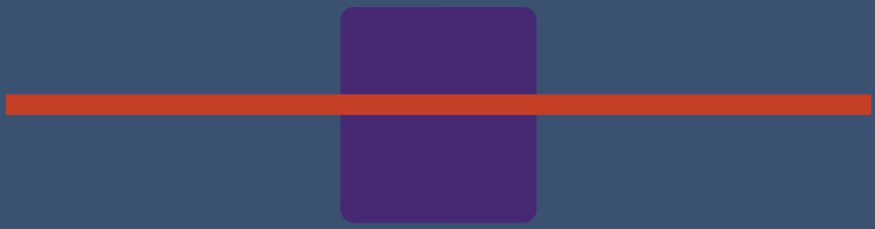
A Child Psychotherapy Primer

Evaluation



Josiah B. Dodds PhD

EVALUATION

Josiah B. Dodds Ph.D.

e-Book 2016 International Psychotherapy Institute

From *A Child Psychotherapy Primer* Josiah B. Dodds Ph.D.

EVALUATION

HOW DO YOU EVALUATE TREATMENT PROGRAMS?

Evaluating change in therapy has long been an extremely complex and difficult task. Typically, therapy outcome researchers have looked to three major sources for evaluation data: reports from the client (including psychological tests), reports of others who have frequent contact with the client (parent, teacher, therapist), and "objective" measures, such as measures of frequency of behavior, or external criteria, such as school or job achievement. Each of these sources has its limitations. The client may behave in a very different way but feel unchanged, or feel very differently but behave the same. his/her reports would most likely reflect changes in feeling. Observers may be biased due to some emotional involvement (parent) or vested interest (therapist). Objective measures may not reflect the client's improved or worsened subjective feelings. They might also be influenced by many factors outside of therapy, e.g., grades changing because of a change in teachers. Also, test results and behavior counts might not be too central to what is truly important in the client's life. Just as the careful researcher attempts to use several measures, so the therapist should obtain data from several sources in order not to be misled by one source of possibly skewed data.

The conscientious therapist systematically evaluates the client's progress, or lack of progress, in order to have some idea of the efficacy of the treatment method. The therapist has a contractual obligation to deliver a helpful service and an ethical obligation not to continue ineffective treatment.

The therapist trying to observe changes in therapy is a bit like the person concentrating on the minute hand of a watch in an attempt to detect movement. Similarly, changes in a child from session to session are usually impossible to see, but if anchor data are obtained at one point in time and the same order of data are obtained at longer-than-l-week intervals (minimum six weeks?), changes are more likely to be seen.

What kind of data should be obtained and from what sources? Obviously, this question has to be answered in terms of the original difficulties that brought the child into treatment. If the complaint was a

specific symptom such as bed-wetting, not eating, truancy, or hitting the baby, the progress is relatively easy to measure if one can keep a running tally of the behaviors. In fact, since these behaviors occur outside the therapy room, there is no other way to measure progress than to go to the site of the behavior. If the behaviors could occur in the therapy room (cursing, temper tantrums, nervous habits, etc.) one would still need a record of behaviors outside of the therapy room, since the child may cease the behavior in the therapy room but not outside. For example, a child may not cling to the therapist any longer but continue to cling to the parent or the teacher. The external person with the greatest vested interest in changing the child's behavior (usually parent or teacher) may not be the most valid observer and recorder of behavior but is probably the most conscientious.

If the presenting complaint is more internal, relating to the child's feelings or attitudes, then progress is more difficult to evaluate. Feelings such as depression, anger, and fear may be displayed in the therapy room through behaviors associated with those feelings. The clinician is probably an imperfect counter of these behaviors but must do his/her best in using these behaviors to make judgments such as: Mark is less depressed than he was two months ago, Sally is just as nervous as when she started therapy, and Debbie is more angry than she was six weeks ago. If the therapist notes marked changes in mood, the child is probably demonstrating mood changes outside the therapy room but *one cannot automatically assume so.* Outside observers such as parents and teachers must be asked their judgments about any changes in the child's mood.

Attitudes such as self-denigration, dislike of teachers, or distrust of peers can often be obtained by direct questioning. As a supplement to the child's expressed attitudes, or particularly when the child cannot express his/her attitudes verbally, projective tests can be very useful. Interpretation of a single set of test protocols is often difficult, especially for the beginning student who does not have a large set of internal norms. Comparison of before-and-after test protocols is more reliable. One can simply count and compare, say, the number of negative statements about the teacher, scary stories, dependency themes, or themes of vulnerable, failing heroes.

Achievements by the child in the cognitive sphere are easier to evaluate. The following are three examples: (a) the child might learn that it is possible to both love and hate his/her father; (b) the child might understand that he/she is failing at school because of fear of what he/she thinks the teacher might

say; and (c) the child might understand the reasons for his/her mother deserting the family. These cognitive changes are easy enough to evaluate; information or ideas that were not there are now present. What remains less clear is how well the child makes use of the new information or understanding. One would have to look for consequences of the cognitive changes. Consequences in the three examples above might be as follows: (a) the child reports less guilt about his/her anger toward father and is able to enjoy their time together more; (b) the child works harder at school and achieves more; and (c) the child feels less responsible for the mother's desertion because his/her perceived unloveworthiness was not the cause for the desertion.

The child may show changes for the better in areas other than those specified in the therapy goals. Possibly the therapeutic relationship was a factor in the observed changes, but the therapist must be careful not to take all the credit for normal growth and maturation. Even for changes toward the goals of therapy, the ascription of causes for those changes as lying within the therapy relationship is a highly tenuous exercise. One could say that all positive changes are due to the therapy and all negative changes the parents' fault, but presumably the statement would be made in jest. If positive changes occur in the direction of the therapy goals, the exact causal chain would be impossible to demonstrate in a single case. The therapist at this point must rely on theory to "explain" the observed events.

The evaluation of psychotherapy progress is often neglected and perpetuates the notion that this method of helping children is so much wishful thinking. We do not, in fact, have many well-designed and well-executed studies of the efficacy of child psychotherapy or any good research on the factors in the therapeutic process that effect change. This is all the more reason clinicians must keep careful records of treatment progress with each individual client.

One cannot fall back on the literature to say, "Well, if we just continue doing this, the child has an eighty percent chance of improving." The place to start this task is at the beginning of therapy when specific goals and methods of obtaining those goals are written. These goals and methods may be changed as the treatment progresses, but with such a list one at least has some kind of anchor point in a change continuum.