report by therapists and their child clients. Again, therapist and client perceptions of process variables provide valuable sources of information on their subjective experiences of therapy. A more thorough examination of the process could be provided by including objective data, such as observer ratings of therapy tapes. Unfortunately, observer ratings were not employed in the present study.

Fourth, the study is limited in generalizability due to the fact that the project was conducted in a training clinic. It has been suggested that therapists in training differ from more experienced therapists on a number of dimensions. Studies indicate that they tend to feel more inadequate, use more conservative techniques, and may defensively distance themselves from clients more than do experienced therapists (Auerbach & Johnson, 1977). Because only inexperienced therapists participated in the study, it was impossible to test for the effects of experience level on therapy process variables. Thus, the findings reported here may be more

reflective of the therapists' inexperience than of the general process of therapy with children.

The fifth limitation of the study is that the methodology employed does not allow causal interpretation. The correspondence between child and therapist perceptions was examined through correlational procedures, revealing only the level of association among variables. Similarly, the group-by-time repeated measures ANOVA's allowed the exploration of level of process variable over time, but it was unclear whether or not the presence of the variable was the cause or the effect of group differences.

In addition, almost half the children in the study (45%) had family members who were in some type of therapy during the time of the study. It is clear that children can be effected by change in the family system, and one would expect more system change if more than one member participated in therapy. In some of these instances, periodic conjoint family meetings were held, as well. The amount of therapy received by the family system was not controlled in this study, and it may be that some of the positive change seen could have been attributed to treatments besides those studied here.

Finally, hindsight reveals the limitation of using

open-ended questions as a method of studying the child's goals for the session. Because categorical data were elicited in this section, the types of analyses possible pertaining to the child's goals for therapy were severely limited.

Bearing in mind the aforementioned limitations, the study yielded a number of findings that confirmed hypotheses relating to the process of child therapy. Significant findings were achieved in several areas, including internal consistency of instrument scales, correlations among and between scales, effects of time and group on various process measures, and effects of outcome.

#### Instrument Characteristics

Given that the CR is the first instrument designed to assess children's views of the process of individual psychotherapy sessions, the preliminary question under investigation was whether or not child clients' views could be measured reliably. Currently, instruments are in existence which tap the child's understanding of the general purposes and procedures of psychotherapy (Bonner & Everett, 1986; Kaser-Boyd et. al, 1986), but these instruments have been used to demonstrate a child's readiness for therapy or ability

to consent to treatment. None of these instruments have produced scales which empirically examine the child's affective experience during the therapy session and their perceptions of the therapist's feelings and behaviors within the session. Thus, the first major finding was that the CR produced seven scales with adequate levels of internal consistency.

Internally consistent scales of the CR included measures of the client's positive and negative affect, perceptions of positive and negative affect in the therapist, and perceptions of the therapist structuring the session, communicating warmth, and providing an accepting manner ( $r$ 's ranged from .67 to .86). This breakdown loosely parallels the scales produced in studies of adult therapy clients. In the therapist behavior section, scales were identical to those produced in adult studies, suggesting that basic therapeutic procedures or techniques are perceived similarly in both instances. Notably, these scales exhibited higher levels of internal consistency in this study ( $r$ 's  $>$  .68) than those evident with adult clients, where  $r$ 's ranged from .29 to .65. Affect scales adapted for this study measured global positive and negative affect in the client and therapist, as opposed to more

specific feelings measured on the adult instrument. While this finding might suggest that children are less able to differentiate more subtle feeling states, this difference may instead reflect different standards for internal consistency. The current author wished to develop scales with internal consistency figures of at least .65, whereas  $r$ 's on the adult instrument ranged from .29 to .65 on the nine affect scales.

In looking further at the characteristics of the CR, it appears that the open-ended questions in the C-Goals section were also able to tap specific process elements for children. In almost every question, responses were not randomly distributed, suggesting some type of characteristic response to the question. Unfortunately, it is difficult to interpret the pattern of these responses without the ability to analyze the responses further. An initial perusal of responses might suggest that children view therapy predominantly in terms of playing and enjoying themselves. A closer look, however, reveals that children do recognize and believe that therapy helps with problems, although they are unsure about the mechanism of change. In addition, the children in the study were invested in attending therapy, and had very few negative things to say about

therapy. In other sections of the CR, however, children were sometimes negative about certain elements of therapy. Thus, the relationship between the child's enjoyment of and investment in therapy and his/her negative evaluation of certain elements of the therapy process is unclear. Nevertheless, the ability of the CR to assess both negative and positive emotions of children is important, since ambivalence in client's feelings is likely to be a relevant dimension in many therapeutic situations.

Similar to the CR, the TR produced a number of internally consistent scales. These included the same seven scales listed above (positive and negative affect, perceptions of positive and negative affect in the child, structuring the session, communicating warmth, and providing an accepting manner). Three additional reliable scales in the therapist goals section were providing catharsis, providing insight, and encouraging independence. Reliability coefficients ranged from .61 to .88. As in the CR, it is striking that the therapist behavior section yielded identical scales to the original adult instrument, with higher internal consistency levels than reported with the original instrument, where  $r$ 's ranged from .25 to .32. Identical

scales were not produced in the remaining sections, however, which included child and therapist affect sections and therapist behavior. In the therapist goals section, three of five scales achieved adequate internal consistency, while in both affect sections, two of nine scales achieved adequate internal consistency. These findings may suggest that in working with child clients therapists experience a narrower range of affect and goals than with adult clients. As with the affect scales of the CR, however, a more likely explanation is different standards for acceptable internal consistency levels, as these levels ranged from .13 to .49 on the original instrument.

In summary, both the CR and TR yielded adequately reliable scales that measured dimensions of child and therapist affect and therapist behavior. The TR also produced scales relating to session goals, while this was measured with categorical variables on the CR. It is worthy of note that on both the CR and the TR, scales were consistently more reliable than those produced in studies with the original instruments (Howard, 1987). This finding suggests that child clients and their therapists may have more uniform or consistent experiences of the therapy process than do adult clients

and their therapists. The reasons for this difference are not clear. Because the study was completed in a training agency, it may be that participation in supervision tends to create a more uniform treatment. Currently, the psychotherapy research literature suggests the usefulness of supervision in standardizing the treatments under study (Kazdin, 1986; Strupp, 1986). Another possible reason for the high internal consistency of scale in this study lies within the process of child therapy. Some authors suggest that treatment of children follows a more uniform course than treatment of adults (McDermott & Harrison, 1977), in part due to the typical goal of returning the child to a normative developmental level (Phillips, 1987).

#### Patterns of Relationships among Scales

Another important set of findings relates to patterns of relationships within and between scales of the CR and TR. In examining these issues, it is important to note that adults studies have not usually employed correlational procedures to look at relationships among or between scales. Instead, second level factor analytic procedures were used to look for constructs which encompass more than one scale (Orlinsky & Howard, 1975). Thus, the ability to compare this study



to those in the adult literature regarding relationships among scales is limited.

The correlations obtained among the CR scales revealed two general patterns, one suggestive of positive experiences and the other of negative experiences. Moreover, each pattern of affective experience was associated with perceptions of different therapist behavior. The child's experience of therapist warmth, acceptance, and perception of therapist's positive affect was associated with the child's positive affect (average  $r = .61$ ). In contrast, the child's experience of the therapist structuring the session and perception of therapists negative affect are associated with the child's negative affect (average  $r = .71$ ). The high level of correspondence between the child's feelings and perceptions of the therapist's experience and behaviors may indicate the the child's experience is extremely reactive to the therapist's cues (Esman & Shapiro, 1984). Because these data are correlational, however, this interpretation must be made tentatively. It may be that rather than reacting to therapist's cues, for example, children at a concrete operational cognitive level may instead judge sessions negatively when they experience negative emotions (Dare, 1977),

which would explain the level of agreement between child affect and perception on therapist affect, as well as the dichotomy of positive and negative affect.

As mentioned earlier, the CT-Structuring scale was comprised of items relating to the therapist influencing what was talked about in the session. Given that some type of structuring of the verbal content by the therapist is essential in order to promote personality and/or behavior change (Shapiro & Esman, 1985), the fact that verbal structuring is perceived negatively by the child seems to suggest an instance of the children disliking something that is ultimately good for them. What may be missing from these dimensions of the CR, however, is a measure of positive influence or support that might be viewed less negatively by the child. In addition, it is difficult to interpret these findings without knowing whether the negative aspects of structuring the session related to differences in the child and therapist's goals for the session, since the child's goals were measured categorically and cannot be correlated with other scales.

Within the TR several scales were correlated, although a global patterning of process elements is not evident. In general, when therapists reported positive

affect they perceived it in their clients, and when they reported negative affect they perceived it in their clients. In terms of affect, then, both therapists and clients are likely to feel what they perceive the other is feeling, similar to findings in the adult literature (Orlinsky & Howard, 1975). There was not a negative correlation between positive and negative affect scales on the TR, suggesting that therapists did not experience a polarity between positive a negative affect, however. This finding, which contrasts to the pattern evident on the CR, could be explained by the therapists' ability to acknowledge the presence of conflicting feelings simultaneously (Shapiro & Esman, 1985), an ability that is less common in children.

Turning to therapists' goals and behaviors, it was predicted that scales within these sections would break down into two general dimensions. The first dimension represents directive, structured approaches to therapy and would be reflected through scales that measured encouraging independence, promoting insight, and structuring the session (Johnson et al., 1986). The other dimension would represent supportive, nondirective approaches and would be reflected through scales that measured promoting catharsis, communicating warmth, and

providing acceptance (Dare, 1977). In general, these hypotheses were not confirmed. All therapist goals for the session were highly intercorrelated, suggesting that therapists do not consider several theoretically divergent aims, as described above, mutually exclusive. Thus, therapists reports of providing catharsis, promoting insight, and encouraging independence were related. In contrast to the association between different goals, none of the scales measuring therapist behaviors was related. Contrary to what was expected, then, therapists simultaneously endorsed goals and behaviors common to both supportive and problem-oriented strategies. This finding suggests that therapists in the study employed the type of integrative model that has been described as increasingly prevalent in recent literature (Blom, 1977; Jones et al, 1988).

Rather than falling into a pattern of supportive versus directive approach, therapist goals and techniques seemed to relate highly to perceptions of negative affect in the child. Therapist reports of structuring the session and providing acceptance were associated with promoting catharsis and insight, as well as with a perception of negative affect in the child ( $r$ 's ranged from .45 to .78). Further, therapist reports

of communicating warmth were also related to perceptions of negative affect in the child ( $r = .72$ ). It may be that these therapist behaviors and goals reflect a mobilization of several therapy tools in reaction to perceptions of the child's negative feelings.

Another informative aspect of the correlational analyses involved exploring the relationship between scales of the CR and TR. There were significant correlations between perceptions of therapists and clients in the areas of therapist positive affect and therapist warmth, but these represent the only direct correspondence between the scales. It is notable that agreements occurred on scales relating to the therapist's behaviors and feelings. These findings alert one to the sensitivity of children in general. Recent research in developmental psychology suggests that even very young children are acutely aware of the feelings of others, particularly in those to whom they feel close (Stern, 1986). It is not surprising, then, that children would be attuned to the affect and level of warmth described by the therapist. The fact that children were aware of therapists' positive affect may also point out the needs of children in treatment to look for positive experiences in their therapists

(Taylor, et al., 1985). Given that children in treatment have typically experienced rejection and witnessed negative feelings in parents and teachers (Reisman, 1973), their sensitivity to the more positive environment of therapy appears to parallel to the tendency for adults to seek out a "corrective emotional experience" in therapy (Strupp, 1986).

Other correlations shed light on less positive aspects of therapy for the child. When therapists report higher levels of promoting insight, children experience lower levels of therapist acceptance ( $r = -.65$ ). Similarly, when therapists encourage independence, children report greater therapist negative affect ( $r = .61$ ). Again, these findings must be interpreted with caution given the inability to explore these variables according to stage in treatment. In general, however, it appears that when the therapist takes a more active stance, the child may interpret these actions as the result of the therapist's negative feelings, perhaps towards the child (GAP report, 1982).

The absence of correlations among other scales of the CR and TR is worthy of discussion. The child's perception of the therapist structuring the session was associated with negative affect, as mentioned above; but

the therapist's experience of structuring the session and the child's seem to be very different (i.e. they were not correlated). In like manner, there was no correspondence between the child's experience of the therapist's acceptance and the therapist's report of providing acceptance ( $r = .01$ ). Finally, the lack of agreement between the child and therapist's perceptions of the child's affect is puzzling as well as notable ( $r = .21$ , n.s.). Therapists are trained to recognize feelings that are not expressed directly in children as well as in adults (Halpern & Kissel, 1976), which may explain the discrepancy. Yet one wonders if this tendency to look beyond the obvious may lead therapists to miss basic elements of the child's affective experience within the therapy session.

### Effects of Time

An important finding obtained in this study is that children's and therapists' responses differed significantly over time. In general, children's responses exhibited a drop in positive experience after time two, which then gradually increased. Therapists responses revealed a tendency for an increase in structuring the session, promoting catharsis, promoting insight, and encouraging independence over the six sessions examined.

More specifically, children's feelings changed over the six sessions. Children's positive affect dropped following the second time then increased thereafter, while negative feelings exhibited the opposite pattern. Similarly, the child's perception of therapist acceptance was initially high, then dropped following the second time, and generally increased over the last few sessions.

Current findings seem to reflect a microcosm of the types of experiences expected in different stages in treatment (Sloves & Peterlin, 1986), and warrant a brief discussion of global changes that would be expected in process measures in various therapy stages. Very generally, most theories pertaining to therapy stages highlight an early stage in which the client feels very positively about the therapist and is optimistic about change. Following this period, a middle stage ensues in which the client becomes disillusioned with the therapist and faces the frustration of the problems for which therapy was sought. The client begins to approach problems differently with the help of the therapist, and develops a more realistic positive relationship with the therapist. Finally, the client feels better able to cope with the original problems, and therapy is terminated.



Within the current study, at time one children report initially positive feelings and perceive high levels of therapist acceptance. After the second time, children's positive feelings, perception of therapists' positive feelings, and perceptions of therapists' acceptance dropped, which would suggest that children were entering the middle phase of treatment. Following these negative perceptions, however, children began to experience higher levels of positive affect and therapist acceptance. Some variations were evident among later sessions, but the primary trends were the initial drop followed by an increase in positive variables, which is consistent with the notion that positive experiences gradually increase as problems are faced and begin to be resolved therapy stages (McDermott & Char, 1984). Because stage in treatment could not be tested directly, this interpretation is necessarily tentative, but findings suggestive of pattern in children's perceptions of therapy are highly provocative.

Several scales of the TR also revealed change over time. The general pattern in therapists' reports of promoting catharsis and structuring the session was similar; in each case, there was a tendency for therapists to increase both activities significantly

following the first and second times. Increases continued over time, with a slight but insignificant decrease in the last time. This pattern may indicate that therapists feel that the use of these techniques and aims becomes gradually more appropriate as their relationship with the child deepens (Halpern & Kissel, 1976). Further, these changes are also suggestive of a middle, or problem-solving, stage in therapy (Sloves & Peterlin, 1985) that begins at approximately time two. Changes within therapist reports of promoting insight and encouraging independence also revealed similar patterns. In both scales there was an initial drop following the second time, with a significant increase over the last three times. The reason for the drop at time two is unclear; as mentioned above, there is a rise in child negative affect at time two, and it may be that the child's feelings served as an indicator to the therapists that they should temporarily decrease the use of these interventions.

Numerous authors have highlighted the need to examine a sequence of therapy sessions in order to understand process elements (Windholz & Silberschatz, 1988), yet the most prevalent method of studying process to date is to average scores over sessions or to examine

only one session (Greenberg, 1986). In fact, many studies concentrate on only a small portion of one session in order to examine the therapy process (Jones et al., 1988). One question which has plagued psychotherapy researchers is whether process instruments are sensitive to small increments of change (Jones et al., 1988). The presence of significant change in process variables on both the CR and TR during a three month period, then, is extremely significant.

#### Group Differences over Time

The next set of findings pertains to differences in process variables of the CR and TR according to the diagnostic group of the child and to the level of symptom change exhibited by the child. Interestingly, although the CR yielded significant findings in the areas already discussed, the TR was much more highly related to differences according to diagnostic group or to client symptom change than was the CR.

Diagnostic Group Differences. Group differences were evident on scales of the TR, although not in the areas predicted. It was anticipated that therapists would report structuring the session and promoting insight more frequently with externalizers. It was also predicted that therapists would use catharsis,

acceptance, and warmth more with internalizers (GAP,1982). While therapists tended to promote insight more with externalizers than with internalizers, mean differences were not significant, and expected differences did not emerge in the other scales listed above. Instead, therapists reported higher levels of positive affect with externalizing clients, and perceived more positive affect in these clients. This finding may relate to the fact that therapists in the study were in training and had limited therapy experience with children. In a systematic review of outcome research with children, Weisz et al. (1987) reported that experienced therapists were more successful than were beginning therapists with overcontrolled clients. New trainees may perceive the withdrawn, depressed behavior seen in overcontrolled children as rejection, or may find such behavior difficult to tolerate in children (Reisman, 1973).

Although there was no main effect for diagnostic group on therapists' use of catharsis, there was a group-by-time interaction which reveals a pattern very consistent with the literature. Therapists were consistent in promoting catharsis with externalizers, but began by promoting relatively less catharsis with

internalizers, then increasing over the six sessions until catharsis was promoted more with internalizers than with externalizers. It appears that therapists expected internalizers to feel more discomfort than externalizers when they were expected to show feelings, and chose a gradual increase in promoting catharsis with internalizers (Robins, 1979).

Another group-by-time interaction was evident in therapist reports of communicating warmth. Initially therapists communicated less warmth with internalizers, and their use of warmth was variable across the six sessions with this group; with externalizers, however, therapist warmth was initially higher, dropped at time two, and then rose to remain fairly constant. The variable nature of communicating warmth to internalizing clients may also relate to the therapists lack of experience (and possible feelings of incompetence) with children exhibiting these types of symptoms (Auerbach & Johnson, 1977).

Interactions between diagnostic group and time were also found on BPRS scales, including the motor agitation scale. As would be expected, externalizers were rated more highly on this scale, but their rating dropped over the six sessions, while for internalizers rating

increased during the middle three sessions. Further, a similar interaction was evident in the total symptom scale of the BPRS. These patterns are consistent with the literature relating to differing goals for therapy with both types of children; one would expect that the structure of the therapy hour would decrease the motor activity of the externalizing child, while the support and acceptance provided in therapy would allow the internalizing child to express more agitation and overt symptomology (Ponzo, 1984).

Interestingly, there were no significant differences between diagnostic groups on any of the scales of the CR, nor were there significant interactions between group and time on the CR. It was initially predicted that externalizers would perceive higher levels of structuring due to the need for limit setting with these children, and that internalizers might report higher levels of therapist warmth and acceptance (Reisman, 1973). Instead, what is most notable is the lack of differences between groups. It seems that whatever the child's presenting problem, the most salient elements of the therapy process, in the child's view, are similar. Whether this finding reflects a limitation of the sensitivity of the CR or the

uniqueness of the current sample, however, is unclear.

Outcome Differences. The first major finding of interest is that there were significant improvements in symptoms over the six sessions. Improvements were evident on the motor agitation, organicity, and thinking disturbance scales, as well as on the total symptom scale. Further, these differences were evident when using residual scores to account for initial level of symptomology. A recent meta-analysis of child psychotherapy outcome suggests that the majority of children do show symptom improvement after therapy (Weisz et al., 1987), which is consistent with these findings. As mentioned earlier, however, measures of client improvement were based on therapist report only, therefore these findings must be interpreted with caution.

Findings pertaining to the factors which relate to or promote symptom change are difficult to interpret, as well. There were no client improvement group differences on any of the CR or TR scales, suggesting that the simple presence or absence of a particular diagnostic or process variable was not responsible for positive outcome. Further, there were no interactions between client improvement group and time on the CR.

This suggests that children's perceptions of the therapy process, at least in the dimensions measured in this study, are not related to improvement during the period of study.

In contrast, there was an interaction between client improvement and time on three scales of the TR. This finding is similar to findings in adult therapy studies, which reveal that therapist perceptions of the therapy process are most frequently related to symptom change (Orlinsky & Howard, 1986). Within the high client improvement group, therapists gradually increased their use of encouraging independence, then decreased in the sixth time. Within the low change group, therapists dropped their use of independence in the second time, increased thereafter, and increased dramatically in the sixth time. It is difficult to know whether the extreme differences in the sixth time are the cause or the effect of change within each group; it may be that when change became evident therapists felt it was possible to discontinue their encouragement of independence, while the lack of change in the other group caused them to increase this encouragement.

Interactions were also evident in the therapists' positive feelings and their perceptions of the child's



positive feelings. In both instances, therapists reported higher levels of positive affect in the low change group, which decreased by the sixth time. In the high change group, positive feelings were initially lower, then increased beyond those described in the low change group. Again, it is difficult to know whether this pattern is the cause or the effect of symptom change. Because the study was done with relatively inexperienced therapists, it may be that these perceptions reflect disappointment in the lack of change (Auerbach & Johnson, 1977). Looking to the adult therapy literature, negative perceptions may also reflect the therapists reaction to the client's decreased involvement in the therapy process (Windholz & Silberschatz, 1988). This variable has been significantly related to change in several adult studies, but was not measured in the current study.

#### Implications of the Study

The primary implication of the study relates to the fact that the CR appears to provide a reliable and sensitive means of measuring the child's perception of the therapy process. Numerous references in the literature point to the difficulties of doing psychotherapy research with children (Mannarino, 1982;

Phillips, 1987), while there is an equal abundance of sources highlighting the need for such research (Weisz et al., 1987). The cooperativeness of the child subjects in the study, the internal consistency of the CR scales, and the confirmation of several theoretically-based hypotheses point to the usefulness of the methodology employed in this study.

As alluded to in the limitations delineated in the beginning of this section, several modifications could be made to further enhance the study of the process of child therapy. First, a larger number of subjects need to be studied. With a greater number of subjects, both the CR and TR could be factor analyzed to confirm the factor structure of the scales. Such data would provide valuable information on the dimensions of child therapy as viewed by the child and the therapist and the correspondence between the child and therapist's perspectives.

In addition, with a greater number of subjects results could be analyzed by stage in treatment as well as by diagnosis and client improvement group. Several findings from the current study suggest the presence of different process variables according to changes in stage of treatment (Mann, 1976), but this could not be

measured directly in the present study.

The second major modification would involve changing the format of the C-Goals section to a Q-sort response to allow a more complete statistical analysis of this section. Within the TR, sections on therapists' goals and behavior were not related in the expected manner. Given this discrepancy, it would be especially important to include the child's perception of therapy goals in future studies.

Further, in future studies outcome measures could be completed by parents, teachers, and other sources. Psychotherapy studies done with adults suggest that therapists recognize client change more quickly and consistently than do clients and other observers (Windholz & Silberschatz, 1988), which suggests the importance of including other sources of outcome data. In order to more closely parallel studies with adults, it would also be useful to include a self-report outcome rating by child clients (Strupp, 1986).

Other implications relate to possible extensions of the use of the TR. It appears that the high level of cooperation by therapists in the study may relate to the fact that it is a training agency. Therapists expressed interest in the measure, and it seems that the measure

could be useful in supervision. In the adult psychotherapy literature, authors often mention therapists' increased awareness of the psychotherapy process as one of the benefits of research (Kazdin, 1986). Within a training agency, this benefit seems especially relevant. Increasingly, psychotherapy research has been described as a tool which describes the therapy process (Strupp, 1986). It seems clear that this type of descriptive process could have broad educational benefits.

The TR might also be modified for use by independent observers. The use of audio or video tapes would add an important dimension to the study of child psychotherapy and would counter the limitation of relying solely on self report data that exists in the present study (Gendlin, 1986). The adult version of the TR has been useful in rating adult therapy sessions (Windholz & Silberschatz, 1988), and it appears highly likely that the child version of the TR could be used for the same purpose.

### Conclusion

In sum, the findings obtained in this study can be likened to pieces in a jigsaw puzzle. While the puzzle is incomplete, the pieces that have emerged provide an

intriguing outline of the child therapy process. The basic form of the puzzle is supplied by the finding that both the CR and TR yield highly reliable scales. In turn, this form allows the testing of several types of empirical questions. The view we are afforded of the therapy process is comprised of measures of child and therapist affect, therapist behavior, and therapist goals. Interestingly, the structure provided by these scales is highly similar to that seen in studies with adults. The section which was not designed to produce scales, C-Goals, was characterized by responses which were not randomly distributed, suggesting that this section could also produce internally consistent scales.

An area beginning to come into focus relates to patterns of responses among scales. A major image that emerges is that children tend to view the session as essentially positive or essentially negative. Notably, the only therapist behavior associated with the child's negative perception was structuring the session. It appears that therapists should not be distressed about their use of structuring the session as a therapeutic technique, however, as this variable was not associated with negative outcome. In fact, none of the scales on the CR was related to outcome. This may suggest either

that children's negative views of the therapy process do not inhibit change, or may indicate that the limited perspective inherent in the current measure of outcome is not reflective of children's views of their symptom improvement.

While patterns on the CR were relatively clear-cut, there was little agreement between child and therapist reports of process variables. Among the more provocative pictures drawn from the correspondence between scales was that children were sensitive to therapists expression of warmth and experience of positive affect. Other images suggest less positive experiences for children, however. For example, as therapists reported increasing their use of promoting insight, children perceived higher levels of negative feelings held by the therapist. Similarly, as therapists reported increased promotion of insight, children experienced less therapist acceptance.

Another important area of the child therapy puzzle relates to changes in process over time. Significantly, both the TR and CR were sensitive to these variations. Overall, findings suggest that children tended to express more positive and fewer negative feelings over time, and their perception of therapist acceptance also

increased. Therapists use more catharsis, insight, encouraging independence, and structuring the session, although these patterns were not entirely linear. These changes provide an illustration that generally corresponds to therapy stages which have been described in recent literature. Children's positive experiences dropped in the second time, suggesting a sense of disillusionment after initially positive feelings. However, positive experiences continued to increase gradually following this period, indicating the continued building of the therapeutic relationship (Sloves & Peterlin, 1985). Therapists decreased the use of active and direct techniques in the second time, possibly in response to child negative affect. Next, these therapist behaviors increased during the middle times, perhaps indicating a problem-solving phase of treatment (Esman & Shapiro, 1985). Further, the use of these techniques decreased in the sixth time, suggesting a resemblance to the termination phase (Parloff, 1986).

Other aspects of the study give glimpses of differences over time by diagnostic group and client improvement group. Although these patterns are incomplete, variations in the therapy process in each of these groups seemed to reflect both planned strategies

by the therapist and the effects of therapist inexperience. Within the configuration relating to planned strategies, therapists incrementally increased their promotion of catharsis with internalizers. This picture is consistent with theoretical recommendations regarding treating these children (Reisman, 1973). Similarly, symptom changes differed in accordance with theory. Symptoms of externalizers decreased, while internalizers exhibited an increase in symptoms in the middle sessions. This pattern suggests that therapists provided support that allowed internalizers to exhibit some of the symptoms which had been overcontrolled. Further, images of client improvement represent behavior consistent with therapy guidelines. Therapists tended to decrease their use of encouraging independence when change is evident, but show an increase in this variable when there is no change (Parloff, 1986)

Another pattern seems to depict the results of therapist inexperience or frustration. The variations seen in therapist reports of communicating warmth with internalizers seem to reflect feelings of inadequacy that stem from the withdrawn behavior of these children (Auerbach & Johnson, 1977; Wiesz et al., 1987). In a related vein, therapists feel and perceive lower levels



of positive affect with clients who do not exhibit positive change, illustrating the frustration that results from little progress. Interestingly, this pattern is consistent with research on adults clients and with experienced therapists (Orlinsky & Howard, 1977).

In conclusion, this study provides an intriguing view of the child therapy process, particularly because it incorporates the child's perspective. At present, the picture that emerges from these findings is not fully formed. However, the success of the methodology and the results obtained are revealing. We see that children and child therapists can report on meaningful aspects of the therapy process. In doing so, their reports are similar in form to those seen in adult therapy studies. Secondly, reports vary over time in patterns suggestive of therapy stages. Further, therapists employ differential treatment according to diagnosis. Positive outcome was evident in this study, and information emerged on variables associated with positive outcome. Current findings also give shape to the contours of the missing pieces necessary to obtain a more thorough picture of child psychotherapy. Most importantly, the study illustrates the possibility that

the therapy process with children can be measured as reliably and sensitively as it has been with adults.

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**APPENDIX A**

Note. Items marked with an \* were retained in scales for final analyses.

### Child Therapist Therapy Session Report

This sheet contains a series of questions about the therapy session which you have just completed. These questions have been designed to make the description of your experiences in the session simple and quick.

The questions are followed by a series of number on the right-hand side of the page. After you read each of the questions, you should circle the number "0" if your answer is "no..." Circle the number "1" if your answer is "some," etc.

Once you have become familiar with the questions, answering them should take only a few minutes. Please feel free to write additional comments in the space provided when you want to say things not easily put into the categories provided.

BE SURE TO ANSWER EACH QUESTION.

Client Identification \_\_\_\_\_  
 Therapist Identification \_\_\_\_\_  
 Date of Session \_\_\_\_\_  
 (Therapist Goals)

In what direction were you working with your client this session?

(For each item, circle the answer which best applies.)

I was working toward:

	No	Some	A Lot
1. Helping my client feel accepted in in our relationship.	0	1	2
2. Getting a better understanding of my client, of what was really going on.	0	1	2
*3. Helping my client talk about his (her) feelings and concerns.	0	1	2
*4. Helping my client get relief from tensions or unhappy feelings.	0	1	2
*5. Helping my client understand the reasons behind his (her) reactions.	0	1	2
6. Supporting my client's self-esteem and confidence.	0	1	2

	No	Some	A Lot
*7. Encouraging attempts to change and try new ways of behaving.	0	1	2
*8. Moving my client closer to experiencing emergent feelings.	0	1	2
*9. Helping my client learn new ways for dealing with self and others.	0	1	2
10. Establishing a genuine person-to-person relationship with my client.	0	1	2
*11.Helping my client get better self control over feelings and impulses	0	1	2
*12.Helping my client realistically evaluate reactions and feelings.	0	1	2
13. Sharing empathically in what my client was experiencing.	0	1	2
14. Getting my client to take a more active role and responsibility for progress in therapy.	0	1	2
15. Encouraging my client to review progress already made in therapy.	0	1	2
*16.Helping my client plan behavior outside the session.	0	1	2

(Therapist Interpersonal Behavior)  
During this session, how much:

	None	Some	A Lot
*1. Did you talk?	0	1	2
*2. Were you attentive to what your client was trying to get across?	0	1	2
*3. Did you tend to agree with or accept your client's ideas or suggestions?	0	1	2
*4. Were you critical or disapproving towards your client?	0	1	2
*5. Did you take initiative in defining the issues that were talked about?	0	1	2
*6. Did you try to change your client's point of view or way of doing things?	0	1	2
*7. Were you warm and friendly towards your client?	0	1	2
8. Did you express feeling?	0	1	2
*9. Did you play with the client?	0	1	2
*10.Did you observe the client in play?	0	1	2



	None	Some	A Lot
*11. Did you attempt to nurture or support the client?	0	1	2
*12. Did you offer novel solutions to the client's problems?	0	1	2

How did your client seem to feel during this session?  
(For each item, circle the answer which best applies)

*1. Confident	0	1	2	*18. Affectionate	0	1	2
*2. Embarrassed	0	1	2	19. Serious	0	1	2
*3. Relaxed	0	1	2	*20. Anxious	0	1	2
*4. Withdrawn	0	1	2	21. Angry	0	1	2
5. Helpless	0	1	2	*22. Pleased	0	1	2
*6. Determined	0	1	2	*23. Inhibited	0	1	2
*7. Grateful	0	1	2	24. Confused	0	1	2
*8. Relieved	0	1	2	*25. Discouraged	0	1	2
9. Tearful	0	1	2	*26. Accepted	0	1	2
*10. Close	0	1	2	27. Cautious	0	1	2
11. Impatient	0	1	2	*28. Frustrated	0	1	2
*12. Guilty	0	1	2	*29. Hopeful	0	1	2
*13. Strange	0	1	2	*30. Tired	0	1	2
*14. Inadequate	0	1	2	*31. Ill	0	1	2
*15. Likeable	0	1	2	32. Sexually attracted	0	1	2
*16. Hurt	0	1	2	33. Other _____	0	1	2
*17. Depressed	0	1	2				

### Therapist Feelings

How did you feel during this session?  
(For each item, circle the answer which best applies.)

*1. Confident	0	1	2	*18. Affectionate	0	1	2
*2. Embarrassed	0	1	2	19. Serious	0	1	2
3. Relaxed	0	1	2	*20. Anxious	0	1	2
4. Withdrawn	0	1	2	*21. Angry	0	1	2
*5. Helpless	0	1	2	*22. Pleased	0	1	2
6. Determined	0	1	2	*23. Inhibited	0	1	2
*7. Grateful	0	1	2	*24. Confused	0	1	2
8. Relieved	0	1	2	*25. Discouraged	0	1	2
*9. Tearful	0	1	2	*26. Accepted	0	1	2
*10. Close	0	1	2	27. Cautious	0	1	2
*11. Impatient	0	1	2	28. Frustrated	0	1	2
*12. Guilty	0	1	2	*29. Hopeful	0	1	2
*13. Strange	0	1	2	30. Tired	0	1	2
*14. Inadequate	0	1	2	31. Ill	0	1	2

## APPENDIX B

Note. Items marked with an \* were retained in scales for final analyses.

### Child Session Report Responses

Child's Name \_\_\_\_\_  
 Child's Number \_\_\_\_\_  
 Date \_\_\_\_\_  
 Examiner \_\_\_\_\_

Part I - Child's Feelings - Please put 2 to indicate, "A lot," 1 to indicate, "A little," or 0 to indicate, "Not at all."

- \*1. safe \_\_\_\_\_ \*2. sad \_\_\_\_\_ \*3. cheerful \_\_\_\_\_  
 \*4. stubborn \_\_\_\_\_ \*5. proud \_\_\_\_\_ \*6. made \_\_\_\_\_  
 \*7. happy \_\_\_\_\_ 8. tired \_\_\_\_\_ \*9. scared \_\_\_\_\_  
 \*10. bored \_\_\_\_\_ \*11. relaxed \_\_\_\_\_ \*12. liked \_\_\_\_\_  
 \*13. angry \_\_\_\_\_ \*14. worried \_\_\_\_\_

Part II - Child's Perception of Therapist Behavior  
 Please indicate "A lot" with 2, "A little" with 1, and "Not at all" with 0.

- \*1. My therapist played with me a lot this session. \_\_\_\_\_  
 \*2. My therapist watched me while I played. \_\_\_\_\_  
 \*3. My therapist listened while I talked. \_\_\_\_\_  
 \*4. My therapist was friendly this session. \_\_\_\_\_  
 5. Today my therapist paid attention to me. \_\_\_\_\_  
 6. Today my therapist was thinking of other things besides me. \_\_\_\_\_  
 \*7. My therapist talked a lot this session. \_\_\_\_\_  
 8. I did most of the talking this session. \_\_\_\_\_  
 9. My therapist chose things for us to do this session. \_\_\_\_\_  
 10. My therapist let me choose what to do this session. \_\_\_\_\_  
 \*11. My therapist had rules about what I could and could not do. \_\_\_\_\_  
 \*12. I chose what to talk about today. \_\_\_\_\_  
 \*13. Today my therapist chose what to talk about. \_\_\_\_\_  
 \*14. My therapist made me feel I did something wrong this session. \_\_\_\_\_  
 \*15. My therapist made me feel I did something right. \_\_\_\_\_  
 \*16. My therapist let me do whatever I wanted this session. \_\_\_\_\_  
 \*17. My therapist liked my ideas today. \_\_\_\_\_  
 \*18. My therapist wanted me to change my mind today. \_\_\_\_\_

19. My therapist and I worked together during this session. \_\_\_\_\_

20. I did lots of work during this session. \_\_\_\_\_

21. I was very busy in therapy today. \_\_\_\_\_

### Part III - Child's Aims and Understanding of Goals of the Session

E. - Children come to therapy for lots of reasons and try to do different things in therapy. Now I want you to answer some questions about how therapy is for you. There is no right or wrong answer; I just want to know what you think.

1. Why do you come to therapy? \_\_\_\_\_

2. What problems did you want to work on in therapy today? \_\_\_\_\_

3. How does therapy help you with your problems? \_\_\_\_\_

4. What do you like the best about therapy? \_\_\_\_\_

5. What is the worst thing about therapy? \_\_\_\_\_

E. Now I will read two sentences to you and you can tell me which one you like best or agree with the most. (Please circle the response given.)

6. Would you rather
  - a. leave therapy early or
  - b. stay late in therapy
7. Would you rather
  - a. talk about problems
  - b. talk about other things
8. Would you rather
  - a. come to therapy
  - b. stay at home and play

Part IV - Child's Perception of Therapist's Feelings  
Please indicate, "A lot," with 2, "A little," with 1,  
and "Not at all," with 0.

- \*1. safe\_\_\_\_      2. sad\_\_\_\_      \*3. cheerful\_\_\_\_  
\*4. stubborn\_\_\_\_      \*5. mad\_\_\_\_      \*6. proud\_\_\_\_  
\*7. tired\_\_\_\_      \*8. happy\_\_\_\_      \*9. scared\_\_\_\_  
\*10. relaxed\_\_\_\_      \*11. bored\_\_\_\_      \*12. liked\_\_\_\_  
\*13. angry\_\_\_\_      \*14. worried\_\_\_\_

## APPENDIX C







## APPENDIX D

## Coding Responses

1. Why do you come to therapy?
  - 0 = don't know
  - 1 = I'm required to
  - 2 = It helps with problems
  - 3 = I like it, it's fun
  - 4 = To talk
  
2. What problems did you want to work on in therapy today?
  - 0 = Don't know
  - 1 = None
  - 2 = School
  - 3 = Parents
  - 4 = Family
  - 5 = Peers
  - 6 = Termination
  - 7 = Relationship with therapist
  - 8 = Other
  
3. How does therapy help with your problems?
  - 0 = Don't know
  - 1 = Expression of feelings, talking
  - 2 = Solving problems
  - 3 = Relationship
  - 4 = Helps-generic
  
4. What is the best thing about therapy?
  - 0 = Don't know
  - 1 = Nothing
  - 2 = Playing
  - 3 = Relationship
  - 4 = Helps with problems
  - 5 = Enjoyment
  
5. What is the worst thing about therapy?
  - 0 = Don't know
  - 1 = Nothing
  - 2 = Talking about problems
  - 3 = Missing events
  - 4 = Relationship, restrictions
  - 5 = Too short

APPROVAL SHEET

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The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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