

Child Therapy Training: Closing Gaps With Research and Practice

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Previous surveys have revealed troubling gaps between training and research and practice in psychotherapy. In this study, a selective review of research on child therapy and therapy training was conducted in order to address questions concerning who, what, how, and when to train child therapists. This review revealed substantial gaps in our current empirical knowledge about child therapy training, but some promising leads as well. A science-based approach to child therapy training is advocated.

Not long ago surveys of psychologists who provide therapy to children pointed to a marked discrepancy between training and practice (Routh, 1985; Tuma & Pratt, 1982). For example, in their survey of members of American Psychological Association's Division 12, Section 1 (Clinical Child Psychology), Tuma and Pratt found a substantial number of respondents who viewed their training in child therapy to be far from ideal. Many respondents, most of whom received their degrees in the 1960s and early 1970s, reported that their training was deficient because it lacked a foundation in developmental processes, overemphasized techniques that were suitable primarily for adults, and provided limited supervised experience in child treatment (Tuma & Pratt, 1982). It appeared that many of the respondents designed their own child therapy training through optional courses, specialized internships, or on-the-job experience. This picture of the training experiences of child clinicians stands in sharp contrast to the profile of the systematically trained child specialist (Ross, 1959; Tuma, 1989; Wohlford, 1979).

One might assume that the gap between training and practice has closed with the substantial increase in clinical child training programs. According to Mannarino and Fischer (1982), there was a dramatic increase in the number of programs offering training in clinical child psychology between the mid-70s and early 80s, from 12 programs to 36 "formal programs" and 29 "informal programs." This trend has continued during the 1980s, although at a slower rate (Tuma, 1990). However, as Routh (1985) has observed, the absence of explicit training standards and the lack of confirmation of reported data necessitate a cautious interpretation of this apparent growth.

Undoubtedly there is considerable variability in what constitutes a training program in clinical child psychology. Nearly a decade ago, Roberts (1982) identified four basic types of graduate training programs; however, given the substantial variability across programs, he concluded that the absence of training

guidelines made it "far too easy for a student to 'pick up' brief, superficial training (e.g., attend a few workshops or take a semester or two of child work) and then join the specialty ranks" (p. 20).

In an effort to align training with the needs of practice, the Hilton Head conference was held in 1985. This conference yielded a set of proposals for training child clinicians at the graduate school, internship, and postgraduate levels (Drotar, 1985; Finch & Robbins, 1985; LaGreca, 1985). There appeared to be consensus that competence in clinical child psychology required a strong foundation in developmental processes; broad supervised clinical experiences with diverse populations of children who vary in age, gender, type of disorder, and ethnic background; familiarity with multiple methods of assessment and intervention; an awareness of the unique ethical and legal issues related to serving children and their families; and an understanding of the systems that form the social-developmental contexts of children's lives.

By identifying broad areas of competence in clinical child psychology, the work of the Hilton Head conference represented a promising start. However, specific recommendations for training in most areas were not elaborated. The proposals for child therapy training were no exception. Specific questions concerning who, what, how, and when to train child therapists were not addressed. These questions have become increasingly urgent in light of recent evidence for the limited effectiveness of child therapy as delivered in naturalistic settings (Weisz & Weiss, 1989).

How, then, is one to arrive at a set of specific guidelines for training child therapists? Although consensus among experts represents one approach to the problem, it seems important to consider the empirical foundation on which such a consensus might be based. Thus, our purpose was to review existing research that might be used to anchor a set of guidelines for training child therapists. Although the paucity of research on child therapist training is likely to make this effort premature, such an attempt should uncover the gaps in our current knowledge. In essence, our aim was twofold: first, to review what is currently known and ought to be applied to training child therapists, and second, to explicate what is not known but would be useful to know for establishing training guidelines.

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The Who, What, How, and When of Child Therapy Training

Who Should Be Child Therapists?

Our experience has suggested that clinical training does not begin with the application of a well-designed curriculum, but with the selection of suitable trainees. The question of *who* makes the most suitable therapists has been debated for some time (Holt & Luborsky, 1958; Lambert, Shapiro, & Bergin, 1986; Luborsky, Singer, & Luborsky, 1975). Over the last two decades comparative outcome studies, with their emphasis on between-groups designs, have tended to equate therapist differences with differences in theoretical orientation. The prevailing assumption in this line of research has been that differences in what therapists do (technique) are more important than who the therapists are (therapist characteristics). This view has not always been so dominant. For example, Rogers (1951), whose clinical theory evolved from his early experience treating children and parents, emphasized the importance of a set of deeply ingrained therapist attitudes for effective therapy. According to Rogers, these attitudes could not be replaced by well-developed technical skills.

Results from a number of recent large-scale studies of adult psychotherapy have revived interest in therapist characteristics (Lambert, 1989). For example, in reanalyzing the results of four major psychotherapy projects, Crits-Christoph et al. (1990) found that the amount of outcome variance that could be attributed to the individual therapist was substantial, in fact, greater than that accounted for by theoretical orientation. "Therapist effects" undoubtedly encompass a variety of processes, including characteristics specific to therapy (e.g., level of competence or level of experience) and those that are nonspecific to therapy (e.g., capacity for relationship or emotional well-being; Beutler, Crago, & Arizmendi, 1986). As Lambert (1989) has concluded, "There is empirical support for the notion that the individual therapist can have a substantial effect on process and outcome, one that often exceeds that attributable to technique and one that justifies thoughtfulness and care in making referrals" (p. 480). Evidence for "therapist effects" may also carry implications for trainee selection, particularly if the characteristics implicated by research appear to be nonspecific to therapy and possibly more difficult to modify through therapy training.

Perhaps the most compelling evidence for therapist effects in child treatment comes from the "Supershrink" study conducted by Ricks (1974). Ricks examined the adult status of 28 severely disturbed boys who had been treated by one of two "comparably" experienced therapists in a major child guidance clinic. Although the caseloads of the two therapists were quite similar, the outcomes were significantly different. Fifty-five percent of the boys were judged to be schizophrenic as adults; however, only 27% of Supershrink's cases had such an outcome, compared with 84% for the other therapist. Although the therapists shared the same theoretical orientation, an analysis of process revealed substantial differences in therapeutic style, delivery, and manner. Some of these differences could be readily addressed through training. For example, compared with the other therapist, Supershrink worked more directly with the boys' parents. Other differences appeared to reflect

nonspecific characteristics of the therapists that might be difficult to modify through training. For example, Lambert (1989) observed that the less effective therapist appeared to be frightened by the boys' psychopathology and easily caught up in their depression despite the fact that the two therapists were equally experienced. Although the study does not allow us to determine the relative contribution of different therapist variables to outcome, it does suggest that both technical and nontechnical characteristics of therapists may play a role in differential outcome. Recently, Poal and Weisz (1989) found that a nontechnical characteristic, the number of childhood behavior problems reported by child therapists, was related to the magnitude of change in child clients' externalizing problems.

Unfortunately, research in the area of child psychotherapy remains a long way from providing us with empirically derived selection criteria for therapist training. In fact, the only therapist characteristic that has received more than passing attention has been level of therapist training. This research has not yielded consistent main effects for treatment outcome across professionals, paraprofessionals, and graduate students. However, level of training has been shown to interact with both child age and problem type, thus suggesting that training may enhance effectiveness with older and overcontrolled children (Weisz, Weiss, Alicke, & Klotz, 1987). Although the absence of a main effect for level of training might be seen as an indictment of current child therapy training, it should be noted that treatments delivered by graduate students and paraprofessionals frequently have been conducted under the close supervision of professionals.

In summary, given the paucity of research on child therapist characteristics, it seems fair to say that we know precious little about the characteristics of therapists that are associated with effective child treatment. In the absence of systematic research, it is tempting to consider characteristics of other caregivers (e.g., parents) that have been shown to be associated with "successful" child development. It remains to be seen whether therapist effects are as substantial in child treatment as they are in adult therapy, whether such effects are equally evident across various types of child treatment, and whether therapist characteristics associated with effectiveness can be acquired through training. However, the identification of personal or interpersonal characteristics that are consistently related to the effectiveness of child therapy could entail important implications for the selection of training candidates and possibly for reconceptualizing child therapy training as involving both skill acquisition and personal development.

What Should Child Therapy Training Include?

Since 1983, five conferences and task forces have promulgated guidelines and recommendations for training in clinical child psychology (Tuma, 1990). These efforts have consistently identified a number of broad, generic competencies such as child psychopathology, child assessment, and developmental theory as essential ingredients of training (Pion & Sechrest, 1990). In the area of child therapy, training guidelines have been equally global. The principal recommendation to emerge during the last decade has emphasized *breadth* and *diversity* in child therapy training. For example, one of the most explicit

sets of recommendations, the "Guidelines for Clinical Child Psychology Internship Training" (Elbert, Abidin, Finch, Sigman, & Walker, 1988), called for internships to provide "as diversified a training experience as is possible" in child treatment and intervention. Diversity was conceptualized along several dimensions including patients' developmental level, type and severity of presenting problems, ethnic origins and socioeconomic status, intervention setting, methods and modalities of treatment, and methods of supervision (Elbert et al., 1988).

The emphasis on diversity in child therapy training can be viewed as a tacit rejection of the "uniformity myths" of psychotherapy (Kiesler, 1966). Child therapy is far from a unitary process (Shirk, 1988b), and the children who receive such treatments are far from homogeneous (Kendall, Lerner, & Craighead, 1984). Kendall (1984) has observed that clinicians who view children, even children with the same diagnosis, as essentially alike embrace the "developmental level uniformity myth" (p. 143). Thus, diversity in child therapy training is antithetical to the uniformity assumption that alternative treatments are equally effective across developmental levels, types of problems, and treatment settings. Conversely, recommendations favoring diversity could be seen as embracing Paul's (1967) well-known *matrix* formulation that effective therapy is a function of *who* delivers *what* type of treatment for *which* individual with *what* type of problem in *which* setting. Thus, recommendations for diversity in child therapy training appear to be based on the assumption that effective child therapy requires the flexible application of multiple interventions. Achenbach (1990) has explicitly proposed this view by contending that "multiple interventions are therefore needed in many cases, and the trainee must be prepared to use a greater variety of techniques than when treating only adults, who often seek a practitioner specializing in one treatment approach" (p. 81).

It should be noted that the matrix approach to child therapy training (i.e., training therapists to select and deliver the appropriate intervention as a function of psychopathological, developmental, demographic, and contextual factors) entails areas of competence corresponding to each dimension of the treatment matrix. For example, treatment selection based on the type and severity of psychopathology implies competence in diagnostic assessment. If one assumes that all therapies are not equally effective for all disorders, then selective intervention must follow from differential diagnosis. Traditionally, it has been assumed that research would reveal which "brand-name" therapy is most effective for what type of clinical syndrome (Beutler, 1989). Recent meta-analyses of child therapy have not revealed a clear pattern of Treatment Type \times Problem Type interactions (Casey & Berman, 1985; Weisz et al., 1987). In part, this has resulted from the application of alternative treatments to different types of problems. For example, Casey and Berman found that behavior therapies tended to produce large treatment effects for impulsivity/hyperactivity, phobias, and somatic complaints, but the scarcity of nonbehavioral treatment studies for these conditions made a direct comparison impossible. Only for problems of social adjustment, a category of considerable heterogeneity, were both major types of intervention frequently used. Here the effects produced by nonbehavioral approaches were slightly, but not significantly, larger than those produced by behavioral treatments (Casey & Berman, 1985).

Thus, for many diagnostic groups, the selection of treatments based on differential effectiveness awaits further empirical support.

Others have been less optimistic about the usefulness of current diagnostic systems for guiding psychosocial interventions (Beutler, 1989; Perry, 1987; Strayhorn, 1988). For example, Beutler has argued that the descriptive dimensions embedded in the current diagnostic system provide little direction for the selection of psychosocial treatments. Similarly, Strayhorn has pointed out that a diagnosis such as childhood depression (dysthymia) can be applied to children with diverse underlying problems such as parental unavailability or peer rejection. In such cases the diagnosis does not provide an adequate framework for intervention. Instead, the target for and method of treatment follow from a formulation of the factors contributing to the child's depression. Given these criticisms of the existing diagnostic system, not to mention other developmental considerations, competence in child diagnosis cannot be equated with familiarity with current diagnostic codes. With respect to child therapy training, child clinicians should be taught to select treatments on the basis of a diagnostic process that is not limited to a description of symptoms but includes consideration of etiological and dispositional characteristics (Beutler, 1989).

A second area of competence implied by the matrix approach to training is developmental theory. Although a firm grounding in developmental theory has been regarded as essential for distinguishing normality from psychopathology in children (Cicchetti, 1984; Russ, 1990; Wenar, 1982), knowledge of developmental processes is also critical for the selection, design, and implementation of effective interventions. As Kendall et al. (1984) have maintained, "When treatments are designed for 'children,' too many developmental stages are ignored, and the resulting therapy is less than optimally prescriptive" (p. 74). Similarly, Shirk (1988b) has contended that processes of child psychotherapy are embedded in, and at times constrained by, the course of development. For example, Shirk (1988a) has conducted a developmental analysis of interpretations in insight-oriented child therapy. This work shows that the causal structure implicit in many interpretations is far more complex than the causal reasoning of most "normal" young children, let alone disturbed children. Similarly, Kendall and Wilcox (1980) have shown that forms of self-instructional training interact with developmental level to produce differential treatment effects. These findings suggest that child therapists should be trained to conduct developmental task analyses of psychosocial interventions to maximize the likelihood that treatment processes are compatible with the child's level of development.

A third area of competence implied by the matrix approach is cultural sensitivity. Cultural sensitivity refers to the child clinician's ability to balance a consideration of universal norms, specific group norms, and individual norms for implementing appropriate interventions (Lopez et al., 1989). Previous guidelines for training have emphasized the importance of clinical experience with children from diverse ethnic and socioeconomic backgrounds. In fact, epidemiological data reveal that children who are poor, Black, or Spanish-speaking and are living in urban environments evidence mental health problems at a higher rate than the national average (Office of Technology

Assessment, 1986). These populations are both at risk and underserved (Kazdin, 1990).

Although there have been a growing number of clinical studies of the treatment of minority children (cf. Juarez, 1985; Paster, 1985), research on child therapists' racial, cultural, and class attitudes is sorely missing. As a comparison, research on adult psychotherapy has revealed a relationship between therapists' cultural sensitivity and effectiveness with low socioeconomic, minority patients (Terestman, Miller, & Weber, 1974) and a negative relationship between therapists' ethnocentric attitudes and treatment duration with Black patients (Yamamoto, James, Bloombaum, & Hattem, 1967). These results are consistent with the view that the therapist's interpretation of the client's cultural experience has an important bearing on the ambience that is necessary for facilitating therapeutic collaboration (Juarez, 1985).

A number of investigators have reported on the development and implementation of culturally sensitive interventions for minority children and families (Costantino, Malgady, & Rogler, 1986; Szapocznik, Scopetta, & King, 1978). For example, Costantino et al. developed a time-limited treatment for young Puerto Rican children and their mothers that used folktales or *cuentos* as the therapeutic medium. Among the findings in this study, results indicated that the culturally derived treatment significantly reduced children's trait anxiety relative to traditional play therapy and no intervention. These results are promising and suggest that well-designed treatments that take cultural factors into consideration can be effective with populations that might not benefit from traditional therapeutic methods. Hopefully, child therapists who have been trained to be sensitive to cultural and class issues will be in a position to depart from "tradition" when necessary.

A related area of competence might be termed *contextual sensitivity*. Class and cultural factors clearly represent one type of *context* for treatment. However, child therapy is typically embedded in a number of intersecting contexts including the specific treatment setting (e.g., pediatric ward vs. child guidance clinic), the child's family, and other systems that have an important impact on the child's development (e.g., the child's school). Each of these contexts can have an important bearing on the conduct of child treatment. For example, treatment in the context of a short-term pediatric hospitalization must be time-limited; the absence of an alliance with the child's parents can affect the child's own treatment process; and the lack of communication between therapist and teachers can result in systems working at cross-purposes. In brief, child therapy does not occur in a vacuum, and child therapists must be prepared to function as consultants, mediators, and advocates.

Of particular importance is the family context. The growing body of empirical evidence showing relationships between child psychopathology and aspects of family functioning (cf. Downey & Coyne, 1990; Jacobs, 1987; Patterson, 1982) represents a serious challenge to child therapies that focus exclusively on the child as the locus of intervention. Although research has not yielded unambiguous results regarding the relative effectiveness of child-focused versus integrated child and family treatments (Casey & Berman, 1985; Hazelrigg, Cooper, & Borduin, 1987), an emerging series of family therapy outcome studies suggest that the treatment of the family context is a promising

method for intervening in childhood emotional and behavioral problems (Hazelrigg et al., 1987). Thus, the ability to understand problems in their social context, particularly their family context, is critical to the selection and delivery of effective treatment strategies.

A final, but essential, area of competence implied by this approach to training is research competence. Training therapists to select and deliver interventions as a function of psychopathological, developmental, demographic, and contextual factors stands in sharp contrast to a training model based on allegiance to a particular therapeutic orientation. According to this approach, the selection of treatment strategies is based on their potential for effecting change, not on loyalty to a treatment method. This approach assumes that clinicians will have the capacity to evaluate the effectiveness of alternative treatments, or minimally will be able to use research to inform treatment practices. The foundation for this approach to clinical work is an *empirical attitude* toward the process and outcome of psychotherapy. We believe that the cultivation of such an attitude depends on training that integrates clinical and research perspectives, including substantial involvement in ongoing research during training. This position appears to be consistent with recommendations that call for research experience at both the graduate school and internship levels of training (Cicchetti & Toth, in press; Elbert et al., 1988; LaGreca, 1985).

Training therapists to selectively deliver treatments as a function of a matrix of factors implies a working knowledge of multiple treatment methods. This does not mean that the competent child therapist will be capable of delivering all forms of treatment. However, familiarity with alternative treatments and their differential utility is critical for treatment planning, which may involve referral to the appropriate therapist. The impossibility of attaining competence in all methods and modalities is underscored by Kazdin's (1988) identification of 230 published forms of child therapy. The question, then, is how to determine which treatments to emphasize in clinical training.

Pion and Sechrest (1990) have suggested that a critical step in this process involves collecting data on what practicing child therapists are doing and are finding useful. A number of surveys of child practitioners have revealed that behavioral, psychodynamic, and more recently, cognitive and family systems approaches receive the highest ratings of usefulness (Koocher & Pedulla, 1977; Snow & Paternite, 1986; Tuma & Pratt, 1982). Client-centered, gestalt, and existential approaches have fared less favorably in these surveys. Obviously such surveys represent only a starting point in the selection process. Evidence for effectiveness must be considered along with practitioners' ratings of utility. For example, many practitioners use a psychodynamic approach to treating children and report it to be useful. Unfortunately, this form of treatment has been chronically neglected by child therapy researchers (see Kazdin, Siegel, & Bass, 1990; Russell & Shirk, 1988). Ironically, other approaches rated by practitioners as far less useful (e.g., client-centered methods) have been overrepresented in the nonbehavioral outcome literature (see Russell & Shirk, 1988). Continued inclusion of treatment approaches in training programs requires that the observations of practitioners be supported by systematic research. Finally, a third inclusion criterion involves evidence of a treatment's *acceptability* to the consumer (Calvert & Johnston,

1990; Kazdin, 1980; Kazdin, French, & Sherick, 1981). As Kazdin et al. (1981) state, acceptability refers to judgments by clients, parents, and other nonprofessionals of whether a proposed treatment is "appropriate, fair, and reasonable for a problem or client" (p. 900). In summary, the criteria of effectiveness and acceptability represent the foundation for socially responsible training.

How Should Child Therapists Be Trained?

"Quality assurance in the preparation of mental health professionals is assumed more often than verified. The content, instructional methods, and evaluation procedures of graduate and professional training have been criticized because they lack an adequate empirical foundation" (Alberts & Edelstein, 1990, p. 497). Thus did Alberts and Edelstein summarize the findings of past reviews, nor did their own updated review offer any new encouragement.

When we examine the procedures by which neophyte therapists are trained, we again are thrown back on adult-oriented literature and again must be struck by the yawning gap between what we do know about effective training and our contrasting usual practice. Kazdin (1988) has pointed out that the way in which therapy skills are taught fosters the view that therapy is an art, an attitude that in turn discourages, indeed thwarts, empirical progress. Perhaps symptomatic of this attitude is the dearth of research on the basic clinical curriculum. Kazdin's cautionary characterization of clinical training underscores the absence of clarity about what needs to be learned in order to perform therapy well, uncertainty about designing experiences to accomplish this learning, and inattention to evaluation of student progress according to objective criteria.

Kazdin goes on to argue that this tacit acceptance of therapist quality as totally subjective and judgmental is a major influence on separating students into clinicians versus researchers, to the detriment of both enterprises. One might then want to ask whether, if adult therapy is seen as art, is child therapy seen as play, even less in need of research on its imparting?

Similarly, training itself apparently is often regarded as art (or common sense), not to be guided by the evidence—a point made, for example, in the review by Matarazzo and Patterson (1986). They also point out not only how little knowledge has been added in the past 15 years but also that the experimental literature primarily pertains to novice acquisition of basic interviewing–relationship skills, coming for the most part from counseling literature. Thus, paralleling the case in psychotherapy research, where the least research has been done on the most widely used treatment approaches, the least empirical attention has gone into the sorts of therapy supervision that are the bulk of our training efforts.

These and other reviews of training research over the past decade and more (Ford, 1979; Hess, 1980; Lambert, 1980; Lambert & Arnold, 1987; McColley & Baker, 1982; Newman, Kopta, McGovern, Howard, & McNeilly, 1988; Worthington, 1987) yield several conclusions. First, there are efficient analog training packages to develop basic novice skills, such as the microcounseling techniques of Ivey and his associates (Evans, Hearn, Uhlemann, & Ivey, 1979; Ivey & Authier, 1978), which have demonstrated effectiveness (Moreland, Ivey, & Phillips,

1973), or the instructional package for behavioral assessments developed and tested by Brown, Kratochwill, and Bergan (1982). Second, there are clinical supervision techniques that seem to be more effective or are preferred by trainees, for use with the next level of practice. These include reliance on instruction coupled with modeling (Lambert & Arnold, 1987) and on direct observation or videotape rather than trainee report or process notes, which are well known to be unreliable and incomplete (Luborsky & Spence, 1978; Muslin, Burstein, Gedo, & Sadow, 1967); congruence of supervisor and trainee orientation, which may influence client outcome as well (Steinhebel, Patterson, Cliffe, & LeGoullon, 1984); a high rate of supervisor systematic and objective didactic comments (Freeman, 1985) as opposed to a focus on trainee personal issues—a quasi-therapeutic style is the most objectionable to trainees (Rosenblatt & Mayer, 1975); and specific feedback presented as immediately as possible (Doyle, Foreman, & Wales, 1977; Payne, Winter, & Perry, 1975). A final and telling item on this list is *interest in supervision*, the supervisor characteristic most valued by trainees (Nelson, 1978).

Third, there are strong suggestions that, in academic and internship settings, supervision is low in the hierarchy of faculty activities, which may be why this last factor, *interest*, registers so strongly for trainees. Indeed, supervision skills are themselves rarely taught or later supervised or monitored or evaluated (Worthington, 1987), although some general models for training supervisors are available (e.g., Bernard, 1979, 1981, 1982). The very absence of significant quality research activity suggests that perhaps an atheoretical, mundane-chore flavor plagues therapy training. Because supervisors, as academics, are most often attracted to and rewarded for theoretically relevant research, one is not surprised that they are not drawn to instructional research nor to exerting themselves on behalf of systematic quality-assurance methods in supervision. Casual observation suggests, for example, that whereas classroom ratings may play a significant role in determining raises and promotions, regular, systematic, specific evaluations of supervisor performance are rarely made and so used, nor are training clinic directors often empowered to collect and use such data for major administrative decisions (Hannum, 1988).

Finally, there are available a group of electronic devices that can enhance the immediacy, specificity, and performance-connected nature of supervisory feedback. Again, one gains the impression that these are described with enthusiasm but used on a regular basis much more rarely. They include the bug-in-the-ear (Ward, 1960) to prompt within-session trainee changes, simultaneous recording of session and of observing supervisor's commentary on separate stereo tape tracks (Harmatz, 1975), and videotapes for joint review or stimulated recall (Kagan, 1980). Of course, cotherapy or direct observation and immediate discussion supply desirable characteristics without recourse to electronic equipment and are highly valued by trainees (Nelson, 1978).

Aside from these summary findings from recent reviews, there are other considerations to keep in mind in evaluating supervision and training practices. For example, because assessment takes up an especially large proportion of the work of child clinicians (Tuma & Pratt, 1982) and because, more importantly, the practical value of assessment must be its treat-

ment relevance, it follows that training in assessment needs to be kept inherently part of treatment skill development. Treatment utility models of assessment are being described (Hayes, Nelson, & Jarrett, 1987), which, although research-oriented, can also offer a model for the trainee's conceptualization of his or her clinical processes in a fashion that unites assessment and treatment. Furthermore, the how-to (administration and scoring) aspects of assessment procedures could be structured and organized into efficient training packages based on a competency model (Blakey, Fantuzzo, Gorsuch, & Moon, 1987; Slate & Jones, 1989). There is, for example, little programmed material for training in *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed. (*DSM-III*; American Psychiatric Association, 1980) diagnoses or structured interviews with children, such as has been produced for adult diagnosis, even though recent developments of structured diagnostic interviews offer important new *clinical* as well as research tools (Hodges, 1985; Kovacs, 1985; Puig-Antich & Chambers, 1978). Similarly, the skills of less structured interviewing of children of different ages, comparable to microcounseling for adults, also have received little research definition, much less training package development.

As others have pointed out (Kazdin, Kratochwill, & VandenBos, 1986; Lambert & Arnold, 1987; Matarazzo & Patterson, 1986), the availability of treatment manuals, as products of efforts to standardize treatments in outcome research, has the potential of revolutionizing therapy instruction and supervision. At their best, manuals are based on a considerable body of evidence for effectiveness, even though they may be developed for use in more extensive clinical trials. They delineate the defining features and techniques, technical and conceptual guidelines, decision strategies, and the like, for the given type of intervention. Rating scales of competence and adherence to treatment prescriptions, when included, provide material for supervisor focus as well as depiction of a trainee's progress over time. Excellent illustrative descriptions of supervision within this sort of manual framework have appeared as an outgrowth of the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (Dobson & Shaw, 1988; Rounsaville, Chevron, & Weissman, 1984; Rounsaville, O'Malley, Foley, & Weissman, 1988; Shaw, 1984).

Although manuals for child therapy were initially almost entirely confined to parent training for conduct disordered children (e.g., Barkley, 1987; Patterson, Reid, Jones, & Conger, 1975), they have begun to appear for a wider array of target problems and treatment modalities, for example, cognitive-behavioral programs (Camp & Bash, 1981; Kendall & Braswell, 1985), adolescent conflict with parents (Robin & Foster, 1989), and adolescent self-management (Brigham, 1988), parental child abuse (Goldstein, Keller, & Erne, 1985), numerous programs for teachers using school-based behavioral interventions (e.g., Blechman, 1985; Buckley & Walker, 1970), adolescent depression (Clarke & Lewinsohn, 1984), child anxiety (Kendall, Kane, Howard, & Siqueland, 1989), and even relationship therapy (Kazdin, Esveldt-Dawson, French, & Unis, 1987). As manuals become more popular, they are tending to be issued with less and less empirical foundation in terms of demonstrated effectiveness and conceptual context, as is true in the adult field as well. Nonetheless, they can provide a framework for supervision that entails a systematic competency-based, ongoing evalu-

ation of trainee performance (Shaw & Dobson, 1988). Used with ratings, videotapes, rapid and specific feedback, and attention to the common-factor skills of relationship building and maintenance (also systematically assessed), manual-based supervision could both derive from and feed into an empirical union of progress in psychotherapy research and training practices (Kanfer, 1990). For this to happen, more manual authors will have to provide model training videotapes not only of their treatment but of application of their rating scales for assessing competence and adherence, with solid data on their merits and instruction in their application.

For adult therapies, the prominent manuals (e.g., Klerman, Rounsaville, Chevron, Neu, & Weissman, 1984; Luborsky, 1984; Strupp & Binder, 1984) presume prior development of sound general clinical skills which, in fact, are not always present even in experienced therapists of good repute (Shaw, 1984). Manual-based instruction requires not only sophisticated trainees but very expert and experienced supervisors. As Shaw (1984) points out, a manual alone cannot do the job, and, one might guess, neither can a brief continuing education (CE) workshop, given the amount of didactic instruction and then long and intensive supervised practice required to get cognitive-behavioral therapy (CB) trainees up to criterion: "The technical acquisition of new CB interventions is rapid whereas judgment about when to apply these interventions develops slowly" (p. 179).

Just how high we must aim in manualized training is an empirical question that begs address. How innovatively or sloppily can Brand X be delivered and still have its good effect? Surely, the standard for therapist competence and adherence demanded by the originators of a therapy, when it is to be subjected to a supreme comparative test, is not the standard reasonably applied to trainees or practitioners. But strikingly, as noted earlier, when Weisz and Weiss (1989) looked at outcome for typical therapy in child clinics, the absence of significant effects undermined the confidence generated by their oft-cited earlier meta-analysis, which drew more on controlled laboratory interventions. This would strongly suggest that greater competence and adherence must be achieved than is now the usual case from our training. As Weisz and Weiss put it: "The control and precision of research therapy may be needed in clinical practice" (p. 741).

When Should Different Training Segments Occur?

What does all of this suggest to improve the economy, effectiveness, and comprehensiveness of training child therapists? For one, a self-conscious, explicit pedagogical model can guide a program's analysis of assumptions and attendant macrogoals into specific skills, attitudes, activities, and habits to be mastered by trainees (and supervisors) and, importantly, a schema for the methods, timing, and sequencing of their acquisition.

Traditionally, the clinical training sequence has been divided into three major levels: graduate school, internship, and post-graduate. In recent years, sets of guidelines corresponding to each level of training have been promulgated (Drotar, 1985; Finch & Robbins, 1985; LaGreca, 1985). However, a recurrent problem with this type of compartmentalization of the training sequence has been the integration of training objectives and

practices across levels of training (Cicchetti & Toth, in press; Wohlford, 1990). The sheer diversity of graduate school and internship programs seems to mitigate against continuity in child therapy training. Although daunting, perhaps it is time to explore general process models that could integrate training experiences across the traditional divisions.

A possible general model we propose here draws on the developmental principles of differentiation and progressive integration. We propose that coherence in training will be maximized when it is based on differentiation of therapeutic approaches in the early phase of training, then works through diversity to achieve a later individual integration of therapeutic methods. In construing a model, a number of factors dictate caution and flexibility: diversity of orientation within and between programs; the myriad roles, settings, and specializations open to child therapists; and discontinuity between graduate school, internship, and postgraduate education. What we offer here are some illustrative comments regarding phases of training.

For example, given the earlier reviews, it makes sense to start novices off with analog workshops on generic interview-relationship skills and diagnostic interviewing, along with how-to assessment drills, while they begin the daunting course curriculum that underpins clinical skills conceptually and empirically. Lambert & Arnold (1987) similarly argue for highly structured methods for efficiently maximizing acquisition of therapist interpersonal skills and attitudes.

What might then guide decisions on the next phase of practicum training? One way to achieve the conceptual integration, basic skill growth, and concrete intervention experience with novice clinicians is next to focus on one of the few well-elaborated, empirically supported minitheories of the development, maintenance, assessment, and change of a given disorder or problem in children or families. The chosen model must have adequately tested measures and a manual associated with it, but of equal importance, it must demonstrate the integration of treatment and psychopathological knowledge. Students can best test the limits of such a minitheory as they learn to operate within it with assured integrity. As the limits are encountered, the student is provoked to think inquiringly about theory, intervention techniques, needed research, complexity of pathology—the whole ball of wax as brought together in one case. For that period, trainee and supervisor would adopt the same orientation, with the advantages mentioned earlier, and innovations in training developed to enhance acquisition would be related to a particular clinical theory, hence clinically relevant and more immediately open to evaluation.

Patterson's (1982, 1986) models of aggressive/antisocial behavior in boys is a prime example of candidates for this approach because of its comprehensive but focused consideration of family system and parental factors, school factors, and child variables, integrated into one explanatory minitheory that indicates where to try to intervene and how to measure results, how to test the adequacy of the model. One particular advantage presumably available to other minitheories is again exemplified by Patterson's work. He and his colleagues (Patterson & Chamberlain, 1988) have begun to be able to identify, inductively, the concrete things a trainee (or expert) does that impede or enhance progress by the parents being trained. This is in striking contrast to the way in which supervisors typically stress tech-

niques that are deductively derived from notions of *good therapy*. Analysis of detailed coding of transactions in therapy sessions of both successful and failure cases has allowed the Patterson group to link outcome to the frequency of episodes of client noncooperation or *within-session struggle*—operationalized, behaviorally defined episodes of what generically is usually given the trait label of *resistance*. They have found significant predictors of the frequency with which these “struggles” occur as well as influences on their occurrence. Importantly, these influences include particular therapist behaviors. In turn, the data indicate how the frequency of struggles affects therapist liking of the clients and subsequent therapist behaviors that affect risk of letting the case fail or drop out. By pinpointing those therapist actions or skills required to teach the parents enough to produce change, while managing the struggles and countering the therapist's own reactions to them, the model contains clear guidance for what to train and how to monitor improvement in the novice's development. The skills are learnable, as demonstrated by the lower frequency of struggles in sessions conducted by more experienced therapists and by the observability of their behavioral constituents. And, importantly, requisite therapist skills are inherently a part of understanding important aspects of the total theoretical model of the family's and child's psychopathology. It is just such a conceptual-empirical integration that makes the use of focused training within a given minimodel so attractive.

In view of the renewed interest in psychotherapy process studies, other minitheories may also soon offer better guides for what to do and how to do it. In the meantime, an early sequential focus on one and then another of the best available minimodels would allow the trainee to think in a systematic way about the influence of his or her own interventions, within a given conceptualization, and about how to test for those effects, and to question how broadly across models these lessons can be generalized.

The implications of such an approach for training clinics would be difficult to handle, in settings already plagued with special problems (Hannum, 1988), especially given the complexity of usual referrals from which suitable minimodel cases would have to be selected. In fact, to the degree that the balance between clinical training and clinical service tips in the direction of service delivery, the application of this approach could be problematic. However, it may be possible to structure training clinics in graduate programs, as well as subspecialty tracks in internships (e.g., behavioral medicine rotations or attention deficit clinics), in ways that permit relatively homogeneous case selection. Within these programs, therapy training could be geared toward teaching the developing therapist to operate within the conceptual and empirical structure of a systematic model. Such an organization would also lend itself to the conduct of child psychotherapy research.

Advanced clinical training, then, would involve exposure to the diversity and complexity of typical clinical referrals. Indeed, it is handling all the comorbidities, family, school, and peer dysfunctions, and all the rest that a typical child case can entail, that would be one of the major objectives of internship training. Having learned to operate within the conceptual and empirical structure of a systematic model, the trainee is ready to use those skills in the more pragmatic arena of piecing to-

gether less developed models to tackle more multifaceted cases. The advanced trainee is confronted with diagnostic confusions, is drawn into broader community systems, is challenged with more severe pathology, and becomes familiar with diverse ages, problems, and therapeutic approaches. For many child and family problems, no manual exists, but increasingly there are available excellent reviews of relevant basic and applied research, directed specifically to child clinicians, such as the B. B. Lahey and A. E. Kazdin's volumes on *Advances in Clinical Child Psychology* from Plenum Press; the journal *Clinical Psychology Review*; the Psychology Practitioner Guidebooks published by Pergamon Press; and Sage's Developmental Clinical Psychology and Psychiatry Series, edited by A. E. Kazdin. Furthermore, one might hope that the sort of "guidebooks" becoming available for adults will be developed for children; these offer clear process goals and steps, within a *general* orientation, that can guide treatment strategies and techniques through the hypothesized stages of a course of treatment (e.g., Kanfer & Schefft, 1988). This third level of training, extended over time and across settings, should naturally culminate in a process of integration, in keeping with the current trend.

For the mature clinician, the difficulties paradoxically seem greater. Continued development can be stimulated through reading and through the myriad workshops and brief courses now available. The oft-reported avoidance by clinicians of research reports and new models and techniques derived therefrom may (one hopes) be waning, witness the spread of more recent approaches among clinicians, most of whom claim *eclectic* as their orientation. However, it is uncertain what level of competence short courses or workshops do or could produce. Does reading a manual, taking a 40-hr course or a weekend workshop, and trial-and-error practice produce a reasonably effective cognitive therapist? And how much does it matter, with respect to client benefit? Work we have reviewed suggests that competence does matter and that it takes a good deal of supervision to achieve it, even with experienced clinicians. What can be and is being achieved by various strategies and durations of CE is an area begging for study.

Conclusion

The organizing assumption of this article has been that guidelines for child therapy training must ultimately be anchored to an empirical foundation. In essence, we have advocated a science-based approach to child therapy training. Our review has revealed substantial gaps in our current knowledge about who, what, how, and when to train child therapists, but some promising leads as well. Thus, given the fledgling state of our current empirical knowledge, at this time, consensus among experts may represent the best available strategy for establishing training guidelines. However, by no means does a working consensus justify the continued neglect of research on child psychotherapy and its training.

A science-based approach to child therapy training entails a process of *instrumental* research use (Rich, 1977; i.e., an awareness, consideration, and implementation of research data by training faculty). Previous surveys of practitioners have revealed low levels of instrumental research use. As summarized by Morrow-Bradley and Elliot (1986), "The typical practicing

psychotherapist does not do research, publishes little or nothing, is unwilling to participate in research, and has a more generally negative attitude toward research and research training than have academic colleagues" (p. 188). Surveys with child clinicians have shown that research books and articles are rated the lowest in terms of their usefulness to service delivery (Cohen, Sargent, & Sechrest, 1986). A comparable study of training directors has not been conducted; therefore the degree to which child therapy research guides training remains unclear. However, if we expect practicing clinicians to use research in making treatment decisions, child therapy training must make explicit use of existing data (Kanfer, 1990).

Given the gaps in our current knowledge about child therapy training, perhaps it is unfair to expect substantial instrumental research use. Inconclusive findings in the psychotherapy literature mitigate against widespread use of research by practitioners (Parloff, 1977). At this time, it may be more realistic to press for *conceptual* research use in child therapy training. Conceptual research use refers to the gradual, indirect effects of research on the decision-maker's conceptualization of issues and awareness of alternatives (Cohen et al., 1986). In effect, turning to existing research to answer questions about who, what, how, and when to train child therapists represents a start in this practice.

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Received December 5, 1990
 Revision received May 6, 1991
 Accepted May 7, 1991 ■

Correction to Iberg

In the article "Applying Statistical Control Theory to Bring Together Clinical Supervision and Psychotherapy Research," by James R. Iberg (*Journal of Consulting and Clinical Psychology*, 1991, Vol. 59, No. 4, pp. 575-586), one of the variables in Table 5 on p. 581 was labeled incorrectly. "Student D level" should read "Student E level."
