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An Examination of the Process of Child Psychotherapy Across Stages in Treatment

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AN EXAMINATION OF

THE PROCESS OF CHILD PSYCHOTHERAPY

ACROSS STAGES IN TREATMENT

by

Ruth Cliffer Greenthal

A Dissertation

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VITA

Ruth Cliffer Greenthal, the daughter of Cecile Adler Cliffer and the late Harold Jacob Cliffer, was born on April 10, 1957 in Harvey, Illinois. Ruth obtained her secondary education at Rich Central High School in Olympia Fields, Illinois, graduating in June 1975. In June 1979, Ruth graduated from Northwestern University with a Bachelor of Arts, with a double major in psychology and sociology.

Ruth worked as a mental health worker following her college graduation, first at Children's Memorial Hospital in the Division of Child Psychiatry and later on the Adolescent Psychiatric Inpatient Unit at Northwestern Memorial Hospital.

Ruth entered graduate school in the Clinical Division of the Department of Psychology at Loyola University of Chicago in 1983. She received her master's degree in 1986. During graduate school, she worked as a therapist at the Charles I. Doyle Center and at Loyola's Student Counseling Center. Ruth completed a year of clinical internship training at Ravenswood Hospital Community Mental Health Center, where she has since been employed part-time as a staff therapist.

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INTRODUCTION

Most clinicians are aware that without attention to the "process" in a psychotherapy session, the treatment may suffer miserably. Orlinsky and Howard (1986), two of the foremost authors in the area of adult process and outcome research, define process as "everything that can be observed to occur between, and within, the patient and therapist during their work together" (pp. 311,312). Orlinsky and Howard summarized over 1100 adult therapy studies that analyzed process variables in relation to outcome, and found that certain variables were significantly related to the effectiveness of adult psychotherapy.

Most research on child therapy has been on efficacy or outcome. The latest in-depth meta-analytic reviews (Casey & Berman, 1985; Weisz, Weiss, Alicke & Klotz, 1987) indicate that child therapy is better than no treatment for children. Therefore, it makes sense for researchers to move toward a better understanding of what happens between therapists and their child clients during therapy.

Few studies have examined the process of child

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psychotherapy. Some early studies (Snyder, 1945; Landisberg & Snyder, 1946; Moustakas & Schlalock, 1955) found that there were processes and therapist behaviors that defined nondirective play therapy, but that it was difficult to distinguish problem children from normal children according to interactions in therapy. In 1972, Wright, Truax, and Mitchell attempted to develop reliable process ratings during child therapy, but this research area was not pursued in subsequent studies.

One pertinent question of research on the process of psychotherapy is how the process changes over time, as treatment proceeds. The literature is clearly deficient in assessments of the child therapy process. The present study builds upon a previous empirical investigation of the process of child therapy (Tucker, 1988). Tucker adapted Orlinsky and Howard's (1975) adult measures for use with child clients and their therapists, yielding the Child Report (CR) and the Therapist Report (TR). The variables Tucker studied were therapist and child affect, perception of each other's affect, therapist and child goals, and both therapist and child perceptions of therapist behavior in session. Tucker's major finding was that the Child Report (CR) and Therapist Report (TR) produced scales with adequate levels of internal consistency, and that

these scales either closely paralleled or were identical to the scales produced in studies of adult therapy clients. Although Tucker suggested that her results were influenced by using only beginning therapists, she could not demonstrate this empirically because she had no advanced therapists in her sample. Tucker's data suggested that changes may occur in the process of therapy over time; however, the investigation did not sample from a broad enough range of time to yield data from the beginning to end of treatment.

Tucker's (1988) study, while promising and pioneering, left several questions unanswered. Most importantly, how do process variables relate to stages in treatment? Investigating stages in treatment will assist us in gleaning a deeper and richer understanding of the process of child therapy over time. The present study employs Tucker's process measures, with some revisions.

The present study was designed to explore the relationship between process variables and stages in child psychotherapy. The process variables were the therapists' and the child clients' own feelings, their perceived feelings of each other, their session goals, and their perceptions of therapist behavior in the session. An effort was made, first, to replicate

Tucker's (1988) findings regarding internal consistency of the CR and TR. Next, the present study explored how the therapeutic process changes over time, as a function of three stages in treatment. These stages have been defined and described by numerous therapists and writers in the field of psychology: 1) rapport-building, 2) working, and 3) termination.

The Therapist Report, the Child Report-Revised, and the Stage Form were used to measure the variables of interest. The first two measures were originally developed by Tucker (1988), as adaptations of Howard and Orlinsky's (1975) Therapy Session Report. The Stage Form, developed by this researcher, was used by the therapist to identify stage of treatment.

The major hypothesis of this study was that the process of child treatment would differ across stages. Accordingly, the data were expected to reveal significant differences in process across the three stages of treatment such that structuring, insight and catharsis would be highest in stage 2, encouraging independence would be highest in stage 3, and children would understand their treatment goals best in stage 3.

Results were also expected to replicate Tucker's (1988) data regarding levels of internal consistency for the TR and CR scales, showing that process variables in

child therapy can be measured as reliably and sensitively as in adult therapy. The revised Child Goals scales were expected to reach adequate levels of internal consistency. It was also expected that children's affect would be positively and significantly associated with their perceptions of their therapists' affect. Data were collected at two mental health centers; the influence of agency, level of experience, and diagnostic category on the stage data was tested.

In summary, this study was designed to assess empirically how the process of treatment might differ as a function of stages, adding a new dimension to our current comprehension of psychotherapy with children. The results of this work should provide a better understanding of how the process of child psychotherapy unfolds over time.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

Introduction

    There are five sections in this literature review.
The first section summarizes general findings in child
psychotherapy research,   focusing on   the   need for
detailed research on the   process of child treatment.
Next, stages in treatment are discussed. The third
section presents a synthesis of stages in treatment,
including a breakdown of the three stages that stand out
in the literature: rapport-building, working, and
termination.   A brief section about research on stages
follows.   After that, the present study is described and
the hypotheses are presented.

Research in Child Psychotherapy

    In the early years of child psychotherapy research,
the primary focus was on outcome. For example, earlier
studies of child treatment usually examined whether
treatment was more effective than no treatment, or
superiority of certain treatments over others. Eysenck
(1952) and Levitt (1957, 1963), for example, found that
there was little difference between treated and
nontreated children. Barrett, Hampe and Miller (1975)

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questioned the adequacy of psychotherapy research with children, and pointed to the lack of response to such controversial findings regarding the effectiveness of therapy.

More recent data and conclusions differ from the early findings on the effectiveness of child therapy. The latest meta-analytic reviews of child treatment have used more rigorous methodologies and have drawn from a wider, more sophisticated research base than did earlier reviews. Casey and Berman (1985) reviewed seventy-five studies and found that child therapy is similar in effectiveness to therapy with adults; that is, treated children achieved outcomes about two-thirds of a standard deviation better than untreated youngsters. Weisz, Weiss, Alicke and Klotz (1987) reviewed 108 well-designed studies and concluded that therapy was more effective for children than for adolescents, and that across various outcome measures, the average treated child was better adjusted after treatment than 79% of those not treated.

Given the magnitude of these recent findings, Casey and Berman (1985) suggest that there is reason for optimism about the effectiveness of therapy with children. The authors suggest that previous doubts about the overall efficacy of psychotherapy with

children can be laid to rest. They maintain that the state of research on child psychotherapy is still incomplete in certain important respects; missing features often include clear diagnostic information, or careful descriptions of treatment, particularly for nonbehavioral therapies. In agreement with Casey and Berman, Cass and Thomas (1979) point to limitations of the focus on treatment outcome without attention to the therapy process itself. Basically, Cass and Thomas suggest that more attention to the process of therapy would enable future research on psychotherapy with children to be more directly applicable to clinical practice.

Process Research

In the mid-1940's, formal investigations of the process of child therapy began. Snyder (1945) was among the first to investigate the nature of non-directive play therapy, with a focus on process. On the basis of four cases, which generated 5751 analyzable statements, Landisberg and Snyder (1946) concluded that there were processes and therapist behaviors that defined nondirective play therapy. For example, they found that therapists were nondirective, that the therapist made only 40 percent of the responses, and that the nondirective response "reflection of feeling" preceded

57 percent of all client responses.

Moustakas and Schlalock (1955) analyzed therapist-child interaction in play therapy. Subjects were ten four-year-old nursery school children classified as "without emotional problems" and another five children rated as having emotional problems sufficient to impair personal and social relations in nursery school. Two of the ten children without problems were seen for one 40-minute play session, and the remainder were seen for two such sessions. This investigation involved 4610 observations for the first group and 4934 for the disturbed group. The authors concluded that the two groups were more alike than different in their interactions, but that "problem" children spent more time than normal children in noninteractive play that did not involve the therapist.

Nearly 20 years later, Wright, Truax and Mitchell (1972) investigated the possibility of obtaining reliable process ratings during child psychotherapy. Trained raters were presented video tape segments from each of two therapy interviews. The following variables were rated: accurate empathy (AE), nonpossessive warmth (NPW), and genuineness (GEN). Therapists included four clinical child psychologists, six third-year psychiatry residents, and six clinical psychology trainees.

Interrater reliabilities were low but statistically significant (r's were .72 for AE, .52 for NPW, and .34 for GEN). These findings suggested that process ratings of child psychotherapy might, with further development, become practical and useful. Wright, Truax and Mitchell developed instruments parallel to those used in adult psychotherapy research, but to this author's knowledge, the measures they developed have not been used by subsequent researchers.

Orlinsky and Howard's (1986) Model of Process Research in Adult Therapy

Orlinsky and Howard have examined extensively both process and outcome in adult psychotherapy. These authors reviewed over one thousand studies that analyzed process variables in relation to outcome, in order to determine what is "effectively therapeutic" about psychotherapy. The studies included in their review involved those with real clients in actual treatment settings, spanning 35 years of scientific research. The studies evaluated process via client report, therapist report, and/or observer rating, and measured outcome from a variety of perspectives as well. The authors looked at a large number of process variables, including: the therapeutic contract; therapeutic interventions made by therapists; patient participation

in therapeutic interventions; the therapeutic bond; therapist role-investment and parallel aspects of patient role-investment; empathic resonance; mutual affirmation; overall quality of the therapeutic bond; patient self-relatedness; therapeutic realization; and treatment duration.

Orlinsky and Howard's (1986) summary indicated that the following were associated with positive outcomes: collaboration between therapists and patients in sharing initiative and responsibility; therapists' use of confrontation, interpretation, and exploration; therapists' focus on patient's affect and transference reactions; therapists' skillfulness; patients' experience of negative affect, such as distress and hostility, especially early in treatment; the greater immediacy of patient expression of affect and the occurrence of affective discharge (i.e., emotional catharsis); therapists' engagement (versus detachment), credibility, genuineness, and confidence; patients' perceptions of therapists' empathy; patients' perceptions of their own expressiveness; and therapists' and patients' warmth or acceptance, especially when viewed as reciprocal affirmation. Orlinsky and Howard concluded that researchers should study process and outcome systematically over the course of treatment, and

from a variety of perspectives.

Recent Child Process Studies

Tucker (1988) followed the Howard and Orlinsky model of process and outcome research in adult psychotherapy in a pioneering investigation of child psychotherapy. This study adapted Orlinsky and Howard's (1975) adult measures of the psychotherapeutic process for use with children.

Tucker (1988) studied a series of six therapy sessions over a three month period. In Tucker's study, therapists and their child clients answered questions after each session. Variables of interest were therapists' and children's affect, perceptions of each other's affect, their goals, and their perceptions of therapist behavior in session.

Tucker (1988) demonstrated adequate internal consistency for her instruments; Tucker also found that children's and their therapist's reports were similar in form to those seen in adult therapy studies. Furthermore, Tucker found that children tended to view their sessions as either essentially positive or essentially negative, and that no process variables from the children's perspectives were significantly related to outcome. Tucker also found that there was little agreement between child and therapist reports of process

variables, and that both therapists and children perceived changes in the process over time which generally corresponded to therapy stages described in the literature.

Tucker (1988) primarily used beginning psychotherapists in her study and suggested that her findings were influenced by this factor. However Tucker could not confirm this hypothesis empirically, since all of the therapists in the study were novice therapists.

The six sessions after which data were collected in the Tucker (1988) study did not represent any particular stage in the treatment process. Subjects had been involved in long-term individual psychotherapy, and data were taken at whatever point the therapy happened to be in. While the Tucker study was promising and pioneering, an important remaining question is: "How do process variables relate to stages in treatment?"

In summary, there have been no studies in the child psychotherapy literature comparable in depth or breadth to Orlinsky and Howard's (1986; 1978; 1975) work on adult process and outcome. This does not come entirely as a surprise since studies on child psychotherapy have a tendency to lag behind those on adult psychotherapy. In fact, child therapy has not been investigated in the quality or quantity that adult therapy has been

(Barrett, Hampe & Miller, 1978). Although process studies have been rare in research on child therapy, there is a small research base. Especially in recent years, there has been a move toward examining the process of child psychotherapy over time. The Tucker (1988) study initiated the empirical study of processes in child therapy.

<u>Stages in Treatment</u>

Although there has been little research on the process of child psychotherapy, there has been even less on the stages of treatment. Therefore, this section discusses stages in treatment as reflected in the theories, case studies, and informal clinical observations of influential writers in the field of child therapy. The literature suggests that stages can be characterized by therapist behaviors, child client behaviors, and the influence of one upon the other.

Coppolillo (1987) described three stages in psychodynamic psychotherapy with children: beginning the therapy; the middle phase; and termination of treatment. Coppolillo outlined five important achievements that are optimally attained in the first phase: 1) the child attains a degree of comfort that permits him to be productive in the sessions, 2) the child communicates as a matter of course, 3) child and

therapist achieve a working alliance or therapeutic alliance, 4) the child becomes aware that some of his mental activities are internally generated rather than elicited by external circumstances, and 5) child and therapist begin to share modes of representing the child's internal states with words, images, and symbols. Coppolillo described four main undertakings in the middle phase of treatment: 1) isolation or definition of the child's conflicts or deficits, 2) articulating these problems in the context of the child's life, 3) understanding and applying the principle of abstinence (based on the principle that frustration of a wish is necessary so that the wish may be perceived and articulated), and 4) culmination of the process of interpretation. Coppolillo noted that unilateral decisions to terminate treatment made either by the therapist or by the patient far outnumber genuine shared decisions that treatment is no longer necessary. He discussed premature terminations, terminations initiated by the therapist, premature terminations caused by conditions in the child, terminations due to environmental circumstances, and therapeutic terminations.

McDermott & Char (1984) and the GAP Report (1982) describe five stages of psychotherapy with children:

1) establishment of a working relationship, 2) analysis of the problem and its cause, 3) explanation of the problem, 4) establishment and implementation of a formula for change, and 5) termination. Other writers have presented different models. Proskauer (1977), for example, described three phases in short-term treatment including: 1) forming a relationship and defining the focus, 2) facilitating change in a limited area of the child's functioning, and 3) termination involving stabilization of gains, so that children can sustain them after the end of treatment. This author also suggested that there are parallels for the supervisory process, regarding supervisors' responsibilities.

Ponzo (1985) stated that people enter counseling because there is a discrepancy between their current and preferred feeling, thinking, and behavior; he described three phases in a more cognitive-behaviorally oriented treatment: 1) awareness: the therapist attempts to increase client's and therapist's awareness of the problematic situation, and attempts to establish a caring, honest, and competent atmosphere; 2) cognitive reorganization: building on accomplishments of phase 1, the therapist questions and challenges the client's assumptions about life and teaches him or her to do the same, and 3) behavior change: the therapist is

supportive and demanding, as the client works to implement a behavior change program.

Mann (1973) developed a system of time-limited psychotherapy which has been adapted for use with children by Sloves & Peterlin (1986). The child-adapted Mann model includes three distinct phases: 1) an opening phase involving relationship building, 2) a "working through" phase, and, finally, 3) a termination phase.

Moustakas (1953), a "client-centered" child therapist in the tradition of Carl Rogers (1951), discussed attitudes and affect according to four "levels" in child therapy. In early interviews, children's negative attitudes often are diffused and pervasive. At the second level children fluctuate between anxiety and hostility. In the third level, children express feelings more directly. At the fourth level, ambivalences come to the fore, with expression of a mixture of positive and negative attitudes.

Some authors only focus on one or two stages of the treatment in their work. Anna Freud (1927) discussed the differences between children and adults in analysis, referring to the importance of priming the child prior to the "actual analytic work," since it usually is not the child's decision to enter the treatment relationship. Anna Freud called this initial stage of

treatment the "introductory period" or "training," and said the goals during this time with a child patient are "producing in him an insight into his illness, arousing confidence in the analysis and the analyst, and transforming the decision to be analyzed from an outward to an inner one" (p. 3).

Neubauer (1978) wrote about the "opening phase of child analysis," noting that this stage has been described for adults as well as children. He cited Glover's (1955) statement that the opening phase "is determined less by the conditions of psychoanalysis than by spontaneous reactions of the patient" (p. 19). Gitelson (1973) applied knowledge of child development and said that the "first phase of analysis of adults is based on the symbiotic phase of the dyadic relationship" (p. 318) between mother and child (Mahler, Pine & Bergman, 1975). Spitz (1956) who also referred to the early mother-child relationship, asserted that while the analytic patient is in an anaclitic (dependent) position, the analyst maintains a "diatrophic" (caring) attitude. In their discussion of the treatment alliance, Sandler, Dare and Holder (1973) raised the idea of Erikson's (1950) "basic trust," an attitude which is based on the infant's experiences of security in the first months of life, as being an essential

aspect of the early treatment relationship.

Neubauer (1978) noted that the characteristics of the opening phase of analysis are not unique, but represent the beginnings of complicated processes that continue throughout the treatment. He suggested that the characteristics of the opening phase vary with the child's developmental stage and degree of pathology. Neubauer argued that the preparatory phase changes over time, such that certain functions of the preparatory phase are no longer necessary. Neubauer suggested that several processes possibly involved in an opening phase are establishing the therapeutic alliance through interpretation of defense, taking information from the parents (while imparting some too), and evaluating a child's capacity to establish and analyze transference experiences.

Parloff (1986) referred to early and late stages of treatment. The aim at the outset of treatment is to cultivate the patient's hope of receiving help. In effect, treatment ends with the patient developing a realistic sense of mastery and confidence. Parloff noted that in early phases of therapy, specific techniques may be less important than nontechnical aspects of therapy, including the nature and quality of the relationship, the characteristics of the therapist,

and evidence of the therapist's skills. Parloff's description parallels work on the therapeutic alliance, the development of which is seen as essential to the early stages of treatment (Allen et al., 1984). Parloff contends that stages of psychotherapy may be "nonspecific factors" in treatment (Frank, 1973), i.e. common elements of all treatment, regardless of theoretical orientation.

Abrams (1978) discussed termination in child analysis, with respect to the three parties involved: child, parent(s), therapist. Abrams pointed out that the decision to terminate requires the agreement of all the parties to the contract. This author made a distinction between the termination of a treatment and an interruption. Further, he outlined practical considerations regarding the end of the treatment.

Beatrice (1982-83) and Smith (1982-83) have written about premature, interrupted, and forced terminations, revealing how complex this particular stage of treatment can be. Beatrice summarized writers' shared criteria for termination to begin, including: successful resolution of the transference neurosis, attainment of treatment goals, reduction of symptomatology, and structural changes commensurate with reported changes in external life.

Although many authors have written about stages, there is no agreement about how many there are or about the characteristics of each stage. Furthermore, stages have not been clearly defined or operationalized by writers, and their rationale is often unclear. Nevertheless, common themes regarding stages of treatment in child therapy can be discerned. Three major stages of treatment can be identified from the child therapy literature: 1) rapport-building, 2) working, and 3) termination.

Synthesis of Stages in Child Treatment

The Rapport-building Phase

In this phase, the therapist works to understand the child's world and perspective, to establish contact with the child, engaging the child's trust and confidence. Feelings of hope, the expectation of help, and the client's belief in a helping person are keys to this phase (GAP, 1982). Hallmarks of this stage include efforts toward establishing a good rapport between client and therapist, and the therapist working toward conveying empathy to the client, creating an "alliance" between the two. The child develops some understanding of why he or she is seeing a psychotherapist and of what they are going to do together (Kessler, 1966). Specifically, the therapist clarifies the child's

understanding of why he or she is in treatment, explores the child's views on the problem, learns the child's approach in dealing with his problems, and examines the child's perception of the ways the therapist can help with the problem (Reisman, 1973). Simultaneously, the therapist gains an understanding of the clinical problems of the child (Halpern & Kissel, 1976). Based on this assessment, the therapist and client then build a collaborative relationship in which shared goals can be addressed (GAP Report, 1982). Thus, the essential elements of this phase include evaluating the problem and building a therapeutic alliance with the client. However, symptom reduction frequently begins in this phase (GAP, 1982; Sloves & Peterlin, 1986).

The Working Stage

In this stage, the therapist applies his or her understanding of the child and the child's problem(s) to the alliance established in stage 1, in order to implement a strategy for change. The work in this stage may shift to a more cognitive level for both the therapist and the client, such as with goal selection (GAP, 1982). Contained within this phase is the so-called "corrective emotional experience," which is a process the child undergoes as the therapist treats the child in a presumably more healthy manner than he or she

was originally treated by parents or parent figures. This corrective experience may be a more crucial phenomenon in child than adult therapy (GAP, 1982), since children are younger, more impressionable, and less habituated than most adults. Although specific techniques may relate to the therapist's theoretical orientation, in most current models there is a dual focus on providing a cognitive understanding of the problem and encouraging behavior change in and outside of the sessions (GAP, 1982).

The phenomenon of insight is also considered by some to be crucial to the working phase. Most models suggest that after an initial period of assessment and relationship building, the therapist should provide an explanation of the problem that can be understood by the child and will facilitate the development of a therapeutic contract (Reisman, 1973). Depending on the approach of the therapist, this contract may be specific and concrete, and may be modified according to joint decisions (GAP, 1982). The therapist may promote change by working with the behavior directly, by providing an understanding of the situation that will facilitate cognitive change, or by supplying the emotional support necessary for the child to express feelings and concerns more directly (Ponzo, 1985). The emotional viewing and

reviewing of the same problem in many situations comprises "working through" (Glenn, 1978). Symptom reduction and improved functioning are expected to continue through this phase, although improvement may not be linear (Reisman, 1973).

Within the working phase, specific techniques bring about cognitive, affective, and behavioral change (Karasu, 1986). Therapists may use a variety of supportive, confrontive, and interpretive techniques to facilitate reality testing, cognitive and experiential learning, and self-esteem (Parloff, 1986). Over time, the patient achieves a sense of mastery and competence within the therapy sessions and in the outside world, and the process of termination begins.

Termination

This stage includes an acknowledgement of changes achieved by the child and how problems were resolved. The therapist assists the child in the transition to end the therapy. Besides symptom alleviation, the therapist may notice that the child handles problems outside therapy more adequately and no longer utilizes the therapy hour to handle problems (GAP, 1982). The most frequently stated task of the therapist during this stage is to review strategies and bolster confidence in the child's ability. However, relatively few analyses

of children are terminated according to plan (Sandler, Kennedy & Tyson, 1980). Many are interrupted by various external circumstances such as the patient or therapist moving away, illness of a parent, or the impending birth of a sibling (Reisman, 1973). Some believe that termination can be the high point in the therapeutic relationship (Adams, 1974). According to Adams, the decision to stop is guided not by the achievement of perfection, but by the achievement of therapeutic goals.

Throughout the last treatment phase, the therapist helps the client solidify the gains by providing evidence of successes achieved during therapy (Lambert, Shapiro & Bergin, 1986; Parloff, 1986), and assists the client in planning future coping strategies. In addition, feelings about the loss of the relationship are also prominent (Mann, 1973).

Research on Stages

To this author's knowledge, no one has done an empirical study on stages in child treatment, in accordance with current theory and conceptualizations. Such research is important, particularly because short-term therapies are being explored as a way to meet the needs of those seeking mental health services. The more we know about stages in treatment, the more we can ultimately learn about how long these stages need to be

under various circumstances, and about what factors make each stage effective. Furthermore, research on outcomes alone has solved expressed outstanding controversies; the state-of-the-art in psychotherapy research is to explore process and outcome together, with an emphasis on processes of change occurring over the course of therapy (Kiesler, 1985). Although Tucker (1988) was able to note changes over time during psychotherapy, she was unable to tie these changes to particular stages in treatment. Tucker left the question of how process variables relate to stages in treatment to future research.

The Present Study

The present study sought to examine the process of psychotherapy with children over three stages of treatment: 1) rapport-building; 2) working; and 3) termination. The central research questions were, "What process variables are predictably associated with each stage of treatment?" and, "Which process elements differ across stages?" The data were collected at two urban community mental health centers, referred to as Center A and Center B, and subjects were child therapy clients and their therapists. Data from each subject included multiple data points, collected either weekly for two or three weeks, or every other week for six data

collection points.

The primary variables in this study included: child's and therapist's affect, and their perceptions of each other's affect; their perceptions of therapist's behavior in session; and their goals. The psychotherapeutic process was measured using an adaptation of a widely used and well-standardized instrument in adult psychotherapy research, applicable to a variety of theoretical orientations (Orlinsky & Howard, 1975). The TR (Therapist Report) and a modified version of the CR (Child Report) were both adapted to study child psychotherapy by Tucker (1988). One section of the CR has been modified by this author and two colleagues, to provide further insight into children's perceptions about therapy (see "Child's Aims and Understanding of Session Goals" in Part III of Appendix C). Stage in treatment was measured by the Stage Form, an instrument developed by this researcher, based on common themes in the psychotherapy literature (see Appendix D).

In the present study an effort was made to replicate Tucker's (1988) study regarding internal consistency for the TR and CR scales. Primary hypotheses involved how certain process variables would characterize each of the three stages in treatment.

Secondary analyses were performed to examine whether the stage data were influenced by differences between agencies, levels of therapist experience, or diagnostic categories.

Agencies

Data were collected at Center A and Center B. Theoretical orientation of therapists is similar at Centers A and B. However, treatment at Center A is short-term, with 20-session treatment plans (with an option to extend if indicated), while treatment at Center B is not restricted, resulting in long term therapy. It was necessary in this study to conduct a set of analyses to examine whether differences between agencies influenced the stage data. (See Method section for details.)

Diagnostic Category

Barrett, Hampe and Miller (1978) and Cass and Thomas (1979) agree that response to treatment is partly a function of the child's diagnostic category, and that this variable has received minimal attention in child therapy research. Achenbach (1978) recognized the importance of diagnostic category as a unique and significant aspect of child psychopathology, and developed a "broad-band" classification system. Children were classified as "externalizers" or

"internalizers." Externalizers overtly act out problems, as in hyperactivity or conduct disorders. Internalizers hold problems inside, as in overanxious or separation anxiety disorders. In the present study, children were categorized into one of Achenbach's diagnostic groups to test whether these differences influenced the stage data.

Therapist Experience

Lambert, Shapiro and Bergin (1986) reviewed controversial studies regarding whether differences in therapeutic outcome are associated with differences in therapist's level of experience. The authors concluded that such an association could be detected when there was a large discrepancy in experience between the therapists offering the treatment, or when the treatment modality involved more than simple counseling or specific behavioral techniques. To test if and how therapist's level of experience influenced the stage data, the therapists involved in the current study were grouped as having high or low levels of experience.

Hypotheses

There are two kinds of hypotheses in this study: 1) hypotheses related to replication of a previous study (Tucker, 1988); and 2) major hypotheses related to the design of this study.

Replicatory Hypotheses

In a previous investigation (Tucker, 1988) adequate levels of internal consistency were reached for 10 TR and seven CR scales (r's $\geq$ .61), and a number of significant relationships were found between and across TR and CR scales. It was hypothesized that the following major findings from that study would be replicated:

1) It was expected that the TR and CR-R would produce internally consistent scales.

2) It was expected that children's affect would be positively and significantly associated with their perceptions of their therapists' affect.

Primary Hypotheses

The novel hypotheses of this study relate to differences in the process of child treatment across stages. Accordingly, significant differences were expected across stages on several process variables, as follows:

3) Structuring would be highest in stage 2, as perceived by both children and their therapists.

4) Insight and catharsis would be highest in stage 2.

5) Independence would be encouraged most by therapists in stage 3.

6) Children's knowledge of reasons why they come to

treatment (C-Motivation), of therapist expectations (C-Understanding), and of how therapy helps them would be highest in stage 3 (C-Works).

7) Finally, it was predicted that the new Child Goals scales would reach adequate levels of internal consistency.

The general hypothesis in this study is that different process variables are significantly associated with particular stages in child psychotherapy. No empirical data bearing on this hypothesis have previously been collected.

CHAPTER III

METHOD

Settings

This study was conducted at two separate urban
community mental health centers (Center A and Center B).
Both centers serve ethnically diverse lower and middle
class communities, and are training sites for graduate
students in psychology and social work programs. The
clinical work at Center A is conducted by both student
therapists and fully trained mental health
professionals. At Center B, in contrast, services are
provided exclusively by student therapists. Both
clinics operate on a sliding fee scale, and most
referrals to both agencies come from area schools,
churches, friends of clients, and other community
agencies. Both mental health facilities provide
psychotherapy and assessment services for children,
adolescents, adults, and families.

The therapeutic orientation of all therapists in
this study was similar to the broad-based psychodynamic
model described by Silver and Silver (1983). At both
agencies, a combination of verbal and play therapy was
administered, with emphases on developing a caring

therapist-client relationship, facilitating the expression of feelings, increasing the child's self-esteem, and encouraging adaptive behavior. Center A has a short-term treatment policy, which customarily involves the use of a 20-session treatment plan. It should be noted that any treatment plan at Center A can be extended if clinically necessary or justifiable. In contrast, however, treatment at Center B was unrestricted, and thus was generally conceptualized as long term. All therapists in this study participated in weekly individual or group supervision to facilitate their work.

Subjects

Subjects included 47 pairs of therapists and their child clients, 33 from Center A (70%) and 14 from Center B (30%). Tables 1, 2 and 3 summarize demographic data; Table 4 shows demographic differences between the samples from the two centers.

Children beginning or already receiving individual psychotherapy were eligible for the study. The sample included 16 girls (34%) and 31 boys (66%). Subjects were placed in three groups, with each group representing a stage in treatment. The stage in treatment was rated by the therapists on the Stage Form each time they filled out the Therapist Report,

Table 1

Selected Characteristics of Client Sample

Characteristic	Center A	Center B	Total
	--------	--------	-----
	n (%)	n (%)	n (%)
	-----	-----	-----
Gender			
Male	23 (49%)	8 (17%)	31 (66%)
Female	10 (21%)	6 (13%)	16 (34%)
Total	33 (70%)	14 (30%)	47 (100%)
Ethnicity			
Caucasian	20 (43%)	4 (9%)	24 (51%)
Black	3 (6%)	7 (15%)	10 (21%)
Hispanic	9 (19%)	3 (6%)	12 (26%)
American Indian	1 (2%)	0	1 (2%)
Total	33 (70%)	14 (30%)	47 (100%)
Diagnosis			
Externalizer	13 (28%)	3 (6%)	16 (34%)
Internalizer	20 (43%)	8 (17%)	28 (60%)
Missing Data	0	3 (6%)	3 (6%)
Total	33 (70%)	14 (30%)	47 (100%)
	Mean (SD)	Mean (SD)	Mean (SD)
	-----------	-----------	-----------
Age	9.5 (2.17)	9.9 (1.94)	9.6 (2.09)

Table 2

Selected Characteristics of Child Treatment

Characteristic	Center A	Center B	Total
	n (%)	n (%)	n (%)
Stage in Treatment			
1	13 (28%)	5 (11%)	18 (38%)
2	15 (32%)	6 (13%)	21 (45%)
3	5 (11%)	3 (6%)	8 (17%)
Total	33 (70%)	14 (30%)	47 (100%)
	Mean (SD)	Mean (SD)	Mean (SD)
Length of Treatment			
in Number of Sessions	13.9 (17.2)	31.4 (20.8)	18.8 (20.0)

Table 3

Selected Characteristics of Therapist Sample

Characteristic	Center A	Center B	Total
	n (%)	n (%)	n (%)
Gender			
Male	5 (17%)	2 (7%)	7 (24%)
Female	12 (41%)	10 (34%)	22 (76%)
Total	17 (58%)	12 (41%)	29 (100%)
Level of Education			
Working on PhD or PsyD	11 (38%)	5 (17%)	16 (55%)
Working on MA	0	2 (7%)	2 (7%)
Working on MSW	1 (3%)	4 (14%)	5 (17%)
Working on P.C.*	0	1 (3%)	1 (3%)
Has PhD	2 (7%)	0	2 (7%)
Has MA	2 (7%)	0	2 (7%)
Has MSW	1 (3%)	0	1 (3%)
Total	17 (59%)	12 (41%)	29 (100%)
	Mean (SD)	Mean (SD)	Mean (SD)
Child Clinical Experience in Number of Years			
Student	3.1 (2.70)	1.6 (0.86)	2.3 (2.87)
Staff	8.3 (5.34)	0	8.3 (5.34)
Total	5.2 (4.75)	1.6 (0.86)	3.7 (4.09)

* Pastoral Counseling degree

Table 4

Comparisons of Sample Characteristics across Agencies

Characteristic	Statistic/Value	df	p value
Client Gender	$X^2=$ .24	1	.62
Client Age	$\underline{t}$ = -.62	45	.54
Client Ethnicity	$X^2=$ 10.26	3	.02
Diagnosis	$X^2=$ .13	1	.72
Stage in Treatment	$X^2=$ .28	2	.87
Therapist Years Experience	$\underline{t}$ = 3.14	45	.003
Therapist Status	$X^2=$ 12.39	1	.0004
Therapist Education	$X^2=$ 5.78	1	.02
Length of Treatment	$\underline{t}$ = 2.96	45	.001

Note: $\underline{X}^2=$ chi-square; $\underline{t}$ = $\underline{t}$-test

following each session. Stage 1 represented the engagement phase, stage 2, the working stage, and stage 3, the termination phase. Overall, 18 subjects were in the first stage (38%), 21 were in the second stage (45%), and 8 were in the third stage (17%), as summarized in Tables 2 and 4.

Mean age of child subjects was 9.6 years, with a standard deviation (SD) of 2.09, and a range of 5 to 13 years. Twenty-four Caucasians (51%), ten Blacks (21%), twelve Hispanics (26%), and one American Indian ((2%) were included. A Chi-square analysis indicated a significant association between ethnic population and agency, X^2(3, n = 47) = 10.26, p=.02. A greater percentage of Caucasian and Hispanic subjects was in the sample from Center A, whereas proportionally more Black subjects were at Center B, as shown in Tables 1 and 4.

Children were evaluated prior to therapy, resulting in a recommendation for individual treatment. At each agency, one child declined to participate in the study after parental permission was obtained, and three parents altogether, at both centers, refused participation for their children. Since the consent agreement did not require reasons for subject refusal, the reasons these people chose not to participate are unclear. Informal observations suggested that refusal

was related to perceptions that participation in the study would be too demanding or intrusive. Also, one of 15 original subject pairs from Center B was dropped from the study due to missing stage data.

The children in this study were in individual therapy for a variety of family or school problems. All child subjects at Center A were given DSM-IIIR (American Psychiatric Association, 1987) diagnoses after their initial evaluations. Six (43%) of the child subjects from Center B were given DSM-IIIR diagnoses. Diagnoses included anxiety and depressive disorders, hyperactivity, conduct disorders, and family problems. For the purpose of this study, diagnoses were collapsed into two categories identified by Achenbach (1978) as "externalizers" and "internalizers." These categories reflect whether the disorder results in an overt, acting out of problems, as in hyperactivity or conduct disorder ("externalizers"), or whether the disorder involves symptoms of holding problems within, as in overanxious disorders or dysthymia. Subjects from Center B who were not given formal diagnoses were categorized as either "externalizer" or "internalizer" through use of the Child Behavior Checklist (Achenbach, 1983) or through consultation with the therapist or supervisor involved with the case. Assessments yielded diagnoses of 16

externalizers (34%) and 28 internalizers (60%); three child clients were not categorized due to lack of diagnoses (6%). Tables 1 and 4 present these data.

Length of treatment in number of sessions (prior to being studied) ranged from one to 94 sessions with a mean of 18.8 and SD =20.0. All subjects participated once weekly in individual psychotherapy, except one who came twice weekly. At Center B, clients such as those in this study were commonly transferred from one trainee therapist to another over the course of treatment; this happens only occasionally at Center A. Length of treatment differed significantly between the two agencies in the study, with therapist-client pairs at Center B having a significantly greater number of sessions than those at Center A, $t(45)$ = 2.96, p=.001. These data are shown in Tables 2 and 4.

The 29 clinicians who participated were all either graduate trainees (on practicum or internship) or staff therapists with master's or Ph.D. degrees. Twenty-two therapists were female (76%) and 7 were male (24%). Table 3 shows that the sample included 22 student therapists (76%) and 7 staff therapists (who all work at Center A; 24%). Two of the seven staff therapists were working on graduate degrees. Eleven of the 17 therapists from Center A and two of the 12 from Center B

treated more than one client in the study (eight therapists treated two clients, two therapists treated three clients, and one therapist treated five clients). Although one therapist at Center A declined to participate early in the data collection process, she later changed her mind. All therapists at Center B who were asked to participate in the study did so from the beginning. A Chi-square analysis indicated an association between agency and status of therapists (students vs. staff), $\underline{X}^2$(1, $\underline{n}$ = 29) = 12.39, $\underline{p}$=.0004. There were significantly more staff therapists at Center A than at Center B, as can be seen in Tables 3 and 4.

Therapists' clinical experience with children ranged from zero to seventeen years, with a mean of 3.7 years and $\underline{SD}$ =4.09. A $\underline{t}$-test indicated significant differences between agencies in therapists' experience working with children, $\underline{t}$(45) = 3.14, $\underline{p}$=.003. Therapists at Center A had significantly more experience than did those at Center B, as shown in Tables 3 and 4.

Overall, most of the student therapists (55%) were working toward either a Ph.D. in clinical psychology or a doctor of psychology degree (Psy.D.). The remainder of the student therapists were working toward a master of arts degree (M.A.), a master's in social work (M.S.W.), or a degree in Pastoral Counseling (P.C.).

Other therapists were fully trained mental health professionals with either Ph.D.'s, M.A.'s, or M.S.W.'s. Tables 3 and 4 show an association between agency and the degree of training of the therapists, $X^2(1, \underline{n} = 29) = 5.78$, $\underline{p}=.02$. Center A had significantly more therapists who had completed their training than did Center B, at which all were working towards degrees.

In summary, significant differences across agency included: more Caucasian and Hispanic child clients at Center A and proportionally more Black child clients at Center B; more staff therapists at Center A than at Center B, where all therapists were students; more therapists at Center A had completed their training than at Center B, where all were working towards degrees; more years of experience in working with children among therapists at Center A than among those at Center B; finally, therapist-client pairs at Center B had a greater number of sessions prior to being studied than those from Center A.

Experimenters and Examiners

There were two experimenters in this study, one at each center; the Center A experimenter was this author, and the Center B experimenter was another clinical psychology graduate student. The experimenters were assisted by eight examiners, all of whom administered

the child instrument. At Center A, the majority of the data collection (108 of 119 total number of data points = 91%) was done by this researcher; however, on a few occasions (11 of 119 = 9%) one of three other people assisted: two were psychology interns who had no clients in the study and one was a therapist in the Adult Outpatient division of the clinic. The examiners at Center B included four undergraduate students majoring in psychology and one who was a first-year clinical psychology graduate student. Overall, there were seven female and one male examiners, and all had prior experience working with children and/or as research assistants. The examiners were trained to administer the CR-R by the experimenters in a standardized fashion through demonstration, and confidentiality was emphasized. A standard set of instructions was used in administering the Q-sort to child subjects.

Measures

Two measures were used to examine the therapists' and children's perceptions of their therapy sessions, the Therapist Report (TR) and the Child Report-Revised (CR-R). A third brief measure to identify stage of treatment was also completed by the therapists (see Appendix D). Lastly, a short demographic form was used to collect data about the therapist and the client.

Therapist Report (TR)

Tucker (1988) adapted Howard and Orlinsky's (1978) Therapy Session Report for use in child therapy. On the original instrument, responses to 152 items were obtained along three-point Likert scales ("none," "some," "a lot"). Items had been designed to address ten aspects of a therapist's experience during a session and, for Tucker's study, four aspects of the therapist's experience were examined: 1) the therapist's affect during the session (T-Affect), 2) the therapist's goals for the session (T-Goals), 3) the therapist's perception of his/her interpersonal behavior during the session (T-Behavior), and 4) the therapist's perception of the client's affect (TC-Affect). Tucker's modifications to the original instrument were to make it relevant to psychotherapy with children rather than with adults.

In the adapted instrument, the T-Affect section consisted of 33 items, the T-Behavior portion consisted of 16 items, the T-Goals section contained 12 items, and TC-Affect section consisted of 33 items. The adapted TR was designed to yield the same subscales as the original adult measure. Higher scores on each scale reflect higher levels of the construct being measured. Tucker (1988) was able to establish adequate internal consistency and reliability for TR scales (r's ranged

from .61 to .88, with a mean of .77). (See Appendix A for the TR.)

Client Report-Revised (CR-R)

Tucker (1988) adapted Orlinsky and Howard's (1975) client form of the Therapy Session Report for use with children, creating the Client Report (CR). This measure concentrated on four dimensions of the child's experience, including the child's affect (C-Affect), the child's perception of the therapist's affect (CT-Affect), the child's perception of the therapist's behavior (CT-Behavior), and the child's goals for the session (C-Goals). The C-Affect and CT-Affect sections contained 14 items each, the CT-Behavior section consisted of 21 items, and the C-Goals section included 8 items, with five open-ended questions and three forced-choice items. Tucker (1988) was able to establish adequate internal consistency for three CR sections (C-Affect, CT-Affect, and CT-Behavior), including seven scales (child's positive and negative affect, child's perceptions of therapist's warmth, structuring and acceptance, and child's perceptions of therapist's positive and negative affect), with reliabilities ranging from .68 to .86. The C-Affect, CT-Affect, and CT-Behavior items were completed by the child using the Q-Sort technique. (See Appendix B for

CR.)

The Q-Sort technique has been shown to be useful in eliciting children's responses to question about their feelings and perceptions of interpersonal behavior (Sines, Pauker & Sines, 1974). On the CR, the children were instructed to indicate the extent to which they experienced a particular item during the past therapy session. For example, subjects were given cards containing feelings (e.g., "safe" or "worried"), or containing sentences like, "My therapist wanted me to change my mind today." The children were then asked to place these cards in one of three piles indicating to what extent they experienced the feeling ("not at all," "a little," or "a lot"), or to what extent they thought the therapist displayed the designated behavior during the therapy session just completed. The three Q-Sort sections of the CR were designed to parallel those in the TR, and higher scores on each scale again reflected higher levels of the construct being measured.

In Tucker's (1988) Child Report (CR), the section pertaining to the child's aims for the session (C-Goals) did not involve a Q-Sort technique. Instead, Tucker used open-ended questions and forced choice items. Findings yielded interesting qualitative data, but not quantitative data that could be evaluated along with the

other scales.

Tucker suggested that a revised Goals section of the CR should include Q-Sort items to enable the researcher to analyze these data along with the rest. Therefore, this researcher and two colleagues used Tucker's data and suggestions to develop a new section to replace the Goals section of the CR. This new section consists of 23 items which were designed to be added to the other CR Q-Sort sections, to investigate the "Child's Aims and Understanding of Goals of the Session" (see Appendix C, Part III). The child's aims and understanding of treatment portion of the CR-R involved three parts: 1) why children think they come to therapy, 2) how well children understand what to say and do in therapy, and 3) how children think therapy helps them. As with the other scales, higher scores on each scale reflected higher levels of the construct being measured. The revision of the CR will be addressed herein as the "CR-Revised," or the "CR-R."

Stage Form

The Stage Form was a measure developed for this study. Stages were defined operationally by the researcher, based on the literature (see Literature Review). On this measure, the therapist was instructed to circle one of three treatment stages that best

identified the treatment at that particular session.

The following descriptions of these stages appeared on

the form (see Appendix D), to facilitate the therapist's

choice:

1) rapport-building; creating the "therapeutic
alliance":

You are working to understand the child's world and
perspective in order to establish contact with the
child, thereby engaging the child's trust and
confidence. You are trying to establish a good rapport
between yourself and the client, and you are working
toward conveying empathy to the client, thus creating an
"alliance."

2) working:

You are applying your understanding of the child and the
child's problem(s), and using the alliance established
in stage 1 to encourage behavior change in and outside
of the sessions. You may be doing this by being
supportive and encouraging, helping the child understand
him/herself and his/her actions, or facilitating the
child talking about or playing out his/her issues, for
example.

3) ending the treatment; preparing for actually
terminating:

You are acknowledging changes achieved by the child, and
you are making efforts to assist the child in undergoing
the transition to end the therapy. You are reviewing
the treatment, talking about what does and does not help
as a way to manage problems better, and so on.

Short Demographic Form

Therapists filled out this form prior to their

participation in the study. Questions on this form

included items such as child client's age and diagnosis,

how many sessions had been held in the treatment, how

many more were anticipated, and therapist's previous

experience.   (See Appendix E.)

Procedure

This author   collected data at Center A and another experimenter did so at   Center   B.   Identical measures were   given   to   all   subjects.   In   addition to being included in this study, data from Center B were analyzed and reported as a separate study (Faier-Routman, 1990).

Experimenters informed all of the child therapists who worked in the clinics of the nature of the study and the   eligibility   criteria.   When   permission from the therapist, parent(s), and child was obtained,   then data collection for that therapist-client pair began.

The procedures for the study were similar, but not identical at the two agencies. At Center B, each client was asked to participate in the study six times, every other week, to replicate Tucker's (1988) data-collection procedures exactly.   At Center A, clients were asked to participate three times, for three weeks in a row. The major reason that data collection was altered from six data points and from every other week (Tucker, 1988) to three data points and to every week is that treatment at the clinic at which Tucker conducted her study (that is, Center B) is generally conceptualized as long-term, whereas Center A has a short-term treatment policy that customarily   involves   a 20-session   treatment   plan.

Therefore, assessing three consecutive sessions made an overlap in stages during data collection less likely for a given subject pair at Center A. Furthermore, three sessions were assumed to be representative of the psychotherapeutic process in a shorter-term model.

At both mental health centers, following the therapy session, an examiner met the child and accompanied him or her to a quiet office where the CR-R was administered in 10-15 minutes. The child was then thanked for participating and given a choice of two inexpensive "rewards," such as a sticker or a small ball. At Center A the researcher gave the therapist and parents the option not to offer the child a reward; on three occasions they chose this option. These children appeared as motivated to participate as those who were given tangible reinforcers.

After the same sessions for which the child subjects were tested, their therapists completed the Therapist Report and the Stage Form. Demographic data were gathered once from therapists. In all cases, when a child missed a session in which data collection was scheduled, the CR-R, the TR, and the Stage Form were rescheduled for the next session.

CHAPTER IV

RESULTS

Overview

The present study included both replication of parts of the Tucker (1988) study and unique procedures to explore whether process variables are associated with stages in a child's treatment. The replication of Tucker's study was intended to determine whether her findings could be generalized across populations, as well as to determine whether the same scales would emerge as useful on the Therapist and Child Reports.

The data analysis was conducted in four phases. The first was to assess how many data points were necessary to obtain stable process data for each child. In the second phase of data analysis, internal consistencies were computed to determine the reliability of the scales in the Therapist Report (TR) and in the Child Report-Revised (CR-R). The third phase involved computing Pearson product-moment correlations for all scales which attained adequate levels of internal consistency, to examine relationships both within and between the instruments used to gather process data (TR and CR-R). Finally, multivariate analyses of variance

were used to explore whether there were differences in the process data as a function of stages in treatment. Each phase of data analysis is described in detail below.

Number of Data Points

The original goal was to collect process data at three points in time within a single stage for each subject at Center A. However, after fifteen months of data collection, only 24 of 34 subjects had provided three data points in any single stage at Center A and few had provided three data points for stages 1 or 3. All subjects from both centers had provided two or more data points. Therefore, an exploration was made of whether two data points might provide nearly equivalent information to that provided by three. If two data points were sufficient, no further data collection would be necessary.

To investigate whether two data points would be sufficient to measure process data, the process data from the 31 subjects from both centers who had all three data points was examined in the following way. Data collected at the first two data points for each of the TR and CR-R scales were averaged for each scale; then the data across all three data points were averaged for each scale. Pearson correlations were then calculated

to explore how highly correlated the data were when collected at two and three points in time, for each scale. For example, the child's positive affect scale averaged across all three data points on the 31 subjects correlated .98 with the average of the values at the first two data points. Table 5 presents correlations for all the TR and CR-R scales; they ranged from .84 to .99, with an average of .93. These results show that the averages from two data points provide nearly equivalent information to that from the averages of all three data points. Therefore, for 16 of 47 subjects (34%), 10 from Center A and 6 from Center B, two data points were used, and for the 31 remaining subjects three data points were used.

For 14 of the 33 subjects at Center A (42%), data were collected at more than the intended three points in time. The reasons data collection took place on more than three occasions for some subjects were the following. In 3 cases, a meeting with parent(s) was held rather than an individual session, but the lack of a usual session was not discovered until after the data were collected (three cases). For 11 cases, the stage changed during the first three data points. For every case in which data were collected on more than three occasions, irrevelant data were thrown out. Thus, no

Table 5   54

Pearson Correlations between TR and CR-R Process Data Collected
_____

at Two Data Points vs. Three Data Points for 31 Subjects
_____

---- THERAPIST REPORT ----		-- CHILD REPORT-REVISED --	
Scale	Alpha	Scale	Alpha
-----	-----	-----	-----
T-Catharsis	.94	C-Pos Affect	.98
T-Insight	.91	C-Neg Affect	.89
T-Independence	.96	C-Structuring	.91
T-Structuring	.84	CT-Acceptance	.93
T-Acceptance	.94	CT-Warmth	.96
T-Warmth	.93	CT-Pos Affect	.99
T-Pos Affect	.94	CT-Neg Affect	.96
T-Neg Affect	.89	C-Motivation	.97
TC-Pos Affect	.93	C-Understanding	.84
TC-Neg Affect	.92	C-Works	.95

subject pair was represented in more than one stage.

Instrument Reliabilities

Due to the small sample size, it was not possible to conduct a factor analysis on the TR and CR-R. It was hypothesized, therefore, that items on the CR-R and the TR would fall into the same scales as they did in a previous investigation (Tucker, 1988). Cronbach's alpha was computed to test the internal consistency of each scale. Since the Goals section of the CR-R was revised to conform with a forced-choice format rather than the open-ended questions in Tucker's study, it was hypothesized that the items in this section would fall into three scales: 1) the child's motivation to come to therapy (C-Motivation), 2) the child's understanding of the therapist (C-Understanding), and 3) the child's understanding of how therapy works (C-Works). In order to examine internal consistency, mean item scores were computed by averaging process data from each item on each scale across data points for each subject after which the appropriate items were combined to form average scale scores. The average item and scale scores were then used to perform tests of internal consistency.

Therapist Report

When the ten TR scales developed by Tucker (1988) were tested for internal consistency, seven achieved

acceptable levels of internal consistency; all r's were $\geq$.65). Unfortunately, internal consistency was initially poor for three scales: T-Warmth, T-Structuring, and T-Acceptance. The dropping of item 9 (Did you play with the client?) from the T-Warmth scale yielded an acceptable internal consistency of .72. Therefore, a 3-item version of T-Warmth was used in subsequent analyses (see Table 6). However, no combination of item elimination or addition on the T-Structuring and T-Acceptance scales produced an internal consistency higher than .06; therefore, both of these scales were omitted from all subsequent data analyses. Table 6 presents TR internal consistency data.

Child Report-Revised

Five of the seven CR scales developed by Tucker (1988) achieved acceptable levels of internal consistency; i.e. all r's were $\geq$.62. Internal consistency was poor for two scales, CT-Structuring and CT-Acceptance. Internal consistency for CT-Warmth was marginally acceptable, so an effort was made to increase the reliability with additions or deletions. Dropping item 14 (My therapist made me feel I did something wrong this session.) from the CT-Acceptance scale yielded an adequate internal consistency level of .64, and turned

Table 6   57

Internal Consistencies for TR Subscales

| | | | Initial | Final |
Section	Scale	Original Items	Alpha	Alpha
T-Goals	T-Catharsis	3,4,8	.65	.65
	T-Insight	5,12	.72	.72
	T-Independence	7,9,11,16	.86	.86
T-Behavior	T-Warmth	2,7,9,11	.48	.72*
	T-Structuring	1,5,12	.06	.06
	T-Acceptance	3,4,6,10	-.18	-.18
T-Affect	T-Pos Affect	1,3,6,7,8,10, 15,18,22,26,29	.85	.85
	T-Neg Affect	2,4,11,13,14, 16,17,20,23,25, 28,30,31	.83	.83
TC-Affect	TC-Pos Affect	1,7,10,15,18, 22,26,29	.86	.86
	TC-Neg Affect	2,5,9,11,12,13, 14,16,17,20,21, 23,24,25,28,30, 31	.85	.85

* omitting item 9 from T-Warmth scale

it into a three-item scale. Adding item 5 (Today my therapist paid attention to me.) to the CT-Warmth scale increased the internal consistency to .66. However, no combination of item elimination or addition on the CT-Structuring scale produced an internal consistency figure higher than .07; hence this scale was omitted from all subsequent analyses. Table 7 contains CR-R internal consistency data.

Table 8 presents internal consistency data for the Goals section of the CR-R. All of the new C-Goals scales achieved adequate levels of internal consistency, with r values ranging from .79 to .81.

In summary, the effort to replicate the internal consistency data of Tucker's TR and CR scales was fairly successful. Twelve of the seventeen original scales achieved adequate levels of internal consistency (r's ranged from .64 to .87). Slight scale modification produced adequate reliability for two additional scales (T-Warmth and CT-Acceptance), with final alphas of .72 and .64, respectively, and raised the reliability of one scale (CT-Warmth) from .62 to .66. In general, as predicted, scale reliabilities were good, as 14 of 17 achieved adequate levels of internal consistency.

Correlational Analyses of Scales

Pearson correlations were calculated to explore

Table 7   59

Internal Consistencies for CR-R Subscales

			Initial	Final
Section	Scale	Initial Items	Alpha	Alpha
-------	-----	-------------	-----	-----
C-Affect	C-Pos Affect	1, 3, 5, 7, 11, 12	.87	.87
	C-Neg Affect	2, 4, 6, 9, 10, 13, 14	.78	.78
CT-Behavior	CT-Warmth	1, 2, 3, 4	.62	.66*
	CT-Structuring	7, 11, 12, 13, 18	.07	.07
	CT-Acceptance	14, 15, 16, 17	.43	.64**
CT-Affect	CT-Pos Affect	1, 3, 6, 8, 10, 12	.80	.80
	CT-Neg Affect	4, 5, 7, 9, 11, 13, 14	.71	.71

*   adding item 5 from Tucker's (1988) original CT-Warmth scale

** omitting item 14 from CT-Acceptance scale

Table 8   60

Internal Consistencies for Goals Section of CR-R

Section	Scale	Items Retained	Alpha
C-Goals	C-Motivation	1,2,3,4,5,6,7,8,9,10,11	.81
	C-Understanding	12,13	.81
	C-Works	14,15,16,17,18,19,20,21,22,23	.79

relationships within and between the TR and CR-R scales which had achieved at least minimally acceptable Cronbach alphas (i.e. $\underline{r}$'s were $\geq$.62), as presented in Tables 9, 10 and 11. In order to conduct correlational analyses, the process data from each item on each scale were averaged across multiple points in time for each subject, after which appropriate items were combined to form average scale scores. These average scale scores were then used for correlational analyses. To avoid accumulating Type I errors, Bonferroni adjustments were used for all correlations; for each set of correlations, the $\underline{p}$ value was divided by the number of correlations performed; this computation yielded a new and more conservative $\underline{p}$ level according to the Bonferroni correction.

Within Instrument Scale Correlations

Therapist Report. Table 9 presents several significant relationships within the TR. Nine of the 28 possible correlations achieved significance with $\underline{p}$ values of .05, adjusted by the Bonferroni correction. The therapists' reports of positive affect were strongly and positively related to the therapists' perceptions of positive affect in their clients ($\underline{r}$=.78). Similarly, therapists' reports of negative affect were significantly and positively related to their

Table 9   62

Scale Correlations within TR

SCALE	T-Cathar	T-Insight	T-Indep	T-Warmth	T-Pos-Affect	T-Neg-Affect	TC-Pos Affect	TC-Neg Affect
T-Cath		.59*	.39*	-.07	.37	.23	.30	-.48*
T-Ins			.55*	-.17	.35	.12	.41*	.40*
T-Indep				.05	.38	.17	.49*	.23
T-Warm					-.09	.04	-.05	-.09
T-P Aff						-.10	.78*	.15
T-N Aff							-.03	.42*
TC-P Aff								-.02
TC-N Aff								

* = $p < .05$, after Bonferroni correction

Note: T-Structuring and T-Acceptance scales were omitted due to
        failure to achieve adequate levels of internal consistency

Table 10   63

Scale Correlations within CR-R without Goals

SCALE	C-Pos Affect	C-Neg Affect	CT-warmth	CT-Accept	CT-Pos Affect	CT-Neg Affect
C-Pos Affect		-.43*	.54*	.53*	.43*	-.15
C-Neg Affect			-.24	-.29	-.26	.34
CT-Warmth				.51*	.21	-.18
CT-Acceptance					.34	-.13
CT-Pos Affect						-.77*
CT-Neg Affect						

* = p<.05, after Bonferroni correction

Note: CT-Structuring scale was omitted due to failure to achieve
adequate level of internal consistency

Table 11   64

Scale Correlations within Goals Section of CR-R
_____

SCALE	C-Motivation	C-Understanding	C-Works
C-Motivation		.24	.48*
C-Understanding			.05
C-Works			

* = $p < .05$, after Bonferroni correction

perceptions of negative affect in their clients (r=.42).
There were significant and positive relationships
between therapists' perceptions of positive affect in
their clients and two of the therapists' goals, namely
insight and encouraging independence (r's were .41 and
.49, respectively). There was an inverse relationship
between therapists' perceptions of their clients'
negative affect and the therapists' goal of catharsis
(r=-.48). There was a significant and positive
correlation between therapists' view of clients'
negative affect and therapists' goal of insight (r=.40).
Other relationships which were found in the TR included
positive and significant correlations between therapist
goal scales of catharsis, insight, and encouraging
independence (r's ranged from .39 to .59), indicating
that these scales may measure similar constructs.

Child Report-Revised. Table 10 presents scale
correlations within the CR-R without the revised Goals
section. Six of 15 relationships among scales were
significant. Children's perception of therapists'
positive affect was strongly inversely related to
children's perception of therapists' negative affect
(r=-.77). As in the TR, the children's positive affect
was significantly and positively associated with
children's view of therapists' positive affect (r=.43).

Children's positive affect was also significantly and positively associated with children's perception of therapists' warmth (r=.54). Children's negative affect was significantly inversely related to children's positive affect (r= -.43). Children's feeling of being accepted by their therapist was significantly and positively correlated both with children's positive affect and with children's perception of therapist warmth (r's were .53 and .51, respectively).

Revised CR-R Goals Section. Table 11 presents scale correlations within the CR-R for the revised Goals section, indicating one significant relationship out of three possible. Results revealed that children's motivation was significantly and positively associated with children's understanding of how therapy works (r=.48).

Child Report-Revised and Revised CR-R Goals Section. The Pearson correlations between the internally consistent scales for the CR-R and revised CR-R Goals section can be found in Table 12. One correlation between the CR-R and the revised CR-R Goals section was significant, a positive correlation between children's own positive affect and their understanding of how therapy works (r=.42).

In summary, correlational analyses within scales

Table 12   67

Scale Correlations between CR-R and Revised CR-R Goals Scales
----

| | ----- REVISED CR-R GOALS SCALES ------ | | |
CR-R	C-Motivation	C-Understanding	C-Works
C-Pos Affect	.16	.02	.42*
C-Neg Affect	-.14	.14	-.30
CT-Warmth	.19	.18	.15
CT-Accept	.16	.02	.38
CT-Pos Affect	-.06	.08	.18
CT-Neg Affect	.12	-.06	-.06

* = p(.05, after Bonferroni correction

Note: CT-Structuring scale was omitted due to failure to achieve

       adequate level of internal consistency

yielded interesting results. Most outstanding were correlations indicating that therapists' own positive and negative feelings were positively and significantly related to their perceptions of the same in their clients. But the children agreed with therapists' views only in terms of positive affect. Children's perceptions of affect in general were that positive and negative feelings could not coexist, and children who had more ideas about why they went to therapy were those who understood most about how their therapists helped them. Furthermore, children reported more positive affect when they understood more about how their treatment works.

Between Instrument Scale Correlations

Therapist Report and Child Report-Revised. The Pearson product-moment correlations between the internally consistent scales for the TR and the CR-R including the revised Goals section can be found in Table 13. Only one of 72 was significant following the Bonferroni correction. Therapists' view of their own warmth was significantly and positively associated with childrens' perception of therapists' warmth ($r=.49$).

Analyses of Process Data Across Stages in Treatment

Multivariate analyses of variance were conducted on process data across stages in treatment for each of the

Table 13   69

Scale Correlations between CR-R and TR

| CR-R SCALES | ------------------- TR SCALES --------------------- | | | | | | | |
	T-Pos Affect	T-Neg Affect	TC-Pos Affect	TC-Neg Affect	T- Warmth	T- Cath	T- Ins	T-Enc Indep
C-Pos Affect	.33	-.13	.35	.06	.11	-.02	.11	.06
C-Neg Affect	-.24	-.09	-.28	.15	-.01	.20	.11	-.17
CT-Pos Affect	.26	.02	.30	.17	.15	.03	.03	.16
CT-Neg Affect	.00	-.04	.03	-.09	-.06	-.01	.12	-.18
CT-Warmth	.02	.05	.11	.02	.49*	-.03	-.03	.02
CT-Accept	.16	.17	.25	.05	.18	-.01	.09	-.02
C-Motivation	.06	-.04	.10	.04	.32	-.04	.30	.35
C-Understand	-.13	.03	-.13	.15	.30	.03	-.03	.09
C-Works	.05	-.12	.18	.07	-.02	.02	.40	.23

* = $p < .05$, after Bonferroni correction

Note: T-Structuring, T-Acceptance and CT-Structuring scales were

omitted due to failure to achieve adequate levels of internal

consistency

internally consistent TR and CR-R scales. The rationale

for conducting MANOVA's rather than univariate ANOVA's

was that theoretically therapist data and child data are

related within each domain, and the two domains are

separate. In other words, conceptually there are

differences in looking at the treatment process from the

therapists' and the children's views. The Goals section

was newly added and correlational analyses revealed that

these scales seemed to measure a different construct

than the other CR-R scales. Table 12 shows only one

significant correlation between the TR, CR-R and the

revised C-Goals section. Thus, these scales were

examined separately as well.

Therefore, three MANOVA's were conducted across

stages in treatment, one with TR scale data only, one

with CR-R scales, and one with the revised CR-R Goals

data. Each MANOVA was conducted by averaging process

items within each scale over multiple data points for

each subject and then analyzing mean scale scores.

Stage in Treatment. Of the three MANOVA's

conducted on stage in treatment, one revealed

significant differences across stages. The therapy

process, viewed from the therapists' perspective (TR),

differed significantly from stage one through stage

three, $\underline{F}(16, 74) = 1.76$, $\underline{p}=.05$. Contrary to

predictions, neither the CR-R or the CR-R Goals section yielded significant changes across stages. Tables 14 and 15 present MANOVA results. Univariate F's were calculated for each of the TR scales to determine which contributed to the significance of the overall MANOVA. Significant ANOVA's were obtained for the therapists' goal of encouraging independence, $F(2, 44) = 7.53$, $p=.002$, and therapists' negative feelings, $F(2, 44) = 4.33$, $p=.02$. In turn, these results were submitted to Duncan's multiple-range test to determine which stage means were significantly different from one another.

Duncan tests revealed that for T-Encouraging Independence, stages 1 and 2, and stages 1 and 3 differed significantly, whereas stages 2 and 3 did not. For T-Negative Affect, stages 1 and 3, and stages 2 and 3 differed significantly from each other, whereas stages 1 and 2 did not. The scale means for each stage can be viewed in Table 14. The Duncan post-hoc results indicated that therapists encouraged independence significantly more in stages 2 and 3 than in stage 1, and that therapists acknowledged feeling negative affect significantly more in stage 3 than either stages 1 or 2. The results of Duncan's tests which were performed by using means from stage by process data, mean square within groups, and harmonic n's, as instructed by

Table 14

Mean TR Process Data across Stages and Summary of F Analyses
----

and Duncan's Tests

		--------- Mean (SD) ---------		
	F (p)	Stage 1	Stage 2	Stage 3
	-----	-------	-------	-------
		(n=18)	(n=21)	(n=8)
T-Catharsis	1.47 (.24)	1.09 (.42)	1.30 (.37)	1.19 (.38)
T-Insight	2.06 (.14)	.64 (.52)	.91 (.48)	.97 (.26)
T-Independence	7.53 (.002)	.37ᵃ(.36)	.80ᵇ(.40)	.83ᵇ(.37)
T-Warmth	.26 (.77)	1.71 (.31)	1.77 (.28)	1.70 (.18)
T-Pos Affect	2.79 (.07)	.87 (.28)	1.09 (.27)	.97 (.34)
T-Neg Affect	4.33 (.02)	.19ᶜ(.12)	.17ᶜ(.12)	.37ᵈ(.32)
TC-Pos Affect	2.99 (.06)	.75 (.35)	1.01 (.28)	.95 (.41)
TC-Neg Affect	.01 (.99)	.42 (.18)	.41 (.24)	.42 (.28)
OVERALL	1.76 (.05)			

Notes: 1) Duncan's Test: Means with a and b superscripts differ from

one another at the p<.01 level

2) Duncan's Test: Means with c and d superscripts differ from

one another at the p<.05 level

3) T-Structuring and T-Acceptance scales were omitted due to

failure to achieve adequate levels of internal consistency

Table 15   73

Mean CR Process Data and Child Goals Process Data across Stages
----

with Summary of F Analyses

	F (p)	--------- Mean (SD) ---------		
		Stage 1	Stage 2	Stage 3
	-----	-------	-------	-------
		(n=18)	(n=21)	(n=8)

CHILD SCALES WITHOUT GOALS

C-Pos Affect	.55 (.58)	1.52 (.36)	1.55 (.44)	1.71 (.53)
C-Neg Affect	2.69 (.08)	.27 (.29)	.19 (.20)	.05 (.09)
CT-Acceptance	3.22 (.05)	1.22 (.44)	1.26 (.48)	1.67 (.34)
CT-Warmth	1.51 (.23)	1.47 (.36)	1.44 (.42)	1.70 (.29)
CT-Pos Affect	.41 (.67)	1.37 (.46)	1.51 (.46)	1.42 (.58)
CT-Neg Affect	.06 (.94)	.40 (.32)	.37 (.32)	.40 (.40)
OVERALL	1.11 (.36)			

CHILD GOALS ONLY

C-Motivation	.89 (.42)	1.13 (.39)	1.29 (.39)	1.28 (.45)
C-Understanding	.33 (.72)	.73 (.56)	.60 (.49)	.71 (.57)
C-Works	1.60 (.21)	1.53 (.32)	1.61 (.34)	1.77 (.21)
OVERALL	.90 (.50)			

Note: CT-Structuring scale was omitted due to failure to achieve

       adequate level of internal consistency

Bruning & Kintz (1977), are presented as superscripts in Table 14.

Because of the small sample size, it was not possible in the stage MANOVA's to divide the data in order to enter other variables that might have contributed to current findings (differences between agency data, levels of therapist experience, and child diagnosis, age, gender and ethnicity). The possible influence of these variables was therefore investigated in two ways. First, the presence of each of the above variables was examined across stages in $\underline{X}^2$ analyses or in an ANOVA to insure that the values of these variables were randomly distributed across stages. The results of these analyses are presented in Table 16, all of which were nonsignificant; these findings indicate that these six variables were not differentially represented across stages. Second, the TR process data were averaged over stages and the possible influence of three of the above variables was examined via MANOVA's; this procedure was done only with TR process data, since CR-R process data did not have significant effects. These analyses examined the questions of whether across all stages Center A subjects provided significantly different process data than Center B subjects, whether more experienced therapists provided significantly different

Table 16   75

Selected Characteristics Examined across Stages

	X^2	df	Level of Sig
Agency	0.28	2	.87
(Center A vs. Center B)			
Therapist Experience	3.49	2	.17
(2 yrs or under vs. over 2 yrs)			
Diagnosis	3.97	2	.14
(Externalizer vs. Internalizer)			
Client Gender	0.05	2	.97
(Male vs. Female)			
Client Ethnicity	0.03	2	.99
(Caucasian vs. Minority)			

	F	df	Level of Sig
Client Age	0.09	2,44	.92

Table 17

Selected Characteristics Examined across Process Data from TR

	F	Level of Sig
Agency	.46	.88
(Center A vs. Center B)		
Therapist Experience	.42	.90
(2 yrs or under vs. over 2 yrs)		
Diagnosis	.71	.68
(Externalizer vs. Internalizer)		

process data than less experienced therapists, and whether process data for internalizing vs. externalizing children differed. These results are presented in Table 17, and again there were no significant findings. Taken together, the above analyses suggest that stage data were not confounded with other variables in this study.

In summary, analysis of process data across stages in treatment confirmed some hypotheses and failed to confirm others. As predicted, from the therapists' perspective there were significant differences noted across stages. Therapists' goal of encouraging independence and their negative affect were both most prominent at the end of treatment. On the other hand, contrary to predictions, the child instrument did not reflect any significant differences in process variables over stages in treatment. These findings will be discussed in greater detail in the next section.

DISCUSSION

Overview

This chapter is divided into three sections. First, the major findings will be reviewed; second, limitations of this study will be discussed; and finally implications for future research will be considered.

Major Findings

Internal Consistency of the TR and CR-R Measures

As predicted, the majority of scales (14 of 17) on the TR and the CR-R reached adequate levels of internal consistency. Findings for eleven of these 14 scales directly replicated results from a previous investigation of these measures (Tucker, 1988); that is, modifications to achieve adequate internal consistency were necessary for only three of Tucker's scales (see Tables 6 and 7). Moreover, the present study found, as did Tucker (1988), that both the TR and CR-R scales were more internally consistent ($\underline{r}$'s $\geq$.64) than those produced in studies with comparable adult instruments ($\underline{r}$'s between .29 and .65) (Howard, 1987), after which the TR and CR were modeled.

The present study built on Tucker's study by

demonstrating that these measures are useful with a more generalized population, including both new and experienced therapists. Thus, the present study suggests that the TR and the CR-R are reliable and useful measures of features of child therapy. This finding has promising implications for use of these measures in future studies of child psychotherapy.

Contrary to predictions, therapists' behaviors related to structuring (T-Structuring), acceptance (T-Acceptance), and children's perceptions of therapists' structuring (CT-Structuring) did not reach adequate levels of internal consistency. Although it is unclear why these scales were not internally consistent, revision of these scales seems to be necessary.

Addition to the CR-R: Child Goals Section

All three scales of the revised Goals section of the CR-R reached adequate levels of internal consistency (r's ranged from .79 to .81). These scales assess why children think they come to therapy, children's understanding of therapist's expectations, and children's understanding of how therapy works. In the initial investigation of the Child Report (CR), Tucker (1988) suggested that if the open-ended questions about child goals were transformed into quantitative scales, perhaps they would comprise scales as reliable as the

other CR scales.   The present data confirmed this hypothesis.

Patterns of Relationships Among Scales

Because the results of the present study are correlations, interpretations of causal relationships among correlated variables must be accepted only after further testing and confirmation.

Correlations within TR.   Within the TR were four important findings that support the basic tenets of a broad-based psychodynamic model of treatment (Silver & Silver, 1983; Mishne, 1983).   Each finding will be discussed below.

1)   Therapists' reports of positive affect were significantly and positively related to the therapists' perceptions of positive affect in their clients ($r=.78$). A similar relationship was found regarding negative affect ($r=.42$).   These results replicate those from adult therapy studies (Orlinsky & Howard, 1975). In addition, they are consistent with principles of psychodynamic theory (Reisman, 1973; Truax & Carkhuff, 1967), in which therapists strive to be "in synch" with their clients' feelings in order to be empatnic. Interestingly, however, the therapists' perceptions of children's feelings were not significantly correlated with the children's reports of their own feelings.

Assuming that the children's reports of their own feelings were accurate, this result indicates that the therapists were not accurately perceiving children's feelings. In fact, the therapists may have been projecting their own feelings onto their child clients. Such projection may interfere with the above-described empathic process.

2) There were significant and positive relationships between therapists' perceptions of positive affect in their clients and two of the therapists' goals, of providing insight and encouraging independence (r's were .41 and .49, respectively). This result suggests that therapists who believe that they provide more insight and that they encourage more independence in their clients perceive their clients to be feeling better during sessions. An alternative interpretation is that the therapists provided insight and encouraged independence when they perceived their child clients to be feeling good. Either interpretation may be related to the established idea that achievement of greater insight is associated with feeling better, and this association is considered by some to be critical in the treatment process (Shapiro & Esman, 1985; Carek, 1979; Reisman, 1973).

3) There was a significant inverse relationship between

therapists' perceptions of their clients' negative affect and the therapists' goal of catharsis ($r=-.48$). Thus, therapists perceived that their clients' bad feelings lessened as therapists facilitated more cathartic therapeutic experiences. This result suggests that therapists may have perceived their attempts to provide catharsis, the discharging of bad feelings, as successful. The process of facilitating catharsis is a common ingredient of child psychotherapy (Carek, 1979; Reisman, 1973; Tuma & Sobotka, 1983).

4) There was a significant and positive correlation between therapists' views of clients' negative affect and therapists' goals of providing insight ($r=.40$). Thus therapists believed that their clients' bad feelings increased when therapists provided more insight. Taken together with finding #2, finding #4 suggests that therapists believed that their clients felt both good and bad feelings when therapists provided insight. This is consistent with the idea that the process of gaining insight in therapy is a painful and difficult one, yet one that can also provide relief, thus eliciting experiences of both positive and negative feelings.

Correlations within CR-R. Within the CR-R, there were five important findings which were consistent with

concepts taken from psychodynamic theories (i.e. Shapiro & Esman, 1985; Reisman, 1973), client-centered theory (Rogers, 1951), and a cognitive developmental understanding of children (Harter, 1977). Each finding will be discussed below.

1) Children's perception of therapists' positive affect was strongly, significantly and inversely related to children's perception of therapists' negative affect (r=-.77). Children's own positive and negative affect followed the same pattern (r=-.43). These results indicate that children do not see positive and negative affect as occurring simultaneously, either in themselves or in their therapists. These findings are consistent with developmental theory. The young child subjects in this study were probably not cognitively sophisticated enough to understand and express feelings that appeared to be contradictory and seemingly in conflict (Harter, 1977).

2) Children's positive affect was significantly and positively associated with children's perceptions of positive affect in their therapists (r=.43), of therapists' warmth (r=.54), and of therapists' acceptance (r=.53). Children's negative affect was not significantly associated with these perceptions they had of their therapists. These results show that child

clients felt good when they perceived their therapists as feeling good, warm and accepting. Alternately, the therapists may have been responding to good feelings in the child by feeling good, warm and accepting themselves (at least according to children's perceptions). Interestingly, children's negative affect was not associated with these variables. According to some theories, therapists should be warm and accepting when faced with either positive or negative feelings in their clients (Tuma & Sobotka, 1983; Carek, 1979). Perhaps children either did not feel bad or were not aware of doing so when their therapists were warm and accepting, unconsciously not wanting to interfere with such a positive process. On the other hand, maybe therapists in this study were not able to be warm and accepting when children expressed negative affect. Or, perhaps when the children were experiencing negative affect, they were unable to perceive warmth and acceptance that their therapists may have been attempting to convey. In any case and if it is necessary for bad feelings to emerge (e.g. catharsis) for a "cure" to take place, as some theorists contend (Carek, 1983; Reisman, 1973), these data raise questions regarding the possible effects of these patterns on treatment outcome.

3) Children's positive feelings were significantly and

positively correlated with children's perceptions of therapist's positive feelings (r=.43). This result was predicted, and suggests that positive affect may be "contagious" between therapists and their child clients. Shapiro and Esman (1985) suggested that the child's experience is extremely reactive to the therapist's cues. However, this finding can also result from the therapists reacting to the children. In either case, an important variable in the process of child therapy appears to be a mutual exchange of positive affect between therapists and their child clients. Such an exchange has been identified in the adult therapy literature as reciprocal affirmation or mutual affirmation (Orlinsky & Howard, 1986), for example.

4) Children's views of their therapist's acceptance were significantly and positively correlated with children's positive feelings (r=.53). This result shows that children like feeling accepted, consistent with common sense, humanistic theories and Rogerian theory. Rogers (1951) suggested that unconditional positive regard leads to clients' greater self-acceptance.

5) Children's positive affect was significantly and positively related to children perceiving knowledge of how therapists help the children (C-Works (r=.42). Children knowing reasons they come to treatment (C-

Motivation) was also significantly and positively correlated with children perceiving knowledge of how therapists help the children (C-Works) (r=.48), but not with understanding of therapists' expectations (C-Understanding). These results reveal that children who think they know how therapists help them also know more reasons they come to therapy and endorse items revealing that they have many positive feelings in their sessions. In addition, the more children understand what is going on in their sessions, the better they feel. This finding provides empirical evidence consistent with a premise of many theories of psychotherapy, that greater levels of awareness lead to feeling better (Shapiro & Esman, 1985). Outcome was not assessed in this study, hence it remains unclear as to whether the children who claim to understand more about their therapy also show a greater response to treatment.

The three new goals scales added to the original CR were internally consistent but did not correlate significantly with any of the original CR scales (or the TR scales). This result indicates that the C-Goals section was measuring something different than the other process scales. Perhaps the new goals section tapped children's cognitive understanding of treatment rather than their affective reactions to it, which were

assessed by the original CR. To investigate this premise, future research should more directly compare and contrast children's thoughts and feelings about their own treatment.

Correlations Between Instruments. There was only one significant correlation between TR and CR-R scales, a positive correlation between children's perceptions of therapists' warmth and therapist's endorsement of items characterizing their own warmth ($\underline{r}$=.49). These data show similarity in regarding children's and their therapists' perceptions of how much warmth the therapist is exuding. Warmth is considered a means by which the therapist creates an atmosphere in which the client can feel safe, secure and respected as a person (Tuma & Sobotka, 1983). Therapists' and their child clients' agreement about therapists' warmth is thus important.

Other correlations between TR and the CR-R scales were not significant. This indicates that child clients see most aspects of therapy differently than their adult therapists, which is not surprising since there are developmental, emotional, cognitive, and other differences between children and their adult therapists. Children's cognitive processes are simply not equivalent to those of adults (Garbarino et al., 1990; Bierman, 1983; Harter, 1977; Inhelder & Piaget, 1958).

However, one would expect some significant relationships among the TR and the CR-R scales. For example, the most noteworthy nonsignificant results in patterns of relationships among scales were the following. Therapists' perceptions of children's positive or negative affect were not significantly correlated with children's own positive or negative affect. These results are of concern because many theories contend that empathy and the therapist's accurate perception of the client's affect are key elements of effective treatment (Reisman, 1973; Truax & Carkhuff, 1967; Rogers, 1951). One alternate way to interpret these results is that therapists are trained to recognize feelings that are not expressed directly (Halpern & Kissel, 1976). In other words, children may or may not know better than their therapists how they themselves are feeling. It is possible that children in therapy are themselves out of touch with their "true" feelings. However, this hypothesis is almost impossible phenomenon to test; it is the child's word against the therapist's. Such a dilemma is a central part of the controversy in recent years about whether children are competent enough to participate in decision-making about important events in their lives, such as abortion, custody, and even their own therapy, without parental

consent (Kaser-Boyd et al., 1986). Accurate assessment of children's feelings is clearly an important area for research.

In summary, relationships among TR and CR-R scales supported several notions from psychodynamic, client-centered, and cognitive developmental theories. At the same time, therapists and child clients differed in their perceptions of affective experiences. Additionally, feelings of warmth, positive and negative affect, insight, catharsis, independence, acceptance, and understanding the treatment were shown to be significant variables in relationships between therapists and their child clients.

Process Across Stages

Consistent with expectations, the data in this study revealed that the therapy process as perceived by the therapists differed significantly across stages ($F(16,74)=1.76$, $p=.05$). As predicted, therapists were significantly more likely to encourage independence in stages 2 or 3 than in stage 1, and therapists were significantly more likely to acknowledge their own negative feelings in stage 3 than in either stages 1 or 2. As has been mentioned, therapists' behaviors related to structuring (T-Structuring), acceptance (T-Acceptance), and children's perceptions of therapists'

structuring (CT-Structuring) did not reach adequate levels of internal consistency. Therefore, the prediction that structuring would be the highest in stage 2 could not be tested.

Therapists' Perceptions Across Stages. It makes sense that therapists encourage independence in their clients towards the end of treatment, when children will soon be without their therapists. It is less clear why therapists acknowledge more negative affect in the third stage of treatment. Perhaps the negative affect simply reflects the attachment between therapist and client, and therapists feel badly as they say goodbye. Or, combining these results with those on independence, more negative feelings on the therapist's part may emerge as children are being encouraged to become more independent. Separation-individuation theory (Mahler, Pine & Bergman, 1975), the "empty nest phenomenon" (Whitaker, 1989) and Erikson's (1980) generativity vs. stagnation stage characterize this affect-laden struggle.

Seven of the eight (88%) therapist-client pairs that terminated did so partly because the therapist was leaving the agency. The eighth pair terminated mainly due to poor attendance. These terminations, complicated by therapists' own schedules, may have resulted in the

therapists having more negative affect upon termination than if the terminations were more mutually agreed upon.

The "rapport" and the "working through" stages did not correlate significantly with process variables that would characterize these stages. However, certain process variables (therapists' encouraging independence and therapists' negative affect) did correlate significantly with stage 3 data, suggesting that termination is a qualitatively different, unique phase of treatment for therapists. Coppolillo (1987) suggested that termination is a difficult stage to study due to interrupted terminations, premature terminations, and the like. Therefore, the present data are valuable.

Authors who have discussed feelings related to termination have generally focused on the clients' rather than the therapists' reactions. Mann (1973) noted that feelings about the loss of the relationship, namely separation-individuation issues, are prominent in the termination phase of treatment. Beitman (1987) and Budman and Gurman (1988) also referred to difficult and painful feelings being associated with termination. On the other hand, termination has been described as a primarily positive experience or a high point in the treatment process (Marx & Gelso, 1987; Adams, 1974). Future research regarding therapists' and clients'

affect during termination will help clarify what factors may be associated with positive and negative affect, as well as how such feelings during termination relate to treatment outcome.

The terminations from this study might best be designated as "interruptions" or "forced terminations," terms suggested by Abrams (1978), Beatrice (1982-83) and Smith (1982-83), rather than "therapeutic terminations" (Coppolillo, 1987), thus accounting for greater quantities of negative affect. In other words, the therapists may have been feeling badly that their own departure from the agency necessitated the termination of treatment. The therapists may have had feelings of guilt, narcissism, abandoning, or powerlessness, none of which were included on the feelings list on the TR. Encouraging independence may have felt especially bad to therapists if they were imposing termination on clients who otherwise would not have been ready for independence from their therapists. One wonders whether therapists who are experiencing a high degree of negative affect can facilitate a constructive experience for their clients. On the other hand, maybe therapists who are more aware of negative feelings at termination are best at facilitating helpful terminations. These are interesting questions which could be pursued in future

studies, exploring process variables along with treatment outcome in various stages of treatment.

It could be that therapists of child clients have a greater tendency to have negative feelings during termination than therapists of adult clients. One reason for this may be that therapists perceive and have compassion for the vulnerable nature of children receiving treatment. However, this hypothesis could not be tested because the present study included only child clients. It remains unclear as to what impact clients in this study being children had on the therapists' negative feelings during termination, another question for future research.

Contrary to predictions, therapists' goals of providing insight and catharsis were stable across stages in treatment. Although not predicted, these results are consistent with the idea that therapists provide a stable, predictable, safe environment throughout the course of therapy. These qualities are part of "the emotionally corrective experience" (Carek, 1979), or "nonspecific factors" (Parloff, 1986), thereby accounting for why these variables remained consistent across stages.

Children's Perceptions Across Stages. Contrary to predictions, information collected from the children did

not indicate any significant change over time. It was
hypothesized that children would understand why they
come to therapy, what their therapists' expectations
were and how therapy helps them more in stage 3 than in
the first two stages. However, the data did not support
these predictions.

Why did children's perceptions of these or other
process variables not differ across stages? Average
mean scores and average standard deviations were
computed separately for all the process data on TR and
CR-R scales, to determine whether differences in
variance may account for why TR scales varied
significantly across stages but CR scales did not.
Post-hoc t-tests revealed no significant differences
between the average means or variance for process data
on the TR and the CR-R, suggesting that neither
restriction in range nor ceiling effects could explain
the consistency of the children's data over time.

There are several ways to understand therapists
having identified significant differences in treatment
between stages, while children did not. First, children
are probably less aware of the grand scheme for the
treatment, whereas therapists usually have a treatment
plan of some kind in mind. Thus, children may be more
likely to have a constant view of the treatment.

Children may be so focused on the routines that develop in therapy that they are not aware of changes in the process over time. If this were the case, it could speak to the needs of many individual child therapy clients for consistency and predictability. Alternately, perhaps therapists tend to overemphasize consistency and predictability with their child clients, rather than to devote attention to both routines and movement toward change in the treatment.

Although we don't know whether the children who note more changes over time have better treatment outcomes, this would seem logical. Children who are more aware of changes in the therapy process would probably be more likely to note their own progress, which is one kind of change; it is undoubtedly necessary for progress to be recognized in order for successful treatment outcome to be documented. Maybe therapists should take more responsibility for conveying the treatment plan and progress to the child in a way that can help the children notice changes. If the children have no cognitive framework for their treatment, as the data suggest, their perceptions may be so similar over time that awareness of differences across stages may be difficult. This could impede effective treatment, a question for future research.

A second interpretation of children not identifying significant differences across treatment stages involves children's cognitive abilities. Maybe children cannot comment meaningfully on subtle changes occurring across stages in therapy, since young children (less than eleven years old) are generally concrete rather than abstract thinkers (Bierman, 1983; Harter, 1977; Inhelder & Piaget, 1958). Noting changes in the therapy process over time requires identifying the intangible, a skill in which young children are not well-versed.

A third way to interpret children not identifying significant differences in treatment across stages is that the measure was not sensitive enough to access children's views. Garbarino et al. (1990) described differences between children and adults in communication. The current CR-R may insufficiently tap children's awareness of their own treatment. Therefore, the CR-R measure, although internally consistent, may need revision. Open-ended interviews may be helpful, to understand what content and process areas are most relevant to the children themselves. Also, study of children's ability to answer objective questions about hypothetical therapy situations may be helpful, to explore whether they can comment meaningfully about a therapy situation not their own. Future studies should

explore how to reach children more effectively with research measures. Based on current data, a conclusion that children are not capable of commenting meaningfully on the process of their own therapy would be premature.

<div align="center">Limitations</div>

The sample size, although more than twice that of Tucker's study, was the greatest limitation in the present study. Studies on the process of adult therapy have generally used factor analysis rather than correlational procedures to look at relationships among scales (Orlinsky & Howard, 1975). However, the small sample size did not allow factor analysis, to determine the factor structure of the TR and CR-R. Also, the small sample size ruled out the possibility of looking separately at the process data according to diagnostic category, therapist level of experience, and agency, to examine possible influences of these factors more effectively.

A second limitation was that the present study did not assess outcome in treatment, but rather was confined to process variables. Therefore, the implications of the results of this study for the therapy process are difficult to assess; connections between process and outcome could not be tested. For example, we know that therapists experience significantly more negative affect

in stage 3 than in stages 1 or 2, but cannot draw conclusions about how or if therapists' negative affect in stage 3 impacts treatment outcome.

A third limitation was that only self-report measures completed by therapists and their child clients were used. Although self-report measures provide a valuable source of information, objective data such as observer ratings of the therapy process would be helpful to cross-validate subjective experiences reported by therapist-client pairs. Multiple measurement of the therapy process would provide more information and increase the validity of the findings.

A fourth limitation was the measure of stage of treatment used in this study. The Stage Form was developed based on the literature; whether the stages on the form were clinically meaningful to the therapists who filled them out is unclear. For one (but only one) therapist-client pair, for instance, the assessment went from stage 2 to stage 1 and then back to stage 2 again. This example raises the question of whether the stages were as distinct as the measure represented them to be. In future studies, it would be helpful to interview therapists to get their conceptualizations about stages in treatment; such a procedure would assist in determining how stages in therapy can be delineated most

meaningfully.

The methodology in the present study does not lead to unequivocal causal interpretations, a fifth limitation. For example, the correspondence between child and therapist perceptions revealed only the degree of association among variables, rather than which aspects of the therapy process influenced which others.

A sixth limitation of the present study is the possibility of a social desirability effect. Subjects might have skewed their answers to make a good impression. However, a study such as this is impossible to conduct without informed consent of both clients and therapists. Furthermore, neither the children nor the therapists the study seemed uncooperative, guarded or "put on" in a way that would indicate difficulty sharing candid thoughts or feelings.

This study was designed as a cross-sectional (between subjects) study primarily for practical reasons. Therefore, each client-therapist pair was studied in only one stage of treatment. This is a seventh limitation because it remains unclear as to whether therapists' perceptions actually changed across stages, or whether the stage 3 therapists might have had different perceptions all along. With a cross-sectional design, no method is available to correct for this

possibility. A longitudinal (within subjects) design would be the best solution to this problem. However, substantially more time would be required for data collection, which was not available for the present study.

Generally, a relatively large range of responses for dependent measures is desirable. An eighth limitation in the present study was the limited range of possible responses to each item on the TR and CR-R. There were only three options from which to select. Ceiling or floor effects created by limited choices can restrict the amount of change that can be shown. More latitude on each scale, such as five instead of three choices, might have increased the ability of the analyses to detect changes across stages in treatment. A disadvantage to more options, however, is that child clients may have difficulty making finer distinctions.

Implications for Future Research

In spite of the above limitations, the present study confirmed hypotheses relating to the process of child therapy. This study also confirmed results from previous research (Tucker, 1988; Orlinsky & Howard, 1986), demonstrating that the TR and CR-R are useful and internally consistent instruments with which to measure the process of child therapy. Significant correlations

among scales also emerged, lending empirical support for several theories in psychotherapy (Shapiro & Esman, 1985; Harter, 1977; Riesman, 1973; Rogers, 1951).

The present study forged new territory as well, confirming that the revised Child Goals scales were internally consistent, and offered insight into how children perceive the purpose of their own treatment. Additionally, for the first time, stages in child treatment have been studied in a formal investigation.

The present study leaves many questions unanswered, but points to areas for future research. First, although as a result of this study we know more about process in child therapy, this exploration can be continued by perfecting our measures to better access both therapists' and child clients' experiences in treatment relationships. Furthermore, to conduct clinically meaningful studies on stages in treatment, further investigation of how treatment stages can be understood and measured will be helpful. Third, use of the Orlinsky and Howard (1986; 1985; 1979; 1975) model to investigate process and outcome simultaneously will be optimally advantageous in the future.

The study of stages in treatment is fertile ground for investigation. The hope is that in the future, therapists will be able to use different interventions

at different stages of treatment, depending on how process variables are found to impact treatment outcome. Through this study a picture has begun to emerge that can be used to guide therapists to conduct more effective psychotherapy for children with psychological disturbances.

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APPENDIX A

Date _____   Client Code _____

                             Therapist Code _____

Child Therapist Therapy Session Report (TR)

        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 numbers
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.

Part I. 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 Alot

1. Helping my client feel accepted in   0   1   2
    our relationship.
2. Getting a better understanding of   0   1   2
    my client, of what was really going on.
3. Helping my client talk about his/her   0   1   2
    feelings and concerns.
4. Helping my client get relief from   0   1   2
    tensions or unhappy feelings.
5. Helping my client understand the   0   1   2
    reasons behind his/her reactions.
6. Supporting my client's self-esteem   0   1   2
    and confidence.
7. Encouraging attempts to change and try   0   1   2
    new ways of behaving.
8. Moving my client closer to   0   1   2
    experiencing emergent feelings.
9. Helping my client learn new ways for   0   1   2
    dealing with self and others.
10. Establishing a genuine person-to-   0   1   2
    person relationship with my client.
11. Helping my client get better self-   0   1   2
    control over feelings and impulses.

12. Helping my client realistically   0   1   2
    evaluate reactions and feelings.
13. Sharing empathically in what my   0   1   2
    client was experiencing.
14. Getting my client to take a more active 0   1   2
    role and responsibility for progress
    in therapy.
15. Encouraging my client to review   0   1   2
    progress already made in therapy.
16. Helping my client plan behavior   0   1   2
    outside the session.

Part II.   Interpersonal Behavior.

During this session, how much: No Some Alot

1. Did you talk?   0   1   2
2. Were you attentive to what your   0   1   2
    client was trying to get across?
3. Did you tend to agree with or accept   0   1   2
    your client's ideas or suggestions?
4. Were you critical or disapproving   0   1   2
    towards you client?
5. Did you take initiative in defining   0   1   2
    the issues that were talked about?
6. Did you try to change your client's   0   1   2
    point of view or way of doing things?
7. Encouraging attempts to change and try   0   1   2
    new ways of behyaving.
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
11. Did you attempt to nurture or support   0   1   2
    the client?
12. Did you offer novel solutions to the   0   1   2
    client's problems?

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

               No Some Alot   No Some Alot

1. Confident   0   1   2   18. Affect-   0   1   2
                                   ionate
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. Discour-	0	1	2
				aged			
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	0	1	2
16. Hurt	0	1	2	attracted			
17. Depressed	0	1	2	33. Other:	0	1	2

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

	No	Some	A lot			No	Some	A lot
1. Confident	0	1	2	18. Affect-	0	1	2
				ionate			
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. Discour-	0	1	2
				aged			
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	0	1	2
16. Hurt	0	1	2	attracted			
17. Depressed	0	1	2	33. Other:	0	1	2

APPENDIX B

Child Session Report Responses (CR)

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. mad _____
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 put 2 to indicate "a lot," 1 to indicate "a
little," or 0 to indicate "not at all."

1. My therapist played with me 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

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? _____
_____

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 home and play

Part IV - Child's Perception of Therapist'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. mad _____   6. proud _____
7. tired _____   8. happy _____   9. scared _____
10. relaxed _____   11. bored _____   12. liked _____
13. angry _____ 14. worried _____

APPENDIX C

<u>Instructions for Child Report-Revised</u>

This measure is to be used at the end of the therapy
session. It is composed of items that cover four areas:
child's feelings during the session, behavior in
session, child's understanding of the goals of therapy,
and child's perceptions of the therapist's feelings
during the session. The measure will utilize a Q-sort
technique. Instructions are as follows:

Today I will be asking you some questions about the

therapy session you just finished. It is important that

you understand that your answers to the questions will

be kept confidential. That means that I won't tell your

therapist or your parents your answers to these

questions. If <u>you</u> want to talk to your therapist or to

your parents about what we talk about, then that is

okay. But <u>I</u> won't be telling them about your answers.

Part I - <u>Child's Feelings</u>

These questions are about your feelings during the

therapy session that you just had. Children feel lots

of different things when they are in therapy. I have a

stack of cards here that list several feelings that

children can have in therapy. I want you to put these

cards into three stacks. If the card describes

something that you felt very strongly or very much in

this session, put it in the stack that says, "A LOT."

If the card describes a feeling that you had a little,

put it in the stack that says, "A LITTLE." If the card

describes something that you did not feel, put it in the

stack that says, "NONE." I will read each card, then

let you put it in one of these stacks. There are no
right or wrong answers; I just want to know how you
felt.

Word list: safe, sad, cheerful, stubborn, proud, mad,
happy, tired, scared, bored, relaxed, liked, angry,
worried.

Part II - Child's Perception of Behavior in Session

This part is about what happened in therapy today. Lots
of different things happen in therapy, and this stack of
cards tells some of the things that might have happened
in your session today. I will read each card and you
will put it in a stack. If the card says something that
happened a lot this session, put it in the stack that
says, "A LOT." If the card says something that happened
a little, put it in the stack that says, "A LITTLE." If
th card says something that didn't happen at all, put it
in the stack that says, "NONE." Let's do some examples
first. If a card said, "My therapist stood on his/her
head this session," where would you put that?" If a
card said, "My therapist stayed in the room with me this
session," where would you put that? Good. Let's go on.

Item list: 1. My therapist played with me 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 did most of the talking 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 today.
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 worked hard during this session.
21. I was busy in therapy today.

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

Children come to therapy for lots of reasons and try to do different things in therapy. I will read some more cards and I want you to tell me how much each card describes you and why you see your therapist. If the card describes you "a lot," it goes here, if it describes you "a little," it goes here, and if it doesn't describe you at all, it goes in this pile. Remember – there are no right or wrong answers; I just want to know how therapy is for you.

Items: I COME TO THERAPY:
1. because my parents think it will help me.
2. because I think it will help me.

3. so that I will stop getting into trouble
at school (e.g. my teacher won't yell at
me).
4. so that I will do better work at school
(e.g. get better grades, finish my work,
pay attention).
5. because I'm a bad kid.
6. so that I will feel happier.
7. so that I can get rid of my "yucky"
feelings (e.g. like sad, mad, bad,
scared, or any kind of feelings like
those).
8. so that I can get along better with my
family (e.g. so that my parent won't
yell at me or punish me so much).
9. so that I can get along better with
other kids (e.g. so that I can make more
friends, not fight with friends so much,
play more with friends).
10. because I like to have fun and play.
11. so that someone will listen to me.

I REALLY DON'T KNOW WHAT MY THERAPIST WANTS ME
TO:

12. talk about in therapy.
13. do in therapy.

MY THERAPIST:

14. helps me talk about whatever I want to
talk about.
15. helps me talk about what's bothering me.
16. thinks it's okay to have "yucky"
feelings.
17. helps me work on my problems.
18. helps me feel good about myself.
19. gives me ideas for how to get along
better with other people.
20. helps me consider (notice) the feelings
of others (e.g. parent, brother or
sister, teacher, friends).
21. understands me.
22. helps me make sense of the worries I
have.
23. I trust my therapist.

Part IV - Child's Perception of Therapist's Feelings

Okay, this is the last part. Just like kids, therapists

have lots of different feelings during therapy sessions.

Many of the feelings that therapists have during sessions are listed on these cards. I want you to put these cards in three stacks like you did before. If you think the card describes a feeling your therapist had very strongly during this session, put it in the stack that says, "A LOT."   If you think it describes a feeling that your therapist had a little, put it in the stack that says, "A LITTLE." If you think it describes a feeling your therapist didn't have at all, then put it in the stack that says, "NONE." Remember, these are what you think your therapist was feeling during session today.

Word list: safe, sad, cheerful, stubborn, mad, proud, tired, happy, scared, relaxed, bored, liked, angry, worried.

Date _____   Child's Code _____

                               Therapist's Code _____

                               Examiner _____

Child Session Report Responses - Revised (CR-R)

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. mad _____
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 put 2 to indicate "a lot," 1 to indicate "a
little," or 0 to indicate "not at all."

_____   1. My therapist played with me 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 did most of the talking 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 today.
_____   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 worked hard during this session.
_____ 21. I was busy in therapy today.

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

I COME TO THERAPY:

_____ 1. because my parents think it will help me.
_____ 2. because I think it will help me.
_____ 3. so that I will stop getting into trouble at
         school (e.g. my teacher won't yell at me).
_____ 4. so that I will do better work at school (e.g.
         get better grades, finish my work, pay
         attention).
_____ 5. because I'm a bad kid.
_____ 6. so that I will feel happier.
_____ 7. so that I can get rid of my "yucky" feelings
         (e.g. like sad, mad, bad, scared, or any kind
         of feelings like those).
_____ 8. so that I can get along better with my family
         (e.g. so that my parent won't yell at me or
         punish me so much).
_____ 9. so that I can get along better with other kids
         (e.g. so that I can make more friends, not
         fight with friends so much, play more with
         friends).
_____ 10. because I like to have fun and play.
_____ 11. so that someone will listen to me.

I REALLY DON'T KNOW WHAT MY THERAPIST WANTS ME TO:

_____ 12. talk about in therapy.
_____ 13. do in therapy.

MY THERAPIST:

_____ 14. helps me talk about whatever I want to talk
          about.
_____ 15. helps me talk about what's bothering me.
_____ 16. thinks it's okay to have "yucky" feelings.
_____ 17. helps me work on my problems.
_____ 18. helps me feel good about myself.
_____ 19. gives me ideas for how to get along better
          with other people.

_____ 20. helps me consider (notice) the feelings of
          others (e.g. parent, brother or sister,
          teacher, friends).
_____ 21. understands me.
_____ 22. helps me make sense of the worries i have.
_____ 23. I trust my therapist.

Part IV - Child's Perception of Therapist'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. mad _____   6. proud _____
7. tired _____   8. happy _____   9. scared _____
10. relaxed _____   11. bored _____   12. liked _____
13. angry _____   14. worried _____

APPENDIX D

Date _____   Client Code _____

                                       Therapist Code _____

                          <u>Stage Form</u>

It is important in this study to identify when, during
the course of treatment, this data is being collected.
Writers have described three stages that commonly occur
in treatment. Please read the descriptions below and
indicate the stage of therapy (circle the number) that
best-describes the treatment now.

              1   2   3

1) RAPPORT - CREATING THE "THERAPEUTIC ALLIANCE"

You are working to understand the child's world and
perspective in order to establish contact with the
child, thereby engaging the child's trust and
confidence. You are trying to establish a good rapport
between yourself and the client, and you are working
toward conveying empathy to the client, thus creating an
"alliance."

2) WORKING PHASE OF TREATMENT

You are applying your understanding of the child and the
child's problem(s), and using the alliance established
in stage 1 to encourage behavior change in and outside
of the sessions. You may be doing this by being
supportive and encouraging, helping the child understand
him/herself and his/her actions, or facilitating the
child talking about or playing out his/her issues, for
example.

3) ENDING TREATMENT - PREPARING FOR ACTUALLY TERMINATING

You are acknowledging changes achieved by the child, and
you are making efforts to assist the child in undergoing
the transition to end the therapy. You are reviewing
the treatment, talking about what does and does not help
as a way to manage problems better, and so on.

APPENDIX E

Date _____   Client Code _____

                                         Therapist Code _____

Short Demographic Form

Please either circle the correct answer and/or fill in
the blank.

1. Are you a) male
           b) female?

2. Which category below best describes your professional
   training level? (please circle letter a,b, or c, <u>and</u>
   appropriate degree)

a) working toward Ph.D. in psychology, Psy.D., or M.S.W.
b) possess Ph.D., Psy.D., or M.S.W.
c) possess degree other than described in a. and b.,

   please specify: _____

3. Please indicate the number of years you have been
   doing therapy which has directly involved children
   (including family treatment):

   years and months of experience _____

Please indicate the number of years you have been
doing therapy of any kind (including adult treatment,
this time):

   years and months of experience _____

4. Has this child had therapy before now?

    a) Yes - if yes, please specify modality:
       _____ (individual, family, or group).
       When was it? _____
    b) No

5. Is this client in any other modality of treatment at
    the present time?

    a) yes - if so, please specify modality:

       _____
    b) no

6. How many therapy sessions <u>have you had</u> with this
    child client?

                  _____

7. Please estimate how many more sessions <u>you plan to</u>
    <u>have</u> with this child client (after today).

    _____

8. Do you expect that this child will participate in a
    different modality of treatment after terminating
    with you?

    a) Yes — if yes, please specify modality:

    _____ (individual, family, or group)

    b) No

9. Is the child client
    a. male or
    b. female?

10. What is the age of the child you are participating
    in this study with, in years and months? (Circle
    the appropriate letter <u>and</u> fill in the blank,
    please.)

a) 5 years, _____ months   e) 9 years, _____ months
b) 6 years, _____ months   f) 10 years, _____ months
c) 7 years, _____ months   g) 11 years, _____ months
d) 8 years, _____ months   h) 12 years, _____ months

11. What is the DSM-III diagnosis of the child with
    whom you are participating in this study? Please
    include Axis I and Axis II.

Axis I: _____

Axis II: _____

The dissertation submitted by Ruth Cliffer Greenthal has been read and approved by the following committee:

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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

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

November 26, 1990
Date   Director's Signature