Developing Methods
To Study Child Psychotherapy
Using New Scales
Of Therapeutic Alliance and Progressiveness

Steven A. Foreman, M.D.

John Gibbins, Ph.D.

John Grienenberger

Jack W. Berry, Ph.D.

San Francisco Psychotherapy Research Group

Abstract

The purpose of this study was to adapt a methodology, which has previously been successfully employed in adult psychotherapy research, to study videotaped play therapy sessions with children. Therapist interventions in a child psychotherapy case were rated for Plan-compatibility, a case-specific measure of predicted helpfulness based on an independently generated case formulation. Independent judges rated patient material before and after each intervention with the Progressiveness Scale for Children, a generic measure of patient progress, and the Child Therapeutic Alliance Scale, an eight item measure which assessed elements of the patient's working capacity. A significant association was found between the Plan-compatibility of therapist interventions and changes in patient behavior following the interventions on some items of the Child Therapeutic Alliance Scale and to a more modest extent, on the Progressiveness Scale for Children. This method shows some promise for use in assessing immediate changes in patient process in child psychotherapy.

Developing Methods

Control Mastery Theory, developed by Joseph Weiss and empirically tested by Weiss, Harold Sampson, and the San Francisco Psychotherapy Research Group, is a theory of psychotherapy which has been the basis of process and outcome studies of psychoanalysis and brief therapy in adult and geriatric populations (Weiss,1993; Weiss et. al., 1986), but has not been used previously to study psychotherapy with children. The purpose of this study was to adapt the existing research method to study child psychotherapy.

Weiss theorized that as a result of real, traumatic interpersonal interactions, children develop negative, hurtful "pathogenic" beliefs about themselves in relation to others. He hypothesized that patients are intrinsically motivated to overcome these pathogenic beliefs and relieve themselves of the attendant pathological behaviors and emotions. Weiss proposed that patients come into therapy with an intent and a plan, partly conscious and partly unconscious, to overcome these pathogenic beliefs. Weiss formulated much of what occurs in psychotherapy, particularly the reenactments of childhood experiences, not as wishes for gratification but as tests of the therapist, whose purpose is to undermine pathogenic beliefs (Foreman, 1996; Weiss, 1993). Weiss hypothesized that if the therapist acts in a way which helps challenge the patient's pathogenic beliefs, the patient will feel better, bring new unconscious material to consciousness, and make progress in his or her outside life. Conversely, if the therapist "fails" a test or says something which confirms the patient's pathogenic belief, the patient will show signs of anxiety, inhibition, and appear worse in the therapy as well as in his or her outside life.

Weiss' clinical assumptions have been operationalized in a research model (Weiss et. al. 1986). The first step is a method of developing reliable case formulations for each research subject called "plan formulations", developed by Caston (Weiss, et. al., 1986, pp. 277-320) and further refined by Curtis and Silberschatz (Curtis et. al., 1988, 1994). Plan formulations consist of a series of statements about a patient's therapeutic goals and methods of working in the therapy which are generated and reliably rated by independent judges.

Based on these plan formulations, independent judges then assess therapist interventions in psychotherapy as to whether they are supportive of the patient's plan. "Plan compatible" interventions are predicted to be helpful to the patient while "plan incompatible" or "anti-plan" interventions are predicted to cause patient retreat. Plan-compatibility ratings of therapist interventions can be correlated to independent measures of patient process and outcome.

In support of Weiss' theory, research has demonstrated that therapist actions, rated in the context of case-specific plan formulations, can predict immediate changes in patient process using multiple measures including experiencing, insight, relaxation, boldness, regression in the service of the ego, and a computer enhanced measure of voice quality (Broitman, 1985; Fretter, 1984; Silberschatz 1978; Silberschatz & Curtis, 1993; Silberschatz et. al. 1986; Weiss, et. al., 1986, pp. 255-266, 299-320). Initial data supports that plan compatibility of therapist interventions is not only associated with changes in process measures of patient progress but also with multiple measures of patient outcome recorded at termination and follow-up (Fretter, 1984; Norville, 1989).

Based on this work with adult patients, we have adapted a methodology for studying the process and outcome of psychodynamic play therapy with child patients. The current study

Developing Methods

reports initial work with two patient process scales, the Progressiveness Scale for Children (PSC) (Foreman, 1990) and the Child Therapeutic Alliance Scale (CTAS) (Grienenberger & Foreman, 1993), in which the utility of therapist interventions is related to changes in patient process in a child psychotherapy case.

"Progressiveness" was conceptualized as an amalgam of relaxation, boldness, and how well the therapist and patient were working together, which were intuitively thought to be relevant to patient improvement in therapy.   Relaxation and boldness had both been shown to be useful in research with adults showing patient improvement following therapist interventions (Weiss et. al., 1986). The patient and therapist working together, a notion similar to the therapeutic or working alliance, was thought to be an important marker of patient progress within sessions.

A second scale, the CTAS, was developed because the patient's contribution to the therapeutic alliance early in the therapy has been one of the few factors in psychotherapy research which has been shown to be predictive of outcome (Hartley, 1985; Horvath & Greenberg, 1989; Marmar et. al., 1989) and the role of the alliance in adult psychotherapy research has been given increasing importance in the past two decades (Horvath & Greenberg, 1994).   Early studies looked at the alliance as a predictor of outcome, implying a fixed quality of the patient's ability to work collaboratively with the therapist (Gaston, 1990; Horvath & Greenberg, 1994). Foreman and Marmar (1985), however, observed that the therapeutic alliance can change during the course of therapy and explored therapist interventions which were associated with improved alliances and successful outcome versus unimproved alliances and poor outcome.

This study is the first attempt in the child psychotherapy literature to relate immediate changes in patient progress within sessions to specific therapist interventions rated by independent judges based on case specific formulations. It is also the first attempt to use elements of the therapeutic alliance as a process measure of patient change on a moment to moment basis to analyze the utility of different therapist interventions. Two studies (Shirk and Saiz, 1992; Smith-Acuna et. al., 1991) applied self-report alliance measures to children but did not relate therapist behavior to changes in patient process or outcome.

The purpose of the current study was to use the San Francisco Psychotherapy Research Group's procedures and scales newly applied to child psychotherapy and demonstrate a relationship between therapist interventions and patient progress in a child therapy case. Specifically, the question to be answered was whether ratings of the plan-compatibility of therapist interventions, rated by one set of judges, would be associated with changes in patient progress immediately following each therapist intervention in play psychotherapy with a child, using different process measures, rated by independent sets of judges.

Method

Subject

This was a single case study design. The subject, Suzy, was a 10 year old girl seen in weekly play therapy at a university clinic by a student therapist for 50 sessions over 2 years. The

Developing Methods

therapist was naive to the theory and research methods of the San Francisco Psychotherapy Research Group and conducted therapy based on standard psychodynamic, client centered play therapy technique (Axline, 1964) under university clinic supervision. The therapist allowed the patient to bring up themes in play or speech and then responded in a way to allow exploration, clarification, problem solving, and emotional support to the child. The therapy was videotaped. Videotapes and transcripts were available to judges for ratings of patient and therapist behavior. The patient and her mother gave informed consent to be research subjects. Efforts were made to disguise their identities.

History. Suzy presented to the clinic with complaints that she had no friends, was taunted by peers, felt frustrated, and had poor grades. She was born 12 weeks premature requiring a respirator for the first few days of life and was hospitalized until 12 weeks of age. She was three weeks old before her mother first held her, who complained she "missed bonding" with Suzy.

Suzy lived with her mother and a 6 year old blind brother who attended special classes in reading and math. He required Suzy's care and attention when Mother was busy elsewhere. Suzy and her brother spent much time together and fought often. The parents were divorced since just before the brother's birth when Suzy was four years old. Father provided no further financial support to the family, saw the children "a few times a year" and was inconsistent in his contact.

 Though Mother spent a great deal of time with her children, she rarely talked or played with them but usually watched TV or talked with friends on the phone. Mother worried that she might be laid off her job of 20 years. Suzy felt humiliated that she was held back in first grade. She played primarily with younger children and had few friends her own age.

Following the method of Curtis et. al. (1988, 1994), a plan formulation was devised by an independent set of 5 judges familiar with Control-Mastery theory, based on the history and the first four therapy hours (Gibbins & Foreman, 1989). The judges independently created lists of *goals*, *obstructions*, *tests*, and *insights* for the case. They were instructed to include both items they believed were relevant to the case and "alternative" items they thought might be reasonable for a different case but which had less relevance to this one. The lists of goals, obstructions, tests, and insights generated by the five judges were pooled in master lists and given to the judges to rate on a five point scale as to how relevant each item was to this child's plan formulation. Only items with relevance ratings at or above the median of all the judges ratings were included in the final plan formulation. Intraclass correlations were calculated for the four items as shown in Table 1, using the notation of Shrout and Fleiss (1979). The ICC (3,k) is mathematically equivalent to Cronbach's alpha coefficient.

(Table 1 about here.)

Plan Formulation. Suzy's *goals* were to feel less obligated and less responsible for her mother and brother, and to become independent of them. She wished to feel more comfortable being better off than her brother, and more comfortable complaining about him, specifically as to what a burden he was to her. She wanted to have more friends that were peers rather than having to care for younger children. She wanted to feel more deserving and less guilty meeting her own needs and asking for more. She wished to feel less worried burdening others (like her mother) with her needs.

Developing Methods

Her pathogenic beliefs which served as *obstructions* to her goals were that she believed that if she stopped feeling responsible for everyone, most notably her mother and brother, they would deteriorate. She felt she would be too selfish not caring enough for others and overwhelming them with her own needs. She felt she should have a hard life like her mother, and not have any more advantages than her brother.

Instruments

The Progressiveness Scale for Children (Foreman, 1990) is a 5 point scale from 1 (inhibition and retreat) to 5 (high expressiveness and progressiveness) measuring how well the patient is working with the therapist, and how relaxed and bold is the patient. See Appendix 1,

The Plan-compatibility Scale for Children (Foreman & Gibbins, 1990) is a 9 point scale from -4 (strongly antiplan) to +4 (strongly proplan), describing how consistent with the patient's plan or how helpful each intervention was deemed to be based on the judges' reading of the patient's plan formulation. This was adapted for child therapy from the Plan Compatibility of Interventions Scale (Weiss et. al., 1986, p. 373).

The Child Therapeutic Alliance Scale (Grienenberger & Foreman, 1993) contains eight items, each a 7-point scale measuring different elements of the patient's contribution to the therapeutic alliance. Appendix 2 shows an abbreviated version of the scale. Based on the California Psychotherapy Alliance Scales (CALPAS) (Gaston & Marmar, 1994), the CTAS was developed to reflect the unique qualities of psychodynamic play therapy with children.

The first four items, 1) Communication, 2) Self-observation, 3) Emotion, and 4) Salience, are related to items from CALPAS' Patient Working Capacity. The next three items, 5) Safety, 6) Closeness, and 7) Engagement, not originally in CALPAS, were introduced because of their intuitive relevance to the alliance. Safety is a feature considered to be central to change in psychotherapy (Weiss et. al., 1986; Sandler 1960). Closeness and Engagement are items assessing physical interactions which were thought to be important to play therapy and easy to rate. Overall Alliance (item 8), is a global measure of the therapeutic alliance. Scores for the first seven items were later summed for each rating to form a measure of Total Alliance.

Procedure

Identifying therapist interventions. Two judges, (SF and JG), with at least 5 years of child therapy experience and quite familiar with Control Mastery Theory and research methods, independently observed videotapes of three therapy hours, hour 13, 41, and 42. These three hours were picked because they had acceptable audio and visual quality, and represented a comparable number of sampling units from the first and third quarters of the therapy. The judges identified *all* therapist interventions which seemed of any importance, including questions, comments, or clarifications which seemed to have any potential meaning to the patient. Brief utterances and non-verbal material were excluded because in previous pilot studies, those were difficult to reliably rate for Plan-compatibility.

Interventions were identified in "chains" comprised of a series of "speaking turn" segments. The therapist and patient often made a string of alternating brief comments, questions, or clarifications rated as speaking turns. Therapist intervention chains were a set of speaking turns

(interrupted by corresponding patient speaking turns) which had a coherent theme, such as discussion of school, peers, or family. When in doubt, the judges broke a chain into the smallest chain reflecting the simplest theme. In the three hours studied, judges identified 39 chains of therapist interventions comprised of 125 speaking turns of material.

<u>Identifying patient material</u>. After chains of therapist interventions were initially identified as described above, corresponding chains of patient speaking turns immediately following the therapist speaking turns were identified by the same judges. If there were 6 speaking turns in the therapist chain, there were 6 "post-intervention" speaking turns in the patient chain.   The patient speaking turn immediately preceding each therapist intervention chain was identified as a "pre-intervention" segment to be rated later in determining the change in patient process as a result of each therapist intervention. Sometimes, the pre-intervention patient speaking turn for one therapist intervention was the post-intervention patient speaking turn for the previous therapist intervention when the material was sequential. For this reason, there were more total patient chains than therapist chains but not twice as many.   In the three therapy hours, judges identified 53 chains of patient material comprised of 139 speaking turns.

<u>Rating therapist interventions</u>. A different set of four judges experienced in child therapy and experienced with Control Mastery theory were trained briefly in the use of the Plan-compatibility Scale. After reading the plan formulation for the Suzy case (previously devised by an independent set of judges), they watched three therapy hours from the case and rated the previously identified 39 chains comprised of 125 speaking turns for plan-compatibility, using the Plan-compatibility Scale.

Each speaking turn in a chain was rated separately and each chain was given an overall rating for plan-compatibility. The hours were presented randomly, but within each hour the material was presented sequentially to allow judges to better understand the context and meaning of each intervention. In addition, an approximate thirty second speaking turn of patient and therapist material before each therapist intervention was presented, enough time to give context for the judges to understand the meaning of each intervention. Then the therapist material was presented with the intervening patient material muted. Transcripts, with patient material deleted, were given to the judges to supplement the videotapes. The transcripts gave a brief description of the patient material, such as whether it was a question or a comment, and occasionally mentioned the content as context so judges could better understand the meaning of the therapist's intervention.

<u>Rating patient material with the PSC</u>. Five judges (clinicians or students with less experience with child therapy and less familiarity with Control Mastery Theory than the plan-compatibility judges) observed videotapes of therapy hours 13, 41, and 42 presented in the same sequence as in the plan-compatibility study. After brief training in the PSC and with no knowledge of the patient's plan formulation or history, the judges rated each of 139 speaking turns and gave overall progressiveness ratings to 53 chains previously identified. The therapist material was muted and transcripts were provided which deleted the therapist material but gave contextual information such as whether the patient was responding to a comment or a question, and occasionally gave brief cues to help the judges understand the content of the patient's material.

Developing Methods

Rating patient material with the CTAS.   A different set of four judges rated the same patient material in hours 13 and 41 using the CTAS, which was previously rated using the PSC. CTAS judges were social workers with two to four years of post graduate experience in child and family therapy and little to no previous exposure to Control Mastery theory and research. Because the CTAS was much more time consuming than the PSC, there was not enough time in one sitting for the judges to rate all three therapy hours previously rated, so hour 42 was deleted. Training in the use of the CTAS took approximately 15 minutes and involved the judges making several practice ratings of patient material from different therapy hours from the same case. The judges had no knowledge of the patient's plan formulation or history and the therapist material in both the videotapes and transcripts was omitted.   Whereas the PSC judges rated both chains and individual speaking turns, the CTAS judges only rated chains, since several of the alliance items required more patient material to meaningfully rate than was available in the speaking turns. A total of 42 chains of patient material were rated with the CTAS.

Results

Reliability of Measurement Scales

PSC & CTAS. Table 2 presents reliability data for the PSC and the eight items of the CTAS and Total Alliance. Intraclass correlations, which measure interrater reliability, were calculated for each item (Shrout and Fleiss, 1979). ICC (2,1) is the reliability of a single rater, assuming the raters are a random sample from a larger population. ICC(2,k) is the reliability of the mean of a set of k raters. There were 5 raters in the PSC study and 4 raters in the CTAS study.

(Table 2 about here)

CTAS Coefficient Alpha. The eight items of the CTAS were correlated with each other; the correlations ranged from .24 to .98. The first seven items (all but the Overall Alliance measure) were summed and each item was correlated with this sum, yielding a corrected item-total correlation for each item. These correlations ranged from .55 to .93. Cronbach's alpha coefficient, measuring the internal consistency of the scale, was .90.

Plan-compatibility Scale. Intraclass correlations were used to estimate the reliabilities of four judges rating therapist interventions using the Plan-compatibility Scale. For rating speaking turns (n=125), the ICC(3,1) was .58 and the ICC(3,4) was .85. For rating chains (n=39), the ICC(3,1) was .64 and the ICC(3,4) was .88. For chains, the mean plan-compatibility rating was 1.62 (S.D. 1.17).

Relating Therapist Plan-Compatibility and Patient Process Measures

Therapeutic Alliance. The plan-compatibility of each intervention was correlated with residualized gain scores for each of the 7 items of the CTAS, with Total Alliance, and with Overall Alliance, across chains. The residualized gain score is a change score that is adjusted to take the pre-intervention score into account. A linear regression was used to predict the post-intervention scores from the pre-intervention scores, and the residuals from this regression were used as the residualized gain score. Because the data were collected over time, Cochrane-Orcutt methods were used to adjust for autocorrelation.

Developing Methods

The correlation between the plan-compatibility of therapist interventions and the residualized gain scores of patient alliance measures was statistically significant across both therapy hours for Total Alliance (r = .46, p = .009) and three patient alliance items, Communication (r = .40, p = .02), Salience (r = .35, p = .05), and Safety (r = .38, p = .03). Residualized gain scores of Overall Alliance did not correlate significantly with therapist plan-compatibility (r = .16).

Progressiveness. Correlations between Plan-compatibility and residualized gain scores of Progressiveness were calculated across three therapy sessions, and for each of the three sessions separately, across speaking turns and chains, using Cochrane-Orcutt methods to adjust for autocorrelation.

The Pearson correlation between therapist Plan-compatibility and residualized gain scores of patient Progressiveness across speaking turns was statistically significant for hour 13 (n= 59, r = .26, p = .04), but not for hours 41 (n = 46, r = -.15), 42 (n = 19, r = -.17), nor for the combined therapy hours (n = 125, r = .15).

The correlation between therapist Plan-compatibility and residualized gain scores of patient Progressiveness across chains for the three hours (r = .14, n = 39) was not significant.

The Pearson correlation between Progressiveness and Total Alliance scores was significant (r = .83, p < .0001). Progressiveness also correlated highly (r value ranged between .85 and .90) with 5 of the CTAS items: Communication, Safety, Closeness, Engagement, and Overall Alliance.

Discussion

 Each item on the CTAS was easy to learn and rate in that judges attained acceptable reliabilities in one rating session after only brief training. Items were internally consistent with a strong Chronbach's alpha. Construct validity of the CTAS was tentatively supported by its correlation with the plan-compatibility of therapist interventions and with patient progressiveness.

The PSC was similarly easy to learn in that judges attained acceptable reliabilities in one rating session after brief training. Its construct validity was partly supported by its high correlation with Total Alliance and several CTAS items.

A weakness of the PSC was that it correlated only .26 with therapist plan-compatibility in one hour and not in the two others studied, suggesting that its construct validity was not as robust as that of the CTAS. This may have been because the PSC is a single global assessment of a multidimensional construct. Just like Overall Alliance, which is a single global measure of all the alliance items, it did not correlate as strongly with Plan-compatibility. The items which correlated more highly with Plan-compatibility were more specific (or the sum of specific measures) and showed more variability with larger standard deviations than other items.

This study is limited in its application because of the small amount of clinical material analyzed and there was only one subject. Graf (1995) has looked at 9 sessions from the Suzy case relating therapist Plan-compatibility to changes in child process measures, attaining small but significant correlations. However, Graf only looked at therapist interventions following key

Developing Methods

patient tests and the only patient process measures used were Progressiveness and two CTAS items, Salience and Safety. The current study needs to be repeated using the entire CTAS on more hours sampled throughout this case. More child therapies will need to be studied, including long term and brief therapies from different schools of theory to test Weiss' assumptions about the importance of plan-compatibility to patient process and outcome.

References

Axline, V.M. (1964). Nondirective therapy. In M.R. Haworth (Ed.), Child Psychotherapy: Practice and Theory. New York: Basic Books.

Broitman, J. (1985). Insight, the mind's eye: An exploration of three patients' process of becoming insightful. Doctoral Dissertation, Wright Institute. Dissertation Abstracts International, Vol. 46, No. 8. University Microfilms No. 85-20425.

Curtis, J.T., Silberschatz, G., Sampson, H., Weiss, J. (1994). The Plan Formulation Method. Psychotherapy Research, 4, 197-207.

Curtis, J.T., Silberschatz, G., Sampson, H., Weiss, J., & Rosenberg, S.E. (1988). Developing reliable psychodynamic case formulations: An illustration of the plan diagnosis method. Psychotherapy, 25:2, 256-265.

Foreman, S.A. (1990). Progressiveness Scale for Children. Presented at the 21st annual meeting, Society for Psychotherapy Research, Wintergreen, Virginia, 1990.

Foreman, S.A. (1996) The Significance of Turning Passive into Active in Control Mastery Theory, The Journal of Psychotherapy Practice and Research; 5:106-121.

Foreman, S.A. & Gibbins, J.D. (1990). The Intervention Plan-compatibility Scale.   Presented at the 21st annual meeting, Society for Psychotherapy Research, Wintergreen, Virginia.

Foreman, SA. & Marmar, C. (1985). Therapist Actions That Address Initially Poor Therapeutic Alliances in Psychotherapy.   American Journal of Psychiatry, 142(8), 922-926.

Fretter, P.B. (1984). The immediate effects of transference interpretations on patients' progress in brief, psychodynamic psychotherapy (Doctoral dissertation, University of San Francisco, l984). Dissertation Abstracts International, 46:6, (University Microfilms No. 85-12112).

Gaston, L. (1990). The Concept of the Alliance and It's Role in Psychotherapy: Theoretical & Empirical Considerations. Psychotherapy, 26, 139-148.

Gaston, L. & Marmar, C. (1994). The California Psychotherapy Alliance Scales. In A.O. Horvath & L.S. Greenberg, (Eds.), The Working Alliance: Theory,   Research, and Practice. Wiley Series On Personality Processes. (pp. 85-108). New York: John Wiley & Sons.

Gibbins, J.D. & Foreman, S.A. (1989). The plan formulation of a child psychotherapy case. Presented at the 20th annual meeting, Society for Psychotherapy Research, Toronto.

Developing Methods

Graf, T. (1995). Effects of therapist interventions in the context of child testing of pathogenic beliefs during child psychotherapy. (Doctoral dissertation, The Wright Institute, 1995).

Dissertation Abstracts International, 57 (1). Section B, page 0696, University Microfilms No. AAI 9615427.

Grienenberger, J. & Foreman, S.A. (1993). Development of the Child Therapeutic Alliance Scale (CTAS). Presented at the 24th annual meeting, Society for Psychotherapy Research, Pittsburgh.

Hartley, D. (1985). Research On the Therapeutic Alliance in Psychotherapy. In R. Hales & A. Frances (Eds.), Psychiatry Update American Psychiatric Association Annual Review, 4, 532-549.

Horvath, A.O. & Greenberg, L.S. (1989). Development and Validation of the Working Alliance Inventory. Journal of Counseling Psychology, 36(2), 223-233.

Horvath, A.O. & Greenberg, L.S., Eds. (1994). The Working Alliance: Theory, Research, and Practice. Wiley Series On Personality Processes. New York: John Wiley & Sons.

Marmar, CR., Weiss, DS, & Gaston, L. (1989). Toward the Validation of the California Psychotherapeutic Alliance Rating System. Psychological Assessment, 1(1),46-52.

Norville, R. (1989). Plan compatibility of interpretations and brief psychotherapy outcome. Doctoral Dissertation, Pacific Graduate School of Psychology, Palo Alto, CA.

Sandler, J. (1960). The Background of Safety. International Journal of Psycho-Analysis, 41, 352-356.

Shirk, S. & Saiz, C. (1992). Clinical, Empirical, and Developmental Perspectives On the Therapeutic Relationship In Child Psychotherapy. Development and Psychopathology, 4, 713-728.

Shrout, PE & Fleiss, JL (1979). Intraclass correlations: Uses in assessing rater reliability, Psychological Bulletin, 86, 420-428.

Silberschatz, G. (l978). Effects of the analyst's neutrality on the patient's feeling and behavior in the psychoanalytic situation. Doctoral dissertation, New York University.

Silberschatz, G. & Curtis, J. (1993). Measuring the therapist's impact on the patient's therapeutic progress. Journal of Consulting and Clinical Psychology, 61(3), 403-411.

Silberschatz, G., Fretter, P., & Curtis, J. (1986). How Do Interpretations Influence the Process of Psychotherapy? Journal of Consulting and Clinical Psychology, 54(5), 646-652.

Smith-Acuna, S., Durlak, JA, & Kaspar, CJ (1991). Development of Child Psychotherapy Process Measures. Journal of Clinical Child Psychology, 20(2), 126-131.

Weiss, J. (1971). The emergence of new themes: A contribution to the psychoanalytic theory of therapy. International Journal of Psycho-Analysis, 52(4), 459-467.

Weiss, J. (1993). How Psychotherapy Works: Process and Technique. New York: Guilford.

Developing Methods

Weiss, J., Sampson, H., & the Mount Zion Psychotherapy Research Group. (1986). The psychoanalytic process. Theory, clinical observations, and empirical research. New York: Guilford.

Developing Methods

Table 1

Plan Formulation Reliability of Ratings

	n	Median	ICC (3,1)	ICC(3,5)
Goals	96	2.8	.44	.80
Obstructions	85	2.8	.40	.77
Tests	62	2.4	.23	.60
Insights	66	3.1	.30	.68

Note. ICC = Intraclass Correlation. ICC(3,1) is the reliability of a single judge and ICC(3,5) is the pooled reliability of 5 judges. See Shrout & Fleiss (1979).

Developing Methods

Interrater Reliabilities and Descriptive Data for Patient Process Scales

Items	n	M	SD	ICC(2,1)	ICC(2,k)
PSC				ICC(2,1)	ICC(2,5)
Speaking turns	139	3.28	0.79	.61	.89
Chains	53	3.50	0.72	.58	.87
CTAS (Chains only)				ICC(2,1)	ICC(2,4)
Communication	42	4.68	1.14	.63	.87
Self-Observation	42	3.13	0.84	.29	.64
Emotion	42	3.43	0.71	.32	.67
Salience	42	4.38	1.19	.55	.83
Safety	42	4.64	0.97	.61	.86
Closeness	42	4.57	0.73	.50	.80
Engagement	42	5.07	0.97	.63	.88
Overall Alliance	42	4.70	0.91	.64	.88
Total Alliance	42	29.91	5.69		

Note. PSC = Progressiveness Scale for Children. CTAS = Child Therapeutic Alliance Scale. ICC = Intraclass correlation. ICC(2,1) is the reliability of a single rater. ICC(2,k) is the reliability of the mean of k raters, 5 raters used the PSC and 4 raters used the CTAS. See Shrout & Fleiss (1979). Chains are groups of speaking turns on one topic.

Developing Methods

Appendix A: Progressiveness Scale for Children

1. Patient manifests clear-cut anxious retreat or inhibition. Patient is isolated from therapist, feelings, and thoughts.

2. Patient manifests a mild to moderate degree of anxious retreat, inhibition and isolation.

3. Patient manifests ambiguous trends or mixed attempts to be open to therapist, feelings, and thoughts.

4. Patient manifests moderate progressiveness dealing with feelings and thoughts with moderate openness to the therapist.

5. Patient is openly expressive to the therapist of feelings and thoughts in speech and play.

Instructions to Raters: This is a 5-point scale that measures the degree to which the patient is able to be progressive in his or her therapeutic work. The key element to look for is the patient's relatedness to the therapist in working on therapeutic issues. At the low end of the scale, the patient is timid and inhibited. Play or speech is used to distance from the therapist. Affect is constricted. Expression of feeling is narrow. Play or speech is uncommunicative and isolative. Play or speech may be repetitive, stereotyped, or fragmented. Speech or play content centers on trivial issues, avoiding the patient's life concerns or problems. At the high end of the scale, the patient is open to the therapist, communicating thoughts and feelings, and involving the therapist in play and conversation. The patient seems to feel safe in expressing inner feelings such as pleasure, anger, or sadness (any feeling other than anxiety) with the therapist. Content of play or speech is meaningfully related to the patient's life concerns, involving parental figures, the therapist, the patient, siblings, or peers.

Developing Methods

Appendix B: Child Therapeutic Alliance Scale, Abbreviated Version.

1) <u>Communication</u>: Patient effectively communicates thoughts and feelings to the therapist in speech or play.

> 1: Flat affect, very low verbalization, low levels of clarity and organization of thinking, non-expressive play. 4: Moderate affect and verbalization, clearer thinking, moderately rich play behavior. 7: High quality of expression, affect is present when relevant, great clarity of thinking, verbal expression is present.

2) <u>Self-Observation</u>: Patient self-observes behaviors.

> 1: Patient does not discuss behavior. 4: Patient begins to discuss behavior and the roles he or she may play in her own problems. 7: Very insightful self-observations, great insight into linkages between feelings, behavior, and experience.

3) <u>Emotion</u>: Patient expresses emotions (either verbally or affectively).

> 1: Patient does not express any emotion. 4: Patient expresses a moderate degree of emotion.

7: Patient fully expresses powerful emotion.

4) <u>Salience</u>: Patient explores themes which are salient and meaningful such as important relationships, life goals, or feelings.

> 1: The content of the patient's expressions lacks meaning and depth. 4: The patient explores themes of moderate meaning and depth. 7: The themes explored are extremely salient to the patient's life.

5) <u>Safety</u>: Patient exhibits feelings of trust in the therapist and safety in the therapeutic milieu.

> 1: Patient seems guarded or fearful of the therapist, patient displays fears about the physical safety of either herself or the therapist. 4: Mixed signs of guardedness and comfort, moderate displays of trust. 7: Patient shows great confidence and trust in the therapist and a strong sense of safety in the therapeutic milieu.

6) <u>Closeness</u>: The patient appears to be physically and emotionally close to the therapist.

> 1: Patient is extremely distant from the therapist both physically and emotionally. 4: Mixed signs of distance and closeness, patient interested but not highly connected, may be some displays of affection present. 7: Patient is physically close to the therapist, patient is affectionate and shows emotional closeness by smiles and warm voice tone.

7) <u>Engagement</u>: Patient is able to engage with the therapist in speech or play.

> 1: Patient actively avoids engagement with therapist, isolates herself, ignores therapist's comments, appears anxious or closed in posture. 4: Level of engagement is neutral or mixed, patient may respond indirectly or passively to therapist's comments. 7: Patient is extremely open and natural with the therapist, relaxed in posture, and responsive to the therapist's comments.

Developing Methods

8) <u>Overall Alliance</u>: Overall therapeutic alliance rating: how well the patient is working with the therapist in therapy. 1: Extremely low 4: Moderate 7: Extremely high.