

**Early Changes in Credibility of Therapies Offered  
in Child and Family Work.**

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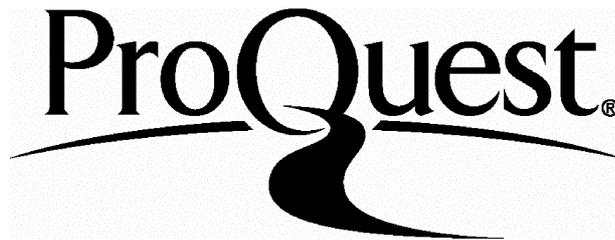
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## **Abstract**

The aim of the research was to quantify some changes in families' beliefs about therapies that can occur very early on in the therapeutic relationship (Hardy et al, 1995). Brief descriptions were developed of the three main therapies offered at a child and family clinic to help families with reported difficulties with their children. Prior to being seen for an assessment interview, 33 mothers and 18 fathers rated the credibility of each of the therapy types by reading therapy descriptions and answering questions adapted from Borkovec & Nau (1972) in a postal questionnaire. Psychological mindedness was also assessed by administering a questionnaire adapted from Conte et al.'s (1990) Psychological Mindedness Scale. The credibility of the therapies was re-assessed by each mother and father immediately after the assessment interview using the same measure. At the same time, the main therapist involved in the interview also assessed the credibility of the therapies, according to how suitable they felt each of the therapies would be for the family just seen.

The direction of changes in beliefs was measured, to see if there was a convergence towards the therapists' beliefs, as Atkinson et al. (1991) had shown. The research also investigated whether psychological mindedness affected the convergence of beliefs. The main finding was that mothers' therapy ratings all increased after assessment, significantly so for parent and family therapies. Some evidence was also found that mothers' therapy ratings began to converge towards those of the therapists:-

- Mothers rated child therapy highest before assessment and then lowest after assessment. This change corresponded with the therapists' ratings since the therapists

rated child therapy significantly lower than the other two therapies.

- The group of more psychologically-minded mothers were significantly more pro-therapies than the other mothers.

Finally, the therapists who assessed the more psychologically-minded mothers were more optimistic about the benefits of therapy for them than for the other mothers.

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## **1. Introduction**

This research project started with the idea in mind of an investigation into useful relationships, along with an interest in research into family therapy, where several relationships can exist concurrently. No claim is made regarding the superiority or otherwise of a family approach since there is no systematic proof from outcome research to show that family approaches are any better than a group or individual treatment, other than when the problem is clearly a marital one (Gurman, Kniskern & Pinsof, 1986). However, the researcher's focus of interest lay in researching a small area within the area of child and family work. A dilemma in deciding whether to carry out qualitative or quantitative research was described by Alexander, Holtzworth-Munroe and Jameson (1994). They point out that qualitative studies are preferred sources of information for many family therapists, these studies having an advantage of employing new and emergent epistemologies and can reflect idiosyncratic processes of family therapy as applied to individual families highlighted as case studies. The alternative, a quantitative study, offers none of these attractions but can offer instead the potential benefit of commenting on processes that are generalisable between families. To be of any use, such processes must not fall within the trap that Brown (1998) described as "aggregated data that ... has no counterpart in the individual". A decision was made to try and avoid the trap and to carry out a quantitative study with families.

### 1.1 Choosing a process to research.

The twentieth century has been the century of psychotherapy. As it draws to a close, a larger than ever number of constantly evolving psychotherapies continue to enjoy enormous popularity in the Western world. There has been a vast investment in psychotherapies within health systems which implies that there is a strong belief amongst both patients and therapists that therapies are useful in some way. The investment in these therapies has led to increasing scrutiny of the utility of therapies and a much stronger focus on evidence-based approaches. Clinical audit and a focus on outcomes have become linked to the continued funding of many therapies; the climate demands demonstrable benefits to clients, to be brought about in a cost-effective way. This has led to a rise in the popularity of brief therapy approaches.

One important factor strongly associated with outcome is therapeutic alliance. This construct is particularly important within brief therapies because with few sessions available, it is imperative that the alliance develops very early on. Therapeutic alliance was therefore identified as a factor worth investigating. Assessing outcome becomes difficult if families drop out, so dropout was considered another factor worth investigating. This introduction briefly reviews the literature examining dropout and therapeutic alliance and then makes some links between the two constructs. A description of some measures to assess therapeutic alliance in individuals and families then follows. Attention is then drawn to some limitations of these measures and the focus moves towards examining credibility of therapies. This construct is allied to therapeutic alliance and can be quantified very early on in the therapeutic relationship. The rationale is then explained for investigating credibility of therapies and another

factor, psychological mindedness. The introduction concludes by proposing some research questions to investigate.

## 1.2 Dropout and therapeutic alliance.

An overview of these concepts is described below.

### 1.2.1 Research into predicting dropout.

Following up dropouts to find out about outcome is obviously difficult, because the clients are usually unavailable. However, some researchers have investigated factors that influence dropout, which can inform practice.

Duehn and Proctor (1977) reported dropout rates from individual therapy that ranged from 28 per cent to 80 per cent in the studies they investigated, whilst Fowler (1967), cited in Hoffman (1985), suggested an estimate of one third dropout. Hoffman only investigated client characteristics, so there was no possibility of commenting on the relationship between the therapist and patient. Baekeland and Lundwall (1975) describe how dropout from different types of medical and psychiatric therapies can cause difficulties beyond reducing treatment effectiveness. For example, dropout from medical programmes can bias the validity of outpatient studies partly because those remaining are those with a higher compliance to treatment and are also the group less likely to make up the chronic category of patient. The authors decided to ask why dropouts leave treatment. They defined dropouts as those who declined or refused to return or who were expelled from a treatment programme for being uncooperative or non-compliant in some way. Fifteen factors were reported to predict dropout in the

large majority of studies looked into. Some of the factors included therapist attitudes and behaviour, discrepancies between therapist and patient expectations and low psychological mindedness.

Allgood and Crane (1991) noted that most previous research into dropout had concentrated on personal therapies and chose instead to investigate marital therapy dropouts. They found that fifteen per cent of the sample met the criteria for dropout and noted that the best predictors of couples dropping out were: - having fewer than two children, having a male assessment clinician and having a presenting problem perceived to relate to either one spouse only or to the whole family. However, it is difficult to comment on the external validity of the findings since, despite the large sample size ( $n=474$ ), 95 per cent of the sample were Mormons; the highly observant and strict approach to family life prescribed by that group might not be generalisable to other populations with respect to the variables under investigation.

Epperson (1981) found that the gender of the therapist was an important variable, but the direction of the association was the opposite from that found by Allgood and Crane (1991). Mennicke, Lent and Burgoyne (1988) (cited in Longo, Lent & Brown (1992)) focused on contradictory findings like these and noted that investigations into global and static client or counsellor variables in order to predict client attrition have not yielded consistent or practically useful findings. Amongst their recommendations, Mennicke et al. highlighted the need for more theory-driven research examining cognitive and interpersonal mechanisms that could play a part in dropout occurring.

McCallum, Piper and Joyce (1992) conducted a study into dropout from short-term psychoanalytically oriented group therapy. The main finding from the study was that low psychological mindedness, problem severity and psychiatric symptomatology were strong predictors of dropping out. The authors noted that it is possible that different therapy formats might yield different variables that predict dropouts so that no generalisation could be extended with any certainty towards other therapies.

In summary, dropout rates from therapy have been reported to range widely, whilst a conservative estimate is one third. The great majority of the studies have focused on individuals, where many factors have been attributed to dropout. In marital therapy, the research has not yielded consistent results, whilst in group therapy, several factors were identified that influence dropout but the authors could not be sure whether different factors would have been identified if a different therapy format had been employed. However, both Baekeland and Lundwall (1975) and McCallum et al (1992) cite patient low psychological mindedness as a factor influencing dropout and was a factor considered worth returning to later on.

### 1.2.2 Investigating therapeutic alliance

The concept of alliance comes from psychoanalysis. Therapeutic alliance, or working alliance, is generally defined as the feelings that arise in therapy when the therapist and client feel that they care for each other in some way and that they can work together towards shared goals. Luborsky, Barber and Beutler (1993) suggest that therapists need to foster with the client the development of a sense of collaboration and trust, agreed upon goals and faith in the procedures of therapy.

The relationship between therapeutic alliance and outcome has been extensively documented (Horvath & Greenberg, 1994; Orlinsky & Howard, 1986). Kolden (1996) noted that the findings have been particularly consistent when the patient is the one who assesses the quality of alliance. Kokotovic and Tracey (1990) cite Gelso and Carter (1985) who state that the establishment of a strong working alliance is viewed as crucial to successful counselling and that the quality of the alliance is especially important early on in counselling.

### 1.2.3 Links between dropout and therapeutic alliance.

Tracey (1986) investigated the relationship between premature termination from individual therapy and early agreement between therapist and patient about what is to be done in therapy sessions and how it is to be done. The measure of task agreement was defined as the proportion of topic initiations by the therapist or patient, subsequently followed by the other participant. The measure was used as an indicator of the strength of therapeutic alliance. The authors pointed out that previous investigators (Horvath & Greenberg, 1985) found that early task agreement was associated with outcome later and that Lennard and Bernstein (1967) had hypothesized that therapist-client dyads who dropped out were those where there was a lack of an early task agreement. Tracey found some support for the relation between topic determination and premature termination, especially for topics initiated by the therapist and subsequently followed by the patient. Bordin (1979) proposed that bonding slowly developed between therapist and patient and occurred after the initial framework of agreement had been established. Thus, there is some evidence, albeit inconclusive, to show that dropout can be reduced by the establishment of a

therapeutic alliance early on in the lifetime of the therapy.

#### 1.2.4 Measures developed to assess therapeutic alliance in individuals.

The advantage of having a construct to describe therapeutic alliance is that it can be incorporated within several theoretical approaches, the construct describing variables common to many forms of intervention (Frank, 1961, Frank & Frank 1991). Development of a measure to describe and evaluate the construct could be a useful predictive tool for clinicians. The next brief section describes some measures that have been developed to measure the alliance for individuals in therapy and is followed by a longer section dealing with how therapeutic alliance has been conceptualised and measured in families.

Horvath and Greenberg (1989) developed a measure they termed the Working Alliance Inventory (WAI). They cited four major theoretical areas to provide the basis of empirical investigation into the construct: Rogers' (1951) client-centred theory, Strong's (1968) social influence theory, the psychodynamic perspective on the working relationship (Greenson, 1967) and Bordin's (1975) integrationist formulation of the working alliance. The working alliance was developed around Bordin's ideas. Bordin (1979) proposed a definition of working alliance occurring between client and counsellor that comprised three related components: the agreed goals of treatment, the agreed tasks of treatment and the personal bonds that develop in the relationship. The measure that Horvath and Greenberg developed and initially validated involved a self-report questionnaire to measure both the client's and counsellor's perception of the working alliance at some point in counselling.

Kokotovic and Tracey (1990) applied the WAI (Horvath and Greenberg, 1989) to an outpatient group and noted that the quality of alliance was not associated with dropout, although they only measured the alliance at the end of the first session. This finding surprised the authors and contradicted Bordin's (1979) suggestion that one consequence of a poor early working alliance was dropout. Kokotovic and Tracey suggest that the working alliance could vary in the first few sessions, so that the relationship might only become apparent after the first three sessions. Clients whose difficulties in developing a therapeutic alliance and which could not be remedied early on would then be more likely to drop out. Safran and Muran (1996) described a model for understanding breakdowns in the therapeutic alliance that they termed 'ruptures', which could then lead to dropout or treatment failure. They state that ruptures in therapeutic relationships can be repaired by the therapist and implicitly attribute the cause of the ruptures to patients' maladaptive interpersonal schemas.

A model for predicting quality of alliance by the end of the first interview was proposed by Ryan and Cicchetti (1985). They believed that the end of the first interview was a valid time to try and measure quality of alliance, citing Morgan, Luborsky, Crits-Christoph et al. (1982) who had suggested that the quality of alliance is maintained over time and predicts outcome. Ryan and Cicchetti's main experimental finding was that 40 per cent of the variance in predicting the quality of therapeutic alliance could be accounted for by several predictor variables that included object relations, hope, psychological mindedness, psychic pain and intrapsychic flexibility. Therapeutic alliance was viewed by the authors as a dual concept, comprising an expressive dimension and a collaborative one. More recently, Sexton,

Hembre and Kvarme (1996) in an exploration of the moment-to-moment interactions that could contribute to the alliance process, also found that the alliance measured in the first session was very highly correlated with alliance in each of the nine following sessions in their study. They concluded that the formation of the therapeutic alliance usually occurs by the end of the first session.

#### 1.2.5 Therapeutic alliance in couples and families

In individual psychodynamic therapy there has been extensive writing about the therapeutic alliance. It has been viewed as an exclusive phenomenon pertaining to the relationship with the single client so that any wider systemic relationships have been ignored. In contrast, a systemic view of therapeutic alliance is acknowledged in the family therapy literature since the systemic model moves away from dyad relationships towards family system relationships. The literature has been mainly descriptive because the language used to describe the alliance has not lent itself to a quantitative approach.

Attempts to model the processes that influence the alliance in families are described below. There have been a few attempts to model and initially validate a systemic measure of therapeutic alliance in couples and families and to develop scales for these measures. These studies are also described.

#### Processes that influence therapeutic alliance in families.

Solomon (1977) described some systemic techniques to apply early on in family therapy in order to sustain the process long enough for a therapeutic alliance to be

formed. The techniques all involved family tasks played out in the therapy room that were explained within a psychodynamic framework and were based on a structural approach of joining and accommodating (Minuchin, 1974). Haley (1976) described employing an initial social stage of therapy to engage family members whom he generally expected to be defensive and anxious, whilst Woody (1990) prescribed weighing up the potential ethical and legal risks before embarking on such strategies to promote alliance in family therapy. Minuchin and Fishman (1981) discussed 'joining' techniques in detail, the term being used interchangeably with 'therapeutic alliance'. They said that the therapist has to earn the right to lead the family but to achieve this, various strategies might need to be employed. This could involve accommodating, seducing, submitting, supporting, directing, suggesting and following in order to lead. Greif (1990) talked about a checklist of basic techniques for 'joining' the family in areas such as body posture, breathing and eye contact. Suggestions included making a point of remembering the names of all the family members and letting the family members choose the seating arrangements. Greif cited Anderson and Stewart (1983) who talked about having to break down initial resistance to family therapy in order to lead.

Reimers and Treacher (1995) cite Maluccio (1979) whose research into the processes of engagement in therapy led him to conceptualise breaking the process into three phases; getting engaged, staying engaged and becoming disengaged. Maluccio believed that clients remembered the process of getting engaged early on better than the therapist, who tended to focus on and remember the content of sessions, rather than the process. He described several early tasks of engagement for both therapist

and client that needed to be recognised, each of them involving complementary functions and responsibilities.

Barnard and Kuehl (1995) described procedures to employ in family therapy to maintain therapeutic alliance, regardless of techniques used or schools of family therapy. They conceived therapeutic alliance as being central to successful family therapy and that it could be maintained by the procedures of what they called 'ongoing evaluation'. These procedures involved asking the family about process questions according to whether therapy was in the beginning, middle or final stage. The questions were all aimed at generating or recovering trust, in order to build up therapeutic alliance. The authors acknowledged the general trend in psychotherapies to recognise the importance of the therapist's use of self in therapy. The therapist's role has changed from being somewhat intrusive towards a more collaborative one, ideas from constructivist notions having forced family therapists to consider how their own world view influences families' views of reality.

#### Measures of therapeutic alliance in families.

Pinsof and Catherall (1986) noted that previous instruments to measure therapeutic alliance were rooted in the theories of individual psychotherapy and that the concept had been overlooked in the family therapy literature. This was probably because modelling therapeutic alliance gets complicated when applied to families, since the therapist has to deal with several relationships at once. The authors modelled therapeutic alliance in family therapy as existing on at least three levels. Alliances between the therapist and each individual family member made up the lowest level,

whilst at the highest level the therapist was allied to the whole family as a group. The middle level they saw as occupied by the various sub-system alliances. None of the alliances could be considered in isolation since all alliances affected one another in a circular, reciprocal fashion, some alliances having more influence than others. Alliances were seen as instantaneous, so that they could vary from one session to the next. At the highest level, the therapist could have a split or intact alliance with the whole family, depending on which members felt positive towards the therapist or therapy. In a split alliance, the authors described the importance of forming alliances with the most powerful subsystems in order to have a strong enough alliance overall to keep the whole family in therapy. In addition, the authors felt that their measure should include a social dimension to take account of the impact on those people who were not necessarily directly involved in therapy but who were still part of the patient and therapist subsystems. In this way, therapeutic alliance with individuals, couples and families could be integrated as a concept.

Separate instruments were developed for individual, couple and family therapy, to take account of the interpersonal differences associated with having, respectively, one, two and three or more patients. Each scale derived from two theoretical dimensions. One scale, 'content', came from Bordin's (1979) previously mentioned definition of working alliance which involved 3 categories, namely tasks, bonds and goals. The other scale, 'interpersonal' comprised the individual patient's view of alliance between (1) self-therapist: the individual himself and the therapist (eg "I trust the therapist"); (2) other-therapist: other members of the family and the therapist, (eg "some other members of my family are not in agreement with the therapist about the goals of this

therapy"); and (3) group-therapist: the family or system of which the individual is a part (eg "The therapist cares about my family"). Thus, the dimensions of the measure made up a 3x3 matrix of dimensions, each question falling into one cell of the matrix. The measure used self-report and relied on the assumption that the alliance is an experiential, rather than a behavioural, phenomenon and that it could be measured by tapping the individual's perceptions of indicators of the alliance between the therapist and various subsystems. The instrument assessed family members' perception of alliance, with more than one individual leading to conjoint scores. But the therapist had no part in contributing to the alliance measure and so the instrument only assessed the patient's perception of the alliance. Despite high re-test reliabilities (the authors reported .79 (n=17) and .83 (n=35) respectively for the couple and family instruments), Pinsof and Catherall's attempt at modelling and measuring family therapeutic alliance, despite its simplifications, seemed very complicated. However, in attempting to define a measurable view of the concept of therapeutic alliance, the complexity of such a construct became clear, even though this was not commented upon by the authors.

Martin and Allison (1993) developed a fifteen-item questionnaire to measure family therapeutic alliance that was filled in by family therapy team members. The scale, called the Family Therapy Alliance Scale, developed out of the aim to improve outcome in family therapy. Initially, a questionnaire was developed of 36 items drawn mainly from the individual therapy literature and which concentrated largely on Bordin's concept of goals. Each question was rated on a seven-point Likert scale according to how often its description was judged to be present in the therapy session

observed on videotape. Factor analysis resolved the questions into a two-factor fifteen item scale. The authors noted that developing the scale provided a useful focus for enhancing therapist-family relationships. The measure was quite limited however, since the scale only measured the equivalent of Pinsof and Catherall's highest level of alliance, which was that between the therapist and the family group as a whole. It therefore represented an even greater simplification of the systemic concept of therapeutic alliance than in the previous study. The authors comment on the simplifications made in developing the questionnaire but point out that the scale was able to provide reliable global ratings of the bond between the therapist and family members.

Other researchers have tried to model and initially validate the family alliance, adapting it to a specialised setting. Kroll and Green (1997) developed a measure to describe the quality of alliance amongst the system involved with children and adolescents receiving in-patient treatment. The family system was extended to allow for the hospital hierarchy of doctors and nurses. The research interest in modelling the alliance was once again fuelled by the idea that the quality of the therapeutic alliance can be a major predictor of outcome.

Only two reported studies applied either of the instruments described above. Heatherington and Friedlander (1990, a) reported applying Pinsof and Catherall's (1986) couple and family therapy alliance scales. Overall, the results revealed several strengths in the psychometric properties of both scales. Questionnaires were administered earlier on in therapy than in Pinsof and Catherall's sample because the

authors believed that by the end of the third session the therapeutic alliance would be developed. They also found quite a high incidence of split alliances, defined as a difference of two or more standard deviations between individuals' ratings of their alliance with therapists. In another study, Heatherington and Friedlander (1990,b) investigated the empirical relationship between complementarity and symmetry in the interactions between individuals and the therapist in a session. Therapeutic alliance was viewed as a proximal outcome predictor, but the authors found that neither complementarity nor symmetry predicted family members' perceptions of the therapeutic alliance as measured by Pinsof and Catherall's (1986) couple and family therapy alliance scales.

#### 1.2.6 Summary

Therapeutic alliance has been suggested to be crucial to successful therapeutic outcome. Some researchers suggest that it can be predicted early on in therapy and that early alliance predicts successful alliance throughout therapy, whilst other researchers suggest that it can vary during the lifetime of therapy and that the therapist can intervene to influence the alliance. There have been few quantitative measures of alliance developed, especially in family therapy. Modelling systemic relationships is fraught because of the various combinations of relationships to take into account. Some researchers have developed quite complex models, but even these are very simplified accounts of the overall alliance and stand alone since there have been few reports of their use or validation by other researchers. Perhaps this reflects the complexity of trying to measure a systemic concept as opposed to describing it.

### 1.3 Investigating other measures associated with early alliance.

Early alliance effects have been identified as an area suitable for investigation, but measures of therapeutic alliance in families have been shown to be complicated and have not been validated. Some other measures were therefore considered for investigation which were associated with therapeutic alliance but which would be easier to measure.

Orlinsky and Howard (1986) conducted a meta-analysis of psychotherapy process and outcome. They began by listing several factors that could conceivably produce effects (for better or worse) in therapy. These included various characteristics of patients, therapists, the local and the wider system of beliefs within which therapy operates. The factors were categorised into effects on the patient, the therapist, the group, community and system of beliefs and values they operate within. They chose to split their research review into five conceptual elements, to reflect what they described as the 'active ingredients' as opposed to 'brand names' of therapy. These were the therapeutic contract, therapeutic interventions, the therapeutic alliance, patients' self-relatedness and therapeutic realizations.

Interestingly, the area that encompasses what patients thought of the plausibility or credibility of the therapies that therapists offered was not covered in the above review at all, because, presumably, this would have been straying into the area of 'brand names'. However, by leaving this out, the authors ignored the possible effects on outcome of clients' beliefs about therapies; this is a separate issue from the effectiveness of individual therapies. The authors discussed therapist credibility within

the subject area of the therapeutic alliance and reported that therapist credibility was positively correlated with outcome in twelve out of eighteen studies investigated. Thus, within the area of credibility in general, therapist credibility was identified as an area associated with outcome and yet the related subject of credibility of therapies was left out even though it too might have been associated with outcome. Thus, credibility of therapies was identified as a subject worth investigating and is discussed in the next section.

#### 1.4 Credibility of therapies

##### 1.4.1 Outcome and beliefs about the causes and maintenance of problems

Tinsley and Harris (1976) reported that clients' greatest expectations were to see an experienced, genuine, expert and accepting counsellor they could trust. These expectations were influenced somewhat, depending on what type of help-provider clients thought they would see (Tinsley, Brown, de St. Aubin & Lucek, 1984). Whether they can believe in what they are offered is discussed by Lyddon (1989a) who suggested that a shared world view between counsellor and client may be an important index of preference for counselling approach.

Atkinson, Worthington, Dana & Good (1991) discussed the idea of a convergence between client and counsellor's attitudes and values in counselling and how this might be directly related to its effectiveness. They quoted Torrey (1972) who argued that a psychoanalyst can no more cure a patient who does not believe in oedipal conflicts than can a witchdoctor cure a patient who does not believe in spirit possession. The

point was that therapists need to convince their clients to accept their theories about the cause of their difficulties. They also cite Foulks, Persons and Merkel (1986), who devised an experiment that provided some evidence for the hypothesis that compliance in psychotherapy is related to the degree to which patients share their therapist's view of the causes of their difficulties. One part of Atkinson's study was to hypothesise that clients' beliefs about the causes of psychological problems would be closer to those of their counsellors after having received counselling compared with beforehand. They showed that whereas 54 per cent of clients had the same primary view of the cause of their difficulties as their counsellor at the start of their sessions, this figure increased to 69 per cent by the end of the (average of three) sessions. They also showed that perceived, rather than actual similarity of beliefs about the causes of psychological problems between counsellors and clients predicted satisfaction with counselling. Evidence was also found that beliefs about causes of difficulties were related to how credible the counsellors seemed, how well clients felt understood by the counsellor and how satisfied clients were with the counsellor's therapeutic orientation.

#### 1.4.2 The expectancy arousal hypothesis

Another line of enquiry called the expectancy arousal hypothesis (Goldstein & Shipman, 1961) raised the issue of the credibility of different techniques and whether this was a determinant of outcome. The emphasis was on the credibility of the techniques themselves rather than on the techniques the therapist can offer, which would otherwise draw the credibility of the therapist into the enquiry. Evidence from analogue research suggested that psychological treatments differ in the level of

expectation of benefit they arouse in clients because of the credibility each treatment evokes in clients. If such expectancy arousal took place, then comparing treatments with controls might be methodologically flawed; instead, treatments needed comparing with other techniques that clients would rate as equally credible. Otherwise, it would be impossible to know whether it was the treatment or the arousal of the expectations of benefit that led to improvements. Some evidence that expectation played a part in improvement was found in early studies by Kazdin and Wilcoxon (1976) and Borkovec and Nau (1972). They used perceived credibility as a measure of expectancy and showed that the benefits of the technique of systematic desensitisation, the most thoroughly researched therapeutic technique, became statistically insignificant when compared with an equally credible control condition, rather than the normal placebo control condition.

Shapiro (1981) investigated the expectancy arousal hypothesis and stated that analogue studies could provide evidence for the expectancy arousal hypothesis but could not prove whether it was the techniques used or the arousal they produced due to their credibility that was the cause of improvements. In a highly controlled study, Morrison and Shapiro (1987) compared expectancy and outcome in two methods of individual psychotherapy, in this case prescriptive and exploratory techniques. Regression analysis was used to show that the primary impact on outcome was due to the treatment effect rather than due to expectancy. However, the study measured credibility at the end of the second session and the researchers suggested that the study also showed that credibility might not be an invariant attribute of a technique and might instead tap clients' emergent responses to their experience of having

participated in initial treatment sessions. These emergent responses might then play an important part in determining outcome, compared with the treatment procedures themselves.

Thus, the expectancy arousal hypothesis has been neither proven nor disproven. However, the idea that the credibility of a technique might change, after having taken part in the initial treatment sessions, is an issue investigated in the following section.

#### 1.4.3 Stages in the development of credibility of therapies

Wanigaratne and Barker (1995) showed that credibility and preference for therapies were highly correlated, whilst Hardy, Barkham, Shapiro, Reynolds, Rees and Stiles (1995) extended the concept of credibility of therapies to allow for development within therapeutic relationships and to cover a number of related concepts. They referred to stages in 'therapeutic credibility' to describe changes in the credibility of therapies that can occur. They drew a distinction between three types of credibility. Treatment principle credibility was described as a measure of beliefs about a particular technique's theoretical principles before clients are assigned to a particular technique. Initial credibility was described as a measure of credibility after a client has been selected a therapy technique but before treatment has begun, whilst emergent credibility was described as a description of credibility of a technique after the client has experienced a sample of it. They described both initial credibility and emergent credibility as incorporating role and outcome expectations. In their investigation into credibility of two types of therapy, Hardy et al. assessed treatment principle credibility, then initial credibility before the start of the first session and then

emergent credibility immediately afterwards.

Hardy et al.'s results showed that treatment principle credibility was endorsed for both therapies and that clients' emergent credibility of treatments was significantly higher than their initial credibility. The treatment principle credibility of one of the treatments significantly predicted its initial credibility, its emergent credibility and, to some extent, some measure of improvement. The accuracy in predicting improvement across treatments from their initial and emergent credibility was significant only for the group who received eight rather than sixteen treatment sessions, however. This finding stayed true at three-months follow-up as well. Thus, treatment duration appeared to be a factor in significantly predicting improvement. Amongst a complicated set of results, endorsement of one treatment type was found to be the best predictor of improvement for both treatments, as opposed to support for the idea that patients would do better if they received the therapy that matched their preferences.

The authors also noted that their findings went against the expectation that predictions become more accurate as clients gain understanding of their treatments (Hardy et al., 1995, cite Perotti & Hopewell, 1980). They found instead that emergent credibility assessments for the shorter treatment period were no more accurate at predicting improvement than were initial credibility assessments. This means that when the client knew what treatment to expect, the credibility of treatment before treatment had begun was just as accurate a predictor of improvement as when treatment had actually begun. This finding provides further support for the idea that investigation into beliefs

can be a useful predictor of improvement even at the end of the first assessment session. In addition, the study suggested that credibility of therapies can be a significant predictor of improvement in very brief therapies.

### 1.5 Psychological mindedness

Psychological mindedness has already been mentioned as a factor that can predict therapeutic alliance (Ryan & Cicchetti, 1985) and influence dropout (Baekeland & Lundwall, 1975; McCallum et al., 1992). It was considered to be a construct worth further investigation.

Kolden (1996) described recent studies dealing with factors influencing outcome and amongst these, psychological mindedness was included. There is widespread agreement amongst dynamically oriented therapists that psychological mindedness is an important prerequisite of therapeutic success (Conte & Ratto, 1997). Clinicians seem to intuitively understand the concept despite authors defining it in several ways. It has nevertheless received a lot of attention. Conte & Ratto (1997) cite Applebaum (1973) whose definition of psychological mindedness, focused on the individual, was: "A person's ability to see relationships among thoughts, feelings and actions, with the goal of learning the meanings and causes of his experiences and behaviours". Since then, definitions have placed more emphasis on other areas, such as intrapsychic dynamics and reflecting on understanding relationships with others, but the definitions are still far from precise. For example, Ryan & Cicchetti (1985) defined psychological mindedness as "...the quality of the patient's psychological set toward himself/herself and his/her difficulties..".

There have only been a few controlled, systematic trials carried out to measure psychological mindedness, however. Amongst them, Ryan and Cicchetti (1985) constructed a simple rating scale based on interview data. The low point of the scale located a patient's experience of the problem as external and the high point located it as intrapsychic or within the self. Conte, Buckley, Picard and Karasu (1995) described McCallum and Piper's (1990) Psychological Mindedness Assessment Procedure, which used a standardized videotape and interview procedure. However, the only self-report pen-and-paper procedure that has been used to provide ongoing psychometric assessment is Conte, Plutchik, Jung, Picard, Karasu and Lotterman's (1990) Psychological Mindedness Scale (PMS). They conceived the concept of a patient's psychological mindedness as their ability to access their own and others' feelings and utilize these for changing behaviour. They described the PMS as a self-report instrument they had developed to measure psychological mindedness and to determine its value in predicting psychotherapy outcome. The aim of the questionnaire was to tap into the concepts of motivation and capacity for change, access to one's affects, interest in understanding relations between feelings and behaviour, willingness to be open with others about one's problems and interest in the meaning of behaviours.

The PMS scale used a 45 item version of a 65 item questionnaire used in a previous pilot study by Lotterman (1979). Conte et al.'s results showed that the PMS scale was not related to patients' level of functioning or psychiatric difficulties at the time of assessment. However, it was found to be related to improved psychosocial functioning and decreased symptomatology according to outcome measures. This showed that the

higher an individual's PMS score, the higher the likelihood of engagement in therapy and benefitting from it. Twenty of the items on the PMS questionnaire were tentatively selected as the best predictors of outcome and could be divided roughly into four facets or dimensions. Good internal consistency (coefficient alpha = .86) was reported for the scale. Some support for the construct validity of the scale was provided by Conte et al. (1995) who investigated and found evidence for the theoretically expected relations of psychological mindedness to personality traits and ego functioning. The PMS instrument has been used extensively and was considered a reliable and validated measure to employ in the current research.

#### 1.6 The present research.

We have seen that the very early period in the therapeutic relationship can be an important time. Links between the establishment of an early therapeutic alliance and eventual outcome are well-established (Horvath & Greenberg, 1994, Orlinsky & Howard, 1986), whilst the alliance itself usually occurs by the end of the first session and is a strong predictor of the alliance in subsequent sessions (Sexton, Hembre and Kvarme, 1996). In addition, Atkinson et al. (1991) showed how therapeutic outcome can also be affected by the degree to which clients' attitudes and values are influenced by their therapist. If alliance can take place very early on in therapy, is linked to outcome and if the alliance can be influenced by the therapist, all this should focus therapists' priorities towards aiming to establish a therapeutic alliance as early on in therapy as possible. This prioritisation would become even more important in brief therapies since there are few sessions available with which to work with a client.

It was noted that few attempts have been made to measure therapeutic alliance in families and so another construct was sought that was associated with therapeutic alliance and which could be quantified early on in the therapeutic relationship. This construct was credibility of therapies. This seemed particularly relevant to brief therapies since one of Hardy et al's (1995) findings was that credibility of therapies can be a significant predictor of improvement in brief therapies.

The idea of a convergence between clients' and counsellors' attitudes and values in counselling and how this convergence might be directly related to counselling's effectiveness was discussed by Atkinson et al (1991). Applied to families, various challenges to a family's conceptualisation of a child's difficulties may occur as a result of establishing initial contact with a therapist. Parents' beliefs about different types of therapies and what they think would be best for their child might well be influenced in some way according to the therapist's views about how the family can best be helped. If the family can accept what they think the therapist has to offer, this is likely to increase the chances of a good therapeutic alliance forming, and therefore the chances of a successful therapeutic outcome.

Stages of therapeutic credibility were described by Hardy et al (1995). Their stages can be applied to the current research. The period before a family is seen for assessment corresponds to the treatment principle credibility stage, whilst once the family has been seen for assessment, this best corresponds to the emergent credibility stage. Once families meet the therapist(s) for assessment, the therapy has in some ways already begun because all the family present are usually invited to contribute

towards explaining the difficulties that have brought them along. Since the assessment is to some extent already the beginning of the therapy, the period immediately following the assessment corresponds best to Hardy et al's emergent credibility stage of therapeutic credibility.

At the start of family work, the child is often seen as the cause of the problem. However, family work often takes a systemic view of many childhood difficulties, the focus being on how a problem is maintained by the family. Thus, one expectation at the start of therapy might be that beliefs about family work gain in credibility whilst beliefs about child therapy generally become less credible. A third type of therapy identified for the current research was parent therapy. Thus, child, parent and family therapy were the three main therapies identified as being offered to families at a child and adolescent mental health clinic. These three types of therapy were identified in order to investigate early changes amongst families regarding the credibility of those therapies.

Psychological mindedness was the other factor described earlier on to be of interest to the research, since it was shown to be predictive of therapeutic alliance (Ryan & Cicchetti, 1985) and influencing dropout (Baekeland & Lundwall, 1975; McCallum et al, 1992). Conte et al's (1990) PMS scale was used to measure psychological mindedness in families, in order to test the expectation that the more psychologically-minded parents, being better at seeing relationships amongst thoughts, feelings and actions, would display more of a convergence of beliefs about the credibility of therapies towards those of the therapists than the less psychologically-minded parents.

In addition, the more psychologically-minded families would be expected to understand better how children's difficulties can often be maintained by the family system. Overall, the expected effect would be to find that child therapy would be rated lower than the family approach for the more psychologically-minded families.

Thus, the present research attempted to measure the earliest credibility, or treatment principle credibility of some therapies, prior to assessment. This was compared with the later-developing emergent credibility for changes and an investigation into evidence of a convergence of beliefs between parents and therapists was carried out. Measurements were applied at the end of the first session, this having been assumed to be a reliable time to assess emergent credibility, following on from Hardy et al's (1995) work. Psychological mindedness was investigated to see whether the more psychologically-minded families' therapy credibilities would converge more quickly towards their therapist's beliefs than the less psychologically-minded families.

The aim of the research was to quantify some changes in families' beliefs that can occur very early on in brief therapy. If significant changes were identified, this would be a useful contribution towards predicting the utility of brief therapies. It would also add to our understanding of the importance of the very early stages of families' contact with child and family departments.

#### Specific research questions

The research posed specific questions to operationalise and test, as follows. Parents/carers are described as parents for simplicity's sake and because the focus of

the study was not on the area of the relationship of the caregiver(s) to the child. Children in families are referred as 'the child', whilst individual parents are referred to as 'mothers' and 'fathers'. The main therapist who led the assessment session is referred to as 'the therapist'.

The research questions investigated were:-

1. Do families' credibility of therapies increase after assessment, compared with before they have been seen?
2. Do families' credibility of therapies begin to converge with those of the therapists after the assessment session?
3. Do the more psychologically-minded families' credibility of therapies converge more quickly towards the therapists' ratings than the less psychologically-minded families?
4. Do the more psychologically-minded families rate child therapy as less credible than the family approach?

## **2. Method**

### **Overview**

This chapter describes the development of measures used in the study and how they were administered to families. The experimental design is described so that it is clear which questionnaires were administered at each stage.

### **2.1 Design**

The design involved two stages of administration of written questionnaire measures for each family and included a repeated measure. Two questionnaires were posted to families before they were seen at their assessment session, whilst one of the questionnaires was re-administered immediately following the assessment session. A questionnaire was also administered to the main therapist who had led the session, immediately after the assessment session. The questionnaires for families were designed to be filled in by single parents, or by both parents if they were living in the same home. The sequencing of questionnaires is shown in Table 1 below.

**Table 1. Questionnaires administered to parents and main therapist.**

Stage of administration	Stage 1. Pre-assessment questionnaires sent to families, along with consent form	Stage 2. Post-assessment questionnaires filled out immediately after family assessment interview.
FAMILY. Questionnaires administered to each parent.	'Therapies', 'Psychological Mindedness'.	'Therapies'
THERAPIST. Questionnaire filled out by therapist, relating to family just seen.		'Therapies'

## **2.2 Clinic Setting**

The clinic was a rural outpatient psychiatric setting. Most clinic referrals came from general practitioners, paediatricians, health visitors, schools and other hospital specialities when there was concern that a child's mental health might be affected.

The clinic offered a range of psychological approaches for dealing with difficulties that might affect children's mental health. A multi-disciplinary team consisting of clinical psychologists, psychiatrists, family therapists and child psychotherapists offered help to families, couples and individuals. Assessment usually involved one session devoted to hearing family members' perspectives of the history and nature of the difficulties, before deciding what course of approach to offer. Behavioural and cognitive-behavioural work with children and parents, couple therapy and family

therapy were offered, often in combination, to suit families' needs. Psychological therapies were often conducted in conjunction with drug therapies, monitored by the clinic psychiatrists. Turnover of most families was quite rapid; 35 per cent of families were seen for an average of three sessions before discharge whilst half of all families were seen for an average of five sessions before discharge. Few families were seen for more than ten hour-long sessions altogether.

Referrals were usually assessed in one session that involved one or two therapists working with families face-to-face. Typically, seven or eight families were seen for one assessment per week. In addition, one or two families with apparently more complicated or chronic difficulties were often assessed utilizing a one-way screen which allowed other therapists and trainees to observe. After assessment, all families were discussed in a review meeting where possible therapies for the family would be discussed.

#### Assigning therapists to families.

Therapists were not matched to families in any systematic fashion, except when a child's primary difficulty was suspected to be ADHD (Attention Deficit Hyperactivity Disorder). In these cases a psychiatrist would usually be one of the therapists assigned to the assessment interview since it was quite likely that medication would be discussed. This was the only systematic allocation of therapists to families and only made up a very small proportion of families involved in the study. The allocation of therapists to clients for assessment was otherwise random.

### Handling and allocation of Clinic referrals

During the data collection period, family referrals to the department were assessed, prioritised and allocated to therapists using a clear procedure the clinic had developed over several years. This was not influenced by the research study. Referrals were initially screened for appropriateness and to prioritise urgent cases. The dates for initial family assessment interviews were set some weeks ahead, giving families the opportunity to confirm their intention to attend. The clinic cancelled appointments where families had not replied in time and then sent those families a 'last chance' letter offering another appointment if the family confirmed they would attend.

The standard appointment letter sent to families included an invitation to the clinic inviting the family along with anyone else the family might feel would be helpful to have present. In addition, a leaflet describing the clinic and its location was included. A copy of the clinic leaflet is shown in Appendix 9.

### 2.3 Participants

The target population was families referred to the Child and Adolescent Mental Health Clinic over a five month period. One hundred and fifty four families were initially contacted by postal questionnaire, which included a stamp-addressed envelope to send back to the clinic prior to each family's assessment interview session. Table 2 below shows a breakdown of the number of families invited into the research study. Amongst the families who opted out, some actively opted out by replying, having ticked the box indicating that they did not wish to take part. Others did not return any

materials but at the assessment interview had either said that they did not wish to take part or the parents had not filled in or returned the initial questionnaires. Some of these families said that they had either mislaid the questionnaires or had forgotten to fill them in because they had been too busy or they had been confused with the instructions. Some of these families included parents in disagreement about whether to take part and so could not be included because of incomplete data and, more importantly, because of concerns about interfering with the initial alliance process by generating an area of conflict within the family.

Table 2 shows that many families who did not take part gave their reasons at the assessment stage rather than actively opting out by letter. It seems likely that some of these families found it easier to do this rather than face an imagined conflict with the therapist for having refused in writing to take part, despite the opt-out clause having involved simply ticking a box (Appendix 2). Thus, the numbers recorded for the two categories of families who opted out from the study before or at assessment might not be entirely accurate.

The table also records the rest of the families who could not be included in the study for other reasons; these families included those who had dropped out from the clinic without being seen and those who had not arrived for sessions and had not yet finalised a new assessment date.

Table 2. Families involved with the study.

Total contacted	Number of families in study			
	Included in study	Opted out or dropped out		
		Before assessment	At assessment	Other
		Actively opted out	Did not wish to take part/forgot to fill in questionnaires	Dropped out from clinic or were not seen within sampling period
154	34	40	29	51

Exclusion criteria from the study included a few (less than five) referrals for families already known to the service and with ongoing investigations by Social Services concerning allegations of child abuse within those families. It was felt that sending research materials to those families would probably not be welcomed and that the response rate would be poor. These referrals were received from Social Services rather than from the family's GP which was the more usual route.

Fourteen families included in the study only took part once they had been contacted a second time, thirteen by phone and one by post. The issue of families who did not reply is discussed further in Section 2.5.1 (3) below.

#### Ethical approval

Ethical committee approval was granted by the Local Research Ethical Committee of the East Hertfordshire NHS Trust in January 1998. (Appendix 1).

## 2.4 Measures

### 2.4.1 'Therapies'. (Appendix 3).

Brief descriptions of therapy were developed to describe therapies to help with difficulties with children. These described child therapy, parent therapy and family therapy and represented the three main approaches offered in the clinic to help families. Five 10-point Likert scale questions were developed to assess the credibility of the approaches, the same five questions applied in the same order to each of the three descriptions of the therapeutic approaches. This measure was administered to families and therapists; the therapist questionnaire was aimed at finding out the therapist's beliefs about the suitability of each of the three therapies for the family just seen.

### Development of the measure

#### Descriptions

The therapy description for each of the approaches was narrowed down to three sentences, each description starting with the same sentence construction, ie "(Child/Parental/Family) therapy involves ...". Several research psychologists fed back their comments on the descriptions before consensus on the final arrangement was arrived at (Appendix 3).

#### Questions

The five questions used to rate each of the three therapeutic approaches were adapted

from Borkovec and Nau (1972). Examples of the questions used are 'How much sense does this approach seem to make to you?' and 'How willing would you be to take part in this approach?'

#### Scale consistency.

The scale consistency coefficient (Cronbach's alpha) was measured from the data for each of the three therapeutic approaches for four sub-groups, providing twelve values for alpha. The four sub-groups comprised the combinations of mothers and fathers (n=33 mothers, n=18 fathers), before and after assessment. The alpha values obtained were unacceptably low, ranging from a minimum of .44 to a maximum of .83, with a mean value of .62 . A stepwise analysis of items revealed that one particular question was inconsistent with the four others. By removing this question, the scale consistency range improved from a minimum of .79 to a maximum of .94, with a mean value of .85 . The scale used in the analysis therefore included four questions instead of five. The issue of the question having been removed is dealt with in the Discussion section. The combined score obtained from the four remaining questions was used in the analysis.

#### Readability

After the study had been conducted, it became clear that some further work was needed to investigate the effects of the therapy descriptions possibly having been too difficult for parents to understand. Oppenheim (1992) described the importance of testing new materials on a sample of the intended population as a pilot project. If this is not done, then unexpected difficulties with the materials might occur later on when

it is too late to correct them. In the case of the present research study, if the therapy descriptions had been too hard to understand, this might have affected the research findings. Thus, a small study was carried out to check the comprehensibility and readability of the passages. In addition, a sentence structure algorithm was used to assess the readability of the therapy descriptions.

The study involved 10 mothers, each of whom was asked to rate each of the therapy descriptions according to the questionnaire instructions (Appendix 4). To eliminate order effects, the order of presentation of the materials was rotated and the results are shown below in Table 3. The results show that mothers reported finding the passages easy to understand, the mode for each therapy description corresponding to 'easy'. The subjects were also invited to make comments. Two subjects responded, making three comments which broadly suggested that

- some of the sentences were too long;
- parent therapy was not easy to understand; and
- the meaning of part of the description of child therapy was unclear.

Table 3. Ease of understanding therapy descriptions.

Therapy description	M	SD	Mode
Child	2.1	0.57	2 (easy)
Parent	2.6	1.40	2 (easy)
Family	1.9	0.74	2 (easy)

Note. The ease of understanding therapy descriptions were each rated using a seven-point anchored bipolar scale ranging from 1 = "Extremely easy" to 7 = "Extremely difficult".

The sentence structure algorithm used to assess the therapy descriptions was the Fog index. The Fog index algorithm defines the difficulty of a paragraph in terms of the average sentence length and the proportion of words with more than three syllables in order to arrive at an index of readability. An easy passage equates to a Fog index of 8, whilst a level above 12 indicates that the sentences are very hard to read and understand. The therapy descriptions for child, parent and family therapy scored 17.2, 13.6 and 16.8 respectively. These results indicated that the algorithm identified the passages as extremely hard to read and understand.

Section 4.7.2 (4) in the discussion section describes why there may have been such a discrepancy encountered between the results of the small study and the algorithm used to investigate the readability of the therapy description materials.

#### 2.4.2 Psychological Mindedness Scale (Conte et al., 1990) (Appendix 5.)

Psychological mindedness was assessed using 34 questions that represented three out of the four subscales developed by Conte et al. (1990). The Psychological Mindedness Scale (PMS) is a 45 item scale made up of four subscales. The subscales represented are: access to one's feelings, willingness to talk about one's problems, capacity for behavioural change and an interest in understanding other people's behaviour. A decision was made to remove the subscale items that dealt with understanding other people's behaviour because an important issue was to reduce the task requirements as much as possible. Thus, it was felt that administering an extra eleven questions in order to obtain the information that the subscale provided was not justified. It would have been possible to have administered

a 20 item psychological mindedness subset of questions that Conte et al. referred to that covered all four subscales, but they had called its reliability into question. Thus, three subscales were used, whose reliability was better proven.

### Description

PMS items are scored on a four-point anchored scale ranging from 'strongly agree' to 'strongly disagree'. Positive items are scored from one to four whilst almost half the questions are negatively scored; these items are worded such that the scoring scale runs in reverse, from four to one. Items are presented in a mixed order so that positive and negative items and the subscales they represent are presented with no discernible pattern. The PMS total score is the sum of the subscale scores; each subscale score is obtained by summing the item scores belonging to that subscale.

Examples of the questions for items from the 'access to feelings' subscale are: 'Often, I don't know what I'm feeling' and 'Often, even though I know that I'm having an emotion, I don't know what it is'. These are examples of negatively scored items, whilst examples of positively scored ones for the 'willingness to talk about one's problems' are: 'When I have a problem, if I talk to a friend I feel better' and 'It would not be difficult for me to talk about personal problems with people such as doctors and clergymen'.

### Scale consistency.

Cronbach's alpha for each subscale was measured from the data for mothers and fathers (n=33 mothers, n=18 fathers). The alpha values obtained were .81 and .83

for the 'talking' subscale, .49 and .69 for the 'feelings' subscale and .66 and .65 for the 'behaviour' subscale. A stepwise analysis of items revealed that removing one particular item for the 'feelings' subscale improved the alpha values to a slightly more acceptable .57 and .70 .

## 2.5 Procedure

### 2.5.1 Administration Process

#### (1) Contents of posted materials.

During the data collection period, each family received a package which comprised one A5 envelope, containing the following:-

- The standard, sealed departmental letter inviting families to attend the assessment interview. This included the standard clinic leaflet that introduced and explained a little bit about the Department of Child and Adolescent Mental Health (Appendix 9). The sealed letter was included along with the research materials.
- A letter from the department explaining that a research project was being carried out and that the family was invited to take part (Appendix 2).
- A consent form that requested the family to join the research project. The consent form made it clear that for families where there were two adults living at the same address and looking after the child, both needed to consent to take part in the study. The form requested that the questionnaires and consent form be sent back even if families did not wish to take part. (Appendix 2)
- Two double-sided copies of both questionnaires stapled into a separate set for each

parent or carer (Appendices 3 & 5).

- A stamp-addressed envelope, addressed to the researcher at the clinic.

### (2) Administration of questionnaires to families and their main therapist.

The department saw new patient families at specified assessment time slots each week. Stage 2 questionnaire materials were attached to the inside cover of the patient's file along with a sheet with a set of administration instructions for the therapist (Appendix 6). Straight after the assessment session, families still included in the study were asked by one of the therapists to fill out Stage 2 questionnaires in a separate waiting area whilst the main therapist filled out a questionnaire relating to the family just seen. Families were told that the task would only take a few minutes but if they were in a hurry they were given a stamp-addressed envelope and asked to post the materials back to the clinic as soon as possible. For some further possible research, unconnected to the present study, the instruction sheet also invited the therapist to enter the date of the next session, monitoring families beyond the first session.

### (3) Families who did not reply.

Families who did not return the consent form had not made it clear whether they were willing to take part. These families, which made up the majority, had contacted the clinic to confirm the appointment and were followed up. They were phoned midweek, early in the evening (between 6:30 and 7:30 pm). When one of the parents was on the telephone, the wording of the script in Appendix 7 was read out whilst any other dialogue was kept to a minimum. Five families were either not connected to a

telephone or their number was unavailable and were instead sent a reminder letter (Appendix 8).

#### (4) Families who contacted the department prior to returning questionnaires.

In case families phoned the department asking what the research was for, the secretary was instructed to pass those requests onto the researcher. Some families did make enquiries when they phoned to confirm their appointment. However, provided the enquiry did not concern the reason for the research, the secretary answered the question. The most common enquiry concerned whether to send the form back or to bring it along to the family assessment interview.

#### 2.5.2 Impact on departmental administration

The research procedure aimed to have as little impact as possible on the normal administrative running of the department but some unplanned effects did occur. A few families confirmed their intentions by returning a note attached to the research materials whilst several other families confirmed that they would attend by returning just the research materials. For the department to be clear whether these families intended coming along, the returned research envelopes were checked as soon as they arrived.

#### 2.6 Preliminary research design

Until early on in the data collection period, the intention had been to have a third level for the repeated measure, to be administered at the end of the second session. Administration of the Dyadic Adjustment Scale (Spannier, 1976) had been planned

to also take place at this third stage of data collection. This instrument is a 34 item Likert-scale questionnaire for nearly all the items. Each parent, where possible, would have filled out the questionnaire. In addition, the therapist would have rated the improvement of the family using a single 10-point Likert scale question. The design is shown in Table 4 below.

The intention of the third level of the repeated measure was to see how the repeated measure varied at the three stages of measurement of families in therapy. In addition, an estimated outcome measure would have been available, as would a lot of data from the Dyadic Adjustment Scale. Correlations with psychological mindedness, and therapist estimates of therapy credibility would also have been possible.

The third level of the repeated measure was not used because only a quarter of the families who had reached Stage 2 could have been included in Stage 3. This would have resulted in perhaps 10 families being suitable for inclusion in the study. In order to keep the project within a reasonable time frame, the first two levels of the repeated measure were concentrated on. The reasons for the high rate of attrition are discussed in the discussion section.

Table 4 - Preliminary research design

	STAGE 1 - Pre-assessment questionnaires sent to families.	STAGE 2 - Questionnaires administered immediately after assessment session.	STAGE 3 - Questionnaires administered immediately after second session.
Recipients of questionnaires			
FAMILY (One questionnaire per parent/carer)	Therapies, Psychological mindedness	Therapies.	Therapies, Dyadic adjustment.
THERAPIST		Therapies.	Outcome question

### 3. Results.

The results fall into three sections. Some demographic details are followed by the main body of results that investigate each of the research questions in turn. Some subsidiary results are then described.

#### 3.1 Family demographics

Some demographic details of the referred children belonging to the 34 families included in the research are shown in Tables 5,6 and 7 below. Table 5 shows that there were four more girls than boys, the girls were on average 1.4 years older than the boys whilst the age range was wider for the girls than the boys.

Table 5. Children included in the research

	n	Age (years).			
		M	SD	Min	Max
Boys	15	8.7	3.2	4.3	14.0
Girls	19	10.1	3.2	3.7	15.6
Total	34	9.5	3.3	3.7	15.6

Table 6 below shows that there were 17 families with two parents and 17 other families with one parent looking after the child or children. The table also shows that the parent in 16 out of the 17 single-parent families was the mother. Thus, of those who turned up for the assessment session and filled out questionnaires, all but one of the 34 families had a mother in them, whilst only 18 had a father. In the interests of statistical power, mothers were chosen as the main focus of the research but some

preliminary investigation work was also done with fathers, dealt with in 'Subsidiary results' in Section 3.3 below.

Table 6. Families included in the research.

	Mothers in family	Fathers in family	Total families
No. of parents bringing up child			
2 parents	17	17	17
1 parent	16	1	17
Total	33	18	34

The main reason for referral has been simplified into six categories and shown in descending order of frequency in Table 7 below, to show the pattern of referrals. The two largest categories of referral involved hyperactivity, disruptiveness, behaviour difficulties and symptoms of anxiety, depression and parasuicidal behaviour. It was necessary to group some of the difficulties together because some of the referrals described more than one main reason for referral.

Table 7 Categories of referral

Main reason for referral	Frequency
Hyperactivity/disruptiveness/behaviour difficulties	10
Anxiety, depression, parasuicide.	9
Aggression at home or school	5
Bullied at school/school attendance probs	4
Difficulties involving family break-up	3
Risk of or allegations of sexual abuse	3

### 3.2 Main results

#### 3.2.1 Do families' credibility of therapies increase after assessment, compared with before they have been seen?

To investigate this issue, a repeated measures analysis of variance was carried out on mothers' therapy credibility ratings, before and after assessment. The result was significant ( $F[1,32] = 6.15, p < .02$ ). Post-hoc t-test comparisons displayed in Table 8 below showed that the credibility of 'parent' and 'family' therapies increased significantly.

Table 8. Credibility of therapies before assessment and immediately afterwards, for mothers.

	Before assessment		After assessment		t(33)
	M	SD	M	SD	
Therapy type					
Child	26.12	7.20	26.58	7.17	0.62
Parent	26.03	7.57	28.58	4.97	2.33 *
Family	25.85	8.39	28.30	5.90	2.19 *

\*  $p < .05$

#### 3.2.2 Do families' credibility of therapies begin to converge with those of the therapists, after the assessment session?

A repeated measures analysis of variance on the main therapist's three therapy ratings shown in Table 9 below showed that the ratings were significantly different from one another. ( $F[2,64] = 20.16, p < .001$ ). Post-hoc t-tests showed that the therapists' 'child' therapy ratings were significantly lower than those for either 'parent' or 'family' therapies ( $t[32] = 5.52, p < .001$ ;  $t[32] = 5.32, p < .001$  respectively). The mothers' therapy ratings after assessment showed the same pattern (repeated in Table 9) but in this case the differences were not significant ( $F[2,64] = 0.47, n.s.$ ).

However, Table 9 shows that mothers' post-assessment mean therapy ratings were ranked similarly to the therapists, with child therapy rated lower than the other two therapies. The therapists and mothers rated each of the other two therapies similarly. However, looking at Table 8 once again shows that between before and after assessment, the mothers' ranking of child therapy dropped from highest to lowest. Thus, the mothers' rankings for therapies became more similar to those of the therapists.

Finally, the first analysis in Section 3.2.1 showed that the only therapy whose credibility did not increase significantly for mothers from pre- to post-assessment was child therapy, arguably following the influence of the therapists, who rated child therapy significantly lower than the other two therapies. Overall, the patterns of therapy ratings by mothers became more similar to the therapists, but some of the changes were not statistically significant.

Table 9. Therapists' and mothers' ratings of therapy credibilities, after assessment.

	Mothers		Therapists	
	M	SD	M	SD
Therapy type				
Child	26.58	7.17	20.35	6.15
Parent	28.58	4.97	26.74	4.39
Family	28.30	5.90	26.79	5.04

3.2.3 Do the more psychologically-minded families' credibility of therapies converge more quickly towards the therapists' ratings than the less psychologically-minded families?

The measure of psychological mindedness from the Psychological Mindedness Scale (PMS) assigned to each mother comprised three subscale scores which were added together to produce a total combined PMS score. Using mothers to represent families, families were divided into two approximately equal-sized groups to represent the more psychologically-minded families (hiPM) and the less psychologically-minded (loPM). To achieve this, the median from the list of mothers' combined PMS scores was first calculated. Those below or equal to the median were assigned to the loPM group whilst those above the median combined score were assigned to the hiPM group.

Table 10 below shows the loPM and hiPM groups' mean ratings for therapies before and after assessment. Both groups' corresponding therapists' mean ratings for therapies are also shown. A between-groups analysis of variance showed that the

hiPM mothers' therapy ratings were just significantly higher than the loPM group ( $F[1,30] = 4.37, p < .05$ ).

**Table 10. Comparing credibility of therapies between mothers and therapists, the sample split into two groups, according to psychological mindedness.**

	Mothers before assessment		Mothers after assessment		Therapist	
	M	SD	M	SD	M	SD
<b>Therapy type and PMS group</b>						
Child - loPM	24.53	6.66	25.00	7.07	20.00	5.61
Child - hiPM	28.60	7.12	28.87	6.90	21.53	6.61
Parents - loPM	23.41	6.71	27.29	4.36	26.12	4.66
Parents - hiPM	29.53	7.32	30.80	4.23	27.53	4.39
Family - loPM	25.00	8.19	27.71	4.88	26.06	5.15
Family - hiPM	27.33	8.75	29.60	6.62	28.00	5.10

**Note.**  $n=15$  for hiPM group,  $n=17$  for loPM group.

Therapists' mean rating for each therapy type was higher for the hiPM groups than for the loPM groups, indicating that therapists were generally more optimistic about all therapies for the hiPM families they had seen than for the loPM families. However, a between-groups analysis of variance showed that this difference was not significant ( $F[2,60] = 0.84, n.s.$ ).

Post-assessment, the same pattern of therapy rankings appeared to have been preserved as before the population had been divided into two groups. Statistical testing for convergence of mothers' therapy ratings towards those of the therapists was not carried out because of the small group sizes. However, it was clear that there was not a great deal of difference in rating of therapies within the two psychological-mindedness groups.

The therapy ratings for the hiPM group have been shown to be significantly higher, overall, than the loPM group. In addition, in all six cases, the therapy ratings for the hiPM group were higher than the corresponding ratings from the loPM group. However, no further analysis was carried out because the group sizes were small and the researcher was aware of the risk of inflating the type 1 error rate by carrying out too many comparisons. Finally, Table 10 also shows that all corresponding ratings of therapies went up between before and after assessment, preserving the within-groups pattern of increase noted prior to splitting the groups according to psychological mindedness. Again, no analysis was carried out because the group sizes were too small.

Overall, the more psychologically-minded families credibility of therapies did not show signs of converging more quickly towards the therapists' ratings than the less psychologically-minded families. However, the hiPM group were shown to be significantly more pro-therapies than the loPM group, whilst therapists were more optimistic about all therapies for the hiPM families than for the loPM families,

although not significantly so. There was no discernible interaction between PMS group and credibility of therapies. Statistical analysis was limited due to the small group sizes.

#### 3.2.4 Do the more psychologically-minded families rate child therapy lower than the family approach?

From Table 10 above, it can be seen that child therapy became the lowest ranked therapy for both the hiPM and loPM groups after assessment. However, before assessment, the hiPM group rated family therapy *lowest*, so the results are not straightforward. Again, the small group sizes meant that t-test comparisons between child and family therapy for hiPM families after assessment could not be reliably carried out.

#### 3.3 Subsidiary test results.

The results shown so far were derived from analysing mothers' responses only. Two further sets of comparisons were made in order to preliminarily investigate whether some of the main findings also applied to fathers. The comparisons investigated whether fathers' therapy credibility ratings changed between before and after assessment and whether mothers' and fathers' ratings were related to one another. No other comparisons were made because the size of the sample lacked power.

Finally, a test was carried out to check the consistency between the three psychological mindedness subscales.

### 3.3.1 Do fathers' credibility of therapies increase at the start of therapy?

Table 11 below shows that amongst fathers, credibility of therapies between before and after assessment all increased, but none significantly so ( $F[1,16] = 1.48, n.s.$ ).

Table 11. Credibility of therapies before assessment and immediately afterwards, for fathers.

	Before assessment		After assessment	
	M	SD	M	SD
Therapy type				
Child	21.67	8.10	23.11	6.10
Parents	24.11	6.13	25.95	5.91
Family	24.94	7.8	26.22	6.98

### 3.3.2 Are mothers' and fathers' ratings related to one another?

Before-assessment and after-assessment comparisons were made, the results shown in Table 12 below. The table shows that the credibility of each therapy was rated higher by mothers than fathers in all 6 cases. However, a paired-subjects t-test showed that overall, mothers' therapy ratings were not significantly higher than fathers' ( $t[16] = 1.31, n.s.$ ).

The correlations between mothers' and fathers' ratings for both child and family therapies before assessment were very high, dropping to medium after assessment. The corresponding correlations for parent therapy dropped from medium to very low.

**Table 12.-Credibility of therapies between mothers and fathers in families, before and after assessment.**

	Mothers		Fathers		r
	M	SD	M	SD	
Therapy type before/after assessment					
Child, before	26.25	6.53	24.10	6.72	.83 **
Child, after	24.88	6.47	23.71	5.72	.48 *
Parents, before	25.25	8.74	23.40	7.39	.52 *
Parents, after	27.53	4.65	25.76	6.04	.24
Family, before	25.20	9.70	24.35	9.57	.86 **
Family, after	27.35	5.88	26.65	6.95	.54 *

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

### 3.3.3 Consistency of Psychological Mindedness (PMS) subscales

A simple test was carried out to check whether stratifying the mothers' PMS total combined scores (described in Section 3.2.3) also stratified their subscale scores. The reason for doing this was to see if the three subscales correlated well, although the subscales could instead have been correlated separately prior to stratifying.

Table 13 below shows that the mean for each subscale was lower in the loPM group than the mean for the corresponding subscale in the hiPM group. This test result is

what would be expected from a multi-item instrument whose consistency has been well researched.

Table 13. Psychological mindedness subscale ranges.

	Whole sample (n=32)				Subgroups			
	Max	Min	M	SD	HiPM (n=15)		LoPM (n=17)	
					M	SD	M	SD
<b>PMS subscale</b>								
'Talk'	54	32	44.94	5.79	49.67	2.41	40.76	4.51
'Feel'	35	22	27.84	3.26	30.13	2.77	25.82	2.16
'Behave'	37	23	30.56	3.51	32.93	2.91	28.47	2.55
<b>Total (sum)</b>	<b>123</b>	<b>81</b>	<b>103.34</b>	<b>10.99</b>	<b>112.7</b>	<b>5.89</b>	<b>95.06</b>	<b>6.93</b>

## **4. Discussion**

The discussion begins by providing a brief summary of the aims and methods. The research questions and findings are then stated. An interpretation of the findings is then followed by some clinical implications and conclusions. This is followed by some suggestions for further research, limitations of the research and a methodological critique. A summary concludes the discussion.

### **4.1 Summary of aims and methods**

The study aimed to investigate the credibility of the three main therapies offered to families at a child and adolescent mental health clinic. The aim was to investigate whether the credibility of therapies offered can change very early on in the lifetime of the therapy and whether families' views converge towards the therapists' views. The study also aimed to investigate whether the more psychologically-minded families' credibility of therapies would converge more quickly towards the therapists' beliefs than would the less psychologically-minded families. Additionally, it was predicted that the more psychologically-minded families would rate child therapy less credible than the family approach.

Families were sent a pre-assessment questionnaire booklet for each parent to rate their credibility of therapies and psychological mindedness. Immediately after assessment, the parents' credibility of therapies was measured once again, whilst therapists' ratings of the credibility of therapies for the family just seen was also measured, using the same questionnaire. Since 33 out of the 34 families in the study included a mother

compared with only 18 fathers, mothers became the main focus of the investigation.

#### 4.2 Summary of research questions and findings

Specific questions investigated and their associated findings were as follows:-

(1) Do families' credibility of therapies increase after assessment compared with before families have been seen?

Mothers' credibility ratings for both parent and family therapies increased significantly whilst that for child therapy increased a small and non-significant amount. Fathers' credibility ratings displayed the same pattern of change but the increase was non-significant. Mothers' ratings were higher than fathers' in all cases, but again the effect was non-significant.

(2) Do families' credibility of therapies begin to converge with those of the therapists after the assessment session?

Some evidence in support of convergence was found, as follows. Mothers rated child therapy highest before assessment but lowest after assessment, although the effect was non-significant. This change represented a convergence towards the therapists' views; therapists had rated child therapy significantly lower than the other two therapies. Amongst fathers, child therapy was rated lowest both before and after assessment. However, no statistical tests were carried out on the fathers' data due to the small group size.

(3) Do the more psychologically-minded families' credibility of therapies converge more quickly towards the therapists' ratings than the less psychologically-minded

families?

The more psychologically-minded families credibility of therapies did not show signs of converging more quickly towards the therapists' ratings than the less psychologically-minded families. However, some differences between the two groups were noticed:-

- The more psychologically-minded mothers rated therapies significantly higher, overall, than the less psychologically-minded mothers.

- Therapists were more optimistic about all therapies for the more psychologically-minded families than for the less psychologically-minded families, although not significantly so.

(4). Do the more psychologically-minded families rate child therapy lower than the family approach?

There was no evidence found that child therapy was rated lower than the family approach amongst the more psychologically-minded families.

A subsidiary test compared mothers' and fathers' credibility of therapies, to see if they were related to one another. Mothers' ratings were all slightly higher than those of the fathers, both before and after assessment. For each therapy type, there were quite high correlations between mothers' and fathers' ratings before assessment, but this dropped after the assessment.

#### 4.3 Interpretation of findings

The general increase in ratings of therapy credibilities amongst mothers and fathers is in line with Hardy et al. (1995) who predicted that credibility of therapies

developed within therapeutic relationships. Thus, the current study detected a measure of emergent credibility within families that reflected the early development of a therapeutic relationship. Evidence of the alliance forming in the first session is important, since it has been found to be a strong predictor of the alliance in subsequent sessions (Sexton et al, 1996) and of outcome (Horvath & Greenberg, 1994; Orlinsky & Howard,1986).

The findings suggest that mothers' therapy credibility ratings began to converge towards those of the therapists after assessment. The most plausible explanation for this is that therapists encouraged and influenced families to understand their children's difficulties within a systemic framework, where the focus is on understanding how child difficulties are maintained within the family. Thus, the emphasis moves away from causative factors towards maintenance factors in order to construct an effective method to help family dynamics change.

The research findings regarding convergence are in line with those put forward by Atkinson et al. (1991), who found that 69 per cent of clients matched their counsellor's beliefs about the cause of their problem after three sessions. In comparison, the current research found some evidence amongst mothers of a convergence towards therapists' beliefs after just one session. The early change in beliefs amongst mothers might be partly due to the style of the therapists, who favoured a brief therapy model. Thus, alliance effects might tend to occur earlier on in brief therapy to accommodate the model of working.

Although therapists rated child therapy significantly lower than the other two therapies, the findings might have been influenced by the therapists' orientations rather than having been a reflection of the types of presenting problems families brought to sessions. This seems likely, given that the therapists who participated in the study had a primarily systemic orientation. Thus, there are several explanations which could account for why the mothers' therapy credibility ratings began to converge towards those of the therapists. The explanations are not necessarily mutually exclusive and it was not possible to determine the extent to which each explanation might account for the changes that took place.

There was no evidence that the more psychologically-minded families' credibility of therapies converged more quickly towards the therapists' ratings than the less psychologically-minded families. One very likely reason for this was that the therapists' and families' therapy credibility ratings were all clustered quite close together, so any effects detected would have been very small indeed. The group sizes were small, so it was not possible to examine this issue any further. The same reasons might explain why there was no evidence that the more psychologically-minded families rated child therapy lower than the family approach. However, it was clear that psychological-mindedness had influenced families' and therapists' credibility of therapies since the more psychologically-minded families were generally (and significantly) more pro-therapies overall than the less psychologically-minded mothers. This was not a surprising result, since the mothers who valued psychological therapies would have tended to think more psychologically and score high on psychological mindedness.

It was interesting, however, that the therapists who saw the more psychologically-minded families were more optimistic about therapies for them, as a group, than for the other families, although the effect did not reach significance. The therapists who saw the families with a high psychologically-minded mother, having interacted with them in the assessment session, would have been more likely to think that therapies might be more helpful for these families than the other families. This effect showed that therapists can discriminate between these families from the first assessment session. However, it was not possible to say to what extent the mothers' responses were affected by the therapists' optimism. This effect would be difficult to investigate because a complex design would be needed to isolate all the variables that might influence the changes being investigated.

Finally, a test looked at correlations between the mothers' and fathers' ratings of credibility of therapies. For each therapy type, there were quite high correlations between mothers' and fathers' ratings before assessment, but this dropped afterwards. The correlations only applied to half the families, the ones with both parents present. One reason why the correlations became weaker after assessment might be that prior to assessment, many couples will have had opportunities to discuss their children's difficulties with each other. However, by re-measuring therapy credibilities immediately after the assessment session, parents will not have had the opportunity to talk together and consolidate what they had heard in the session. Thus, the parents will not have had time to reach a new shared understanding of their child's difficulties and this would be reflected in decreased correlations between the mothers' and fathers' therapy credibility scores.

#### 4.4 Clinical implications

Many therapies distinguish between the assessment period and the intervention period. However, the research study showed that some quantifiable changes in families' beliefs can occur within the assessment session itself, reminding us that the processes of assessment and intervention can overlap. Thus, intervention effects can begin to take place within the first hour of a family meeting their therapist(s). The importance of this finding is that it is a reminder to therapists to capitalise on the very early period of therapeutic contact, because alliance has been shown to be associated with outcome (Horvath & Greenberg, 1994; Orlinsky & Howard, 1986; Hardy et al, 1995) and to decrease the chances of dropout (Baekeland & Lundwall, 1975; McCallum et al., 1992). This can be achieved by focusing on techniques that allow the alliance to form (eg Solomon, 1977; Minuchin, 1974; Greif, 1990).

#### 4.5 Suggestions for further research

The results showed to some extent that families and therapists believed less in a child therapy approach than the other two approaches. Therapist orientation and problem presentation might have been important factors that influenced those findings, however. Further research to investigate this could determine the impact of these variables and whether some approaches can be generally more credible than others.

The current research discussed some early changes in beliefs about therapy and how these are associated with therapeutic alliance. The early changes in beliefs are important, since early alliance is associated with successful outcome (eg Horvath & Greenberg, 1994). However, it would be useful to investigate early changes in beliefs

and compare this with eventual outcome, to test the predictive value of the early changes in beliefs. The current research did not include an outcome measure because of a time limitation; despite the rapid turnover of most families, there can be a year between referral and discharge for some of them. However, research employing the data from the present research could quite easily investigate this because an estimate of improvement was routinely allocated to all families referred to the department using the Health of the Nation Outcome Scale for Children and Adolescents, (HoNOSCA, Dept. of Health 1992; Gowers 1997). The outcome measure is assigned to each family on discharge and corresponds to the therapist's estimate of change in the family on a four-point anchored scale ranging from 'Much better' to 'Much worse'. The results would need to be qualified however, since an important limitation of the outcome measure is that outcome is estimated by therapists and is not contributed to by the families' own estimates of change.

It would be very useful to establish whether a selection bias influenced outcome. A straightforward piece of research employing the HoNOSCA outcome measure could be carried out to establish this. When all families in the current research have been discharged, the outcome rating of the families who took part in the study could be compared with those of the rest of the families in the original sample of families.

The high overall attrition rate (nearly 80 per cent) from the present research suggests that any further study should involve the presence of a therapist for the first stage of questionnaire administration.

#### 4.6 Limitations of the research study

The study assumed that whoever looked after the child was the mother or father. No distinction was drawn between parents and carers, one or two parent families, ethnic and cultural backgrounds, or the existence of other siblings. The small size of the sample dictated that none of these factors could be distinguished, which limited the generalisability of the study.

The original intention was to investigate a systemic set of views but this is a very complicated construct to quantify. Thus, family views of credibility of therapies became operationalised as investigating just parents' views. This compromised a systemic view by leaving out any other family members. The research was then further simplified by making just mothers the main focus of the research because too few fathers arrived for sessions and too few were living at home.

Group effects have been commented on throughout this study since this is the area analyzed by quantitative research. Family therapists often tend instead to favour qualitative studies since the focus is on the richness of phenomena experienced within families; there is a belief that there are more interesting things to discover within families than between them. However, such discoveries cannot be generalised since group effects are not focused on.

A final limitation of the study was that the uptake rate was low, at 22 per cent. Also, the number of families who took part in the study was small. Therefore, results from statistical comparisons need to be treated with caution.

## 4.7 Methodological critique

### 4.7.1 Design

Change was investigated amongst mothers before and after assessment whilst a paired-subjects investigation was made after assessment between mothers and their therapist. The research issue was therefore inferred from two separate comparisons, slightly increasing the likelihood of a type I error occurring.

### 4.7.2 Materials

#### 1. Scale consistency

##### 'Therapies' (Appendix 3)

This questionnaire included five questions adapted from Borkovec and Nau's (1972) list of questions. However, one question 'Do you think that another approach might be more helpful?' led to written comments on the questionnaire paper from several respondents. The scale item had been ticked, but comments had been added, respondents generally saying that they couldn't say if another approach would be more helpful because they didn't know what else was available. Because responses to the question were not consistent, it was removed from the analysis. The 'therapies' questionnaire consistency became far more acceptable once the question had been removed from the analysis.

### Psychological Mindedness (Appendix 5)

A series of 34 questions were administered that made up three subscales out of four from Conte et al.'s (1990) original 45 item PMS scale. Statistical analysis revealed that there was poor internal consistency between the items on one of the three subscales. Removing one item from this subscale resulted in an improvement in the internal consistency (from .49 to .57). It was not clear why responses to this item had been inconsistent with the rest of the items. However, one possible explanation was that the list of items reversed at this point from negative to positive wording. This change in the structure of the items might have led some respondents to misread the question and make the wrong response. Ideally, negatively and positively worded questions should have been more mixed in order to rule out the possibility of that type of order effect.

### 2. Response bias

The 'therapies' questionnaire was a repeated measure and did not take into account possible order effects due to the presentation of questions. This may have influenced some responses to questions since respondents may have tried to answer questions after assessment using the same pattern of responding as they had used before assessment.

### 3. Confounding issues

There may have been some confusion at the start of the research amongst therapists regarding the questionnaire they were asked to fill out after an assessment session with new families. Even though the research had been discussed with therapists in a

planning meeting that covered the aims of the work, requirements of therapists and impact on the clinic, there may have been some uncertainty whether the credibility of the therapies referred to the family just seen or whether it referred to the therapist's thoughts about those therapies in general. Feedback from therapists early on suggested that the wording on the instruction sheet did not describe the task clearly enough for them. Because of this, some therapists delayed filling out the questionnaire until they had some spare time. This might have affected their responses because even though the questionnaire was filled in the same day, it was not filled out immediately after the family had been seen so the therapists' thoughts might have changed during the interim period.

#### 4. Readability.

There had been some criticism that the therapy descriptions might have been difficult to understand and that their development had not included feedback from service users. In order to address these issues, feedback was obtained from service users and a sentence analysis algorithm was used to assess the readability of the materials. Feedback from service users suggested that the therapy descriptions had been easy to understand but the results from the sentence analysis algorithm indicated that the therapy descriptions were extremely hard to read and understand. This discrepancy might be due to characteristics of service users, since the clinic was based in a relatively privileged area. Alternatively, the results from the algorithm might be invalid because the algorithm did not take into account word frequency and therefore could not distinguish between sentences that incorporated unusual long words from sentences that employed long words in common use. In conclusion, the passages

could have employed shorter, simpler sentences but a small study amongst service users showed that the passages had reportedly been easy to understand.

#### 4.7.3 Allocation of families to therapists

It was important that the randomised allocation of families to therapists did not interfere with the normal running of the clinic. As a result, the allocation of families to therapists was not purely random because children referred with suspected Attention Deficit Hyperactivity Disorder (ADHD) were all seen by the same therapist. However, there is no plausible reason why this would have unduly influenced the research results.

Part of the study involved collecting information from assessment sessions. Therapists conducted these sessions in a fairly standardised way but subjective differences between therapists, such as warmth, empathy or humour, could not be controlled for. One solution would be to use a much larger sample in order that the effect of different therapists could be investigated. This would have necessitated a much longer sampling period than had been available, however.

#### 4.7.4 Selection bias

There might have been a selection bias in the families who chose to participate in the research. Twenty two per cent of families contacted took part, which is rather low. However, this might reflect the general difficulty in persuading families to take part in research because it involves communication between various family members before a decision can be made. Thus, perhaps there was a bias towards families with

good communications between one another who chose to take part in the study. Families could have been provided with some incentive to take part, but this might have introduced other biases into the sample.

#### 4.7.5 Administration issues

One important factor that substantially influenced the research findings was that of the group size. Several factors were identified that lowered the potential number of participants in the study. These were:-

##### 1. Questionnaires forgotten by therapist

Therapists forgot to administer the Stage 2 questionnaires to several families. The most likely reason for this was that the start of the assessment session can be a difficult time for both the therapist and for the family, making the questionnaires easy to forget at the end of the session. Although difficult to measure, it seems that the research was a constraint on therapists throughout the period of data collection, despite therapists showing general interest in the aims of the research.

In some cases, the therapist ascertained at the start of the assessment session whether a family had filled out the Stage 1 questionnaires but then forgot to administer the Stage 2 questionnaires at the end of the session. In these cases, the families were sent the questionnaires with a stamp-addressed envelope on the same day they had attended the assessment session. However, the response rate was then generally quite poor, probably because there is less pressure on families to respond than when there is a therapist present.

## 2. Early ambivalence amongst families

Some two-parent families who did not take part had reported that they had been in disagreement with one another about whether to take part in the research. On these occasions, the importance of the research was de-emphasised to avoid generating conflict in the family. The researcher did not want to jeopardize the alliance at the start of therapy (Solomon, 1977).

## 3. Administration problems

Research materials were sent to families at the same time as details of their assessment appointment. Despite a lot of care having been taken to keep the two issues separate, some families experienced some confusion distinguishing between them. Also, some families had not filled out Stage 2 questionnaires and reported at the next session that they thought there had been a mistake because the form looked similar to the first one they had done at home. The cover of the Stage 2 questionnaire booklet should have been more distinguishable from the Stage 1 questionnaire booklet to allow for this effect.

### 4.7.6 Preliminary research design

The research design had initially included a third data collection period (see Section 2.6 in the Methods section for design description). However, it became clear quite early on in the study that less than a quarter of families who had filled out questionnaires at the assessment session went on to complete materials at the later Stage 3. There are several reasons why the attrition rate was so high, resulting in Stage 3 materials having been left out. These reasons are described below.

### 1. The therapists forgot about the research.

The therapists' instructions for administering the research questionnaires was attached to each family's file. At the start of the assessment session, the therapist opened the family file, saw the research materials and was reminded to ask about the questionnaires straight away. At the second session, the therapist was required to set a further questionnaire if instructions remained in the file. However, many therapists did not necessarily open the file during the second session until after the family was gone and so the research issue was often forgotten.

### 2. Parents prioritised the assessment

Whilst both parents came along to the assessment session (amongst two-parent families), very often only one parent, usually the mother, would come along to the second session. This attrition in numbers meant that some statistical comparisons could not be carried out.

### 3. Families refused to repeat the exercise

Some families commented that they were unwilling to take further part in the research because they felt that some questions asked in the Dyadic Adjustment Scale questionnaire were too personal and that they were unhelpful.

### 4. Which members of the family were seen for follow-up

After the assessment, quite often the therapist decided that one therapist would do direct work with the child whilst the other therapist would work with the adults. In these cases, measuring the credibility of therapies after the second session could have

confounded the research because families had been split up. In some other cases, sometimes only the children were seen after the first session, without the parents. In those cases there was no reason why the adults' perceived credibility of therapies would have changed. A systemic view would be that the whole family's views would have shifted to accommodate change in any individuals. This change could not have been measured straight after the session though, since it would have taken place some time after the children had had further contact with their parents. If those families had been left in the study at Stage 3, the likelihood of a type II error would have increased. However, rejecting them from the study would instead have introduced a systematic bias. These examples show that for many families, the research could not have continued to Stage 3.

#### 5. DNA rates

A departmental audit showed that the DNA rate for any one session was roughly 20 per cent. If the research had required each family to have been present on two occasions instead of one, the probability of them not arriving for at least one of those sessions nearly doubled, complicating the administration.

#### Conclusion

Overall, the preliminary design could not be accommodated within the time limitation and so the design was simplified. Stages 1 and 2 data from the families who had either completed Stage 3 or had dropped out at that point were included in the current study without any fear of confounding the results.

#### 4.7.7 Effect of research on normal attendance

The first stage of the research involved sending out questionnaires to families before they had been seen for assessment. A way of assessing whether this might have affected the normal attendance rate was to compare the methodology with another study that specifically investigated this concern.

The Tavistock Clinic in London routinely sends a psychodynamically- formulated 12-page pre-assessment questionnaire booklet to all new referrals. No formal research appears to have been done on its effects on motivation to attend but O'Loughlin (1997) found that a similarly formulated questionnaire sent to individuals prior to their assessment led to a slight improvement in attendance rates. The cancellation rate also went up, but the did-not-arrive rate went down. The effects noted did not reach statistical significance, however. O'Loughlin's study dealt with individuals rather than families, was psychodynamically formulated and was much more demanding of clients' time. Since the present research was much less demanding of families' time than O'Loughlin's study, it seems reasonable to assume that the research material in the present study was far less likely to have significantly affected families' decision to attend the clinic.

#### 4.7.8 Statistical power issues

Statistical power refers to the probability that a design will detect an effect if it is really present and is defined as the ratio of alpha (probability of detecting a false positive) to beta (probability of detecting a false negative). Cohen (1992) referred to the need for balancing statistical power with effect size, alpha and the number of

subjects. For this study it was difficult to know what effect size to have expected, but Cohen described his selection of a medium effect size as 'likely to be visible to the naked eye of a careful observer'. However, according to Cohen, for a medium effect size with an alpha value of .05, a minimum 64 subjects would have been needed for tests that involved detecting mean differences. Since the number of fathers in the study was small compared with mothers, comparisons involving the fathers must be treated as preliminary investigations, whilst the comparisons involving mothers had more statistical power.

#### 4.8 Summary

Therapeutic alliance was considered an interesting area to research. However, the few instruments that have been developed to measure the construct in families seemed complicated and have not been used widely or validated. Another measure associated with therapeutic alliance was sought instead. Hardy et al's (1995) model of stages of therapeutic credibility was applied, in order to quantify some changes that may occur very early on in the therapeutic relationship.

Families rated the credibility of three types of therapy to deal with children's problems before they had been seen for assessment and again immediately afterwards. Mothers became the main focus of the study since all but one of the families had a mother in them compared with only just over half having a father. Mothers' credibility of therapies changed between before and after assessment with some evidence that the ratings began to converge with the therapists' ratings of therapies for the families. Mothers' psychological mindedness was associated with optimism

about therapies both for mothers and their therapists, but it was not possible to say how much influence families' behaviour had had on their therapist and how much influence therapists had had on mothers.

It was shown that the credibility of therapies can change very early on in the lifetime of a therapeutic relationship. This finding underlines the importance of establishing a therapeutic alliance at the start of therapy, both to decrease the chances of dropout (Baekeland & Lundwall, 1975; McCallum et al., 1992) and to increase the chances of a successful outcome (Horvath & Greenberg, 1994). The main findings are a reminder of how important the first session can be and how families need to be accommodated in as flexible a manner as possible. It is an especially important finding for the proponents of brief therapies, which are becoming more and more prevalent.

The introduction to this research began by talking about useful relationships. The research findings remind us that the assessment session can be a useful relationship that can predict outcome, especially in brief therapy. The initial stages of therapeutic contact should be regarded as the clinician's best opportunity to begin interventions with families presenting with children with difficulties.

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## **Appendices**

### **Appendix 1. Letter granting ethical approval**

**Local Research Ethical Committee**

Ambulance Headquarters  
Ascots Lane  
Welwyn Garden City  
Herts AL7 4HL

Secretary - Jenny Austin  
Ext 3607  
Direct Line: 01707 365229

Steve Morris  
Clinical Psychologist in Training  
Hoddesdon Child and Adolescent Clinic  
Hoddesdon

Dear Steve

**Re: Therapeutic Credibility as a Predictor of Early Missed Sessions in Family Therapy**

I refer to your attendance at the Local Research Ethical Committee on 19th January, 1998 and am pleased to confirm the Committee's approval of the above research in accordance with the application submitted to the meeting. The following members were present at this meeting:

Mr D Rhodes, Chairman & Lay Member  
Mrs J Curtis, District Pharmaceutical Officer  
Dr C Hawley, Consultant Psychiatrist  
Mrs S Michael, Lay Member  
Dr I King, GP  
Dr S Kingsbury, Consultant in Child & Adolescent Psychiatry  
Mr M Lennox, Consultant Surgeon  
Mrs A McPherson, Matron  
Dr P Winocour, Consultant Physician

The Committee require to be advised of the results of the research when they are available, and where they are to be published.

Yours sincerely



Jenny Austin  
Secretary - East Herts NHS Trust LREC



**East Hertfordshire  
NHS Trust**

27 JAN 1998

Our ref: JCA/1.98  
12 January, 1998

Appendix 2. Information sheet and consent form sent to families

**Dept of Child & Adolescent Mental Health  
Health Clinic  
High Street  
Hoddesdon  
Herts EN11 8BE**

**01992 465042**

**FAMILY THERAPY RESEARCH PROJECT - INFORMATION SHEET**

Dr Steve Kingsbury, Consultant Psychiatrist  
Steve Morris, Clinical Psychologist in training at North Thames (University College London)

28/1/98

Dear Family,

We are actively involved in a research project at the Hoddesdon Child and Adolescent Clinic that may help us in our work but it depends on families being willing to take part.

We are writing to families whose children have been referred to our clinic over the next few months to ask if they are willing to take part in the project. All the information you provide will remain confidential to the clinic.

The project looks into attitudes towards different types of therapy that might be offered to see how this affects families' interest in coming along.

**Please read the rest of this note and the consent form and then decide if you are willing to take part in the research.**

Before being seen for assessment at the Clinic, we are asking for the enclosed questionnaire booklets to be filled out and returned to us as soon as possible in the stamp-addressed envelope provided, along with the signed consent form. There is a questionnaire booklet enclosed for each of the parents (or carers) that takes ten minutes or so to fill out. If you are the only parent of your child, please indicate this on the consent form and ignore one set of the questionnaires.

After you have been seen the first time at the clinic and after the second time too, you will be asked to fill in a few similar questionnaires that will only take a few minutes to fill out; these will not need posting.

The information you provide will remain confidential to the project. This means that I will assign each family a number at the start of the project and all names will remain confidential throughout the project. I may also be involved in your family therapy but please be reassured that because all families involved in the research will be referred to by number alone, the information provided will remain totally anonymous.

THANK YOU!



S.Morris, Clinical Psychologist in training

**Dept of Child & Adolescent Mental Health  
Health Clinic  
High Street  
Hoddesdon  
Herts EN11 8BE**

**01992 465042**

**FAMILY THERAPY RESEARCH PROJECT**

Dr Steve Kingsbury, Consultant Psychiatrist  
Steve Morris, Clinical Psychologist in training at North Thames (University College London)

**INFORMED CONSENT FORM**

We have read the information sheet concerning this study and we understand what will be required of us if we take part in the study.

We understand that at any time we may withdraw from this study without giving a reason and without affecting our normal care and treatment.

We understand that any of the information provided will remain confidential to the clinic.

**EITHER:-**

**WE AGREE TO TAKE PART IN THE STUDY.**

CAN BOTH PARENTS/CARERS SIGN THIS FORM BOTH PARENTS NEED TO CONSENT. IF THERE IS ONE PARENT/CARER ONLY, please tick here \_\_\_\_\_

Signature(s) \_\_\_\_\_ Date \_\_\_\_\_

Please print your name(s) \_\_\_\_\_

\_\_\_\_\_

and send this form back with the filled-in questionnaires, in the stamp-addressed envelope provided..

**OR:-**

**WE DO NOT WISH TO TAKE PART IN THE STUDY** (just tick \_\_\_\_\_ and do not bother with signatures, but send this form back with unfilled questionnaires)

Appendix 3. Questionnaire: 'Therapies'

Code:-

(1)

Date:-

Are you male or female? M/F

If male, are you the referred child's father? Y/N

If female, are you the referred child's mother? Y/N

Therapies to help with difficulties with children.

theraps.wp

Read the description below, then tick your answer to each of the five questions below. Please do the same for descriptions 2 and 3 overleaf.

(1) What is child therapy?

Child therapy involves usually one child therapist working with a child in order to help with the problem. This might involve the therapist talking with the child about the problem in the present or establishing possible links between the presenting problem and the past, possibly using art or play materials in sessions. Various approaches are available that are aimed at helping the child overcome the difficulty.

(1a) How much sense does this approach seem to make to you? (tick one box)

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

none at all

some

complete sense

(1b) Does the approach seem a suitable one for your problem?

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

not at all suitable

reasonably

very

(1c) Could other problems be dealt with using this approach?

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

none

some

all problems

(1d) How willing would you be to take part in using this approach?

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

not at all

reasonably

very willing

(1e) Might another approach be more helpful than this one?

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

not at all

somewhat

much more helpful

PLEASE TURN OVER

Therapies to help with difficulties with children.

(2) What is parent therapy?

Parent therapy involves parents and therapists meeting to discuss the difficulties with the referred child. Sometimes, children's difficulties are best helped by parents changing their relationship with the child, brought about by some help for the parents. Parent therapy might involve parental instruction, skills training or advice or it might involve some other approach to help the couple that result in helping the child too.

(2a) How much sense does this approach seem to make to you? (tick one box)

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

none at all

some

complete sense

(2b) Does the approach seem a suitable one for your problem?

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

not at all suitable

reasonably

very

(2c) Could other problems be dealt with using this approach?

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

none

some

all problems

(2d) How willing would you be to take part in using this approach?

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

not at all

reasonably

very willing

(2e) Might another approach be more helpful than this one?

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

not at all

somewhat

much more helpful

Therapies to help with difficulties with children.

(3) What is family therapy?

Family therapy involves the family, therapists looking at a child's problems from the whole family's points of view. Each family member contributes to family life, so looking into how family members get along with each other can change the problem that the family started off with. Family therapy involves a commitment from the immediate family members to come along to the therapy sessions.

(3a) How much sense does this approach seem to make to you? (tick one box)

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

none at all

some

complete sense

(3b) Does the approach seem a suitable one for your problem?

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

not at all suitable

reasonably

very

(3c) Could other problems be dealt with using this approach?

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

none

some

all problems

(3d) How willing would you be to take part in using this approach?

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

not at all

reasonably

very willing

(3e) Might another approach be more helpful than this one?

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

not at all

somewhat

much more helpful

PLEASE TURN OVER

## Appendix 4. Readability study questionnaire

I have developed some short passages to describe different types of therapy and need to find out how easy they are to understand. To help me do this, I am asking some service users to spend a few minutes reading through the passages and to answer some very brief questions.

There are three passages and the whole exercise should take you a few minutes at most.

**Thank you.**

A handwritten signature in black ink, appearing to read 'Steve Morris', written in a cursive style.

Steve Morris  
Clinical Psychologist

123

132

213

231

312

321

Passage 1 2 3.

What is child therapy?

Child therapy involves usually one child therapist working with a child in order to help with the problem. This might involve the therapist talking with the child about the problem in the present or establishing possible links between the presenting problem and the past, possibly using art or play materials in sessions. Various approaches are available that are aimed at helping the child overcome the difficulty.

(1) How easy was it to understand the passage? (tick a box)

1	2	3	4	5	6	7
extremely easy	easy	fairly easy	neither easy nor difficult	fairly difficult	difficult	extremely difficult

(2) If you found the passage difficult, can you say why.

-----

-----

-----

-----

What is parent therapy?

Parent therapy involves parents and therapists meeting to discuss the difficulties with the referred child. Sometimes, children's difficulties are best helped by parents changing their relationship with the child, brought about by some help for the parents. Parent therapy might involve parental instruction, skills training or advice or it might involve some other approach to help the couple that result in helping the child too.

(1) How easy was it to understand the passage? (tick a box)

1	2	3	4	5	6	7
extremely easy	easy	fairly easy	neither easy nor difficult	fairly difficult	difficult	extremely difficult

(2) If you found the passage difficult, can you say why.

-----

-----

-----

-----

What is family therapy?

Family therapy involves the family, therapists looking at a child's problems from the whole family's points of view. Each family member contributes to family life, so looking into how family members get along with each other can change the problem that the family started off with. Family therapy involves a commitment from the immediate family members to come along to the therapy sessions.

(1) How easy was it to understand the passage? (tick a box)

1	2	3	4	5	6	7
extremely easy	easy	fairly easy	neither easy nor difficult	fairly difficult	difficult	extremely difficult

(2) If you found the passage difficult, can you say why.

-----

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-----

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Appendix 5. Questionnaire: 'Psychological Mindedness Scale' (PMS)

ID:  
DATE:

P-M SCALE

Thirty-four statements are listed below. Each statement is followed by four phrases:

Strongly agree  
Mostly agree  
Mostly disagree  
Strongly disagree

Please place a tick in the column which best describes how you feel about each statement.

	Strongly Agree	Mostly Agree	Mostly Disagree	Strongly Disagree
1. I would be willing to talk about my personal problems if I thought it might help me or a member of my family.	_____	_____	_____	_____
2. When I have a problem, if I talk about it with a friend, I feel a lot better.	_____	_____	_____	_____
3. Often I don't know what I'm feeling.	_____	_____	_____	_____
4. I am willing to change old habits to try a new way of doing things.	_____	_____	_____	_____
5. There are certain problems which I could not discuss outside my immediate family.	_____	_____	_____	_____
6. I often find myself thinking about what made me act in a certain way.	_____	_____	_____	_____
7. When you have problems, talking about them with other people just makes them worse.	_____	_____	_____	_____
8. Usually, if I feel an emotion, I can identify it.	_____	_____	_____	_____
9. If a friend gave me advice about how to do something better, I'd try it out.	_____	_____	_____	_____
10. I am annoyed by someone, whether he is a doctor or not, who wants to know about my personal problems.	_____	_____	_____	_____
11. I find that once I develop a habit, that it is hard to change, even if I know there is another way of doing things that might be better.	_____	_____	_____	_____
12. Letting off steam by talking to someone about your problems often makes you feel a lot better.	_____	_____	_____	_____

	Strongly Agree	Mostly Agree	Mostly Disagree	Strongly Disagree
13. People sometimes say that I act as if I'm having a certain emotion (anger for example) when I am unaware of it.	_____	_____	_____	_____
14. I get annoyed when people give me advice about changing the way I do things.	_____	_____	_____	_____
15. It would not be difficult for me to talk about personal problems with people such as doctors and clergymen.	_____	_____	_____	_____
16. I've never found that talking to other people about my worries helps much.	_____	_____	_____	_____
17. Often, even though I know that I'm having an emotion, I don't know what it is.	_____	_____	_____	_____
18. I like to do things the way I've done them in the past. I don't like to try to change my behaviour much.	_____	_____	_____	_____
19. There are some things in my life that I would not discuss with anyone.	_____	_____	_____	_____
20. Understanding the reasons you have deep down for acting in certain ways is important.	_____	_____	_____	_____
21. At work, if someone suggested a different way of doing a job that might be better, I'd give it a try.	_____	_____	_____	_____
22. I've found that when I talk about my problems to someone else, I come up with ways to solve them that I hadn't thought of before.	_____	_____	_____	_____
23. I am sensitive to the changes in my own feelings.	_____	_____	_____	_____
24. When I learn a new way of doing something, I like to try it out to see if it would work better than what I had been doing before.	_____	_____	_____	_____
25. It is important to be open and honest when you talk about your troubles with someone you trust.	_____	_____	_____	_____
26. Talking about your worries to another person helps you to understand your problems better.	_____	_____	_____	_____
27. I'm usually in touch with my feelings.	_____	_____	_____	_____
28. I like to try new things, even if it involves taking risks.	_____	_____	_____	_____

	Strongly Agree	Mostly Agree	Mostly Disagree	Strongly Disagree
29. It would be very difficult for me to discuss upsetting or embarrassing aspects of my personal life with people even if I trust them.	_____	_____	_____	_____
30. If I suddenly lost my temper with someone, without knowing exactly why, my first impulse would be to forget about it.	_____	_____	_____	_____
31. When you have troubles, talking about them to someone else just makes you more confused.	_____	_____	_____	_____
32. I frequently don't want to delve too deeply into what I'm feeling.	_____	_____	_____	_____
33. I don't like doing things if there is a chance that they won't work out.	_____	_____	_____	_____
34. Fear of embarrassment or failure doesn't stop me from trying something new.	_____	_____	_____	_____

Thank you .

Appendix 6. Therapist's file instruction sheet

FAMILY NUMBER \_\_\_\_\_

Research project - Instructions for therapists

frontshl.wp

'that is all' means the family are dropped from the research.

**(1) At start of Assessment (first) session**

Ask if family have completed the questionnaires.

If NO, thank family and *that is all*.

If YES, thank them, ask about questionnaires (did they bring them or post them) and say you'll spend a few more minutes on this at the end of the session.

**(2) At end of Assessment (first) session**

(a) Check:- have all questionnaires been returned + consent form? All filled in?

(Questionnaire 1 (Q1) must have been completed and returned by each parent if there are 2 parents; if Q1 not complete, then *that is all*.)

(b) If all ok so far, ask both parents to fill out Q1 again now, in the Amwell room. Ask them to return them (and any pens!) to the office.

If partner not here, ask if they could get the partner to fill it out at home and send it back to us. Give a Stamp-Addressed Envelope and questionnaire held in envelopes labelled 'stamp-addressed envelopes' and 'spare questionnaires after assessment' in SM's pigeonhole. Please number (family number at top of this sheet) and date the questionnaire and ask them to post it back as soon as possible please.

(c) Can the main therapist fill out the copy of Q1 (now or later), putting the date, their name and the family name on the form. Return form to SM's pigeonhole - spares are held there, in an envelope labelled 'therapist questionnaires'.

(d) Please indicate date of next (second) session with family here \_\_\_\_\_.

(e) Any problems? (eg no consent form, family lost a questionnaire, etc) - write it here and SM will sort it out.

**At end of second session**

(a) Ask if family are willing to fill out a couple more forms.

(b) Give out questionnaires enclosed. There are 2 different ones this time, questionnaire 1 (third time) and the Dyadic Adjustment Scale, one copy per parent. Give them to the family and ask them to return them to the office.

If partner not here, ask if they could get the partner to fill them out at home and send them back to us. Give a Stamp-Addressed Envelope held in SM's spare questionnaires box. Spares of the questionnaire are in an envelope labelled 'questionnaires after session 2' - questionnaires will need numbering (family number at top of this sheet) and date; ask them to post it back as soon as possible please.

(c) Can therapist fill out questionnaire 5, one question that estimates family's improvement. Spares are held in an envelope labelled 'outcome question - therapist'

Thank you!

SM

Appendix 7. Telephone reminder to encourage reply

## Appendix 7.

Telephone message to families who had confirmed their intention to attend an assessment session but who had not returned the consent form. Phone call made two weeks before assessment.

### Message;-

- "My name is Steve Morris and I am phoning from Hoddesdon Child and Family Clinic"

- "You have confirmed that you are coming along to the clinic but I haven't heard from you either way to say whether you are willing to take part in the research. It helps us a lot if families are willing to take part".

If they say 'what research?' then add

- "I sent out questionnaires with the appointment letter."

If they comment on anything else, stay businesslike and keep the exchange to a minimum without appearing rude.

### Then:-

- "I am just phoning to say that if you are willing to take part, can you bring the questionnaires along with you to the clinic. If you do take part, all the information you provide will be confidential."

- "Thank you"

Appendix 8. Reminder letter to encourage reply

**Dept of Child & Adolescent Mental Health  
Health Clinic  
High Street  
Hoddesdon  
Herts EN11 8BE**

**01992 465042**

**FAMILY THERAPY RESEARCH PROJECT**

17/4/98

Dear family,

I sent some questionnaires to you a few weeks ago and asked if you would be willing to take part in a research project. It helps us a great deal if families are willing to take part; if you have not already sent the questionnaires back to us, please bring them along with you to the clinic.

I would like to repeat that if you do take part in the research, all the information you provide will remain confidential.

Thank you!

A handwritten signature in cursive script that reads "S. Morris".

S. Morris, Clinical Psychologist in training.

Appendix 9. Clinic leaflet

## *How to get our help?*

Any family with concerns about their child may ask their GP or Social Worker to make a referral to this service. We are happy to provide further information by telephone.



## DEPARTMENT OF CHILD & ADOLESCENT MENTAL HEALTH

## *Are the sessions confidential?*

All meetings are confidential except for when there are issues of child safety. However, we may ask families for permission to contact other professionals as it increases our understanding of the difficulties. After seeing each family, we write to the General Practitioner and the referring professional with our views of the assessment.

Health Centre  
High Street  
Hoddesdon  
EN11 8BE  
Tel: 01992 465042

Queen Elizabeth II Hospital  
Howlands  
Welwyn Garden City  
Hertfordshire  
AL7 4HQ  
Tel: 01707 365054

Health Centre  
Market Square  
Bishops Stortford  
Tel: 01992 465042

## *What is the Service?*

When parents or those caring for children become concerned about their children's behaviour, emotional well-being or relationships, they may wish to speak to someone outside the family for help. We offer an outpatient service to children and young people up to 16 years or until they leave full-time education. The service is part of the East Hertfordshire NHS Trust.

## *What kinds of things can we help with?*

Family life can be stressful and is often made worse by other events and circumstances such as bereavement and divorce. Children and young people may show their distress and worry in different ways. This can be through: –

- ▶ Disturbed sleep and eating.
- ▶ Behavioural difficulties.
- ▶ Worries.
- ▶ School attendance problems.
- ▶ Conflicts at home.

We also assess and treat specific conditions such as Attention Deficit Hyperactivity Disorder, Tourette Syndrome and Anorexia.

## *Who are we?*

We are a specialist team of people trained to help with emotional and behavioural problems in children and adolescents. The team includes child and adolescent psychiatrists, clinical

psychologists, clinic social workers and family therapists. We work together, combining our different training and experience, to help families deal with the various problems.

## *How do we help?*

In the first instance we usually meet with the whole family who live at home because everyone is affected in some way by the difficulties and can have different points of view. Most sessions are spent talking about problems and feelings and in this way we can explore solutions with the family. Sometimes whole families or individuals are asked to carry out additional tasks between sessions. We might also see parents or children separately and at times offer attendance in a group.

## *What will happen on the first visit?*

We seek each family's help to get a picture of their concerns to help us assess the extent of the difficulties and work out how we might help. This is usually with two team members and takes between one and one and half hours. Subsequent sessions last for about an hour and may be with only one team member.

## *How long will it take?*

Sometimes families feel they have been helped after one or two visits. Others may need more help and are seen regularly for several sessions over a few months.