

# THE EFFICACY OF BRIEF CLINICAL PROCEDURES IN ALLEVIATING CHILDREN'S BEHAVIOR PROBLEMS<sup>1</sup>

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This paper reports the results of a modest investigation into the effects of certain limited clinical procedures in alleviating a variety of psychological problems in children. The method is that of a post-treatment survey, and the procedures were carried out in the comparatively naturalistic setting of a university psychological clinic. Our purpose was not the demonstration of the merits of some particular therapeutic system relative to others. It was the simpler one of determining whether, within this setting, doing something for a patient was better than doing nothing. Eysenck (2, 3) has offered a discouraging answer to this question in his controversial surveys of the consequences of prolonged psychotherapy. As the comparability of his patient and control populations is questionable, some value may be attached to further studies of this problem under conditions of greater control.

## METHOD

*Subjects.* The subjects were the parents of children who had been referred to the out-patient clinic of the psychology department at Ohio State University. Selection of the parents was made on the basis of certain criteria. From all cases where children had been referred at least one year and not more than five years previously, the following were discarded: all cases where another agency had provided treatment during that period; where the evaluation had been for purely descriptive purposes, e.g., estimates of mental retardation; where the children were living in an institution and not a family unit. The subjects who remained in the sample were then grouped into those who had received treatment at the clinic, the treatment group, and those who had not, the control group. As far as can be ascertained there was no systematic bias operating in the rejection of referrals other than lack of clinic facilities, as cases were seen on a first come, first served basis. No bias is evident in the distribution of problems in the two groups, although it must be granted that this inference would be more justified had there been the possibility of using random assignment to conditions at the outset. With this qualification in mind, it appears that the only consistent difference between the two groups was the condition of treatment versus no treatment.

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<sup>1</sup>This investigation received support from research funds granted by Northwestern University and Pennsylvania State University. Acknowledgement is also made of the assistance and facilities made available by Professor Julian B. Rotter, Ohio State University. Parts of this report were presented at the Southern Society for Philosophy and Psychology, St. Louis, March, 1959.

*Follow-up questionnaire.* The follow-up data were gathered through a questionnaire which was mailed to the treatment and the control groups.<sup>2</sup> The parents were asked, "Check any of the following problems which you feel describe difficulties which you may be having with your child at the present time." The check list referred to the general problem areas of (a) eating, 5; (b) toilet behavior, 2; (c) sleeping, 4; (d) nervous habits, 4; (e) school, 10; and (f) others, 14. The numbers following the problem areas refer to the number of specific items listed in each category.

This was followed by two multiple-choice questions: "In general, would you say that the problem about which you consulted us (a) no longer exists, (b) has improved, (c) is about the same, (d) is worse than before?" And "If the problem has not completely cleared up, how would you describe your present feeling about it? (a) More worried than at time of consultation. (b) Worries us about as much as at time of consultation. (c) Less worried than at time of consultation. (d) Not worried at all."

Finally, the parents of the treatment group were asked to answer the following two open-ended questions. "In what way do you think your visiting the clinic was most useful?" And "In what respects do you think the evaluation at the clinic could have been improved?"

*Questionnaire procedure.* Any parent who did not reply to the questionnaire within one month, was mailed a second copy. Failure to reply to this was followed by personal letters and telephone calls until all cases were accounted for by a reply, a positive refusal to complete the blank, or being untraceable by the post office. From a total of 122 cases meeting the selection criteria, 91 returned completed questionnaires. Of the remaining 31, the post office failed to trace 29 and 2 refused to complete the questionnaire. Group totals were: treatment 50, control 41.

*Treatment procedure.* Treatment was not manipulated as an independent variable. Consequently it is only possible to describe the gross characteristics of the typical procedure with a case. In no case was the goal of treatment that of providing "insight" to parents into their own problems, or of "uncovering" problems within the parents themselves. The major technique involved the use of semi-directive interviews with the parents, never exceeding three sessions each of one hour duration or less. The rationale for this approach is described by Rogers (4) under the general rubric of changing parental attitudes. A similar account is available in Rotter's exposition of his theory of social learning (5). Both of these accounts represent, of course, developments of the basic tenets of the Adlerian position (cf. 1).

The sessions with parents were preceded by the use with the children of appropriate conventional diagnostic procedures of psychometric and projective testing, anamnestic interviews, etc. The diagnostic procedures were usually carried out by advanced graduate students in clinical psychology, while the sessions with parents were conducted by a faculty supervisor. During the period under investigation 7 supervisors and 42 students had participated in the treatment of the cases in question. After the treatment sequence a letter was sent to the parents which summarized the major recommendations made during the sessions.

*Initial data sheet.* A written "Statement of Referral" was made by a parent before a child was considered for treatment. These statements were available for all children in both treatment and control groups. They represent the parent's definition and evaluation of the problem before treatment. From these statements an initial data sheet was filled in which was identical with the parents' questionnaire. This was done by two raters who had no access to any other clinical material or to the follow-up data. Thus the pre-treatment problem was defined in a form which would permit of ready comparison with the follow-up data. For each case both raters filled in data sheets independently. Discrepancies were resolved by

<sup>2</sup>Complete copies of the questionnaire may be obtained on request from the senior author, Department of Social Relations, Harvard University, Cambridge 38, Mass.

reference to the criterion that no problem was to be checked as present which was not overtly mentioned. In this way the data were weighted against the probability of fewer complaints after treatment than before.

From comparisons of initial data sheets with follow-up questionnaires it was possible to report (a) the changes in total problems consequent upon the treatment or control conditions, (b) the amenability of particular problem areas to such change, and (c) the parents' estimate of the gross changes in severity of the total referral problem as it existed initially.

## RESULTS

Table 1 presents the parents' follow-up estimates of the severity of the problem and of their worry about it. Chi-square analysis of the

TABLE 1. PARENTS' FOLLOW-UP ESTIMATES OF SEVERITY OF THE PROBLEM, AND OF THEIR WORRY ABOUT IT, IN NUMBERS AND PERCENTAGES

	Treatment group			Control Group		
1. In general would you say the problem about which you consulted us:						
(a) no longer exists	20	20*	40%	8	8	19%
(b) has improved	23	23	46%	15	15	37%
(c) is about the same	6			15		
(d) is worse than before	1	7	14%	3	18	44%
	N = 50			N = 41		
2. If the problem has not completely cleared up, how would you describe your present feelings about it compared to time of consultation?						
(a) more worried	2			10		
(b) worries us about as much	3	5*	17%	15	25	76%
(c) less worried	16			6		
(d) not worried at all	9	25	83%	2	8	24%
	N = 30			N = 33		

\*Difference of the distributions between the two groups significant beyond the .05 level.

difference in severity between treatment and control groups was made by combining responses (c) the same, and (d) worse, into one category of "unimproved," to provide sufficient cases in the cells to permit a valid analysis. The treatment group estimated the problem as less severe than the controls, the difference being significant beyond the .05 level. Furthermore, where the problem had not cleared up completely, the treatment group was less worried than the controls,  $\chi^2$  analysis again showing the difference to be significant beyond the .05 level, after categories (a) and (b) had been combined, as well as (c) and (d).

Table 2 presents the numbers of specific problems recorded for treatment and control groups in the initial data sheets and the follow-

TABLE 2. NUMBER OF SPECIFIC PROBLEMS REPORTED BY TREATMENT AND CONTROL GROUPS, INITIALLY AND IN THE FOLLOW-UP†

Specific problems	Treatment group		Control group	
	initially	follow-up	initially	follow-up
(a) Unimproved whether treated or not treated				
reading	8	7	6	6
arithmetic	8	8	7	7
school discipline	6	6	9	8
lying	7	7	4	4
(b) Improved with treatment but not without it*				
overeating	7	1	5	5
nervous habits	15	3	12	12
fighting with other children	10	3	8	7
destructive behavior	11	2	9	7
(c) Improved whether treated or not treated				
poor appetite	7	0	4	0
toilet behavior	6	2	5	2
feelings easily hurt	8	1	5	0

†Only those problems are included which occurred frequently enough for  $\chi^2$  tests, using Yates' correction.

\*Differences between treatment and control groups significant beyond .05 level.

up questionnaire. Only those problems are shown where the number was adequate for a  $\chi^2$  test, with treatment-control and initial-follow-up the cell dimensions of a 2 x 2 table. The following conclusions receive statistical support: (a) Whether treated or not, no improvement was observed in the school problems of reading, arithmetic, discipline, and in the general problem of lying. (b) Problems which responded to treatment, but did not improve without it, are overeating, nervous habits (such as thumb sucking, nail biting) and tics in general, fighting with other children, and destructive behavior. (c) Problems which improved even without treatment referred to poor appetite, toilet behavior, and "feelings easily hurt."

The answers to the open-ended questions, "In what way do you think your visiting the clinic was most useful?" and "In what respects do you think the evaluation at the clinic could have been improved?" are presented in Table 3. The free-response answers were grouped according to relevant categories. The results show that the clinic was most often useful through providing simple reassurance, and that half the parents who answered the second question had no suggestions for improvement. Paradoxically, the relationship between reporting lack of improvement of the problem, and voicing some complaint about the treatment was not statistically significant.

TABLE 3. PARENTS' OPINIONS REGARDING WAYS IN WHICH THE CLINIC (a) WAS USEFUL (b) COULD BE IMPROVED

The Clinic visits were most useful through:		The evaluation at the Clinic could have been improved through:	
simple reassurance	12	giving more time	4
increased understanding of child's motives	9	more specific instructions	4
specific suggestions	9	less unfeasible recommendations	4
factual changes in child's behavior	5	spending less time with parent	2
they were generally useful	3	diagnosis was incorrect	2
they were not useful	5	unqualified approval	16
	N = 43		N = 32

Additional analyses of the data were performed to ascertain if improvement was related to the sex, intelligence, or age of the child; the supervising therapist; or the number of sessions with the parent. While no statistically significant effects were discovered for any of these conditions, a trend was apparent for younger children to improve more than older ones.

#### DISCUSSION

There seems to be little doubt that the parents of treated children estimate that the problem has improved significantly more often than the parents of untreated children do. Insofar as the treatment is definable as doing "something," this appears to be more beneficial than doing nothing. Thus the results confirm the impression of many clinicians that, notwithstanding some current beliefs in the field, problems cannot always be counted on to get better if they are just left alone. The results do not vindicate a particular therapeutic method in comparison with another, and this was not the investigators' intention. However, to the extent that the present study sheds any light on the efficacy of any particular therapeutic beliefs, it is upon the Adlerian tradition of child guidance that the evidence may bear.

Investigations into the effects of therapy are fraught with methodological dangers. One of the perennial problems is that of deciding a criterion for improvement. In the present study it was decided to use the same criterion for estimating improvement as that which was used for deciding that there was a problem in the first place—namely the opinion of the parents. Inevitably this leaves unanswered the question of whether or not the child's behavior had actually changed in some measurable fashion following treatment. As no independent measures

of behavior change were taken, it is impossible to deal with this question. An ideal study would involve the taking of behavioral measures before and after treatment by independent observers, and the present investigation clearly falls short of the ideal. Nevertheless, the criterion which was used is typical of that which determines admission to clinical treatment in many child guidance clinics and may therefore have some useful generality.

An interesting aspect of the data is the extent to which parents gained reassurance from their contact with the clinic and were aware of the value of this to themselves. A common criticism of reports of improvement following therapy is that the patients did not have "serious" problems anyway. At first sight the effects of reassurance reported in this study might revive this question about the patient population involved. However, reassurance per se was not a part of the therapeutic procedure. Rather it seems to have arisen as a by-product when the parent felt that professional skills were now being applied to the problem.

Large-scale research into the efficacy of clinical techniques is costly. It is best undertaken in circumstances which permit of complete control of all the relevant variables. Nevertheless it is quite feasible to conduct limited studies such as the one reported here with the facilities available in most clinics. Existing files in clinics often prove recalcitrant to research uses because the intake data were not recorded in a manner which would permit systematic follow-up comparisons. The organization of clinical records with an appreciation of their potential value in research would seem to be worthy of general attention.

All in all the results of this investigation are encouraging. Economic reasons compel the continued emphasis on brief therapeutic procedures, and it seems unlikely that the pressures in this direction will ease in the foreseeable future. It is hoped that this report will justify some optimism about the possibilities of brief procedures.

#### CONCLUSIONS

Children treated in a psychological clinic by brief methods designed to change parental attitudes were compared with children who did not receive this help. The follow-up investigation utilized a questionnaire addressed to parents and covered cases seen from one to five years previously. The criterion for estimating improvement was the same as that used for deciding that there was a problem in the

first place—namely the opinion of the parents. Based on the parents' estimates the conclusion emerges that treatment is significantly effective in producing improvement in the referral problem.

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