INFLUENCE OF CLIENT PREPARATION AND PROBLEM SEVERITY ON ATTITUDES AND EXPECTATIONS IN CHILD PSYCHOTHERAPY

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CHAPTER I

INTRODUCTION

Current research in psychotherapy outcome is recognizing that psychotherapy is a multidimensional process with a multidetermined outcome. The major determinants of successful psychotherapy are presently thought to lie in the characteristics of the client, the therapist, and the client-therapist interaction rather than in the treatment procedure (e.g., Frank, 1979, 1982). Recent research has attempted to identify those client and therapist components which are present in many, if not all, therapeutic relationships.

The term "nonspecific treatment factors" refers to those common components which are frequently unspecified but are thought to significantly influence treatment outcome. Although these factors have been discussed extensively (e.g., Bootzin & Lick, 1979; Frank, 1973; Kazdin, 1979; Wilkins, 1979), very little research exists to delineate how these variables influence therapeutic change (Kazdin, 1982).

One factor that has long been thought to affect the process and outcome of psychotherapy is expectations--the client's expectations, the therapist's expectations, and the mutuality of those expectations (Frank, 1959, 1971, 1973; Goldstein, 1962a, 1966). Two major classes of expectations operating in the therapeutic setting have been defined and investigated.

Goldstein (1962a) delineated the difference between participant role expectations and prognostic expectations. Participant role expectations are the anticipations held by the client and therapist regarding the behavior that will be shown by both participants in the therapeutic relationship. Prognostic expectancy is the degree of client improvement anticipated by the client and by the therapist.

Research on the importance of participant role expectations in psychotherapy with children has shown that inappropriate role expectations or misunderstandings about the treatment process have consistently been related to dropout at child psychiatric and guidance clinics (Drucker & Greenson, 1965; Farley, Peterson, & Spanos, 1975; Levitt, 1958; Richardson & Cohen, 1968). Additional studies in child psychotherapy have pointed to the importance of both children's and parents' role expectations to the treatment process (Day & Reznikoff, 1980b; Weiss & Dlugokinski, 1974).

This research followed numerous studies with adults which indicated that a discrepancy between client expectations and actual therapeutic process frequently resulted in premature termination (Clemes & D'Andrea, 1965; Goldstein, Heller, & Sechrest, 1966; Heine & Trosman, 1960; Horenstein & Houston, 1976; Imber, Nash, & Stone, 1955; Overall & Aronson, 1963; Strupp & Bloxom, 1973). Lennard and Bernstein (1960) suggested that a major reason for clients terminating treatment was that they had misconceptions about what they were supposed to do in therapy and how treatment could help them.

To counter clients' incorrect expectations of therapy, investigators turned to the study of preparation techniques to correct treatment expectations. Research with adults demonstrated that preparing clients

corrected inappropriate expectations about treatment, improved attendance and progress, and reduced premature termination (Heitler, 1976). Holmes and Urie (1975) found that a preparation interview with children reduced premature termination, while Day and Reznikoff (1980a) indicated that a videotape preparation procedure was effective in reducing children's and parents' incorrect expectations about treatment.

A recent study by Bonner and Everett (1982) assessed the effects of preparation on normal (non-clinical population) children's attitudes toward and expectations of child psychotherapy. This study found that an audiotape preparation procedure operated in a dual fashion, significantly increasing the children's knowledge of treatment structure and their expectations for treatment outcome.

While empirical research supports the need to prepare clients, Levine, Stolz, and Lacks (1983) also acknowledge ethical and practical reasons for providing systematic preparation information to clients who are beginning therapy. In summary, the current research in both child and adult psychotherapy reflects that incorrect role expectations and misunderstandings about treatment structure can be disruptive to the therapeutic process. Additionally, current findings indicate that preparation procedures are effective in correcting expectations and in reducing premature termination. Additional research is needed with a clinical population of children and parents to further clarify the effects of preparation on attitudes and expectations in child psychotherapy.

Research on the effects of clients' and therapists' prognostic expectations in psychotherapy with children has received little attention. In a study assessing normal children's expectations of psychotherapy, it was found that the children were highly attracted and receptive to

psychotherapy and that they had very positive expectations for treatment outcome (Bonner & Everett, 1982). However, children's and parents' prognostic expectations have not been assessed in a clinical setting. How the participants' initial prognostic expectations affect the process of child psychotherapy is yet to be delineated.

In psychotherapy with adults, research on the influence of clients' prognostic expectations has been sizable; however, no conclusive findings have emerged. Current opinions on the importance of client prognostic expectations as a relevant variable to the therapy process range from Wilkins (1979), who views client expectations as a questionable interpretive artifact for the effectiveness of therapy, to Bootzin and Lick (1979), who regard client expectancy as a viable alternative explanation for the efficacy of psychotherapy.

Early studies on the influence of therapist prognostic expectations suggested that the therapist's prognosis for treatment outcome might be even more important than that of the client (Goldstein, 1960). In a study of brief psychotherapy with children, Wurmser (1974) found that therapist prognostic expectations was a significant variable in the prediction of therapy outcome. More recent studies with adults have supported the importance of therapist prognostic expectations to the treatment process (Berman, 1980; Martin, Sterne, Moore, & McNairy, 1977).

To summarize, research on the influence of participants' prognostic expectations in child psychotherapy is extremely limited. While research with adults increasingly indicates the importance of expectations to the treatment process, few studies exist that assess the influence of this factor in child psychotherapy.

Another client factor that has emerged as salient to the psychotherapy process with both adults and children is the initial severity of the client's problems (Barrett, Hampe,& Miller, 1978; Phares, 1981). Research with children indicates that the severity of the child's problems is a relevant factor in the treatment prognosis (Eisenberg, Gilbert, Cytryn,& Molling, 1961; Persons, 1967; Shore & Massimo, 1973). A major review of research on factors influencing adult psychotherapy concluded that the initial level of the client's problems was a critical factor in the process of treatment (Luborsky, Chandler, Auerbach, Cohen,& Bachrach, 1971).

Numerous studies reflect that children with different kinds of problems or diagnoses will respond differently to treatment (e.g., Heinicke & Strassmann, 1975). While the nature of the relationship between problem severity and improvement has not been clearly delineated, studies with children have indicated that improvement is inversely related to the initial degree of disturbance (Hartmann, Glasser, Greenblatt, Solomon,& Levinson, 1968; Levitt, 1971). A more recent study showed that the initial degree of problem severity was one of the two major predictors in the outcome of brief psychotherapy with children (Wurmser, 1974). However, the degree to which problem severity affects children's, parents', and therapists' expectations for psychotherapy outcome has not been examined.

The purpose of this study was to assess the effects of client preparation on children's and parents' attitudes, expectancies, and understanding of psychotherapy. Additionally, how problem severity affects prognostic expectations and attitudes in child psychotherapy was examined. Specifically, it was hypothesized that:

1. Children and parents who receive information preparing them for psychotherapy will understand more about the structure of therapy, have higher expectations for treatment outcome, and be more attracted and receptive to therapists and treatment than children and parents who do not receive preparation information.

2. Children will understand less about the structure of therapy, have higher expectations for treatment outcome, and be more attracted and receptive to psychotherapy than parents.

3. Older children will understand more about the structure of treatment than younger children. It is predicted that there will be no differences in younger and older children's attraction and receptivity to treatment or their expectations of therapy outcome.

4. Children and parents will see the child's problems as less severe and have higher expectations for treatment outcome than therapists.

5. Children, parents, and therapists will have higher prognostic expectations when they perceive (rate) the child's problems as less severe.

6. Children and parents will be more attracted and receptive to therapists and treatment when they perceive (rate) the child's problems as less severe.

CHAPTER II

METHOD

Subjects

Thirty-eight children, ages 6-0 to 12-0, with one of their parents served as subjects. They were recruited to participate through a comprehensive children's medical center that offers outpatient psychological services and through six child guidance centers in a southwestern state. These clinics serve a predominately white, lower- and middle-class population with referrals coming from schools, physicians, community agencies, parents, and the legal system.

To be eligible for participation, the child had to be recommended for individual psychotherapy with possible parental counseling. Children were not included in this study if they had previously participated in individual psychotherapy, or if they were psychotic, an emergency intake, or severely retarded. In addition, one of the child's parents and the child's therapist had to be willing to participate. Participation in the study was voluntary, the clients could terminate their participation at any time, and the parents were required to sign written consent forms.

The seven clinics involved in the study serve a large number of children and families each year. Data were collected from subjects across a 15-month period. Many children seen at the clinics were not eligible to participate in the study because they had previously been in individual

treatment. Five children who were identified as eligible for participation were not included as the parents chose not to participate. Several other children were not recommended for participation by their therapists due to transportation problems, recent moves into foster care, or other unusual circumstances.

The 38 children studied included 13 boys and 7 girls in the younger group (6-0 to 9-0) and 14 boys and 4 girls in the older group (9-0 to 12-0). Five of the children (13%) were from minority races while 33 children (87%) were white. The total sample had more than twice as many boys as girls (n = 27 to 11), a proportion typically seen in clinic populations (Koocher & Pedulla, 1977; Koss, 1980).

Using the DSM III classification system, the three most frequent diagnoses found in this group of 38 children were Adjustment Disorders (n = 14), Attention Deficit Disorders (n = 12), and Oppositional Disorders (n = 12). Other diagnoses included Conduct Disorders (n = 4), Anxiety Disorders (n = 4), Functional Enuresis (n = 2), and one case each of Functional Encopresis, Schizoid Disorder of Childhood, and Parent-Child Problem. (Note: The total number of diagnoses is greater than 38 as 12 children received more than one diagnosis on Axis I.)

Problem severity was assessed by having the child, parent, and therapist rate the level of the child's problems on the Behavior Assessment Scale, an instrument designed for this study. The instrument uses a nine-point scale with low scores reflecting severe problems and high scores reflecting optimal or healthy functioning. The therapists rated the children's problems as the most severe (M = 19.47), the parents' mean rating was somewhat less severe (M = 23.79), and the children saw their problems as the least severe (M = 32.29).

Problem severity was additionally assessed by the parents on the Child Behavior Checklist (CBCL), a standardized behavior checklist developed and revised by Achenbach and Edelbrock (1983). On this instrument, total behavior problem scores falling at the 90th percentile of the normative group ($\underline{T}$ score = 63) provide the cutoff point for discriminating between clinically referred and nonreferred children (Achenbach & Edelbrock, 1983). The range of the children's $\underline{T}$ scores in this study was from 54 to 83. Thirty-three (87%) of the children's scores fell at or above the 90th percentile ($\underline{T}$ score $\geq$ 63) and five (13%) of the scores fell below the 90th percentile ($\underline{T}$ score < 63). Parental ratings of problem severity on the Child Behavior Checklist and the Behavior Assessment Scale were significantly correlated ($\underline{r}$ = -.54, $\underline{p}$ < .001).

Although the children in this study were being seen for the first time in treatment, the parental reports indicated that 31 of the 38 children (82%) had experienced their presenting problems for over one year. Three of the children (8%) had experienced problems from six months to a year, while the remaining four children (10%) had been having problems for six months or less.

In assessing the children's family situations, it was found that 28 (74%) of these children's natural or adoptive parents were separated, divorced, or had never been married. Eleven (29%) of the children were living in single parent homes with their natural or adoptive mothers, 16 (42%) were living in reconstituted families with a stepparent, 10 (26%) were living with both natural or adoptive parents, and one child was living with her father and grandparents. The parents who participated in the study included 27 natural mothers, 2 natural fathers, 5 adoptive mothers, 3 stepmothers, and 1 grandmother.

Therapists

Eleven female and ten male therapists participated in the study, seeing from a minimum of one child to a maximum of seven children. Their number of years experience in therapy with children included: more than 10 years ($n = 8$), 5 to 10 years ($n = 2$), 2 to 5 years ($n = 6$), 1 to 2 years ($n = 1$), and less than 1 year ($n = 4$).

Therapists who participated included eight PhD level psychologists, ten Master's level psychologists, and one Master's level intern in psychology. Of the ten Master's level psychologists, five were enrolled in doctoral programs. Training backgrounds were in clinical, child clinical, and counseling psychology. Additionally, one Master's level social worker and one resident in psychiatry participated as therapists.

When asked their basic approach to child psychotherapy, 15 (71%) of the therapists reported using an eclectic approach. Other therapists reported using a psychodynamic approach ($n = 2$), relationship therapy ($n = 2$), and play therapy ($n = 2$).

Apparatus

Audiotapes

Two audiotapes of a simulated interview with a child therapist were used in this study. The audiotapes were developed and used effectively by Bonner and Everett (1982) in a study assessing the effects of preparing normal (non-clinical population) children for psychotherapy.

Graduate students familiar with the structure of psychotherapy were used to enact the roles of a female therapist who works with children

and a male radio interviewer. A child whose voice was judged to be non-identifiable with regard to gender played an assistant interviewer.

Depending on the participants' group placement, the parent and child heard an audiotape containing information from one or both of the following areas:

Introduction Information. The audiotape introduced a radio announcer and a child interviewing a child therapist. This section of the audiotape briefly explained what a child therapist does and where he or she usually works with a child.

Preparation Information. This section of the audiotape conveyed information about the structure of therapy. The model presented was generally an eclectic approach to individual child psychotherapy with the parents possibly involved in collateral counseling. Areas specifically covered were the structure and outcome of treatment, resistance to therapy, confidentiality, and the roles of the child, parent, and therapist. Copies of the audiotape transcripts are included in Appendix C.

Instruments

Behavior Assessment Scale. This five-item questionnaire was developed for the present study to assess the child's, parents', and therapists' perceptions of the severity of the child's problem(s). The items assess how the child is feeling, behaving, thinking, and getting along with others, as well as the overall severity level of the child's problems. Responses are rated on a nine-point scale with low scores indicating more severe problems. A total score for each participant is calculated by summing the scores on the five items. The areas assessed and the scaling system follow the general recommendations made by Barrett

et al. (1978) regarding the assessment of the severity of a child's problems. Copies of the three forms of this instrument for the child, parent, and therapist are included in Appendix D.

Therapy Survey. The Therapy Survey, developed and used by Day and Reznikoff (1980b), is a 25-item questionnaire measuring client expectations of the structure of treatment. The items on the questionnaire sample expectations concerning the structure and outcome of therapy, resistance to therapy, confidentiality, and the roles of the child, parent, and therapist. These areas have been reported by previous investigators as being critical aspects of client expectations of treatment (Heitler, 1976; Hoehn-Saric, Frank, Imber, Nash, Stone, & Battle, 1964; Hornstra, Lubin, Lewis, & Willis, 1972; Levitt, 1966; Sauber, 1973). Thirteen of the "yes/no" items are keyed "no" to control for acquiescence.

Day and Reznikoff (1980b) based the construct validity of the Therapy Survey on including items reported by staff members as common misconceptions about child treatment. Test-retest reliability figures for parents and children, respectively, were 0.91 and 0.67 for a one-week interval and 0.81 and 0.94 for pre- and post-treatment session administration (Day & Reznikoff, 1980b).

Modifications of the Therapy Survey were made for a previous study by Bonner and Everett (1982) in order to avoid sex-biased language, to make the questions appropriate to a more general model of child psychotherapy, and to include a "don't know" category. The Therapy Survey yields a total correct score with "don't know" responses counted as incorrect. The child and parent completed the same form of this instrument. Copies of these forms and a scoring key are included in Appendix E.

Attraction-Receptivity Questionnaire. This instrument is a 20-item questionnaire measuring a client's attraction and receptivity to therapists and treatment. The questionnaire is a modification of the Client's Personal Reaction Questionnaire developed by Ashby, Ford, Guerney, and Guerney (1957). Previous modifications of the Client's Personal Reaction Questionnaire have been used meaningfully in a number of studies of the adult therapy relationship (Goldstein, 1962b; Greenberg, 1969, 1971; Greenberg, Goldstein, & Perry, 1970; Snyder, 1961). A study by Bonner and Everett (1982) used a 25-item version of the present questionnaire in measuring normal (non-clinic population) children's attraction and receptivity to therapy.

The questionnaire used in this study consists of 20 statements describing positive or negative aspects of psychotherapy. The client answers "yes," "no," or "don't know" to indicate his or her attitude toward or receptivity to therapists and treatment. The "yes" answers are totaled to yield an attraction-receptivity score, with higher scores reflecting more positive attraction and receptivity. Children and parents complete the same form of this instrument. Copies of both forms and a scoring key are included in Appendix F.

Expectations of Therapy Outcome Scale. This five-item questionnaire was developed for the present study to measure client and therapist expectations of therapy outcome. A comparable five-item questionnaire was used previously in a study assessing normal (non-clinic population) children's prognostic expectations (Bonner & Everett, 1982). The areas assessed and the scaling procedures have been found by previous researchers to be relevant to therapeutic outcome (e.g., Berman, 1980).

Three similar forms of the instrument were used to rate the child's, parent's, and therapist's prognostic expectations. The items assess expectations regarding how the child will feel, act, think, and get along with others, as well as the amount of change expected in the child's problems over the course of treatment. The participants respond on a nine-point scale with higher scores reflecting more positive prognostic expectations. A total score for the child, parent, and therapist is calculated by summing the scores on the five items.

Two additional questions assess the expected helpfulness of therapy and expected satisfaction at the end of treatment. They are answered on a similar nine-point scale by the child, parent, and therapist. Each of the questions is scored separately and higher scores indicate more positive expectations for outcome. Copies of the three forms of this instrument are included in Appendix G.

Child Behavior Checklist. This instrument, originally developed and used by Achenbach (1978), is designed to obtain parental reports of children's social competencies and behavioral problems in a standardized format. This study used the Achenbach and Edelbrock 1981 edition standardized for children ages 6 through 11. Parental responses to the section on behavioral problems were scored and totaled to evaluate problem severity.

The parents respond to 118 behavioral problems, encircling "0" if the item is not true of their child now or within the last 12 months, "1" if the item is somewhat or sometimes true, or "2" if the item is very true or often true of their child. The scores are summed to give a total raw score which is converted to a normalized T score. Based on

the revised scoring system (Achenbach & Edelbrock, 1983), T scores range from 30 to 100 with higher T scores reflecting more severe behavioral problems. Achenbach and Edelbrock (1983) set the 90th percentile (T score = 63) as the cutoff point for discriminating between clinically referred and nonreferred children.

Content validity was established by Achenbach and Edelbrock (1981) when clinically referred children received significantly higher scores ($p < .005$) than similar nonreferred children on 116 of the 118 behavior problem items. Using referral for mental health as a criterion, the authors reported evidence for criterion-related validity in terms of significant differences ($p < .001$) between demographically matched referred and nonreferred children on all scores for all sex/age groups. For total behavior problem scores, the correlation of one-week test-retest reliability of mothers' ratings was 0.89.

Supplementary Questions. Additional questions were developed to assess other factors thought to be relevant in child psychotherapy. The child, parent, and therapist complete separate forms that include items such as duration of the child's problems, expected length of treatment, and preferred therapist characteristics. Copies of the Supplementary Questions for the child, parent, and therapist are included in Appendix H.

Procedure

Twenty younger (6-0 to 9-0) and 18 older (9-0 to 12-0) children and their parents were randomly assigned to a Preparation or No Preparation group. The children and parents who were assigned to the Preparation

group heard an audiotape that presented a brief introduction to a child therapist and information preparing them for the treatment process. Children and parents assigned to the No Preparation group served as a control group and heard only the brief introduction section of the audiotape.

Following an intake interview and a determination by the clinic staff that individual child psychotherapy with possible collateral parent counseling was recommended, initial contact was made with the clients regarding the research project. The author and six research assistants conducted the experimental sessions with the children and parents. All of the researchers were females who either had a Master's degree in psychology or were enrolled in a Master's level program.

If the clients agreed to participate, arrangements were made for them to meet with the researcher at the clinic for one hour prior to the first treatment session. At that time, the parent and child were taken to a clinic room, given written and verbal information regarding the project, and the parent signed a consent form. Copies of the Parent Information Sheets and Consent Form are included in Appendix B.

Participants then completed the Behavior Assessment Scale, an instrument measuring problem severity. The researcher read the instrument to the child and recorded his or her answers while the parent completed the form outside the clinic room.

The child and parent then heard the audiotape appropriate to their group placement. Following the audiotape presentation, the participants completed questionnaires assessing their expectations of the structure of therapy (Therapy Survey), their attraction and receptivity to psychotherapy (Attraction-Receptivity Questionnaire), their prognostic

expectations (Expectations of Therapy Outcome Scale), and a set of Supplementary Questions. The parent answered the questionnaires independently while the researcher read each instrument to the child and recorded the answers. The order of presentation of the Therapy Survey, Attraction-Receptivity Questionnaire, and Expectations of Therapy Outcome Scale was randomized across pairs of children and parents. Following the administration of these instruments, the Supplementary Questions were then completed. At this time, the parent also completed the Child Behavior Checklist, a behavior rating form assessing the nature and severity of the child's problems.

The session with each pair of participants lasted approximately one hour. At the end of the session, the participants were thanked, provided with general information about the study, and told that a letter containing the overall findings of the research would be mailed to them upon completion of the study.

In addition, the child's therapist completed the Behavior Assessment Scale, the Expectations of Therapy Outcome Scale, and a set of Supplementary Questions following his or her initial session with the child. All data were confidential and the therapists did not have access to the child's group placement (Preparation/No Preparation) or to information supplied by the child and/or the parent.

CHAPTER III

RESULTS

The results of this study will be presented in three sections. The first section will examine the effects of client preparation on attitudes and expectations of child psychotherapy. The second section reviews the effects of problem severity on attitudes toward therapy and expectations for treatment outcome. Section three will explore additional factors thought to be relevant in psychotherapy with children.

Effects of Client Preparation

To determine the effects of preparation on children's and parents' knowledge of the structure and process of child psychotherapy, a 2(Preparation) x 2(Age) x 2(Rater) analysis of variance was performed on the children's and parents' scores from the Therapy Survey. This survey is a 25-item instrument in which higher scores reflect more knowledge or understanding of the treatment process.

As there was a lack of certainty regarding the independence of the children's and parents' scores on this instrument, their scores were treated as repeated measures by the same subject. This use of a repeated measures design would result in a conservative test for significance if the scores are indeed independent. Table I presents the analysis of variance for scores on the Therapy Survey.

The significant main effect for preparation shows that prepared

TABLE I

ANALYSIS OF VARIANCE SUMMARY TABLE OF THE EFFECTS OF PREPARATION, AGE, AND RATER ON THERAPY SURVEY SCORES

Source	Sum of Squares	Degrees of Freedom	Mean Square	F Ratio
P (Preparation/No Preparation)	470.01	1	470.01	60.36**
A (Younger/Older)	62.34	1	62.34	8.01*
P x A	1.06	1	1.06	.14
S (Subject) (P x A)	264.76	34	7.79	
R (Child/Parent)	490.12	1	490.12	57.45**
P x R	2.22	1	2.22	.26
A x R	118.69	1	118.69	13.91**
P x A x R	17.40	1	17.40	2.04
S x R(P x A)	290.07	34	8.53	
TOTAL	1716.67	75		

* p less than .01.

** p less than .001.

children and parents had more knowledge about the structure and process of child psychotherapy than nonprepared children and parents, F (1,34) = 60.36, $p < .001$. On the Therapy Survey, the mean score for prepared subjects was 20.92 (SD = 3.95), while nonprepared subjects had a mean score of 15.95 (SD = 4.25). The results also show that parents had significantly more knowledge or understanding about child treatment than children, F (1, 34) = 57.45, $p < .001$. On the Therapy Survey, parents had a mean score of 20.97 (SD = 4.05); the mean score for children was 15.89 (SD = 4.09). However, children's and their parents' total scores on the Therapy Survey did not significantly correlate.

A further finding was that older children (9-0 to 12-0) were significantly more knowledgeable about psychotherapy than younger (6-0 to 9-0) children, F (1, 34) = 8.01, $p < .01$. The mean score for older children on the Therapy Survey was 18.17 (SD = 3.68), while younger children had a mean score of 13.85 (SD = 3.34).

Additionally, the analysis of variance of the Therapy Survey scores showed a significant interaction between age and rater, F (1, 34) = 13.91, $p < .001$. Mean scores on the Therapy Survey by age and rater were:

Younger children M = 13.85, SD = 3.34;

Older children M = 18.17, SD = 3.68;

Parents of younger children M = 21.30, SD = 4.26; and

Parents of older children M = 20.61, SD = 3.88.

This indicates that understanding of psychotherapy for children and parents is related to the age of the child.

An item analysis of the Therapy Survey showed that the most frequently missed items by both prepared and nonprepared subjects were related to aspects of the child's role, the therapist's role, and the

duration of treatment. The item missed most often by children and parents was, "Is it true that when children are in therapy, they can feel sure that the therapist will make their problems go away?". This item was missed by 14 (74%) prepared children, 17 (89%) nonprepared children, 6 (32%) prepared parents, and 7 (37%) nonprepared parents. This item was also found to be the least correctable by preparation procedures. Additional items frequently missed were: "Is it true that therapists try to keep children from getting angry?", "Is it true that children must talk about their problems in therapy or they are wasting the time?", and "Is it true that children in therapy usually need just about one or two sessions?".

The items most often answered correctly by parents and children were, "Is it true that a child sometimes does things that are fun in therapy?" and "Is it true that in therapy both the child and the therapist work on the child's problems?". It was also noted that parents showed more knowledge than children on three items related to the issue of confidentiality in child treatment.

To evaluate the effects of preparation on children's and parents' attraction and receptivity to therapists and treatment, a 2(Preparation) x 2(Age) x 2(Rater) analysis of variance was performed on scores from the Attraction-Receptivity Questionnaire. This questionnaire is a 20-item instrument in which higher scores reflect more positive attraction and receptivity to treatment. The children's and parents' scores were again treated as repeated measures by the same subject. Table II presents the analysis of variance for children's and parents' scores on the Attraction-Receptivity Questionnaire.

The results in Table II show a significant main effect for preparation,

TABLE II

ANALYSIS OF VARIANCE SUMMARY TABLE OF THE EFFECTS OF PREPARATION, AGE, AND RATER ON ATTRACTION-RECEPTIVITY SCORES

Source	Sum of Squares	Degrees of Freedom	Mean Square	F Ratio
P (Preparation/No Preparation)	35.58	1	35.58	4.75*
A (Younger/Older)	4.28	1	4.28	.57
P x A	1.67	1	1.67	.22
S (Subject) (P x A)	254.47	34	7.48	
R (Child/Parent)	1.90	1	1.90	.26
P x R	.21	1	.21	.03
A x R	1.16	1	1.16	.16
P x A x R	2.66	1	2.66	.36
S x R(P x A)	252.07	34	7.41	
TOTAL	554.00	75		

* p less than .05.

F (1, 34) = 4.75, $p < .05$. Prepared children and parents were more receptive and attracted to psychotherapists and treatment than nonprepared children and parents. On the Attraction-Receptivity Questionnaire, prepared subjects had a mean score of 15.68 (SD = 2.72), while nonprepared subjects' mean score was 14.32 (SD = 2.57). No significant differences were found on the Attraction-Receptivity Questionnaire between children and parents or between younger and older children.

To assess the effects of preparation on the participants' prognostic expectations, a 2(Preparation) x 2(Age) x 3(Rater) analysis of variance was performed on the Expectations of Therapy Outcome Scale scores. This scale is a five-item instrument in which higher scores reflect more positive prognostic expectations. Using a scale from 1 (will be much worse) to 9 (will be much better), the most positive prognostic expectations yield a total score of 45. The children's, parents', and therapists' ratings were treated as repeated measures by the same subject.

The analysis of variance on the Expectations of Therapy Outcome Scale scores is presented in Table III. Prepared children and parents had significantly higher expectations for therapy outcome than nonprepared children and parents, F (1, 34) = 6.09, $p < .02$. On the Expectations of Therapy Outcome Scale, the mean expectancy score for prepared children and parents was 39.42 (SD = 4.19), while the mean expectancy score for nonprepared children and parents was 36.11 (SD = 5.79).

An additional finding from the analysis of variance on the Expectations of Therapy Outcome Scale scores was a significant main effect for raters, F (2, 68) = 12.75, $p < .001$. On the Expectations of Therapy Outcome Scale, the children's mean score was 38.37 (SD = 6.61), the parents' mean score was 37.16 (SD = 3.51), and the therapists' mean score

TABLE III

ANALYSIS OF VARIANCE SUMMARY TABLE OF THE EFFECTS OF PREPARATION, AGE, AND RATER ON EXPECTATIONS OF THERAPY OUTCOME SCALE SCORES

Source	Sum of Squares	Degrees of Freedom	Mean Square	F Ratio
P (Preparation/No Preparation)	139.26	1	139.26	6.09*
A (Younger/Older)	6.00	1	6.00	.26
P x A	.19	1	.19	.01
S (Subject) (P x A)	777.85	34	22.88	
R (Child/Parent/Therapist)	505.47	2	252.73	12.75**
P x R	78.53	2	39.26	1.98
A x R	47.37	2	23.68	1.19
P x A x R	27.86	2	13.93	.70
S x R(P x A)	1348.10	68	19.82	
TOTAL	2930.63	113		

* p less than .02.

** p less than .001.

was 33.42 (*SD* = 3.10). Pairwise comparisons using Dunn's method of controlled Type I error showed that children's and parents' prognostic expectations were significantly higher ($p < .05$) than the prognostic expectations of the therapists. No significant differences were found between children's and parents' expectations or between younger and older children's expectations for therapy outcome.

Two additional questions on the Expectations of Therapy Outcome Scale assessed the participants' expectations regarding the helpfulness of therapy and expected client satisfaction at the end of treatment. The child, parent, and therapist responded on a scale from 1 (not at all helpful/satisfied) to 9 (very helpful/satisfied) with a score of 9 reflecting the most positive prognostic expectations. A 2(Preparation) x 2(Age) x 3(Rater) analysis of variance was performed on the scores for each question. The children's, parents', and therapists' ratings were treated as repeated measures by the same subject on both questions.

Table IV presents the anlysis of variance for scores on expected helpfulness. The results show a significant main effect for raters, F (2, 68) = 24.18, $p < .001$. On the item assessing expected helpfulness, the children's mean score was 8.42 (*SD* = 1.06), the parents' mean score was 7.24 (*SD* = 1.48), and the mean score for therapists was 6.26 (*SD* = 1.62). Pairwise comparisons using Dunn's method showed significant differences ($p < .05$) between the children's, parents', and therapists' scores. Children had significantly higher expectations for the helpfulness of therapy than parents, and both children and parents expected therapy to be significantly more helpful than the therapists.

On the expected helpfulness item, an additional significant effect was found for the interaction of age and rater, F (2, 68) = 3.49, $p < .05$.

TABLE IV

ANALYSIS OF VARIANCE SUMMARY TABLE ON THE EFFECTS OF PREPARATION, AGE, AND RATER ON EXPECTED HELPFULNESS SCORES

Scoure	Sum of Squares	Degrees of Freedom	Mean Square	F Ratio
P (Preparation/No Preparation)	.01	1	.01	.00
A (Younger/Older)	.07	1	.07	.03
P x A	.22	1	.22	.09
S (Subject) (P x A)	77.96	34	2.29	
R (Child/Parent/Therapist)	88.75	2	44.37	24.18**
P x R	2.12	2	1.06	.58
A x R	12.81	2	6.40	3.49*
P x A x R	1.53	2	.76	.42
S x R(P x A)	124.78	68	1.84	
TOTAL	308.25	113		

* p less than .05.

** p less than .001.

Mean scores on expected helpfulness by groups were:

Younger children M = 8.45, SD = 1.00;

Parents of younger children M = 6.80, SD = 1.70;

Therapists of younder children M = 6.60, SD = 1.19;

Older children M = 8.39, SD = 1.14;

Parents of older children M = 7.72, SD = 1.02; and

Therapists of older children M = 5.89, SD = 1.97.

Parents appear to expect therapy to be more helpful to older children while therapists expect therapy to be more helpful for younger children.

The analysis of variance for scores on expected client satisfaction is presented in Table V. A significant main effect for raters is again shown, F (2, 68) - 6.99, $p < .01$. On the item assessing expected client satisfaction at the end of therapy, the mean score for children was 7.45 (SD = 2.24), the parents' mean score was 7.21 (SD = 1.28), and the mean score for therapists was 6.00 (SD - 1.61). Pairwise comparisons using Dunn's method revealed no significant differences between children's and parents' expected satisfaction with treatment. However, both children and parents expected to be significantly more satisfied ($p < .05$) with treatment than the therapists expected them to be.

Effects of Problem Severity

To compare children's, parents', and therapists' perceptions of problem severity, a 2(Age) x 3(Rater) analysis of variance was performed on the Behavior Assessment Scale scores. This scale is a five-item instrument that assesses problem severity on a nine-point scale. A total score of 45 reflects optimal or healthy functioning and low scores reflect more

TABLE V

ANALYSIS OF VARIANCE SUMMARY TABLE OF THE EFFECTS OF PREPARATION, AGE, AND RATER ON EXPECTED SATISFACTION SCORES

Source	Sum of Squares	Degrees of Freedom	Mean Square	F Ratio
P (Preparation/No Preparation)	4.64	1	4.64	1.85
A (Younger/Older)	.16	1	.16	.07
P x A	.29	1	.29	.12
S (Subject) (P x A)	85.09	34	2.50	
R (Child/Parent/Therapist)	45.81	2	22.90	6.99*
P x R	11.18	2	5.59	1.71
A x R	14.99	2	7.49	2.29
P x A x R	2.59	2	1.29	.40
S x R(P x A)	222.77	68	3.28	
TOTAL	387.52	113		

* p less than .01.

severe problems. The participants' scores were treated as repeated measures by the same subject.

Table VI presents the analysis of variance on the Behavior Assessment Scale scores. The table shows a significant main effect for raters, F (2, 72) = 45.96, $p < .001$. On the Behavior Assessment Scale, the children's mean score was 32.29 (SD = 8.18), the parents' mean score was 23.79 (SD = 5.15), and the mean score for therapists was 19.47 (SD = 3.94). Pairwise comparisons of means were performed using Dunn's method: the results showed significant differences ($p < .05$) between the children's, parents', and therapists' scores on problem severity. Therapists viewed the children's problems as significantly more severe than the parents, and both therapists and parents saw the children's problems as significantly more severe than the children. No significant differences were found in the ratings of problem severity by younger and older children.

To examine the relationship between problem severity and prognostic expectations, participants' scores on the Behavior Assessment Scale were correlated with their scores on the Expectations of Therapy Outcome Scale. No significant correlations for children's, parents', or therapists' scores were found. The correlation was nonsignificant between parents' ratings of problem severity as measured by the Child Behavior Checklist and their scores on the Expectations of Therapy Outcome Scale.

To investigate the relationship between problem severity and attraction-receptivity to treatment and therapists, children's and parents' scores on the Behavior Assessment Scale were correlated with their scores on the Attraction-Receptivity Questionnaire. No significant correlations were found. Additionally, the correlation was nonsignificant between parental ratings of problem severity on the Child Behavior Checklist and

TABLE VI

ANALYSIS OF VARIANCE SUMMARY TABLE OF THE EFFECTS OF AGE AND RATER ON BEHAVIOR ASSESSMENT SCORES

Scource	Sum of Squares	Degrees of Freedom	Mean Square	F Ratio
A (Younger/Older)	27.48	1	27.48	.69
S (Subject) (A)	1426.32	36	39.62	
R (Child/Parent/Therapist)	3231.53	2	1615.76	45.96*
A x R	44.48	2	22.24	.63
S x R(A)	2531.32	72	35.16	
TOTAL	7261.13	113		

* p less than .001.

their scores on the Attraction-Receptivity Questionnaire.

Supplementary Information

Supplementary questions attempted to examine and further clarify other potentially relevant aspects of child psychotherapy. When children and parents were asked, "Would you rather see (or have your child see) a female therapist, a male therapist, or would you not care?", 27 (71%) of the children and 28 (74%) of the parents stated that they had no preference. For those who stated a preference, 7 (18%) children and 3 (8%) parents preferred a female therapist, while 4 (11%) children and 7 (18%) parents preferred a male. It was also noted that 6 (30%) of the younger children preferred to see a female and 5 (28%) of the parents of older boys preferred for their sons to see a male therapist.

The child, parent, and therapist were asked how many times they thought the child would need to see a therapist. For the children who responded (n = 33), the range was from 1 to 100 sessions with a mean of 9.76 sessions. (Note: One younger child replied, "Two thousand times," and another child stated, "Once a month until I'm 18 or until this problem goes away." These estimates were not included in the analyzed data.)

The range of parents' estimates (n = 31) of treatment duration was from 4 to 52 sessions with a mean of 17.0 sessions. Therapists' estimates (n = 38) of treatment duration ranged from 3 to 52 sessions with a mean of 19.95 sessions. No significant correlations were found between the participants' estimated length of treatment.

When asked to describe the kind of therapist they would like to see, the children's most frequent response was "nice." When asked to describe or tell what a "nice" therapist might do, the children responded that the

therapist would talk to them, play with them, give them treats, and allow them to read books or make things. A preferred therapist would not force them to talk, think badly of them if they were open, spank them, "holler and scream" at them, or "put tape over my mouth."

Other words used less frequently by children to describe a preferred therapist were: friendly, happy, helpful with problems, and one who would not get angry or be mean. Older children stated a preference for therapists who were experienced, trustworthy, and intelligent. In general, the children were hopeful that therapists would solve their problems, make them "do better," and as one child said, "Help you get your dreams over."

Parents' descriptors of a preferred therapists were similar to their children's, with the most frequent response being "understanding." Other preferred therapist attributes included: patient, caring, honest, friendly, compassionate, firm, and concerned. More specifically, parents described a preferred therapist as one who thinks he/she can help, is determined to get to the child's problems, has good common sense, and one who understands both the child's and the parents' problems. Parents preferred therapists who were fully qualified, well-trained, experienced, intelligent, and successful. Parents were also hopeful that the therapist would be able to "read between the lines" and "see through the child's covering up his emotions."

Summary of the Findings

To summarize the results, it can be concluded that:

1. Children and parents who receive information preparing them for psychotherapy understand more about the structure of therapy, have higher

expectations for treatment outcome, and are more attracted and receptive to therapists and treatment than children and parents who do not receive preparation information.

2. Children understand less about the structure of therapy than parents. There are no significant differences between children's and parents' expectations for treatment outcome or their attraction and receptivity to psychotherapy.

3. Older children understand more about the structure of treatment than younger children. There are no significant differences in younger and older children's attraction and receptivity to treatment or their expectations of therapy outcome.

4. Children and parents see the child's problems as less severe and have higher expectations for treatment outcome than therapists.

5. Children, parents, and therapists do not have higher prognostic expectations when they perceive (rate) the child's problems as less severe.

6. Children and parents are not more attracted and receptive to therapists and treatment when they perceive (rate) the child's problems as less severe.

CHAPTER IV

DISCUSSION

Numerous findings emerged from this study examining the influence of client preparation and problem severity on attitudes and expectations in child psychotherapy. The study provides evidence to indicate that an audiotape preparation procedure is effective in increasing children's and parent's knowledge of the structure and process of child psychotherapy, their attraction and receptivity to therapists and treatment, and their expectations for therapy outcome.

Children and parents who received preparation information showed significantly more knowledge about the structure and process of child psychotherapy than children and parents who did not receive preparation information. This finding is consistent with previous research using preparation procedures with normal (non-clinical) and clinical populations of children and parents (Bonner & Everett, 1982; Day & Reznikoff, 1980a; Holmes & Urie, 1975). The finding that children had less knowledge about psychotherapy than their parents is also consistent with previous research (Day & Reznikoff, 1980b). Additionally, it was found that older children (9-0 to 12-0) knew significantly more about the treatment process than younger children (6-0 to 9-0). The earlier finding of significant differences in knowledge of therapy in older and younger non-clinical children by Bonner and Everett (1982) is thus extended to a child clinical population.

A review of the Therapy Survey showed that certain items or categories of items are more likely to be missed by children and parents. This indicates that therapists may want to emphasize certain aspects of the treatment process when preparing their clients. For example, children and parents most frequently missed items dealing with the child's role in therapy, the therapist's role, and the duration of treatment. The review also indicated that therapists should pay particular attention to the issue of confidentiality in preparing child clients.

In general, the results suggest that therapists may need to spend more time preparing children than parents and more time preparing younger children than older children. However, the lack of correlation between children's and parents' scores on the Therapy Survey indicates that children's knowledge or understanding of psychotherapy is not consistent with that of their parents. This finding emphasizes the importance of adequately preparing both children and parents.

The findings additionally show that children and parents are very attracted and receptive to psychotherapists and treatment. With the most positive attraction-receptivity score being 20, the mean for all children and parents was 15.00. Thus, clinicians who work with children and families might be relieved to know that their clients may well approach them with very positive attitudes. Therapists might also note that parents tend to be somewhat more positively oriented toward therapy than their children, while no differences were found between younger and older children's attitudes.

Preparation procedures were found to significantly increase children's and parents' attraction and receptiveness to treatment. The mean score for nonprepared clients was 14.32 and prepared clients had a mean

score of 15.68. While the difference in prepared and nonprepared subjects' scores is statistically significant, it is relatively small and may not be clinically significant.

This finding that preparation affects attraction and receptiveness to treatment is not consistent with previous findings with non-clinical children. Bonner and Everett (1982) found that preparation did not affect non-clinical children's attraction and receptivity to treatment. These differences across studies may result from various factors. It may be that preparation does have differential effects on clinical versus non-clinical populations. However, since the non-clinical population of children scored especially high on the Attraction-Receptivity Questionnaire, ceiling effects may have minimized differences related to preparation. Further, the addition of a "don't know" answer category to the questionnaire for the present study may have influenced the results.

Children and parents were also found to have very positive expectations for treatment outcome. With a score of 45 reflecting optimal or healthy functioning, the mean expectancy score for children and parents was 37.76. Preparation procedures again influenced the children's and parents' scores; nonprepared clients ($\underline{M}$ = 36.11) had significantly lower expectations for treatment outcome than prepared clients ($\underline{M}$ = 39.42). No differences were found between older and younger children's prognostic expectations or between children's and parents' expectations of therapy outcome. The high level of children's prognostic expectations, the effects of preparation in increasing children's expectations for therapy outcome, and the lack of differences in younger and older children's

prognostic expectations are consistent with the results of a previous study with non-clinical children (Bonner & Everett, 1982).

However, children's and parents' prognostic expectations were found to be significantly higher than the therapists'. While significant differences were shown in the participants' prognostic expectations, it should also be acknowledged that all ratings reflected positive prognostic expectations. Clinicians should note that while children and parents have relatively high expectations regarding change by the end of treatment, therapists' expectations for gain are somewhat more moderate.

Two additional questions assessed more general aspects of psychotherapy outcome--expected helpfulness of therapy and expected client satisfaction with treatment. These questions were scored separately with a score of nine reflecting the most positive expectations. On the expected helpfulness item, the mean score for children, parents, and therapists was 7.31, reflecting that the participants expected therapy to be quite helpful. Children's expectations were significantly higher than their parents and both children and parents expected therapy to be more helpful than did the therapists. Of particular interest to clinicians was a finding that parents expect that therapy will be more helpful to older children while therapists think it will be more beneficial to younger children.

The second question assessed the participants' expected satisfaction with treatment. The mean score for children's, parents', and therapists' expected client satisfaction was 6.89, indicating that the participants expect high levels of client satisfaction at the end of treatment. A comparison of scores did reflect that children and parents expected to be more satisfied with therapy than the therapists expected

them to be. Based on these findings, clinicians might anticipate that child clients and their parents will enter therapy with relatively high expectations for the outcome of therapy.

The most salient finding regarding problem severity was significant differences between the children's, parents', and therapists' perceptions. Children evaluate their problems as significantly less severe than their parents, who in turn see their children's problems as significantly less severe than do the therapists. In the initial stages of therapy, clinicians need to be aware that children and parents tend to view the child's problems as less serious than a clinical judgment would tend to warrant.

Children particularly may be unaware of the seriousness of their problems. Traditionally, children are brought to therapy by their parents and they frequently appear to be unaware of their problems or the reasons for initiating treatment. Therefore, clinicians may observe an initial lack of motivation on the child's part to participate. This lack of motivation may also be reflected in the child's wish to terminate therapy prematurely. While parents view the problems as more severe than children do, they still see them as significantly less severe than therapists. Therapists may need to assist parents in acknowledging and dealing with the seriousness of their children's problems.

No significant relationship was found between children's and parents' ratings on problem severity and their attraction and receptivity to treatment. Additionally, perceived problem severity did not significantly relate to children's, parents', or therapists' expectations for therapy outcome. Thus, children, parents, and therapists did not relate higher expectations of treatment outcome to less severe problems.

This lack of relationship between perceived problem severity and attraction-receptivity to treatment and expectations for therapy outcome may have resulted from various factors. Perceived problem severity may indeed not affect the participants' level of attraction and receptiveness or their expectations for outcome. While problem severity has been acknowledged as a salient factor in child psychotherapy, it may be that its effects are more directly related to outcome rather than to initial attitudes and expectations.

However, it should be noted that this study dealt with a population of non-psychotic, outpatient children which possibly produced a restricted range of problem severity scores. This may have minimized relationships between problem severity and other relevant variables. It is possible that when a wider range of problem severity is assessed in child clients, meaningful relationships between problem severity and attraction-receptivity or prognostic expectations will be found.

The relationship between problem severity and other factors related to child psychotherapy appears to be quite complex. It is recommended that studies be conducted on an extended range of problems, further refinements be made on instruments assessing problem severity, and a more comprehensive definition of problem severity be developed.

Several supplementary questions dealt with other relevant factors in child psychotherapy, such as gender preference, expected duration of treatment, and preferred therapist characteristics. Although 27 (71%) children and 28 (74%) parents reported no preference in therapist gender, it was noted that when preferences were stated, younger children asked to see a female therapist and parents of older boys preferred a male therapist. As most clinics and child guidance centers have both male

and female staff members, this issue could be acknowledged and dealt with in the initial contact with the child or parents.

The average length of treatment expected by children was 9.76 sessions with a range from 1 to 100 sessions. These estimates are consistent with the results found in a study with non-clinical children (Bonner & Everett, 1982). They are also consistent with adult predictions about the expected duration of adult psychotherapy (Affleck & Garfield, 1961; Dodd, 1971; Garfield, 1971; Lorion, 1972). A recent report on the actual length of child and adult psychotherapy reported a median of 13 sessions over 5.5 months for children and a median of 8 sessions over 2.5 months for adults (Koss, 1980).

Parents' and therapists' estimates of treatment length were considerably longer than the children's. The parents' range was from 4 to 52 sessions with a mean of 17, while the therapists' range was from 3 to 52 sessions with a mean of 19.95. This difference between childrens' estimates and parents' and therapists' estimates may again alert clinicians to the possibility that children may expect to terminate therapy more quickly than their parents or therapists. No correlation was found between the children's, parents', and therapists' expected duration of treatment. These findings indicate that expected treatment duration is an issue that should be addressed and clarified with parents and children in the early stages of therapy.

When asked to describe what kind of therapist they would like to see, the children's most frequent response was "nice" and the parents' most frequent response was "understanding." The preferred therapist further described by the children and parents in this study appears to be a combination of warmth, genuineness, and empathy as described by

Rogers and his colleagues (Truax & Carkhuff, 1967) and the "active personal participation" concept of Betz and Whitehorn (Dent, 1978; Razin, 1977; Whitehorn & Betz, 1975). These are therapist characteristics frequently associated with successful treatment outcome. Strupp (1978) may have best described the children's and parents' preferred therapist when he stated that the most important quality of a good therapist was "compassion," a deeply felt understanding of another human being's suffering, coupled with tenderness and gentleness.

In summary, the results of this study indicate that an audiotape preparation procedure has multiple effects on children's and parents' attitudes and expectations of child psychotherapy. Preparation is effective in increasing children's and parents' knowledge of the therapy process, their attraction and receptivity to therapists and treatment, and their expectations for therapy outcome. Children and parents were seen as being quite attracted and receptive to psychotherapy and to have very positive prognostic expectations.

Significant differences were found between children's, parents', and therapists' perceptions of problem severity and their expectations for therapy outcome. Therapists saw children's problems as more severe and had lower expectations for therapy outcome than children and parents. No relationship was found between perceived problem severity and attraction-receptivity to treatment or expectations for therapy outcome.

Based on the results of this study, several aspects of preparation and problem severity warrant further investigation. Future studies using preparation techniques might focus on the effects of preparation on attendance and outcome in child psychotherapy. An aspect of problem

severity needing further examination is the relationship between initial problem severity and treatment outcome in child therapy.

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APPENDIX A

REVIEW OF THE LITERATURE

INTRODUCTION

In the past decade, research into the efficacy of psychotherapy has moved away from the question, "Does psychotherapy work?" fostered by Eysenck's (1952, 1961) and Levitt's (1957, 1963) critical reviews. The current emphasis in psychotherapy outcome research has focused on determining, "What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?" (Paul, 1967, p. 111).

This research has led to the realization that psychotherapy is not a unitary process applied to unitary problems--it is a multidimensional process with a multidetermined outcome. It is promising to note that recent reviews indicate increasing evidence for the efficacy of psychotherapy (Bergin, 1971; Meltzoff & Kornreich, 1970; Smith & Glass, 1977).

Expectancy has long been proposed as an important factor in psychotherapy. Cartwright and Cartwright (1958) pointed out that expectancy was frequently confused with faith, belief, credulity, anticipation, confidence, or conviction. To clarify the construct, Goldstein (1962b) reviewed and summarized the studies dealing with the effects of expectancy in psychotherapy. His work differentiated between prognostic and participant role expectancies of both patient and therapist.

Since that time research has focused on further clarification of the effects of clients' and therapists' role and prognostic expectations on the process and outcome of psychotherapy. Further research revealed that congruence or mutuality of the clients' and therapists' expectations was

an important facet; from this data, researchers developed pretherapy or preparation procedures in an attempt to reduce the discrepancy between the clients' and therapists' treatment expectations.

The belief that a client's expectations of therapeutic gain contributed significantly to actual therapeutic improvement was acknowledged by Frank (1959):

> a patient's expectancy of benefit from treatment in itself may have enduring and profound effects on his physical and mental state. It seems plausible, furthermore, that the successful effects of all forms of psychotherapy depend in part on their ability to foster such attitudes in the patient (p. 36).

Integrative reviews by Bootzin and Lick (1979), Berman (1980), Bernstein and Neitzel (1977), Emmelkamp (1975), Frank (1959, 1968a, 1968b), Goldstein (1962a, 1962b), Kazdin (1979), Rosen (1976), and Wilkins (1973, 1979) attest to the substantial amount of attention given to clients' expectations by researchers and theorists.

Adult Psychotherapy

Role Expectations and Client Preparation

Early studies of client role expectations pointed out the misconceptions clients held about psychotherapy and that there were some differences between lower and upper socioeconomic status (SES) clients' expectations about treatment (Aronson & Overall, 1966; Overall & Aronson, 1968). Some areas of misconception concerned the role of the therapist and the duration of treatment. Low income clients were found to enter therapy uncertain as to the appropriateness and efficacy of treatment (Hollingshead & Redlich, 1958) and to have stronger expectations for an active, supportive therapist than upper SES clients (Overall & Aronson,

1963). Garfield (1971) and Lorion (1972) reported that clients expected treatment to require only a few sessions, generally 5 to 10. Other studies by Williams, Lipman, Uhlenhuth, Rickels, Covi, and Mock (1967), Garfield (1971), and Lorion (1972) indicated that the expectations of all social groups tended to be similar--that misconceptions were shared by all social classes.

The combination of client misconceptions about psychotherapy and a sizable body of theoretical and research evidence suggesting that mutuality of client-therapist expectations concerning treatment was of major importance (Clemes & D'Andrea, 1965; Greenson, 1967; Gussow, 1967; Heine & Trosman, 1960; Lennard & Bernstein, 1960; Orne & Wender, 1968; Strupp & Bergin, 1969; Wilkins, 1973) led to the development of preparation or pretherapy orientation procedures for clients. As late as 1975 in a review of factors related to adults dropping out of treatment, Baekeland and Lundwall (1975) found that discrepancies between client and therapist treatment expectations was one of 15 factors related to the prediction of early termination of treatment.

From the early works of Orne and Wender (1968), experimental evidence has emerged to indicate that a direct attempt to influence the adult client's role expectations in a preparatory interview prior to therapy enhanced the client's use of psychotherapy and thereby promoted a more positive outcome (Heitler, 1973; Hoehn-Saric, Frank, Imber, Nash, Stone, and Mann, 1972; Sloane, Cristol, Pepernick, and Staples, 1970; Strupp and Bloxom, 1973; Yalom, Houts, Newell, and Rand, 1967). It has been found that preparation procedures increased client motivation to begin treatment, raised client and therapist expectations of improvement, enhanced client attractiveness to the therapist, and increased appropriate

in-therapy client behavior and satisfaction with treatment (Strupp and Bloxom, 1973). Other effects commonly resulting from preparation procedures have been the correction of clients' expectations about treatment, the improvement of attendance and progress, and the reduction of premature termination (Heitler, 1976).

While empirical research supports the need to prepare clients for psychotherapy, a recent article by Levine, Stolz, and Lacks (1983) emphasizes the ethical and practical reasons for providing systematic preparation information to clients who are beginning therapy. The authors indicate that although few practitioners provide preparation information to clients, there is a growing recognition by professionals and consumer groups of the obligation to protect the right of clients (e.g., Morrison, 1979).

In the 1981 ethical standards and guidelines for the delivery of services, the American Psychological Association advocates that therapists should fully inform clients about the nature of the services they are to receive (APA, 1981a). Additionally, these guidelines state that clients should receive a written plan that describes "the psychological services, their objectives, and the manner in which they will be provided" (APA, 1981b, p. 646).

Prognostic Expectations

In looking at the effects of clients' prognostic expectations on treatment outcome, the research does not currently offer clear conclusions. Wilkins (1973) reviewed the literature which claimed the clients' prognostic expectancies determined the outcome of psychotherapy; he concluded that the results of empirical studies indicated no causal

relationship between expectancy and therapeutic gain. Other researchers have argued that the expectations a client brought to therapy could have a significant effect on the person's progress, attendance, and outcome in therapy (Clemes and D'Andrea, 1965; Goldstein, 1960; Rosenthal and Frank, 1956). Current opinions on the importance of client prognostic expectations as a relevant variable in psychotherapy outcome range from Wilkins (1979), who concluded that client expectations was a questionable interpretive artifact for the effectiveness of therapy, to Bootzin and Lick (1979), who viewed client expectancy as a viable alternative explanation for the efficacy of psychotherapy.

Fewer studies have been conducted to assess the influence of the therapists' role and/or prognostic expectations in psychotherapy with adults. Available data on therapists' expectations for the role behavior of clients is quite limited. Studies have suggested that therapists' expectations tend to mirror or complement those held by patients (Berzins, Herron, and Seidman, 1971; Martin, Moore, and Karwisch, 1977) and thus contribute to patients' and therapists' satisfaction with therapy and probably to the success of treatment (Martin, Sterne, and Hunter, 1976).

Early studies of therapists' prognostic expectancies provided contradictory and inconclusive evidence. Goldstein (1960) found that therapist expectations were correlated with treatment duration but found no significant association between therapist expectancies and change in the client's personality. Research by Uhlenhuth, Carter, Neustadt, and Payson (1959) suggested a relationship between therapists' expectations and patient response to treatment, but the data were based on a small sample and on subjective measures of treatment outcome. Goldstein (1960) suggested at that time that therapists' prognostic expectancies might be

more important than those of the client. Other studies indicated that a favorable expectation of improvement by the therapist could serve to maintain the therapeutic relationship (Heller and Goldstein, 1961) and to increase the client's responsiveness to treatment (Frank, 1968a).

From the information available in 1975, Martin and Sterne (1975) reported that the relationship between therapist prognostic expectancy and treatment outcome was "suggestive" (Goldstein, 1962b) at best. Studies done since 1975 have found that therapists', but not clients', expectations for therapeutic gain were related to objective measures of improvement (Martin and Sterne, 1975; Martin, Sterne, Moore, and McNairy, 1977). A 1980 study by Friedmann, Procci, and Fenn indicated that positive expectations from therapists appeared to have beneficial effects on adult schizophrenic patients.

Following Wilkins' (1978) assertion that there was no evidence to support the assumption that therapists' expectations played a contributory role in causing therapeutic change, Berman (1980) reviewed all available research in which client or therapist prognostic expectancy was directly assessed and then related to outcome measures. It was found that in all studies the expectations of the client and the therapist appeared to be related to outcome; however, in the better-designed studies, only the therapists' expectations maintained a reliable, if modest, relationship with the success of therapy. An empirical study by Berman (1980) indicated that initial therapist expectancy predicted later therapy outcome.

Problem Severity

In a major review of research on factors influencing the outcome of adult psychotherapy, it was found that, by far, the largest number of

significant variables dealt with qualities of the client, while relatively few significant factors were related to the therapist or the treatment method (Luborsky et al., 1971). One of seven client factors found to be significantly associated with adult improvement was the initial psychological health or the severity of the client's problems. However, research on the nature of the relationship between problem severity and improvement has been contradictory and inconclusive.

A generalization used by many clinicians is that clients who need therapy the least are the ones who will receive the most benefit from it (Phares, 1979). Luborsky et al. (1971) reviewed 28 studies that assessed the degree of initial client disturbance and found that 14 studies showed a significant positive relationship between the level of initial personality functioning and the outcome of treatment (e.g., Fiske, Cartwright, and Kirtner, 1964; Karush, Daniels, O'Conner, & Sterne, 1968; Strupp, Wallach, Jenkins, & Wogan, 1963). These studies indicated that the healthier the client was at the beginning of treatment, the better the outcome.

Two major conclusions were drawn from the results of these 28 studies. First, the initial level of the client's problems is a critical factor in psychotherapy; those clients who initially functioned less well did not improve as much with psychotherapy as clients who initially had a healthier level of personality functioning. Second, some degree of improvement was shown by clients, regardless of their initial level of functioning (e.g., Klein, 1960; Luborsky, 1962).

While the Luborsky et al. review supports the generalization that healthier clients have better outcomes, other studies have shown just the opposite. A study by Stone, Frank, Nash, and Imber (1961) indicates that

greater initial client distress is associated with greater improvement. To further complicate the empirical findings, Miller and Gross (1973) contend that the relationship between initial disturbance and improvement is curvilinear. That is, clients who initially are less disturbed or extremely disturbed will show poorer outcomes than those who are moderately disturbed.

In summary, as the search continues to delineate the factors that contribute to the successful outcome of psychotherapy with adults, it appears that the results of research point to the necessity for continued study on the effects of clients' and therapists' expectations, the benefits of preparation procedures, and the relationship between initial problem severity and treatment outcome.

Child Psychotherapy

Role Expectations and Client Preparation

Although there is considerable evidence that expectations are a relevant variable in the process and outcome of adult psychotherapy, few studies have been conducted to assess the influence of expectations in psychotherapy with children. Day and Reznikoff (1980b) designed one of the first studies to look at children's treatment expectations. Because of the importance of parents to a child's psychotheraphy, the expectations of the parents were also investigated.

Prior to beginning therapy and after the first six sessions, each child and parent completed a Therapy Survey, an instrument designed by these authors to measure expectations in the areas of treatment structure, child's role, parents' role, therapist's role, resistance to therapy, and outcome. Day and Reznikoff's findings indicated that inappropriateness

of expectations was related to client dropout. Although expectations were corrected over the first six sessions, it was suggested that inappropriate expectations were as disruptive to child psychotherapy as to adult psychotherapy.

Additional studies have focused on parental expectations about child treatment. As the decision for the child to begin psychotherapy is usually made by parents, and they typically set appointments, provide transportation to sessions, and assume financial responsibility for treatment, parental cooperation is seen as a factor in the process and outcome of child psychotherapy. One of the first studies of parental role expectations was that of Weiss and Dlugokinski (1974). They found that lower-class parents generally expected a more active treatment approach by the child's therapist than did middle- and upper-class parents. However, all socioeconomic classes were found to expect more supportive treatment for daughters than for sons.

A survey conducted by Woods (1978) obtained normative data on the expectations of mothers and child psychotherapists about the process of child psychotherapy. Although the study was somewhat limited by the use of a restricted sample, it pointed to some differences in parental and therapist expectations that could be relevant in a clinical setting. Overall, mothers expected a more personal and less directive approach, a less intensive form of psychotherapy which did not probe the child's unconscious, and a shorter term of treatment than did the child psychotherapists.

Following the lead of researchers in adult psychotherapy, investigators began to apply preparation techniques to correct misconceptions about child treatment. Three basic approaches have been used in preparing

adult clients for psychotherapy: pretherapy reading assignments, a role-induction interview, and vicarious pretherapy training or modeling on film or videotape (Sauber, 1973). These three techniques have been adapted for use with children. Mondy (1969) reported that the use of a brochure to assist parents in preparing their child for a psychologic evaluation was preferable to just the oral communication of the information to the parents by the staff.

Holmes and Urie (1975) used a pretreatment interview to prepare children 6 through 12 years of age for psychotherapy. These investigators found that the prepared children scored significantly higher than nonprepared children on a questionnaire measuring understanding of therapy. The results indicated that preparation procedures did not affect therapist liking for the child or the child's improvement in treatment. It was found, however, that prepared children were less likely to terminate therapy prematurely. This suggested that preparation involving information about therapy could be of considerable practical value as it enabled more clients to potentially benefit from therapy. The authors suggested that an intensive preparation technique, such as videotape or modeling, might be more effective.

Following the suggestion of Holmes and Urie, Day and Reznikoff (1980a) expanded the use of preparation techniques with children and parents by using videotaped modeling in the preparation procedures. Prior to the first treatment session, the families in the experimental group watched a videotape entitled, "What's a Therapy?". The children's and parents' expectations were measured using the Therapy Survey, an instrument described previously. The findings indicated that a large number of incorrect client expectations about the process of child

psychotherapy could result in early termination and that preparation procedures were effective in reducing incorrect expectations. Although there was not a direct relationship between preparation and dropping out of treatment, there was an indirect relationship: dropping out of treatment was related to having a large number of incorrect expectations and the number of incorrect expectations was reduced by the preparation procedures.

Prognostic Expectations

Research on the effects of children's, parents', and therapists' prognostic expectations in child psychotherapy has received little attention. Wurmser (1974) looked at the relationship among patient and therapist variables and three measures of outcome in brief psychotherapy with children. The Degree of Pathology Scale was used to assess the initial level of the child's pathology, the amount of change in pathology expected by the therapist, and the final level of pathology. For all outcome criteria, the therapist variable found to be the best predictor was the therapist's prognostic expectations. Other therapist variables, such as A-B score or number of years experience, did not act as significant predictors.

A recent study by Bonner and Everett (1982) looked at the influence of client preparation and therapist prognostic expectations on normal (non-clinic population) children's attitudes toward and expectations of psychotherapy. The study found that normal children show high attraction and receptivity to psychotherapy and have very positive expectations for therapy outcome. An audiotape preparation procedure was found to operate in a dual fashion, significantly increasing children's understanding of

the structure of therapy and their expectations of treatment outcome. The study further revealed that older (9 to 12) children have a better understanding of treatment structure than younger (6 to 9) children. Therapist prognostic expectations was not found to influence children's attraction and receptivity to therapy or their expectations for treatment outcome in this study.

Problem Severity

The literature in child psychotherapy indicates that the initial severity of the child's problems is a relevant factor in the therapy process (Barrett, Hampe, and Miller, 1978). Numerous studies reflect that children with different kinds of problems or diagnoses will respond differently to treatment (e.g., Heinicke and Strassmann, 1975).

Research with children has shown that the severity of the child's problems is a relevant factor in treatment prognosis (Eisenberg, Gilbert, Cytryn, and Molling, 1961; Persons, 1967; Shore and Massimo, 1973). Two studies have indicated that children's improvement is inversely related to the initial degree of disturbance (Hartman, Glasser, Greenblatt, Solomon, and Levinson, 1968; Levitt, 1971). On all the outcome criteria in Wurmser's 1974 study, the client variable found to be the best predictor of outcome was the child's initial level of functioning.

In a comprehensive review of research on child psychotherapy, Barrett et al. (1978) listed four aspects of the child and the child's disorder that should be carefully described and controlled for in future studies of psychotherapy. One aspect was the severity level of the child's disorder. To standardize the measurement of problem severity,

the authors recommended the use of a rating scale with clearly referenced rating points.

While research appears to indicate that the initial severity of the clients' problems is a relevant factor in the process and outcome of psychotherapy, how this factor influences clients' attraction and receptivity to treatment or their expectations for therapy outcome has not been examined. Further, no research has been conducted to assess children's perceptions of the nature or the severity of their problems.

In conclusion, current psychotherapy research indicates that the major determinants of successful psychotherapy lie in the characteristics of the client, the therapist, and the client-therapist relationship. Studies with both children and adults point to the importance of factors such as expectations, preparation, and initial problem severity to the process and outcome of treatment. Additional research is needed to further delineate the influence of these variables on the therapeutic process.

APPENDIX B

PARENT INFORMATION SHEETS AND CONSENT FORM

Oklahoma
State Department of Health

1000 Northeast 10th Street
Post Office Box 53551
Oklahoma City, Oklahoma 73152

Commissioner
JOAN K LEAVITT M D

July, 1982

Dear Parents:

The purpose of this letter is to invite you and your child to participate in an evaluation/research project being conducted by Frances Everett, Ph.D., Assistant Director of the Psychology Division, Guidance Service, and Barbara Bonner, M.Ed., Oklahoma State University. We are interested in learning more about psychotherapy or counseling with children and the child's and parent's understanding of the therapy process. We are also concerned about preparing or orienting clients to psychotherapy so that it may be a more useful experience for them. This project may help us further enhance the quality of psychological services that are provided to children and their families.

We would appreciate your child's and your participation in this project. Participation is completely voluntary and anyone is free to withdraw at any time. Your participation or non-participation will in no way affect your eligibility for Guidance Services. Involvement in this project will in no way limit the normal or routine services that are offered through the Guidance Centers. Some participants will be asked to listen to an audiotape introduction to psychotherapy to help us evaluate its usefulness. All participants will be requested to complete several questionnaires which assess their understanding of, attraction to, and expectations of psychotherapy. Additionally, parents, their child, and the child's therapist will be asked to complete several child behavior rating scales. Some demographic information will be collected and the child's therapist will be asked to provide information about the child's behavior and nature of the problem (diagnosis). This information will be gathered at the Guidance Center following admission for services, after six weeks of services (if applicable), and at termination or the completion of psychotherapy. Participation will take approximately one hour of your time. All information will be confidential. A brief summary of the findings will be made available to you following completion of this project. Your participation would be appreciated and may help us to structure our services to better meet the needs of children and families.

If you would like additional information about this project, please call:

Frances Everett, Ph.D.
Assistant Director, Psychology Division
Guidance Service
Oklahoma State Department of Health
1000 N.E. 10th Street
Oklahoma City, OK 73152
Telephone No. (405) 271-4477

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Department of Child Psychiatry
CORA BANEZ, M.D.
JOHN D. KARNS, M.D.
PAUL R. LANIER, M.D.

Director of Psychological Services
ROBERT A. BASSHAM, Ph.D.

Director of Social Work Services
BENJAMIN A. WETHERILL, M.S.W., A.C.S.W.

February, 1983

Dear Parents:

The purpose of this letter is to invite you and your child to participate in a research project at no cost to you. The project is being conducted by Frances Everett, Ph.D., Assistant Director of the Psychology Division, State Department of Health, and Barbara Bonner, M.Ed., Oklahoma State University. We are interested in learning more about psychotherapy or counseling with children and the child's and parent's understanding of the therapy process. We are also concerned about preparing or orienting clients to psychotherapy so that it may be a more useful experience for them. This project may help us further enhance the quality of psychological services that are provided to children and their families.

We would appreciate your child's and your participation in this project. Participation is completely voluntary and anyone is free to withdraw at any time. Your participation or non-participation will in no way affect your eligibility for services from Children's Medical Center. Some participants will be asked to listen to an audiotape introduction to psychotherapy to help us evaluate its usefulness. All participants will be requested to complete several questionnaires which assess their understanding of, attraction to, and expectations of psychotherapy. Additionally, parents, their child, and the child's therapist will be asked to complete several child behavior rating scales. Some miscellaneous information will be collected and the child's therapist will be asked to provide information about the child's behavior and nature of the problem (diagnosis). This information will be gathered following admission for services, at several points during therapy, and at termination or the completion of psychotherapy. Participation will take approximately one hour of your time. All information will be confidential. A brief summary of the findings will be made available to you following completion of this project. Your participation would be appreciated and may help us to structure our services to better meet the needs of children and families.

If you would like additional information about this project, please call:

Barbara Bonner, M.Ed.
Clinical Psychology Intern
Children's Medical Center
5300 East Skelly Drive
Tulsa, Oklahoma 74135
Telephone No. (918) 664-6600

Please sign this form below if you and your child are willing to participate. Your signature indicates that you have read and understood the preceding information and that you have had an opportunity to ask questions about this project. Your signature further indicates that you consent for you and your child to participate in this project.

CHILD'S NAME: _____

PARENT'S NAME: _____

SIGNATURE: _____

DATE: _____

Please indicate your mailing address below so that a summary of the findings of this study can be mailed to you upon completion of the project.

ADDRESS: _____

CITY & STATE: _____

ZIP CODE: _____

APPENDIX C

TRANSCRIPTS FOR AUDIOTAPES

Tape Sections Presented to Each Group:

Preparation Group:	Introduction Information Preparation Information Sign-Off
No Preparation Group:	Introduction Information Sign-Off

Transcript of Introduction Information

(Music--Up and out--10 sec.)

REPORTER: Hello! I'm Larry James, a roving reporter for Station KJOO, and with me is--

CHILD: Chris Ford!

REPORTER: --my assistant for today's special report on therapy with children. In the past few years, more and more boys and girls who have problems at home or at school have been working with a counselor or therapist. Today Chris and I will be interviewing Dr. Susan Brown, a therapist who works with children.

THERAPIST: Hello, Larry, Chris.

CHILD: We're going to ask Dr. Brown some questions about what she does as a child therapist. Dr. Brown, what exactly is a child therapist?

THERAPIST: Well, Chris, a child therapist is a person who works with boys and girls to help them with problems they are having.

CHILD: Where do you work?

THERAPIST: A therapist who works with children usually has an office in a clinic and the children come there.

Transcript of Preparation Information

CHILD: When you say problems kids have, what kind of problems do you mean? Do you mean like having a cold, or the flu? Would you give children a shot or medicine to take?

THERAPIST: (Laughs) Oh, no, Chris. We leave shots and medicine to the medical doctors. I work with children with different kinds of problems. They may be having a lot of trouble with their schoolwork, or they may be having trouble making friends--or they may be fighting and arguing with their brothers or sisters--or not getting along with their parents--or they may be just generally unhappy and not feeling very good.

CHILD: Are these children that you work with "bad"?

THERAPIST: No, these children aren't bad, Chris. They are children who are having problems and they may be feeling bad and very unhappy. They may be feeling unhappy because some bad things have happened to them--maybe their parents are getting divorced, or maybe they just can't seem to get along at school, or

sometimes children are unhappy or angry and they don't really know why.

REPORTER: So, generally, you work with boys and girls who are having problems getting along in school, at home, or with their friends.

THERAPIST: Right.

CHILD: What is therapy like? If I had a problem and went to see you about it, what would we do?

THERAPIST: Usually, I meet with the boy or girl once a week, in my office, for about one hour. Most of the time, I see the boy or girl alone--by themselves. We do lots of things in therapy--we play games, draw pictures--sometimes we talk. Children tell me about their secrets, their daydreams; sometimes we don't talk at all, we just play, and that's an important part of therapy, too.

REPORTER: How long does therapy last--or how many times is it necessary to see a child?

THERAPIST: There isn't any one exact length of time that therapy is supposed to last. I can't tell you an exact number of times that I would see a child. The number of sessions depends on what the problem is, how long the child has had the problem, and things like that. So, I can't say exactly how long therapy would last.

CHILD: Could you help me with a problem if you only saw me once or twice?

THERAPIST: Well, Chris, for a child to feel and act better, it usually takes more than a few sessions.

REPORTER: This is Station KJOO bringing you a special report today--an interview with Dr. Susan Brown, a therapist who works with children. What about the child's parents, Dr. Brown? How are they involved?

THERAPIST: If a child is being seen in therapy, both parents sometimes have counseling, too. The therapist would sometimes see the mother--and the father.

CHILD: Well, if I came to see you, who would know what I said to you? Would you tell my parents all about me--like what I said or what I did in therapy?

THERAPIST: I usually don't tell the parents what the child and I talk about--that's just between the child and me. And that reminds me of another important point. I do not tell anyone--

not the child's teachers, or the neighbors, or anyone else that I am working with a boy or girl--unless I have permission to tell them.

REPORTER: Are there other important things that you do in therapy that we should know about, Dr. Brown?

THERAPIST: Yes, Larry, there are a couple of important points I'd like to make. First, I don't listen to children's problems and then just tell them what to do or the answer to their problem. Therapy doesn't work that way. And secondly, I can't make the problem go away!

REPORTER: You mean you <u>can't</u> just say: Abracadabra--Problems go away?

THERAPIST: (Laughs) That's right! I'm not magic. It usually takes a lot of work by the child, by me, by the parents, and sometimes by the teacher, to work out the problems.

CHILD: Would I have to be good when I was with you? I mean, what would happen if I got mad or did something bad?

THERAPIST: I don't punish or scold children for bad behavior or try to stop them from getting angry. Everyone gets mad sometimes--and everyone acts bad once in a while--but, acting bad in therapy could be a problem we would work on.

CHILD: A little while ago you said that if I came to see you, we would talk, or draw, or maybe play games. That sounds like <u>fun</u>, and I didn't think that going to a therapist would be <u>fun</u>.

THERAPIST: Therapy can be <u>fun</u>, Chris--but you have to do some things that are difficult, too. For example, there may be times when you'll talk about things that are hard for you to talk about--or you might have to try to act differently and that may be hard. So there are <u>some</u> times in therapy that are difficult.

REPORTER: What if a child just wanted to play in a session--not talk about the problems--would that be a problem?

THERAPIST: Not necessarily. Playing in therapy is not a waste of time, and it's very important to remember that a child can talk about whatever he or she wants to in a therapy session.

CHILD: Is it all right to miss therapy sessions, Dr. Brown? Can I just come when I feel like it?

THERAPIST: You raised a really important point, Chris. It is very important that the child and the parents attend every session, without missing any--unless there are special circumstances such as when you are really sick or your family is on

vacation. Sometimes, however, a child won't want to go to therapy because the child has reached a difficult time--a time when he or she needs to do something that is hard to do. At these times, children should go to therapy even if they don't feel like it.

REPORTER: If a child is in therapy, Dr. Brown, does that mean they won't be scared or worried--or get angry anymore?

THERAPIST: No, Larry. Therapy doesn't keep children from ever being scared or angry.

Transcript for Sign-Off

REPORTER: Thank you, Dr. Brown, for participating in our special report on child therapy.

(Music up and hold under)

REPORTER: This has been Larry James--

CHILD: and Chris Ford--from Station KJOO.

(Music up and out)

APPENDIX D

BEHAVIOR ASSESSMENT SCALE--CHILD, PARENT, AND THERAPIST FORMS

Behavior Assessment Scale--Child Form

Directions read aloud to the child: As you are about to begin therapy, I have some questions to ask you. As you answer the questions, I want you to tell me, in general, how you have been over the past few weeks and up to now.

1. How are you feeling?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Feeling very bad		Feeling bad		Feeling all right		Feeling good		Feeling very good

2. How are you behaving or acting at home or school?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Behaving very badly		Behaving badly		Behaving all right		Behaving well		Behaving very well

3. How clearly are you thinking?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Not thinking very clearly		Not thinking clearly		Thinking somewhat clearly		Thinking clearly		Thinking very clearly

4. How are you getting along with your teachers, other children, and your family?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Getting along very poorly		Getting along poorly		Getting along all right		Getting along well		Getting along very well

5. Which of the following phrases best describes your problems?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Problems are very bad		Problems are bad		Problems are moderate		Problems are mild		Problems are very mild

Behavior Assessment Scale--Parent Form

Directions: As your child is about to begin therapy, we would like to know how he or she has been, in general, over the past few weeks and up to now.

1. How is your child feeling?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Feeling very bad		Feeling bad		Feeling all right		Feeling good		Feeling very good

2. How is your child behaving or acting at home or school?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Behaving very badly		Behaving badly		Behaving all right		Behaving well		Behaving very well

3. How clearly is your child thinking?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Not thinking very clearly		Not thinking clearly		Thinking somewhat clearly		Thinking clearly		Thinking very clearly

4. How is your child getting along with other children, teachers, and his/her family?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Getting along very poorly		Getting along poorly		Getting along all right		Getting along well		Getting along very well

5. Which of the following phrases best describes your child's problems?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Problems are very bad		Problems are bad		Problems are moderate		Problems are mild		Problems are very mild

Behavior Assessment Scale--Therapist Form

Directions: As this child is about to begin therapy, we would like for you to assess how he or she has been, in general, over the past few weeks and up to now.

1. How is this child feeling?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Feeling very bad		Feeling bad		Feeling all right		Feeling good		Feeling very good

2. How is this child behaving or acting at home or school?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Behaving very badly		Behaving badly		Behaving all right		Behaving well		Behaving very well

3. How clearly is this child thinking?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Not thinking very clearly		Not thinking clearly		Thinking somewhat clearly		Thinking clearly		Thinking very clearly

4. How is this child getting along with other children, teachers, and his/her family?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Getting along very poorly		Getting along poorly		Getting along all right		Getting along well		Getting along very well

5. Which of the following phrases best describes this child's problems?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Problems are very bad		Problems are bad		Problems are moderate		Problems are mild		Problems are very mild

APPENDIX E

THERAPY SURVEY--CHILD AND PARENT FORMS

Therapy Survey--Child Form

Directions read aloud to the child: These are some questions about what therapy is like. If you think the question is true, say "yes." If you think the question is not true, say "no." If you don't know whether the question is true or not, you can say, "I don't know." Now, listen carefully while I read each question.

1. Is it true that children in therapy usually need just about one or two sessions? Yes No Don't know
2. Is it true that children sometimes play in their therapy sessions? Yes No Don't know
3. Is it true that a child who has to go to a therapist is bad? Yes No Don't know
4. Is it true that children tell their therapist about a problem, and then the therapist tells them the answer? Yes No Don't know
5. Is it true that when a child is in therapy, it may be useful for the parents to have counseling, too? Yes No Don't know
6. Is it true that a child sometimes does difficult things in therapy? Yes No Don't know
7. Is it true that therapists try to keep children from getting angry? Yes No Don't know
8. Is it true that children must talk about their problems in therapy or they are wasting the time? Yes No Don't know
9. Is it true that most therapy sessions are about one hour long? Yes No Don't know
10. Is it true that when children are in therapy, they can feel sure that the therapist will make their problems go away? Yes No Don't know
11. Is it true that a child sometimes does things that are fun in therapy? Yes No Don't know
12. Is it true that it's all right for children to talk about secrets in their therapy sessions? Yes No Don't know
13. Is it true that if a child's mother comes for counseling, it is often helpful for the father to come, too? Yes No Don't know
14. Is it true that after children are in therapy, they never feel scared or worried? Yes No Don't know
15. Is it true that a child usually has therapy sessions once a week? Yes No Don't know

16. Is it true that if children don't want to go to their therapy sessions, therapy isn't helping them?
Yes No Don't know

17. Is it true that if a teacher wants to know if a child is in therapy, the therapist will tell the teacher without the parent's permission?
Yes No Don't know

18. Is it true that how long therapy will last depends on many things?
Yes No Don't know

19. Is it true that a therapist will tell other people everything a child says or does in a therapy session?
Yes No Don't know

20. Is it true that it is important for children to attend every one of their therapy sessions?
Yes No Don't know

21. Is it true that in therapy both the child and the therapist work on the child's problem?
Yes No Don't know

22. Is it true that when children behave badly, the therapist scolds them to get them to behave better?
Yes No Don't know

23. Is it true that children may talk about whatever they want to in their therapy sessions?
Yes No Don't know

24. Is it true that playing in therapy sessions is sometimes helpful?
Yes No Don't know

25. Is it true that if some neighbors want to know if a child comes for therapy, the therapist will tell them without the parent's permission?
Yes No Don't know

Therapy Survey--Parent Form

Directions: These are some questions about what therapy is like. Please answer the questions by encircling the appropriate answer.

1. Is it true that children in therapy usually need just about one or two sessions? Yes No Don't know

2. Is it true that children sometimes play in their therapy sessions? Yes No Don't know

3. Is it true that a child who has to go to a therapist is bad? Yes No Don't know

4. Is it true that children tell their therapist about a problem, and then the therapist tells them the answer? Yes No Don't know

5. Is it true that when a child is in therapy, it may be useful for the parents to have counseling, too? Yes No Don't know

6. Is it true that a child sometimes does difficult things in therapy? Yes No Don't know

7. Is it true that therapists try to keep children from getting angry? Yes No Don't know

8. Is it true that children must talk about their problems in therapy or they are wasting the time? Yes No Don't know

9. Is it true that most therapy sessions are about one hour long? Yes No Don't know

10. Is it true that when children are in therapy, they can feel sure that the therapist will make their problems go away? Yes No Don't know

11. Is it true that a child sometimes does things that are fun in therapy? Yes No Don't know

12. Is it true that it's all right for children to talk about secrets in their therapy sessions? Yes No Don't know

13. Is it true that if a child's mother comes for counseling, it is often helpful for the father to come, too? Yes No Don't know

14. Is it true that after children are in therapy, they never feel scared or worried? Yes No Don't know

15. Is it true that a child usually has therapy sessions once a week? Yes No Don't know

16. Is it true that if children don't want to go to their therapy sessions, therapy isn't helping them? Yes No Don't know

17. Is it true that if a teacher wants to know if a child is in therapy, the therapist will tell the teacher without the parent's permission?
Yes No Don't know

18. Is it true that how long therapy will last depends on many things?
Yes No Don't know

19. Is it true that a therapist will tell other people everything a child says or does in a therapy session?
Yes No Don't know

20. Is it true that it is important for children to attend every one of their therapy sessions?
Yes No Don't know

21. Is it true that in therapy both the child and the therapist work on the child's problem?
Yes No Don't know

22. Is it true that when children behave badly, the therapist scolds them to get them to behave better?
Yes No Don't know

23. Is it true that children may talk about whatever they want to in their therapy sessions?
Yes No Don't know

24. Is it true that playing in therapy sessions is sometimes helpful?
Yes No Don't know

25. Is it true that if some neighbors want to know if a child comes for therapy, the therapist will tell them without the parent's permission?
Yes No Don't know

Scoring Key for Therapy Survey

1. N
2. Y
3. N
4. N
5. Y
6. Y
7. N
8. N
9. Y
10. N
11. Y
12. Y
13. Y
14. N
15. Y
16. N
17. N
18. Y
19. N
20. Y
21. Y
22. N
23. Y
24. Y
25. N

APPENDIX F

ATTRACTION-RECEPTIVITY QUESTIONNAIRE--
CHILD AND PARENT FORMS

Attraction-Receptivity Questionnaire--Child Form

Directions read aloud to the child: Boys and girls have different thoughts and feelings about working with a therapist. I would like to know how you feel about it. On these questions, there are no right or wrong answers--I just want to know what you think or feel. Listen while I read each sentence. If you agree with what the sentence says or you think it's right, say "yes." If you do not agree or you think the sentence is wrong, say "no." If you are not sure about what you think, you can say "I don't know."

1. I think I will be pleased with a therapist's interest and attention.
   Yes No Don't know
2. It will be hard for me to talk about myself with a therapist.
   Yes No Don't know
3. I have a very warm feeling toward therapists.
   Yes No Don't know
4. I think only a few people can be helped by therapy.
   Yes No Don't know
5. I think that a therapist will like me.
   Yes No Don't know
6. If I get mad at a therapist, I think he or she would be angry with me.
   Yes No Don't know
7. I will feel nervous when I see a therapist.
   Yes No Don't know
8. I think that a therapist will know how to help me with my problems.
   Yes No Don't know
9. I think that a therapist will really like to spend a therapy session with me.
   Yes No Don't know
10. I would tell a friend who was having a problem to see a therapist.
    Yes No Don't know
11. I do not want to spend some time with a therapist.
    Yes No Don't know
12. A therapist is a warm and friendly person.
    Yes No Don't know
13. I will be afraid to show my real feelings to a therapist.
    Yes No Don't know
14. I have a feeling that a therapist is a person I can trust.
    Yes No Don't know
15. A session with a therapist will seem like a waste of time to me.
    Yes No Don't know
16. I think a therapist will misunderstand me.
    Yes No Don't know

17. A therapist is a person who would really like to help me.
Yes No Don't know

18. I think a therapist will confuse me.
Yes No Don't know

19. I will enjoy meeting with a therapist.
Yes No Don't know

20. I can see where therapy can do a lot to help me solve my problems.
Yes No Don't know

Attraction-Receptivity Questionnaire--Parent Form

Directions: These are some statements about your thoughts and feelings concerning working with a therapist. There are no right or wrong answers--we just want to know what your reactions are. Please encircle the answer that is most appropriate for you.

1. I think I will be pleased with a therapist's interest and attention.
   Yes No Don't know
2. It will be hard for me to talk about myself with a therapist.
   Yes No Don't know
3. I have a very warm feeling toward therapists.
   Yes No Don't know
4. I think only a few people can be helped by therapy.
   Yes No Don't know
5. I think that a therapist will like me.
   Yes No Don't know
6. If I get mad at a therapist, I think he or she would be angry with me.
   Yes No Don't know
7. I will feel nervous when I see a therapist.
   Yes No Don't know
8. I think that a therapist will know how to help me with my problems.
   Yes No Don't know
9. I think that a therapist will really like to spend a therapy session with me.
   Yes No Don't know
10. I would tell a friend who was having a problem to see a therapist.
    Yes No Don't know
11. I do not want to spend some time with a therapist.
    Yes No Don't know
12. A therapist is a warm and friendly person.
    Yes No Don't know
13. I will be afraid to show my real feelings to a therapist.
    Yes No Don't know
14. I have a feeling that a therapist is a person I can trust.
    Yes No Don't know
15. A session with a therapist will seem like a waste of time to me.
    Yes No Don't know
16. I think a therapist will misunderstand me.
    Yes No Don't know
17. A therapist is a person who would really like to help me.
    Yes No Don't know

18. I think a therapist will confuse me.
Yes No Don't know

19. I will enjoy meeting with a therapist.
Yes No Don't know

20. I can see where therapy can do a lot to help me solve my problems.
Yes No Don't know

Scoring Key for High Attraction-Receptivity

1. Y
2. N
3. Y
4. N
5. Y
6. N
7. N
8. Y
9. Y
10. Y
11. N
12. Y
13. N
14. Y
15. N
16. N
17. Y
18. N
19. Y
20. Y

APPENDIX G

EXPECTATIONS OF THERAPY OUTCOME SCALE--

CHILD, PARENT, AND THERAPIST FORMS

Expectations of Therapy Outcome Scale--Child Form

Directions read aloud to the child: On these questions, I want to know how you think things will be at the end of therapy. I will read each one and then you can tell me what you expect when therapy is over.

1. How do you expect to feel when therapy is over?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Will feel much worse		Will feel worse		Will feel the same		Will feel better		Will feel much better

2. How do you expect to behave or act at home or school when therapy is over?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Will act much worse		Will act worse		Will act the same		Will act better		Will act much better

3. How clearly do you expect to think when therapy is over?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Will think much less clearly		Will think less clearly		Will think the same		Will think more clearly		Will think much more clearly

4. How do you expect to get along with your teachers, other children, and your family when therapy is over?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Will get along much worse		Will get along worse		Will get along the same		Will get along better		Will get along much better

5. What change do you expect in your problems by the end of therapy?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Problems will be much worse		Problems will be worse		Problems will be the same		Problems will be better		Problems will be much better

6. How helpful do you expect that therapy will be?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Not at all helpful		Slightly helpful		Moderately helpful		Quite helpful		Very helpful

7. How satisfied do you expect to be at the end of therapy?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Not at all satisfied		Slightly satisfied		Moderately satisfied		Quite satisfied		Very satisfied

Expectations of Therapy Outcome Scale--Parent Form

Directions: On these questions, please encircle the appropriate number to indicate the change you expect your child to make by the end of therapy.

1. How do you expect your child to feel when therapy is over?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Will feel much worse		Will feel worse		Will feel the same		Will feel better		Will feel much better

2. How do you expect your child to behave or act at home or school when therapy is over?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Will act much worse		Will act worse		Will act the same		Will act better		Will act much better

3. How clearly do you expect your child to think when therapy is over?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Will think much less clearly		Will think less clearly		Will think the same		Will think more clearly		Will think much more clearly

4. How do you expect your child to get along with teachers, other children, and your family when therapy is over?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Will get along much worse		Will get along worse		Will get along the same		Will get along better		Will get along much better

5. What change do you expect in your child's problems by the end of therapy?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Problems will be much worse		Problems will be worse		Problems will be the same		Problems will be better		Problems will be much better

6. How helpful do you expect that therapy will be for your child?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Not at all helpful		Slightly helpful		Moderately helpful		Quite helpful		Very helpful

7. How satisfied do you expect to be at the end of your child's therapy?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Not at all satisfied		Slightly satisfied		Moderately satisfied		Quite satisfied		Very satisfied

Expectations of Therapy Outcome Scale--Therapist Form

Directions: On these questions, please encircle the appropriate number to indicate the change you expect this child to make by the end of therapy.

1. How do you expect this child to feel when therapy is over?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Will feel much worse		Will feel worse		Will feel the same		Will feel better		Will feel much better

2. How do you expect this child to behave or act at home or school when therapy is over?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Will act much worse		Will act worse		Will act the same		Will act better		Will act much better

3. How clearly do you expect this child to think when therapy is over?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Will think much less clearly		Will think less clearly		Will think the same		Will think more clearly		Will think much more clearly

4. How do you expect this child to get along with teachers, other children, and his or her family when therapy is over?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Will get along much worse		Will get along worse		Will get along the same		Will get along better		Will get along much better

5. What change do you expect in this child's problems by the end of therapy?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Problems will be much worse		Problems will be worse		Problems will be the same		Problems will be better		Problems will be much better

6. How helpful do you expect that therapy will be for this child?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Not at all helpful		Slightly helpful		Moderately helpful		Quite helpful		Very helpful

7. How satisfied do you expect the parent and child will be at the end of this child's therapy?

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Not at all satisfied		Slightly satisfied		Moderately satisfied		Quite satisfied		Very satisfied

APPENDIX H

SUPPLEMENTARY QUESTIONS--CHILD, PARENT, AND THERAPIST FORMS

Supplementary Questions--Child Form

Directions read aloud to the child: Here are some additional questions to find out more about what you think about therapy. Listen while I read each one.

1. How many times do you think you will need to see a therapist? _____

2. Would you rather see a female therapist, a male therapist, or would you not care? _____

3. What kind of therapist would you like to see? _____

Supplementary Questions--Parent Form

Directions: Please answer the following questions.

1. How old is your child? ____

2. What is your child's gender? Male __ Female __

3. Has your child previously received regular counseling at school or had psychological services? Yes __ No __

4. What grade will your child enter in the fall of 1982? _____

5. With whom is the child currently living?

   Natural Parent(s) __ Adoptive Parent(s) __
   Foster Parent(s) __ Natural Parent and Step-Parent __
   Other _____

6. Marital status of natural parents:

   Married __ Unmarried __ Separated __ Divorced __ Widowed __

7. How long has your child had his/her current problems?

(1)	(2)	(3)	(4)	(5)
Less than one month	2-3 months	4-6 months	6 months to one year	Over one year

8. Please write a number to indicate how many times you think your child will need to see a therapist. _____

9. Would you rather have your child see a female therapist, a male therapist, or would you not care? _____

10. Please describe in single words or short phrases the kind of therapist you would like for your child to see.

_____ _____

_____ _____

_____ _____

Supplementary Questions--Therapist Form

Directions: Please answer the following questions.

1. Please write a number to indicate how many times you think this child will need to see a therapist. _____

2. Which of the following phrases best describes this child's physical development?

(1) Very under-developed for age	(2) Below average development	(3) Average development	(4) Above average development	(5) Very well developed for age

3. Please complete the following questions:

Therapist Gender: Female ___ Male ___

Highest Degree of Training:
B.S./B.A. in _____
M.S./M.A./M.Ed. in _____
Ph.D./Ed.D./Psy.D. in _____
Other: _____

4. Years experience (defined as the number of years you have seen at least 5 to 10 children in individual psychotherapy):

___ Less than one year
___ 1-2 years
___ 2-5 years
___ 5-10 years
___ Over 10 years

5. Basic approach to child psychotherapy:

___ Psychodynamic
___ Play Therapy
___ Relationship Therapy
___ Behavior Therapy
___ Eclectic
___ Other: _____

6. DSM Diagnosis:

Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

APPENDIX I

RAW DATA

TABLE VII

RAW DATA

Children

Subj	Prep	Age	Behv Asmt	Ther Surv	Attr Recp	Exp Out	Exp Help	Exp Sat	Exp Sess	Subj	Prep	Age	Behv Asmt	Ther Surv	Attr Recp	Exp Out	Exp Help	Exp Sat	Exp Sess
1	P	0	24	21	15	35	7	7	4	20	NP	Y	23	14	18	31	9	1	2
2	NP	0	39	17	16	36	9	7	4	21	P	0	45	20	20	45	9	9	4
3	P	Y	35	14	16	37	9	7	4	22	NP	0	29	16	15	37	9	8	6
4	NP	Y	27	17	13	43	9	9	1	23	P	Y	30	15	13	39	9	9	4
5	P	0	39	21	15	45	9	9	8	24	NP	Y	25	8	15	42	9	9	4
6	NP	0	32	16	14	32	9	9	2	25	P	0	39	20	15	39	9	9	10
7	P	Y	17	15	15	42	7	8	16	26	NP	0	21	16	15	45	9	8	3
8	NP	Y	23	14	9	37	9	9	10	27	P	Y	37	16	17	45	9	9	---
9	P	0	42	18	18	45	9	9	7	28	NP	Y	43	15	17	45	9	9	---
10	NP	0	23	12	11	37	9	7	5	29	P	0	34	24	15	44	8	9	---
11	P	Y	19	23	19	34	7	8	16	30	NP	0	32	20	18	41	9	7	4
12	NP	Y	37	12	13	45	9	9	2	31	P	Y	38	14	17	32	9	5	---
13	P	0	21	21	14	34	7	7	16	32	NP	Y	45	12	13	22	6	5	1
14	NP	0	41	14	14	41	9	9	4	33	P	0	41	23	16	45	7	9	52
15	P	Y	39	16	14	43	9	9	7	34	NP	0	33	13	14	33	9	7	3
16	NP	Y	35	11	14	17	9	1	100	35	P	Y	41	15	13	41	9	9	2
17	P	0	20	22	16	34	9	5	15	36	NP	Y	24	9	11	31	7	2	1
18	NP	0	31	13	13	33	5	5	5	37	P	Y	29	12	11	43	7	7	5
19	P	Y	43	16	17	45	9	9	3	38	NP	Y	31	9	15	43	9	9	2

Parents

Subj	Prep	Behv Asmt	Ther Surv	Attr Recp	Exp Out	Exp Help	Exp Sat	Exp Sess	CBCL	Subj	Prep	Behv Asmt	Ther Surv	Attr Recp	Exp Out	Exp Help	Exp Sat	Exp Sess	CBCL
1	P	35	18	9	38	7	7	4	61	20	NP	29	19	12	35	5	7	6	71
2	NP	29	15	15	31	9	7	12	54	21	P	23	24	16	39	9	9	12	61
3	P	31	25	19	45	9	9	24	74	22	NP	23	23	18	35	7	7	24	73
4	NP	19	17	16	35	7	7	---	74	23	P	32	25	15	42	9	9	12	73
5	P	17	22	17	37	9	7	48	74	24	NP	21	18	12	42	9	8	8	76
6	NP	19	18	17	35	7	7	12	72	25	P	20	24	15	34	7	7	---	72
7	P	25	23	17	37	7	7	10	74	26	NP	15	21	12	39	9	7	4	74
8	NP	23	22	13	33	5	6	20	72	27	P	16	24	17	45	3	5	48	83
9	P	21	24	16	35	7	7	20	77	28	NP	22	18	11	35	5	7	6	75
10	NP	26	23	19	43	9	9	15	81	29	P	23	25	11	40	9	8	---	73
11	P	19	25	20	34	7	7	52	73	30	NP	25	20	12	33	7	7	25	75
12	NP	27	10	11	35	7	5	5	55	31	P	21	24	20	39	9	9	20	72
13	P	17	25	18	35	7	7	15	75	32	NP	23	13	13	35	5	5	---	72
14	NP	19	12	14	39	7	9	---	72	33	P	22	22	18	42	8	9	---	82
15	P	31	23	14	41	5	5	12	69	34	NP	24	14	11	35	6	6	---	65
16	NP	37	23	17	37	9	9	6	56	35	P	23	24	12	35	7	9	20	71
17	P	24	22	20	41	8	8	12	66	36	NP	27	30	17	37	7	7	25	74
18	NP	22	19	17	34	7	7	10	75	37	P	29	25	15	37	7	5	16	70
19	P	26	25	11	35	7	6	12	74	38	NP	19	23	19	33	7	7	12	82

Therapists

Subj	Behv Asmt	Exp Out	Exp Help	Exp Sat	Exp Sess	Subj	Behv Asmt	Exp Out	Exp Help	Exp Sat	Exp Sess
1	14	30	5	3	52	20	22	33	7	8	25
2	19	31	6	6	24	21	23	35	7	6	20
3	27	31	7	6	10	22	12	34	9	9	25
4	16	35	6	6	12	23	23	35	7	7	16
5	21	32	6	7	10	24	21	35	7	7	16
6	21	33	6	6	10	25	21	35	6	6	40
7	22	34	6	5	8	26	19	34	6	6	16
8	20	35	7	6	20	27	10	35	7	7	50
9	24	33	7	6	18	28	23	24	6	5	28
10	21	36	9	8	18	29	20	34	7	7	10
11	25	36	8	8	20	30	20	32	5	5	24
12	22	31	6	6	20	31	17	33	5	6	8
13	19	29	3	3	15	32	19	35	7	6	16
14	13	25	2	3	15	33	19	36	6	5	8
15	22	35	7	7	16	34	17	24	2	2	3
16	23	35	7	7	20	35	15	34	6	6	20
17	24	34	7	6	40	36	12	41	9	9	8
18	15	35	7	5	20	37	17	35	7	7	52
19	23	29	3	3	10	38	19	37	7	7	15

VITA 2

Barbara Louise Bonner

Candidate for the Degree of

Doctor of Philosophy

Thesis: INFLUENCE OF CLIENT PREPARATION AND PROBLEM SEVERITY ON ATTITUDES AND EXPECTATIONS IN CHILD PSYCHOTHERAPY

Major Field: Psychology

Biographical:

Personal Data: Born in Lebanon, Tennessee, June 26, 1938, the daughter of Bertha Grissim and Cecil T. Bonner. Married on June 2, 1973, to Andrew J. Haswell, Jr. One daughter, Susan Shields, born on September 1, 1969.

Education: Graduated from Duncan High School, Duncan, Oklahoma, in May, 1956; attended Lindenwood College, St. Charles, Missouri, 1956-1957; received the Bachelor of Science degree in Special Education from the University of Oklahoma, Norman, Oklahoma, in May, 1960; attended the Oklahoma College of Liberal Arts, Chickasha, Oklahoma, 1961; Central State University, Edmond, Oklahoma, 1967-1969; and The University of Texas, Austin, Texas, 1975; received the Master of Education degree in Counseling Psychology, Summa Cum Laude, Central State University, Edmond, Oklahoma, in July, 1977; enrolled in the doctoral program in Clinical Psychology at Oklahoma State University in September, 1979; completed requirements for the Doctor of Philosophy degree in May, 1984.

Professional Experience: Counselor-Interviewer for Oklahoma County Sanity Court, Oklahoma City, Oklahoma, 1970-1971; Clinical Practicum Therapist at the University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma, 1970-1972; Group Therapist at El Reno Federal Reformatory, El Reno, Oklahoma, 1970-1972; Consultant to Oklahoma County Visiting Nurses Association, Oklahoma City, Oklahoma, 1972; Group Therapist for court-related offenders, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma, 1972-1973; Group Therapist for single parents at Family Counseling and Child Development Center, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma, 1974-1975; Clinical Practicum with Head Start children at Family Counseling and Child Development Center,

University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma, 1975-1976; Clinical Practicum Therapist at Mid-Del Youth and Family Center, Midwest City, Oklahoma, 1977; Psychological Associate at the Psychological Services Center, Stillwater, Oklahoma, 1979-1981; Graduate Teaching Assistant for Introductory Psychology at Oklahoma State University, 1980; Psychological Associate, Child Study Center, Oklahoma City, Oklahoma, 1981-1982; Clinical Psychology Predoctoral Intern at Children's Medical Center, Tulsa, Oklahoma, 1982-1983.

Professional Organizations: Memberships include the Oklahoma Psychological Association, American Psychological Association, Women's Division of the APA, Clinical Division of the APA, Child Clinical Division of the APA, Women in Psychology, and the Society of Pediatric Psychology.