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CHILD GUIDANCE OUTCOME AS A FUNCTION OF FOCUS OF TREATMENT

by

MICHAEL T. KLINGER

A Thesis Submitted to the Faculty of the Graduate
School of Loyola University of Chicago in Partial
Fulfillment of the Requirements for the Degree of
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VITA

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INTRODUCTION

One of the areas of child psychotherapy that needs to be more carefully evaluated is the effectiveness of treatment as a function of who is being treated. For example, in attempting to deal with child adjustment problems, it is possible to involve only the child directly in treatment, see the parents but not directly treat the child, or offer treatment to both the parents and child concurrently. However, we currently have very limited information on the comparative effectiveness of these different treatment strategies.

Levitt (1971) noted that the results of two of three studies which compared the above treatment strategies suggest that treating only parents is the most effective of the three methods. However, definitive conclusions were not possible due to methodological deficiencies in the studies reviewed and the small number of studies which directly compare different treatment focuses. Levitt suggests that little work has been done in this area because of the apparently overwhelming logic behind the widely held clinical assumption that parents are the primary source of pathological and/or therapeutic influence on the child.

The objectives of this research are a) to compare the outcomes of three different treatments for child-related presenting problems at an outpatient clinic (child-only group therapy, parents-only group therapy, concurrent treatment of child and parents in therapy groups) against

changes in a waiting-list control group of clinic referred children, b) to address the issue of clinical vs. statistical significance of outcomes in each of the treatment groups, and c) to investigate the interrelationships among and within the dependent measures used to assess outcome (parents' ratings on a symptom checklist, teachers' ratings of school behavior and learning problems, therapists' ratings of post-therapy improvement).

CHAPTER I

REVIEW OF RELATED LITERATURE

Overview of Outcome Research

There is unanimous agreement among reviewers of research on psychotherapy with children and/or their parents (Levitt, 1971; Barrett, Hampe, & Miller, 1978; Heinicke & Strassmann, 1975; O'Leary & Turkewitz, 1978; Cobb & Medway, 1978; Abramowitz, 1976) that the paucity of adequate outcome measures, experimental designs, and subject, therapist, and treatment descriptions precludes drawing any firm conclusions regarding the most effective conduct of child guidance. Child guidance is used here to include a range of interventions employed in the treatment of child-related presenting problems including, but not limited to, psychotherapy with children. Heinicke and Strassmann (1975) offer a characterization of the research in this area which represents the opinions of many other reviewers:

Regrettably,...the level on which much psychotherapy research has been done is somewhat analogous to giving a pharmacist some training in surgical techniques, having him do exploratory brain surgery, and then generalizing the results of his operation to what an experienced neurosurgeon might have accomplished with a specific disorder. (Heinicke and Strassmann, p. 569).

Heinicke and Strassmann (1975) believe that the question framed by most outcome studies, "Does psychotherapy work?", is an incorrect and misleading formulation of the problem. Barrett et al. (1978) and other reviewers agree that the time is long overdue that child psychotherapy researchers began to address the question now more often pursued by their adult psychotherapy colleagues, i.e., "Which set of procedures is effective when applied to what kind of patients with which sets of problems by which sort of therapists?" No single research project is likely to fulfill the host of methodological requirements which are important when one tries to answer the second question rather than the first. Nonetheless, "the extent to which they (methodological requirements) are met,...will clearly increase both the internal and external validity of the research." (O'Leary and Turkewitz, 1978, p. 748).

The need for more specific, controlled research on the effectiveness of child guidance is highlighted by a consistent and disconcerting finding of meta-analyses of past outcome studies. Reviews of "macrovariable" research designs which do not distinguish among diagnostic categories, severity of symptoms, types of intervention, experience of the therapist, etc., and which rate outcome only on the traditional, unidimensional, single-source scale of improved, unimproved, or worse have typically demonstrated that "70% of disturbed children improve with psychotherapy or with time alone." (Barrett, Hampe, & Miller, 1978, p. 430). Maturation is thus a frequent competing hypothesis that child therapy outcome research must address. Since the child who is the object of therapeutic intervention is still developing and since normal

development often entails temporarily "symptomatic" behavior, researchers must attempt to demonstrate that the symptoms being treated would not disappear with time alone and that the presenting problem which brings the child to treatment is more severe than might be expected in a "normal" child. Without these controls, outcome research with children runs the risk of recording normal developmental changes as "therapeutic success." (Levitt, 1971). This study will employ both a waiting list control group to control for maturation and an outcome measure which has been shown to discriminate between normal and disturbed children to assess the degree of deviance of the sample.

An additional concern, unique to child treatment, is the fact that persons other than the child are often treated instead of or in addition to the child. In traditional child guidance clinics, the mother's participation has often been a condition for treatment of the child. When focus of treatment is not specified, it is impossible to determine whose treatment has produced the observed effects. (Levitt, 1971). This is the major concern of this study.

Finally, this study will evaluate the effectiveness of group therapy, an infrequently researched mode of intervention for child adjustment problems. (Abramowitz, 1976).

Focus of Treatment

Only eight studies which directly assess outcome as a function of treatment focus were identified. Although the trend in these studies favors interventions which involve parents over direct treatment of only the child, firm conclusions about the most effective focus of treatment

based on this body of work would be premature. Levitt (1971) reviewed three outpatient studies of focus of treatment (Gluck, Tanner, Sullivan & Erickson, 1964; Lessing & Shilling, 1966; D'Angelo & Walsh, 1966) and suggested that fathers' involvement in the treatment of child related presenting problems was the best predictor of positive outcome for the child. A closer examination of these investigations, however, does not provide clear support for this conclusion.

For example, Levitt's review of this issue includes a post hoc statistical analysis of outcomes for mother-only and mother and child treatment conditions in a large urban mental health clinic (Lessing & Shilling, 1966). This study employed therapist ratings of improvement as the sole outcome criterion. The results seem to favor treatment of both mother and child (70% improvement) over mother-only treatment (62% improvement). However, a closer inspection of the data revealed that the improvement rate reported for the mother-only group referred to the mother's improvement only, making comparisons of child improvement for this group with any other impossible.

The other two studies cited by Levitt did report outcomes for children in all treatment groups compared. Gluck, et. al. (1964) rated mothers' written descriptions of their children's behavior following treatment. The results indicated increasing rates of improvement as more family members were involved in treatment (mother only = 55%, mother and child = 67%, mother and father = 85%, mother, father, and child = 85%), although including the child when both parents were treated was not more effective than treating only the parents.

D'Angelo and Walsh (1967) evaluated an experimental school based mental health service in a lower socioeconomic urban community. 60 children considered in need of treatment were randomly assigned to four groups: no treatment control, child only individual therapy, parent only group therapy, and child in individual therapy, parent in group therapy. There was no specification of which parent, (mother, father, or both), participated in the parent therapy groups and there was no mother and child group as reported by Levitt (1971, p. 488). A five point scale was used to rate 41 items from a standard battery of psychological tests administered before and after the six month treatment period. Seven of the 41 items showed significant differences among the groups. Both parent only and no treatment control conditions showed improvement from pre- to post-testing whereas the parent-child condition showed no change and the child-only group was rated worse at post-test. However, the authors noted that three children from the original control group were transferred to other schools during the study because of increased behavioral or academic problems. Thus, the control group's post-test scores may have been positively biased.

Levitt (1971) suggests that the results of these three studies, while provocative, do not necessarily support the traditional child guidance assumption that mothers of disturbed children must accept responsibility for their children's symptoms and be involved in their own treatment if the child is to improve, a conclusion drawn by Lessing and Shilling (1966) from correlational analysis of their data. Levitt's alternative explanation for children's more favorable treatment outcome

when parents are involved is that it may be due to the presence of a concerned and active father or the severity of the child's symptoms which elicits his involvement rather than the parents' need for and response to their own treatment. The results of the Gluck et. al. (1964) study lend some support to this alternative. The other two studies do not. The results of the two studies that compared outcomes for children across different treatment strategies (Gluck, et. al., 1964; D'Angelo & Walsh, 1967) do suggest both the importance of involving parents in treatment and the possibility that treating only the child may lead to a less favorable outcome. No further inference seems warranted from these data.

A final study of focus of treatment using an outpatient sample (Love, Kaswan, & Bugental, 1972) lends further support to the empirical trend in favor of parent involvement and provides an example of well-designed research. Three treatments were compared (time-limited individual child psychotherapy, parent guidance, and information feedback, an intervention devised by the authors). Outcome measures consisted of school grades and ratings of school behavior by independent observers. A non-referred control group was monitored on both measures to provide a check on normal fluctuations in grades and to assess the reliability and validity of observers' ratings during the course of the study. Socioeconomic status of participating families was rated and included as a factor in the analysis of treatment outcome.

The sample consisted of 91 children referred by their teachers for "chronic social and emotional difficulties" (Love, et. al., 1972) and 29

non-referred children matched on SES and IQ with a randomly selected third of the referred group. The children ranged in age from eight to thirteen. The male to female ratio was 4:1, a proportion typically reported for samples of children in this age range who have been referred for mental health services. Assignment to treatment conditions was random. The vast majority of therapists were experienced clinicians. Psychology and social work graduate students made up the remainder of the clinical team.

Composite grades (averages of academic and conduct grades) and behavioral observations were collected at four times: three semesters and one semester prior to intake and one semester and three semesters following intake. Each treatment was offered for twelve weeks between intake and the next observation time.

The major hypothesis tested in this study concerned the authors' experimental intervention, information feedback. In this treatment, family members and school personnel were interviewed and then given feedback on how the child's presenting problems reflected his inability to adapt to certain aspects of the interpersonal environment. Positive changes were predicted for the child as a result of significant adults' ability to use this information to reduce interpersonal, environmental stress on the child. The therapist in this intervention acted as an impersonal consultant, relied on the adult clients' capacity for self-determined change, and consciously avoided promoting their dependency on his support or advice. This therapeutic rationale contrasts sharply with the other two treatments, individual child therapy and parent gui-

dance, in that psychodynamic interferences with adaptation within the individual child or parent are the targets of change in the context of a relationship which promotes the client's transference to the therapist as the primary vehicle for change. The authors predicted that information alone, used in the fashion described above, would produce therapeutic effects equal or superior to the two traditional relationship therapies.

All three treatment groups showed a decline in grades during the baseline period prior to intake and their grades were significantly worse than grades of non-referred children. At follow-up, the decline in grades was interrupted and leveled off for subjects in the parent counseling and information feedback groups. The grades of subjects in the child therapy condition continued to decline. There was a nonsignificant trend toward improvement of conduct grades in all three groups. Changes in behavior ratings were anticipated only for one set of items on which referred children differed from non-referred children. These items were said to describe negativity and differences on this group of items occurred only during playground observation. All three groups showed improvement on these ratings. No changes were observed in the grades or behavior ratings of non-referred children during the same time period. The authors interpreted the improvement in conduct grades and playground behavior ratings as indicative of the tendency for children's behavior to improve somewhat whenever any special attention is paid to their needs.

Finally, there was a significant interaction between treatment

condition and SES. Information feedback was significantly more effective for high SES families than for low SES families while parent counseling was more effective for low SES families than for high SES families. Individual child therapy was equally ineffective across all SES levels. Further analysis suggested that this interaction might be due to different family structures and different needs at different SES levels. Single mothers were overrepresented in the lower SES group and may have benefited most from the support and advice provided in traditional parent guidance. For this group, extent of mothers' participation in treatment was positively correlated with improvement in child's grades whereas, for the whole sample, the number of sessions was negatively correlated with improvement. At the other end of the scale, fathers' participation was positively correlated with improvement for high SES subjects in the information feedback condition. It was suggested that fathers were more often present and available in high SES families and that the value they place on autonomy and self-determination enabled them to use the information feedback intervention most successfully.

The lack of effectiveness of individual therapy was explored as well. The authors conceded that the length of treatment in this condition (12-20 sessions) was shorter than usually recommended (a minimum of 40 sessions). On the other hand, they point out that such a constraint severely limits the number of clients who could be served using this modality, echoing Levitt's (1971) criticism of service delivery in traditional child guidance clinics. Love, et. al. (1972) concluded that the

superiority of the two treatments involving the parents "indicates that the essential attention comes from parents and that this cannot be quickly replaced by a relationship with a therapist." (p. 359).

In addition to supporting the empirical trend in favor of interventions with parents over direct treatment of children, this study exemplifies the superior quality of inferences which may be drawn from research designs which attend to issues raised by reviewers of psychotherapy outcome studies. By including SES in the analysis of treatment effects, it was possible to identify a characteristic of clients that was a critical determinant of effectiveness for two of the three treatments. This is the type of information that is lost when such variables are ignored. Furthermore, the use of an objective outcome measure (school grades) provided a robust though conservative indication of therapeutic effects. The results of post-therapy comparisons on this measure might have appeared insignificant had the subjects' pre-therapy decline in grades not been recorded. More frequent use of such objective measures may lead researchers and clinicians to revise their expectations and definitions of treatment success depending on how effects are measured. In this study, therapeutic improvement at the group mean level would be defined as prevention of further deterioration on the criterion measure. The interaction of SES and treatment condition showed that this group mean effect concealed differential improvement as a function of subject characteristics; low SES subjects showed improvement in grades following parent counseling and high SES subjects showed improved grades following information feedback to their parents whereas,

when SES was not controlled, group means indicated no change rather than improvement following the two parent treatments. Subjects, therapists, and treatments were adequately described allowing comparison with other populations and treatment settings. Finally, the use of a normal comparison group provided a check on maturation and historical effects and verified the treated subjects deviance from normal performance on the dependent measure.

Cobb and Medway (1978) reviewed four studies which investigated the effectiveness of different treatment focuses for the remediation of underachievement. Each of these studies used samples with presenting problems more limited in scope and less severe than typical problems of the clinic samples described above, reducing comparability of results. However, each of the studies considered next reported results similar to the outpatient studies in that working with parents was as effective and often more effective than direct treatment of children. Furthermore, these studies all used objective outcome measures from independent sources lending validity to their results in support of this trend.

Perkins and Wicas (1971) used verbal group therapy with bright underachievers and/or their mothers. Subjects were 120 ninth grade boys and 60 mothers. Subjects were randomly selected for four groups: weekly group counseling for boys only, weekly group counseling for boys and their mothers separately, weekly group counseling for mothers only, and a no treatment control group. All treatments lasted for twelve weeks. Repeated measures, before and after treatment, included a self-acceptance rating, a standardized inventory of study habits, an anxiety scale,

teachers' behavior ratings, grade point average, and school absences. All three treatment groups showed improvement in grades compared to the control group, although there were no differences on this measure among the treated groups. Ratings of self-acceptance were higher for boys in the two treatment groups which included mothers compared to the boys only and control groups. Changes in teacher ratings, study habits, anxiety, and attendance showed no significant differences between treated and untreated groups or among treated groups. Mothers' participation was thus the determining factor for improvement in boys' self-esteem while grades improved equally when mothers only, mothers and their sons, or only the sons were seen.

Cook (1970) used a similar design with a smaller sample of ninth grade underachievers (N=24) and fewer sessions for parent groups (2 three hour sessions). Dependent measures included school grades, a measure of attitudes, and teacher behavior ratings. Results favored the parents-only group for improvements in grades and "desire to learn." There were no significant differences among treated and control groups on teacher ratings. Control subjects showed more improvement in their "reaction to authority" scores than subjects in the students-only counseling group.

McGowan (1969) used client-centered group counseling for 32 underachieving tenth graders and their parents. Subjects were matched on IQ, age, achievement, reading level, and socioeconomic status and randomly assigned to one of four groups: no treatment control, parents-only counseling, students-only counseling, or parents and students in sepa-

rate counseling sessions. Parent groups met once weekly for 12 weeks while student groups met weekly for 15 weeks. Pre- and post-treatment measures included grades and standardized tests of high school curriculum mastery, personality adjustment, and study habits. Again, results favored parents-only counseling or concurrent parent and student counseling over students-only counseling for improving underachievers' grades. All three treatment groups showed improvements in study habits and on the home adjustment scale of the personality measure compared to the no treatment controls. No negative changes were observed on any of the measures used. No changes were detected in achievement test scores among any of the groups, although pre-therapy scores on this test were above average and no significant changes were anticipated.

A final study of focus of treatment for school problems was conducted by Palmo and Kuzniar (1971). 56 subjects were selected from 80 children in grades one through four who were described by their teachers as manifesting low classroom involvement, acting-out, and low achievement. This was the only one of the four school problem studies to include teachers in consultation efforts, and coincidentally was also the only study of three using teachers' ratings of behavior to report significant treatment effects on this measure. The other dependent measure was a checklist of student coping behaviors in the school environment completed trained by observers. In this study, consultation with parents and teachers replaced the parents-only groups of the previous studies. Pre-test scores were used as covariates in the analysis of treatment effects. Parent-teacher consultation was superior to child

group counseling or a combination of the two treatments on both dependent measures.

In summary, previous studies of focus of treatment suggest that treating parents alone or concurrently with their children is as effective (Perkins & Wicas, 1971) and often more effective (D'Angelo & Walsh, 1967; Love, et. al., 1972; Cook, 1970; McGowan, 1969; Palmo & Kuzniar, 1971) than treating only the child. This trend was observed for samples of clinic-referred children and children treated specifically for school-related problems. In two studies using clinic samples, (D'Angelo & Walsh; Love, et. al.) short-term individual treatment of only the child resulted in negative outcomes on post-therapy measures. Studies that used short-term group counseling for child-only treatment conditions did not report deterioration following this treatment. Another clinic study (Gluck, et. al., 1964) suggested that treating only parents is as effective as concurrent treatment of parents and children. Two school-problem studies (Cook; Palmo & Kuzniar) reported that parents-only treatment was superior to concurrent treatment. All of these studies suggest the importance of involving parents in interventions for their children's adjustment problems. Patterns in the measures used to evaluate outcome in these studies and in several others that used multiple measures and multiple sources are explored in the next section.

Evaluating Outcome: Multiple Sources/Multiple Measures

Strupp and Hadley (1977) have suggested that psychotherapy outcome should be assessed from three different perspectives including society (especially significant others), the identified patient, and the mental health professional. In the case of child psychotherapy, there is a virtual absence of data concerning the child's perspective (O'Leary & Turkewitz, 1978), but outcome data are more frequently collected from parents and teachers of the child client. Since this study uses different dependent measures from three different sources (therapist rating of improvement, teacher behavior checklist, and parent symptom checklist), some discussion of patterns of data from multiple measures and multiple sources is in order.

For instance, of the three focus of treatment studies that used child behavior checklists completed by teachers (Perkins Wicas, 1971; Cook, 1970; Palmo & Kuzniar, 1971), only one (Palmo & Kuzniar) reported significant positive changes on this measure for treated subjects. This study also happened to be the only one of the three that included teachers in the intervention. In contrast, positive changes in grades were reported for underachievers whose teachers were not involved in the treatment (Perkins & Wicas, 1971; Cook, 1970; McGowan, 1969). One post-hoc study of 25 boys treated in group therapy for a variety of learning and emotional problems at an outpatient clinic (Kissel, 1970) reported that subjects' grades were unchanged following therapy and that teachers rated them as more maladjusted. Parents and therapists rated these same children as improved following therapy. Love et. al. (1972)

reported prevention of further decline in grades following successful treatment for clinic-referred youngsters and positive but insignificant improvement in school behavior ratings. Taken together these results suggest that teachers may not report many changes in children's school behavior as a result of therapy unless they are involved in the treatment in some way. Positive changes were reported more often for grades than for teachers' behavior ratings.

Three studies have reported high rates of agreement between parents' and therapists' evaluations of children. (Kissel, 1970; O'Leary, Turkewitz, & Taffel, 1973; Wimberger & Gregory, 1968). Agreement was highest when parents and therapists rated improvement of the same specific presenting problems. Under these conditions, O'Leary, et. al. (1973) reported that parents rated 63 of 70 cases improved (90%) and therapists rated 61 of the same 70 cases improved (87.1%). Correlation between the specific problem improvement ratings of parents and therapists was .51 ($p < .001$). Seventy-seven percent of paired ratings on a seven point scale were within one point. Wimberger and Gregory (1968), in their initial study of the Washington Symptom Checklist, reported that 89% of ratings by parents and therapists on the 66 items of the WSCL were within 1 point on a four point scale and 46% of the ratings were in perfect agreement. Kissel (1970) reported a rate of 64% agreement between parents and therapists who evaluated overall improvement of 24 boys following group therapy. 16 of 24 were rated as improved by both parent and therapist. In a later study comparing mothers' and therapists' evaluations of short-term and long-term treatment for a

larger sample of boys and girls (N=167), Kissel (1974) reported significant differences between mothers' and therapists' ratings of improvement. Overall, parents rated children as more improved (parents, 79%; therapists, 51%). Therapists seemed to be biased in favor of long-term treatment in this study in that they rated significantly more cases in this condition improved (73%) than in the short-term treatment condition (27%). No data were reported for the extent of case by case agreement between parents and therapists.

Finally, Zold & Speer (1971) evaluated treatment outcome using therapist ratings of improvement and changes on a behavior problem checklist completed by parents before and after treatment. Although no direct comparisons of these two measures were made or intended, it is interesting to note the following. When improvement on the behavior checklist was defined as a lower post-therapy score for children who were initially rated more than one standard deviation above the mean on this same measure for a non-clinic group, parent ratings indicated that 74% of these children had improved. For the whole sample, 73% were rated as improved by their therapists. Of course, this comparison is only suggestive since only a subsample of the group rated as improved by therapists were initially rated as deviant on the behavior checklist completed by their parents. Much work remains to be done concerning the relationship between global ratings of improvement and symptom reduction as measured by behavior checklists. An attempt will be made to investigate this relationship in the present study.

Zold and Speer (1971) made a relatively unique attempt to evaluate

the clinical significance of changes on a quantitative measure of adjustment. They used an approach similar to that later recommended by Jacobson, Follette, and Revenstorf (1984). The general problem is how to interpret change scores on dependent measures such as a behavior checklist. Such changes may be statistically significant but clinically ambiguous. Zold and Speer partially resolved this issue by comparing their treated subjects post-therapy scores to the mean of a non-clinic sample. They were then able to determine that, on the average, treated subjects' post-therapy scores were 50% closer to the non-clinic mean than their pre-therapy scores. Jacobson et. al. (1984) went a step further in suggesting that, in addition to comparisons of group means, psychotherapy outcome studies should report improvement on objective measures both in comparison to normal populations and in terms of reliable changes in pre- to post-therapy scores. Application of their suggestions requires that the measure employed has been standardized on both normal and deviant samples and that estimates of reliability, sample means and standard deviations are available. The reliability and standard deviation of the measure are combined to form an index of reliable change which individual difference scores must exceed in order to be considered significant. A cutoff score is determined, using a more or less stringent criterion, between the normal mean and the deviant mean. Using these two indices, it is possible to determine what proportion of subjects have changed significantly, how many subjects have moved from the deviant to the normal distribution (or vice versa), as well as the number of subjects who have demonstrated a significant change which

moved them into the normal range.

Although these techniques can provide a useful estimate of reliable treatment effects, their application is not without problems. Adequate norms do not exist for many widely used outcome measures and different measures used in the same study may diverge in their classification of clients, complicating rather than simplifying interpretation of results. (Jacobson, et. al., 1984). Nonetheless, when a reliable change index and/or cutoff score can be meaningfully established, a clearer description of individual and aggregate responses to treatment can be offered.

Clearly, more information is needed regarding patterns of results to be expected when multiple measures from different sources are used to assess treatment outcome. The research reviewed here suggests the following possibilities pertinent to this study:

1. Teachers are more conservative than parents or therapists in their assessment of changes in children's behavior following therapy unless the intervention involves the teacher or is specifically aimed at alleviating school-related problems.
2. Agreement between parents and therapists tends to increase as a function of the similarity and specificity of judgments they are asked to make concerning a child's behavior or improvement.
3. Comparison of global ratings of improvement with changes on symptom checklists may be attempted using methods suggested by Jacobson, et. al. (1984) to translate quantitative differences

- into estimates of clinically meaningful and statistically reliable change. Such methods are limited by the quality of the outcome measure employed and, in some cases may produce discrepancies among classifications of clients made by different measures.

Formulation of Hypotheses

Based on previous research concerning the relationship between child guidance outcome and focus of treatment, the following hypotheses will be tested in this study of three different treatment approaches for child-related presenting problems:

1. Parents and teachers will rate children in all therapy conditions as more improved than children in the waiting-list control condition.
2. Parents, teachers, and therapists will rate children in both therapy conditions that involve parents (parents-only group therapy, concurrent treatment of child and parents in separate therapy groups) as more improved than children in the child-only group therapy condition.
3. Teachers will report less improvement than parents and therapists for children in all therapy conditions.

CHAPTER II

METHOD

Subjects

The sample for this study was selected from 235 cases seen at an Armed Forces Child Guidance Clinic over a three year period between 1971 and 1974. Criteria for selection were age, mode of treatment, and completeness of relevant data. Twenty-one preschool children (age five or younger) were excluded for lack of teacher ratings and 42 adolescents (age 13 or older) were excluded because adolescent cases were generally treated in family therapy. Group treatment is the mode of therapy to be investigated in this study. Of the remaining 172 cases of elementary school age children, the following cases were excluded: 10 cases missing most data, including indication of treatment group, 3 cases seen in individual child therapy, 6 cases seen for individual parent therapy, 2 cases seen in marital therapy, 1 case seen for family therapy, 3 cases refusing concurrent child and parent group therapy, and 6 cases refusing parent-only group therapy. The final sample selected for analysis consisted of 141 cases.

Table 1 presents summary data on characteristics of the sample. Treatment conditions (child-only treatment, parent-child treatment, parent-only treatment, and waiting-list control) were compared for possible pretreatment differences on age, sex, Hollingshead Index of

Socioeconomic Status, history of previous evaluation for psychological treatment of the child, and duration of the child's presenting problems. Only one of these comparisons approached statistical significance. Children in the parent-only condition were less likely than children in other groups to have had a previous evaluation for treatment, (chi square=5.35, $p < .15$).

Subjects ranged in age from 5 to 12 years old, with an average age of 8.5 years. The male to female ratio was approximately 3 to 1. Fathers of these children were predominantly enlisted men and civilian employees of the military. The Hollingshead Index, computed on the basis of the father's education and occupation, rated the majority of families as low or lower middle SES (69.5%); 21.4% were rated as middle or upper middle SES and 19.1% were rated as hi SES. All but three children came from two parent families.

Referral sources included school personnel (34.8%), doctors or hospitals (34.0%), parents (12.1%), and other sources (19.1%). 42% of the sample had been previously evaluated for psychological treatment. The average duration of presenting problems was approximately 2.5 years (SD=1.5 years). Presenting complaints included behavioral, emotional, and learning problems. Specific diagnoses were not available, but most subjects were characterized (in order of frequency) as behavior disordered, character disordered, or neurotic.

TABLE 1
 Characteristics of the Sample

Variables	Experimental Condition									
	Total Sample		Child-Only		Concurrent		Parent-Only		Control	
Age(Years)										
M	8.50		8.75		8.83		8.33		8.80	
SD	1.75		1.67		1.75		1.83		1.92	
Sex	N	%	N	%	N	%	N	%	N	%
Male	105	74.5	32	74.4	22	71.0	29	82.9	22	68.0
Female	36	24.5	11	25.6	9	29.0	6	17.1	10	31.0
SES										
1 HI	25	19.1	5	12.8	6	19.4	8	25.0	6	20.0
2	11	8.4	3	7.7	5	16.1	1	3.1	2	6.9
3 MID	17	13.0	7	17.9	7	22.6	1	3.1	2	6.9
4	59	45.0	20	51.3	9	29.0	18	56.3	12	41.4
5 LO	19	14.5	4	10.3	4	12.9	4	12.4	7	24.1
Previous Evaluation										
Yes	59	42.1	19	45.2	15	48.4	9	25.7	16	50.0
No	81	57.9	23	54.8	16	51.6	26	74.3	16	50.0
Problem Duration(Months)										
M	29.96		31.65		32.07		30.37		25.25	
SD	18.58		17.34		19.38		20.99		16.57	

Therapists

Therapists included Master's level social workers, Ph.D. child psychologists, psychology technicians and trained college volunteers. The team of therapists was relatively stable over the three years of the study. Cases were assigned to therapists and co-therapy teams according to caseload capacity. Most groups were run by professional/paraprofessional teams. Paraprofessional therapists were always supervised by professional therapists. Social workers received supervision and consultation with psychologists as needed.

Dependent Measures

Each child was evaluated at intake and end of treatment by both parents using the Washington Symptom Checklist (Wimberger and Gregory, 1968) and by his or her teacher using a modified version of Rutter's (1967) Child Behaviour Questionnaire. Waiting-list control children were evaluated on these same two instruments at intake and 4-6 weeks later if the family was still waiting for treatment. Following treatment, children in the therapy conditions were also evaluated by their therapists on a seven-point Lickert scale of improvement (-3 = markedly worse, -2 = moderately worse, -1 = somewhat worse, 0 = no change, +1 = somewhat better, +2 = moderately better, +3 = markedly better). Thus, three outcome measures were used to assess the effectiveness of focus of treatment and two of these measures were applied to assess changes occurring in the waiting-list control group. A sample of each outcome measure is included in the appendix.

The original Rutter Child Behaviour Questionnaire had been routinely used as part of the intake procedure prior to the initiation of this study. However, 9 of the 26 items on the original scale were rarely checked by teachers. These nine items were eliminated and 11 others were added, 3 describing general behavior problems and 8 assessing achievement and academic work habits. The resulting scale consisted of 10 items describing learning problems and 18 items describing behavior problems. Each item was scored on a three point scale (0 = doesn't apply, 1 = applies somewhat, 2 = certainly applies). The maximum possible score for the learning scale is 20, for the behavior scale, 36. Total scale scores on this measure were not analyzed in this study.

To assess the reliability of this revised instrument, 12 teachers from from four different schools were asked to complete the scale twice over a one month period on up to ten children in their class. The test-retest reliability was .87 for the learning scale and .90 for the behavior scale. Furthermore, 9 children who were currently being seen at the clinic differed significantly in both their learning scores ($M=8.57$, $SD=3.13$) and their behavior scores ($M=10.50$, $SD=4.51$) from non-clinic children (learning scale: $M=4.89$, $SD=2.76$; behavior scale: $M=4.50$, $SD=2.25$). These data suggested that the revised school scale had merit in describing children's behavioral and academic school adjustment. Pretreatment scores on the learning and behavior scales for the sample used in the current study (learning scale: $M=8.49$, $SD=4.60$; behavior scale: $M=11.85$, $SD=5.70$) were similar to scores of clinic children in the reliability study suggesting that children in the present

sample were rated by teachers as impaired in their school adjustment.

The Washington Symptom Checklist consists of 66 items rated on a four point scale of frequency of occurrence (0 = never, 1 = seldom, 2 = often, 3 = very often) yielding a maximum score of 198. Wimberger and Gregory (1968) reported a test-retest reliability .84 for a sample of 66 parents completing this scale for 40 clinic-referred children. Inspection of the list of items indicated that five of them described positive behaviors rather than symptoms (e.g., "Is self-sufficient," "Is cooperative and follows directions"). These items were not included in analyses for this study. One of the remaining 61 items was inadvertently omitted resulting in a scale of 60 items rating negative behaviors with a maximum score of 180. Mothers' and fathers' pretreatment ratings of subjects in the present sample were compared to parents' ratings reported for clinic children by Wimberger & Gregory (1968), who reported an average parent rating of 91.40 for 66 items. Checklists completed by mothers and fathers of children in the present sample yielded mean scores of 95.65 and 93.27, respectively, for 65 items. This comparison suggests that parents' ratings of children in this sample on the WSCL were similar to ratings made by parents of clinic children in a previous study.

Treatment

Assignment to treatment condition was based on the administrative policy in effect during each of the three years of the study. In the first year, all cases received child group therapy consisting of social skills training and behavior modification; (N=43). In the second year,

a decision was made to offer group treatment to parents as well as their children; (N=31). This treatment employed a mixture of parent counseling and child management training. In the third and final year of the study, only parent therapy groups were used; (N=35). Thus, all therapists administered all treatments and all subjects were assigned to treatment conditions according to the clinic policy during the year they were seen.

All subjects, including waiting-list controls, were seen for an initial intake interview/diagnostic procedure. This included a social history taken with both parents present, a child diagnostic interview with psychological testing when indicated, and school observations when possible. Parents and classroom teachers completed behavior checklists at this time. All cases were then assessed in a clinic staffing within 1-3 weeks of intake and treatment was begun as soon as possible.

Those cases who remained on a waiting list for treatment for 4-6 weeks were rated a second time by parents and teachers before beginning treatment. Waiting list cases from each of the three years of the study were combined to form the waiting list control condition; (N=32). All children in this group eventually received therapy, but treatment outcome for these subjects is not reported in this study.

Treatment groups were offered in ten week cycles. If a case was judged as in need of further treatment at the end of the first ten sessions, another cycle of ten sessions was offered. The number of sessions attended by children in each of the conditions that used child groups was compared. This comparison was significant ($F(1,72)=10.05$,

$p < .002$) and revealed that subjects in the child only condition attended more treatment sessions than subjects in the concurrent child-parent treatment condition (child only, $M=15.11$; child & parent, $M=11.35$). A similar comparison of the number of sessions attended by parents revealed no significant difference (child & parent, $M=8.67$; parent only, $M=8.03$).

CHAPTER III

RESULTS

Pretreatment Comparisons

Since assignment to treatment condition was not random, initial scores on teachers' and parents' checklists were analyzed to determine possible pretreatment differences among groups. The results of these analyses are presented in Table 2. Separate oneway analyses of variance indicated no differences between groups on teachers' ratings of learning problems, fathers' symptom checklists, or mothers' symptom checklists, ($F's < 1.64$, ns). Significant differences between groups were indicated for teachers' ratings of behavior problems, $F(3,127)=3.21$, $p < .03$. Subsequent comparisons using Duncan's Multiple Range Test revealed that subjects in the child only condition were rated as having more behavior problems ($M=13.81$) than subjects in both the parents only ($M=10.27$) and waiting-list control ($M=10.51$) conditions ($p < .05$). No other comparisons of group means were significant.

Thus, subjects in all treatment conditions were comparable at intake on teachers' ratings of learning problems and mothers' and fathers' ratings of symptoms of maladjustment. Subjects in the child only condition were rated by their teachers as exhibiting more behavior problems in school than two of the other three treatment conditions at intake.

TABLE 2
Group Means and Standard Deviations for Pretreatment
Ratings by Parents and Teachers

Variable	Experimental Condition			
	Child Only (N=42)	Concurrent (N=31)	Parent Only (N=33)	Control (N=31)
Teachers' Rating				
Behavior				
M	13.81	12.23	10.27	10.51
SD	6.03	5.19	5.61	5.39
Learning				
M	9.36	8.93	7.45	8.00
SD	3.98	4.70	4.39	4.94
Parents' Rating				
Fathers	(N=43)	(N=31)	(N=35)	(N=32)
M	85.40	89.06	82.97	79.75
SD	17.07	14.80	17.88	20.30
Mothers	(N=41)	(N=31)	(N=34)	(N=32)
M	90.90	87.10	84.70	82.78
SD	17.03	13.16	16.50	19.13

Note: N's vary due to missing data. Groups differed at pretreatment only on teachers' ratings of behavior problems ($F(3,133)=3.21$, $p<.05$).

Treatment Outcome

To assess outcome differences among the treatment conditions, change scores (Time 1 minus Time 2) on the four checklist variables (teachers' learning and behavior problem scales, mothers' and fathers' symptom checklists) were subjected to oneway analyses of variance. Positive change scores indicate improvement, i.e., a reduction in problem ratings between Time 1 and Time 2. Therapist ratings for subjects in the three therapy conditions were examined using both a oneway analysis of variance of improvement ratings and a chi square test of independence of the distribution of outcome ratings among groups (% somewhat improved, % moderately improved, etc.).

Separate oneway ANOVAs were indicated since these outcome measures were not highly correlated. Pearson correlation coefficients ranged between .16 and .33 for nine out of the ten correlations calculated. Only mothers' and fathers' ratings were moderately correlated, ($r=.58$), suggesting some overlap between these two measures.

Teachers' Ratings

The results of analyses of teachers' ratings are presented in Table 3. Significant differences among groups were indicated for changes in teachers' ratings of behavior problems, $F(3,127)=3.32$, $p<.03$. Subsequent contrasts using Duncan's Multiple Range Test revealed that subjects in both the parents-only condition ($M=3.93$) and the concurrent condition ($M=3.90$) were rated as significantly more improved than subjects in the control condition ($M=.93$), $p<.05$. The mean change score for subjects in the child-only condition ($M=2.15$) was not significantly



different from means of the other three conditions. No significant differences in improvement were indicated on teachers' ratings of learning problems, ($F < 1.23$, ns).

Thus, change scores on teachers' ratings provided partial support for the first hypothesis. Two of the three therapy groups (concurrent condition, parents-only condition) were rated as significantly more improved than the waiting-list control group on teachers' ratings of behavior problems. The child-only therapy condition was not rated as different from the improved therapy conditions or the unimproved control condition. However, this finding may have been due to the initial differences among conditions on this scale. Teachers' ratings of learning problems did not support the first hypothesis, i.e., no therapy condition was rated as significantly more improved on this scale than the waiting list control condition. Finally, teacher ratings provided no support for the second hypothesis, i.e., subjects in the two treatments that involved parents were not rated as significantly more improved than subjects in the child-only treatment.

TABLE 3
 Group Means, Standard Deviations, and F-Tests for
 Change Scores on Teachers' Ratings

Variable	Experimental Condition				F-Test
	Child Only	Concurrent	Parent Only	Control	
	(N=40)	(N=31)	(N=30)	(N=30)	
Behavior					
M	2.15	3.90	3.93	0.93	3.32*
SD	4.82	3.77	5.22	3.62	
Learning					
M	1.03	1.03	1.13	0.10	1.22
SD	2.44	3.48	1.87	1.98	

*($p < .05$)

Parents' Ratings

Parent ratings provided strong support for the first hypothesis. The results of analyses of these ratings are presented in Table 4. The oneway ANOVA for fathers' ratings of symptom improvement on the WSCL was highly significant, $F(3,134)=9.90$, $p<.0001$. Subsequent contrasts using Duncan's Multiple Range Test revealed that all three therapy conditions (child-only, $M=11.93$; concurrent, $M=15.33$; parents-only, $M=15.24$) were rated by fathers as significantly more improved than the waiting list control condition ($M=.53$), $p<.05$. No other contrasts of group means were significant.

The oneway ANOVA on mothers' ratings of improvement was also highly significant, $F(3,131)=14.56$, $p<.0001$. Subsequent contrasts using Duncan's Multiple Range Test revealed that mothers also rated all three treatment conditions (child-only, $M=13.71$; concurrent, $M=15.50$; parents-only, $M=18.375$) as more improved than the waiting list control condition ($M=-.38$), $p<.05$. No other contrasts of group means were significant.

Thus, parent ratings of improvement provided strong support for the prediction that all therapy conditions would be rated as more improved than the waiting list control condition (hypothesis 1), but no support for the prediction that the two treatments involving parents would be rated as more effective than the treatment involving only the child (hypothesis 2).

TABLE 4

Group Means, Standard Deviations, and F-Tests for
Change Scores on Parents' Ratings

Variable	Experimental Condition				F-Test
	Child Only	Concurrent	Parent Only	Control	
Fathers	(N=43)	(N=30)	(N=33)	(N=32)	
M	11.93	15.33	15.24	0.53	9.90*
SD	14.06	12.24	12.63	10.44	
Mothers	(N=41)	(N=31)	(N=34)	(N=32)	
M	13.71	15.50	18.37	-0.38	14.56*
SD	12.51	14.04	12.24	10.52	

*($p < .0001$)

Therapist Ratings

The results of a oneway ANOVA on therapists' ratings of improvement are presented in Table 5. This analysis revealed no significant differences among the three conditions that received therapy, $F < 1$, ns. Each therapy condition received almost identical mean ratings of improvement, indicating that, on the average, therapists rated subjects in all therapy conditions as "moderately improved".

The distribution of therapists' outcome ratings (% no change, % somewhat improved, etc.) for each therapy condition is presented in Table 6. A chi square test for differences among therapy conditions was not significant, although a slightly greater percentage of subjects in the parents only and concurrent therapy conditions received ratings of "markedly improved" than in the child only therapy condition. Therapists rated most subjects as moderately or markedly improved (80.2%); 16% were rated as slightly improved. No subject was rated as markedly or moderately worse. Only one subject was rated as slightly worse and 3 subjects were given ratings of "no change". Thus, therapist ratings did not support the prediction that interventions involving the parents would be more effective than direct treatment of only the child.

TABLE 5

Group Means, Standard Deviations, and F-Test for
Therapists' Ratings of Improvement

Therapist Rating	Therapy Condition			F-Test
	Child Only (N=42)	Concurrent (N=31)	Parent Only (N=33)	
M	1.89	1.85	1.89	.03 ns
SD	.66	.79	.85	

TABLE 6

Distribution of Therapists' Ratings of Improvement

Rating	Therapy Condition					
	Child-Only		Concurrent		Parent-Only	
	N	%	N	%	N	%
Slightly Worse			1	3.2		
No Change	1	2.4			2	6.1
Slightly Better	6	14.3	5	16.1	6	18.2
Moderately Better	25	59.5	16	51.6	15	45.5
Markedly Better	10	23.8	9	29.0	10	30.3

Reliable Change Measures

In order to estimate statistically reliable changes on teacher and parent checklists for individuals in each treatment group and to facilitate comparison of the three outcome measures, a reliable change index (RC) was calculated for each subject's difference score on the four checklist variables (learning and behavior scales on the teachers' questionnaire, mothers' and fathers' ratings on the WSCL). The procedure recommended by Jacobson, et. al., (1984), was followed. To obtain an RC index, the difference score is divided by the standard error of measurement for the outcome measure in question. This standard error is derived by multiplying the standard deviation of the measure by the square root of $(1 - r)$, where r is the test-retest reliability of the measure. The standard error can then be used to describe a confidence interval around a subject's initial score, i.e., the spread of the expected distribution of repeated measurements if no actual change has occurred. An RC index (change score divided by standard error) greater than plus or minus 1.96 would be unlikely to occur ($p < .05$) without actual change.

Standard errors were calculated for each of the four checklist variables using standard deviations of pretreatment scores for this sample and estimates of test-retest reliability from previous studies. For example, the standard error of measurement for the learning scale of the teacher checklist is 2.05. An individual's difference score on this scale would have to exceed $(1.96 \times 2.05 = 4.02)$ in order to be considered a reliable positive change. The RC index was used to classify subjects

on each measure as worse ($RC < -1.96$), unchanged ($-1.96 < RC < +1.96$), or improved ($RC > +1.96$). It was then possible to directly compare classifications of change on parents' and teachers' measures across and within treatment conditions. A rough comparison of therapist ratings with parent and teacher checklist ratings was made by collapsing the therapists' 7-point ratings of improvement into a 3-point scale to correspond with the RC index classifications of change ($-1 =$ worse, $0 =$ no change, $+1 =$ improved). As a supplement to comparisons of group means, the RC index provides a means of estimating the proportion of cases that have changed significantly in each treatment condition as well as a means of comparing the outcome ratings of teachers, parents, and therapists.

Reliable Change Classifications on Teachers' Ratings

The results of treatment outcome classifications based on the RC index for teachers' ratings are presented in Table 7. Chi square tests of independence revealed significant differences among treatment conditions on both behavior problem ratings (chi square=12.80, $p < .05$), and learning problem ratings (chi square=12.6, $p < .05$).

Examination of Table 7 suggests that subjects in all therapy conditions were more likely to be classified as improved than subjects in the waiting list control condition on both scales. The rate of reliable improvement was highest for subjects in the concurrent therapy condition for both behavior ratings (45.2%) and learning ratings (35.5%).

TABLE 7

Classifications of Treatment Outcome Using Reliable Changes
on Teachers' Ratings

Variable	Experimental Condition							
	Child-Only		Concurrent		Parent-Only		Control	
	N	%	N	%	N	%	N	%
RCTB								
Worse	2	5.0			1	3.3	3	10.0
No Change	29	72.5	17	54.8	22	73.3	24	80.0
Improved	9	22.5	14	45.2	7	23.3	3	10.0
Chi Square=12.80*								
RCTL								
Worse	2	5.0	3	9.7			1	3.3
No Change	29	72.5	17	54.8	25	83.3	27	90.0
Improved	9	22.5	11	35.5	5	16.7	2	6.7
Chi Square=12.60*								

Note: RCTB=Reliable Change, Teachers' Behavior Scale;
RCTL=Relaible Change, Teachers' Learning Scale

*($p < .05$)

For the whole sample, few subjects were classified as reliably worse (behavior ratings, 4.6%; learning ratings; 4.6%) whereas the majority of subjects was classified as unimproved (behavior ratings, 70.2%; learning ratings, 74.8%). Waiting list control subjects were most likely to be classified as unimproved (behavior ratings, 80.0%; learning ratings, 90.0%).

Although the chi square test does not unequivocally identify the sources or the direction of group differences, the use of reliable change measures to assess teachers' ratings provided further confirmation of the prediction that subjects in all therapy conditions would be rated as more improved than waiting list control subjects. Furthermore, unlike comparisons of group means on teachers' ratings, reliable change classifications suggested some differences among therapy conditions. The rate of improvement for teachers' ratings of both behavior and learning problems was greater for subjects in the concurrent child and parent therapy condition than for subjects in the child only or parents only therapy conditions, suggesting partial support for the second hypothesis concerning the differential efficacy of the three interventions.

Reliable Change Classifications on Parents' Ratings

The results of treatment outcome classifications based on the RC index for parents' ratings are presented in Table 8. Chi square tests of independence indicated highly significant differences among groups on both fathers' ratings (chi square=25.57, $p < .0003$) and mothers' ratings (chi square=31.49, $p < .0001$). On both measures, subjects in all therapy

conditons were much more likely to be classified as reliably improved than subjects in the waiting list control condition, as predicted. Only one child was rated by fathers as reliably worse following therapy whereas among waiting list control subjects, 4 children were rated as worse by fathers and 3 children were rated as worse by mothers. Most waiting list control subjects were classified as unchanged on fathers' ratings (81.3%) and mothers ratings (84.4%).

However, mothers' and fathers' perceptions of improvement varied among treatment conditions. Fathers' were more likely to rate subjects in the concurrent therapy condition as reliably improved (56.7%) than subjects in the child only (44.2%) or parents only (42.4%) conditions, similar to the pattern observed for teachers' ratings, whereas mothers ratings suggested that parents only therapy was most effective (62.5% improved), concurrent therapy less effective (53.3% improved), and child only therapy least effective (36.6% improved).

Thus, reliable change classifications based on parents' ratings provided further support for the prediction that all therapy conditions would be rated as more effective than the waiting list control condition. Furthermore, as with teachers' ratings, reliable change classifications of parents' ratings suggested some differences among therapy conditions not detected by comparisons of group means. Fathers' ratings provided some support and mothers' ratings provided strong support for the second hypothesis, i.e., that interventions involving parents would be rated as more effective than interventions involving only the child.

TABLE 8

Classifications of Treatment Outcome Using Reliable Changes
on Parents' Ratings

Variable	Experimental Condition							
	Child-Only		Concurrent		Parent-Only		Control	
	N	%	N	%	N	%	N	%
RCFR								
Worse	1	2.3					4	12.5
No Change	23	53.5	13	43.3	19	57.6	26	81.3
Improved	19	44.2	17	56.7	14	42.4	2	6.3
Chi Square=25.57*								
RCMR								
Worse							3	9.4
No Change	26	63.4	14	46.7	12	37.5	27	84.4
Improved	15	36.6	16	53.3	20	62.5	2	6.3
Chi Square=31.49*								

Note 1: RCFR=Reliable Change, Fathers' Ratings on Symptom Checklist
RCMR=Relaible Change, Mothers' Ratings on Symptom Checklist

Note 2: N's vary due to missing data

*($p < .0003$)

Comparison of Outcome Measures

For comparison with reliable change classifications on teachers' and parents' ratings, Table 9 presents therapists' ratings of treatment outcome for the three therapy conditions with the seven point rating scale collapsed into a three point scale. There were no differences among therapy conditions based on this collapsed scale ($\chi^2=7.45$, ns). Table 10 presents a comparison of RC classifications of treatment outcome based on teachers' and parents' ratings and therapists' ratings of treatment outcome on the collapsed scale for all cases in the three therapy conditions. As predicted, teachers reported less improvement than parents and therapists. Teachers also reported more deterioration.

Since therapists rated almost all subjects as improved following therapy, disagreements between therapists' ratings of treatment outcome and RC classifications of outcome based on teachers' and parents' ratings consisted almost entirely of cases judged improved by therapists but unimproved according to the RC index on teachers' and parents' measures. Rates of agreement between therapists' ratings and teachers' ratings and between therapists' ratings and parents' ratings are presented in Table 11. The percentage of cases on which therapists' and teachers' assessments of treatment outcome agreed closely paralleled rates of reliable improvement on teachers' ratings of behavior and learning problems (approximately 30% of all subjects in the three therapy conditions). A similar pattern was observed for agreements between therapists' and parents' assessments of treatment outcome, i.e., rates of agreement paralleled rates of reliable improvement on mothers' and

fathers' symptom ratings (approximately 50% of all subjects in the three therapy conditions). Thus, agreement between therapists' outcome ratings and outcome classifications using teachers' ratings was low, whereas therapists' ratings and outcome classifications based on parents' ratings were in moderate agreement.

TABLE 9
 Therapists' Ratings of Treatment Outcome
 on Collapsed Rating Scale

Rating	Therapy Condition					
	Child-Only		Concurrent		Parent-Only	
	N	%	N	%	N	%
Worse			1	3.2		
No Change	1	2.4			2	6.1
Improved	41	97.6	30	96.8	31	93.9

TABLE 10
 Comparison of Treatment Outcome Classifications Using
 Teachers' Ratings, Parents Ratings, and Therapists' Ratings
 for All Subjects in Therapy Conditions

Rating	Variable									
	RCTB		RCTL		RCFR		RCMR		THRATG	
	N	%	N	%	N	%	N	%	N	%
Worse	3	3.0	5	4.9	1	0.9			1	0.9
No Change	68	67.3	71	70.3	55	51.9	52	50.5	3	2.8
Improved	30	29.7	25	24.8	50	47.2	51	49.5	102	96.2

Note 1: RCTB=Reliable Change, Teachers' Behavior Ratings
 RCTL=Reliable Change, Teachers' Learning Ratings
 RCFR=Relaible Change, Fathers' Symptom Checklists
 RCMR=Reliable Change, Mothers' Symptom Checklists
 THRATG=Therapists' Ratings of Treatment Outcome

Note 2: N's vary due to missing data.

TABLE 11

Percentage of Agreement Between Therapists' Outcome Ratings
and Reliable Change Classifications Using Teachers'
Mothers' and Fathers' Ratings for Therapy Subjects

THRATG With: Variable	Therapy Condition							
	All Conditions		Child-Only		Concurrent		Parents-Only	
	#Agr/N	%	#Agr/N	%	#Agr/N	%	#Agr/N	%
RCTB	36/100	36.0	10/39	25.6	15/31	48.4	9/30	30.0
RCTL	29/100	29.0	10/39	25.6	12/31	38.7	7/30	23.3
RCFR	53/104	52.0	20/42	47.6	17/30	56.7	16/32	50.0
RCMR	51/101	50.5	16/40	40.0	15/30	50.0	20/31	64.5

Note 1: THRATG=Therapists' Ratings of Treatment Outcome
 RCTB=Reliable Change, Teachers' Behavior Ratings
 RCTL=Reliable Change, Teachers' Learning Ratings
 RCFR=Relaible Change, Fathers' Symptom Checklists
 RCMR=Reliable Change, Mothers' Symptom Checklists

Note 2: N's vary due to missing data.

CHAPTER IV

DISCUSSION

The results of the present study supported the hypothesis that children in each of three different therapeutic interventions for adjustment problems would be rated by their parents and teachers as more improved than children in a waiting list control group. Oneway analysis of variance of changes in teachers' ratings of school behavior problems supported this prediction for the two interventions that involved parents in therapy, but not for the child-only intervention. This group was not significantly different from the unimproved control group, but neither was it significantly different from the improved groups. This finding was confounded by pretreatment differences on this scale which indicated that subjects in the child-only condition were rated as exhibiting more behavior problems than two of the other three treatment conditions at intake.

However, since pretreatment group means on teachers' ratings of school behavior problems in all conditions were similar to or more deviant than a previous clinic sample mean, it may be concluded that subjects in the present study were manifesting significant pathology in school and that the improvement observed in two of the three therapy conditions was not due simply to maturation since waiting list control subjects did not demonstrate similar improvement. Although the oneway

ANOVA on changes in teachers' ratings of learning problems was not significant, mean change scores for all therapy conditions were greater than the mean change score for the waiting list control condition. Thus, ANOVA and comparisons of group means on teachers' ratings provided partial support for the first hypothesis, but no support for the second hypothesis.

Parents' ratings provided very strong support for the predicted effectiveness of all therapy conditions as compared with the waiting list control condition. Pretreatment group means on mothers' and fathers' Washington Symptom Checklists suggested that the present sample was manifesting levels of maladjustment as deviant as a previous clinic sample. Highly positive mean change scores were observed on both parents' ratings for subjects in all three therapy conditions whereas mean change scores for waiting list control subjects were close to zero. Again, it may be inferred that therapy was responsible for the improvement observed in parents' ratings since time alone was not sufficient to change parents ratings of subjects waiting for therapy. There were no significant differences among therapy conditions on parents' ratings.

The hypothesis that interventions involving parents would be assessed as more effective than the intervention involving only the child was not supported by analyses of mean change scores on parents' and teachers' ratings nor by analyses of therapists' ratings of improvement. However, supplementary analysis of teachers' and parents' ratings using reliable change scores to assess treatment outcome did suggest differences among treatment conditions in support of this hypothesis.

Reliable change scores on teachers' ratings of both school behavior and learning problems indicated that more children in the concurrent parent and child therapy condition were reliably improved than subjects in the child-only or parents-only therapy conditions. A similar pattern emerged for reliable changes on fathers' ratings whereas reliable improvement on mothers' ratings was greatest for the parents-only intervention, less for the concurrent parent and child treatment, and least for the child-only treatment. These findings suggest some support for the superior effectiveness of interventions involving parents and were not detected in comparisons of group means.

Thus, the present study confirmed the findings of previous research on the effect of focus of treatment; treating only the parents was as effective (teachers', therapists' and fathers' ratings) or more effective (mothers' ratings) than direct treatment of only the child for adjustment problems. Concurrent treatment of child and parent was rated as the most effective treatment by fathers and teachers and more effective than child-only therapy by mothers. However, therapists rated all three treatments as equally effective.

Two other criteria of treatment effectiveness may be noted in this regard. Subjects in the child-only condition attended, on the average, 4 more therapy sessions than children in the concurrent child and parent condition, but did not show as much improvement on four of the five outcome variables. Furthermore, 53% of the cases in the child-only condition attended a second cycle of therapy sessions whereas only 19% did so in the child and parent condition. This suggests that involving parents

in treatment may be more economical than treating only the child in terms of both time and treatment effectiveness. On the other hand, six families refused parents-only group therapy, three families refused concurrent child and parent therapy, but no families refused child-only therapy suggesting that it may be difficult to convince some parents that they need to be involved in therapy when they have come to a clinic seeking treatment for their child. Although there is no substitute for clinical judgment in such cases, the present study does suggest that child guidance clinics may reasonably consider group treatment of parents as an effective alternative or adjunct to direct treatment of child clients.

The results also supported the final hypothesis. Teachers reported less improvement than parents or therapists. Although subjects in all therapy conditions were rated by their teachers as more improved than subjects who were waiting for therapy, less than 30% of the children in this study were classified as improved following therapy according to a measure of reliable change on teachers' ratings of behavior and learning problems. In contrast, reliable changes on mothers' and fathers' ratings classified 50% and 47% of subjects, respectively, as improved, and therapists rated 96% of subjects as improved following therapy. These differences are due in part to the different instruments used in this study to measure teachers', parents', and therapists' assessments of children. Studies which have investigated parents' and therapists' assessments on identical measures have reported high rates of agreement. Nonetheless, some discrepancy among different adults per-

spectives on the same child is evident in these results and is perhaps to be expected.

As previously suggested, teachers may not report significant improvement in children referred for mental health services unless the intervention employed directly involves the teacher or is specifically focused on remediation of school-related problems. Love, et. al. (1972) suggested that limitations on children's behavior in the classroom may decrease the likelihood of observing significant behavioral changes in this setting.

Mothers reported more improvement when they were involved in therapy concurrently with their children than when only the child was treated and the most improvement when parents were the only focus of treatment. This trend may reflect positive changes in mothers' perceptions of their children (as well as concomitant positive changes in the child) as therapeutic attention is focused on the parental relationship. Fathers' reported the most improvement in their children when both were involved in treatment. It may be that fathers interpreted the recommendation of concurrent treatment as indicative of a more serious problem than recommendations of parents only or child only treatment because it required the involvement of the entire family; fathers may have been more motivated under this condition to observe change in their child.

Therapists reported similarly high rates of improvement for all three interventions. This finding was most likely due to the criterion for termination of treatment, i.e., treatment was offered until the child was judged sufficiently improved by his or her therapist.

However, while the present study can point out discrepancies among adults perspectives on therapy outcome for children, more plausible explanations of these discrepancies need to be researched. There is no apriori reason to expect high rates of agreement among different adults observing a child in different settings and using different instruments to record their observations. Future studies should make more frequent use of the methodology employed by O'Leary, Turkewitz, and Taffel (1973) who asked parents and therapists to rate improvement in specific presenting problems which caused the child to be referred for treatment. Not only did this method of treatment evaluation demonstrate high rates of agreement between different adult observers of the same child (77% of paired ratings on a 7-point scale were within one point), it would seem to afford an appropriate and meaningful index of the efficacy of treatment for specific problems in individual cases.

The present study sought to translate changes on symptom checklists completed by parents and teachers into an index comparable to clinicians' judgements of treatment outcome. Such comparisons need to be made carefully. Several characteristics of the outcome measures employed in the present study complicated this attempt. For example, therapists' ratings were not anchored to any explicit standard of functioning. As a result, it is not clear what correspondence, if any, exists between a therapist's rating of "moderately improved" and a statistically reliable change on a teacher's or parent's rating of a child's symptomatic behavior. Given these considerations, it is remarkable that agreement among the different outcome measures was as

high as it was (for all therapy conditions: 50% between therapists' ratings and RC index classifications on parent measures; 30% between therapists' ratings and RC index classifications on teachers' ratings). More importantly, once an individual subject's change over time is considered statistically reliable, the clinical significance of such change needs to be determined (Jacobson, et. al., 1984). However, the clinical significance of observed changes could not be assessed in this study since the parent and teacher checklists employed lacked adequate norms for the discrimination of the behavioral parameters of clinical and normal populations, i. e., it is unknown how normal children are rated on the WSCL or the Revised Rutter Scale. Therefore, no assessment of post-treatment adjustment on these measures was possible. Obviously, the use of standardized measures possessing normative data on both clinical and normal populations is recommended for future studies.

Other limitations of the present study include a lack of follow-up data and inadequate descriptions of the treatments employed. Follow-up data are especially important in the evaluation of child guidance outcome since children may show a variety of responses months or years after treatment that are not evident at the end of therapy. For instance, Heinicke and Strassman (1975) stress the need for follow-up data in assessing the outcome of long-term individual psychotherapy with children since some studies have shown delayed positive effects of this type of treatment. In contrast, Love et. al. (1972) found no such effects in their sample. Little is known about the long-term effects of group psychotherapy with children and follow-up data are especially

important in light of some reports of negative outcomes for this type of treatment. (Abramowitz, 1976). Finally, Levitt (1971) emphasized the need to determine the incidence of symptom substitution in children with bona fide emotional disturbance following apparently successful treatment. He reported that 22% of successfully treated children that he studied had developed new symptoms following treatment. In short, the lack of follow-up data leaves open the question of the durability and long-term effects of the therapeutic interventions employed in this study in spite of their apparent effectiveness as assessed at the close of treatment.

The lack of adequate descriptions of the treatments employed in this study poses a related problem. Without such description, it is impossible to address the questions of why and how a treatment produces change. As demonstrated by Love et. al. (1972), descriptions of specific techniques and mechanisms of change within different treatment modalities allow investigators to formulate testable hypotheses as to why different treatments may be more or less successful for different types of clients. In the context of the present study, it would be important to investigate to what extent parent group therapy affected parents' child rearing techniques and to what extent it affected their perceptions of and attitudes toward their children's behavior. Such information might suggest explanations for differences in mothers' and fathers' ratings of changes in their children's symptomatic behavior under different treatment conditions. Finally, in the absence of working hypotheses concerning the mechanisms of change in each treatment

modality, no attempt was made to investigate relationships between subject characteristics and response to treatment. More research in this area is needed to further our understanding of which treatments are most effective for which clients and why.

In conclusion, the results of this study supported previous research reports of the efficacy of parent focused treatment as an alternative or adjunct to child focused treatment for children's adjustment problems. Future research should concentrate on elucidating the possible mechanisms by which positive changes in children may occur as a result of their parents' involvement in treatment.

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APPENDIX A

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	NEVER	SELDOM	FRE- QUENTLY	VERY OFTEN
35. Talks back to parents				
36. *Has been held back a grade in school				
37. Lacks self-confidence				
38. *Has been in trouble with Juvenile Authorities				
39. Has sleeping disturbances				
40. Prefers to play with children not his/her age				
41. Cries easily				
42. Refuses parental instructions				
43. Gets along poorly with children of opposite sex				
44. Is irritable				
45. Gets along well with grownups				
46. Has speech difficulty				
47. Gets along poorly with brothers and sisters				
48. Is resentful of discipline				
49. Teases others				
50. Is fearful				
51. Is stubborn				
52. Is nervous and jumpy				
53. Is bossy				
54. Is destructive				
55. Is overactive				
56. Is afraid to defend herself/himself				
57. Has physical complaints				
58. Wets bed				
59. Sucks thumb				
60. Bites nails				
61. Masturbates				
62. Shows unusual interest in fires				
63. Has a tic (nervous twitch)				
64. Does not show feelings				
65. Is concerned about neatness				
66. Complains about going to school				
67. Other problems not listed:				

The next nine questions are directed to you, as the child's parents. They may not be exactly appropriate to your special situation, but please answer them to the best of your ability.

	YES	UNDECIDED	NO
68. Do you think that your child has an emotional problem?			
69. Does it embarrass you that your child has an emotional problem?			
70. Does your wife/husband agree that there are problems?			
71. Do you feel in part responsible for your child's problems?			
72. Do you feel that your child will outgrow the problem?			

APPENDIX B

REVISED RUTTER SCHOOL BEHAVIOUR QUESTIONNAIRE

TO BE COMPLETED BY TEACHER

DATE: _____

You are to rate _____

Below are a series of descriptions of behavior often shown by children. After each statement are three columns: "Doesn't Apply", "Applies Somewhat", and "Certainly Applies". If the child definitely shows the behavior described by the statement place a cross in the box under "Certainly Applies". If the child shows the behavior described by the statement but to a lesser degree or less often place a cross in the box under "Applies Somewhat". If, as far as you are aware, the child does not show the behavior place a cross in the box under "Doesn't Apply". Please put ONE check for EACH statement. Thank you.

	Doesn't Apply	Applies Somewhat	Certainly Applies
1. Very restless. Often running about or jumping up and down. Hardly ever still ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Squirmy, fidgety child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Often destroys own or others' belongings ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Frequently fights with other children .. .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Often worried, worries about many things ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Irritable. Is quick to "fly off the handle"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Often appears miserable, unhappy, tearful or distressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Tends to be absent from school for trivial reasons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is often disobedient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has poor concentration or short attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Tends to be fearful or afraid of new things or new situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Fussy or over-particular child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Often tells lies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Has stolen things on one or more occasions .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Has had tears on arrival at school or has refused to come into the building this year .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Bullies other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Does not finish projects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Does not respond to discipline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Doesn't Apply	Applies Somewhat	Certainly Applies
19. Has some speech difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Does not follow directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Is clumsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Is not reading at grade or age level ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. His spelling is poor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Has difficulty with arithmetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Printing, writing or drawing is poor ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Shows disruptive classroom behavior ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Unable to relate well with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. He does not work to capacity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please record the number of times this student has been: absent _____
tardy _____

Do you have any special comments about this student which might aid us in our evaluation.

How well do you know this child?

Very Well Moderately Well
Not Very Well

THANK YOU VERY MUCH FOR YOUR HELP.

SUBJECT _____

SIGNED: _____

(Teacher)

APPENDIX C

THERAPIST RATING FORM

Consider and rate the overall change you have seen from beginning to end of therapy (to include those who dropped from treatment). For each case, if you have seen the child, you are to rate the child; if you have seen the parents, please rate the change in each parent's child rearing techniques; if you have seen both, rate both parents and child. Use this scale:

-3	-2	-1	0	+1	+2	+3
markedly worse	moderately worse	slightly worse	no change	slightly better	moderately better	markedly better

Name of referred child	Rating for child change	Rating for parents' CRT change
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APPROVAL SHEET

The thesis submitted by Michael T. Klinger has been read and approved by the following committee:

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

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

November 4, 1985
Date

Joseph A. Durlak
Director's Signature